PERCEPTIONS OF HEALTH-RELATED QUALITY OF LIFE (HRQOL) EXPERIENCED BY OLDER ETHNIC SOMALIS AGING TRANSCULTURALLY IN THE U.S.: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

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CHAPTER 1

The United States (U.S.) has a protracted history of protecting and assisting persons facing persecution and fleeing violence or conflict. After World War II, the U.S. welcomed over 250,000 war displaced Europeans unable to return to their homes and the first refugee legislation introduced by Congress, the Displaced Persons Act of 1948, was enacted. During the Cold War era, the U.S. resettled refugees fleeing Communist regimes from Southeast Asia, the former Soviet Union, Cuba, Hungary, Poland, Yugoslavia, Korea, and China. In 1975, following the Vietnam War and marking the beginning of the Khmer Rouge genocide in Cambodia, the U.S. resettled hundreds of thousands of refugees from Southeast Asia (Refugee Council USA, 2017). Following this influx, Congress passed the Refugee Act of 1980; the act standardized the definition of "refugee" and led to the creation of the Federal Refugee Resettlement Program and the current national vetting and admission of refugees into the U.S. (Krogstad & Radford, 2017).

Approximately 3 million refugees have been resettled in the United States since Congress passed the Refugee Act of 1980. Historically, the number of refugee admissions to the U.S. has fluctuated in response to global events and U.S. priorities. During the period between 1990 and 1995, approximately 112,000 refugees arrived annually with many originating from the former Soviet Union. This number dropped off dramatically after the terrorist attacks in 2001to around 27,000 in 2002 (Krogstad & Radford, 2017). However, an upsurge in admissions began trending in 2004 with the arrival of Somali refugees (Igielnik & Krogstad, 2017), and the fiscal year of 2016 brought in 84,995 refugees (Krogstad & Radford, 2017). Under a new federal government administration and short-term suspension of immigration allowances, the United States

Department of State (DOS) released refugee admission numbers for fiscal year 2017, recording a total of 53,716 individuals. Over 25,000 refugees were admitted in the first quarter of FY 2017, over 13,000 in the second quarter, and over 10,000 in the third quarter. Compared to the same quarters in FY 2016, first-quarter arrivals reflected an 86% increase, second-quarter arrivals a 12% decrease, and third-quarter arrivals a 51% decrease (United States Department of Homeland Security [DHS], 2018). The fourth-quarter figure for 2016 admissions was seven times greater than 2017's fourth-quarter total (DOS, 2017). More recently released figures recorded approximately 16,000 admitted refugees in the first three quarters of FY 2018. This is a 67% decrease from the same period in 2017 (DHS, 2019a).

The State Department Bureau of Population, Refugees, and Migration's Refugee Processing Center released a demographic profile of Somali refugee arrivals in the United States between October 1, 2000 and September 30, 2016. During this period, 97,447 Somalis were admitted predominately to the resettlement states of Minnesota, Texas, Ohio, New York, and Arizona. Most are Muslim (99.7%) and under 31 years of age (77.4%) with little education (91% with primary or less). An additional 6,588 Somalis have been resettled during the calendar years of 2017-2019 and share a similar profile (DOS, 2019; Refugee Processing Center [RPC], 2019).

The most recent report by the United Nations High Commissioner for Refugees (UNHCR), 2021, estimates that there are 80 million forcibly displaced persons worldwide; over 26 million of these individuals are refugees, the highest level ever recorded. The 1951 Refugee Convention and its 1967 Protocol define a refugee as someone 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 nationality, and is unable to or, owing to such fear, is

> unwilling to avail himself of the protection of that country. (Cultural Orientation Resource Center, 2017)

The Refugee Council USA, 2017, explains that once refugees cross a border to seek safety, there are three 'traditional durable solutions': 1) integration into their country of asylum; 2) returning to their home country; or 3) resettling to a third country. Globally, in 2019, 107,800 refugees were reported resettled (UNHCR, 2020) which is down from 189,300 resettled refugees in 2017 (UNHCR, 2018). Less than 1% of the world's refugees are resettled; resettlement is reserved for the most vulnerable persons who cannot remain where they are or return to their home country (Refugee Council USA, 2017). Resettlement is often distant from home, which means leaving not only one's native culture, but its wider sphere of influence by moving from non-European to European-based cultures and from least developed countries to highly developed countries (Paludan, 1974; Stein, 1986).

Background

Somalia. In an annual ranking from 1980 to 2018, Somalia has been among the top 20 countries of refugee origin 31 times and it has been ranked as number 2-5 each consecutive year between 2002 and 2018 (UNHCR, 2019). The number of Somali refugees worldwide at the end of fiscal year 2016 was 1,012,323 (UNHCR, 2017) and by the end of 2018 had decreased to 949,700 in part due to returns from Yemen and Kenya (UNHCR, 2019). In 2017, Somali refugees represented the fourth largest group admitted to the U.S. preceded by those from the Democratic Republic of Congo, Syria, and Iraq (DHS, 2019b). In addition to being part of the largest numbers of refugees in the U.S., ethnic Somali refugees were also included in the count of 39,000 Muslim refugees that came to the U.S. in 2016. Muslims made up 46% of refugees admitted in 2016, a percentage higher than that of Christians (44%). This was the first time since

2006, when a large number of Somali refugees were admitted, that Muslim refugee numbers exceeded their Christian counterparts' (Krogstad & Radford, 2017).

Somalia, located in eastern Africa, makes up the peak of the Horn of Africa. It is slightly smaller than the U.S. state of Texas. Before the collapse of its central government in 1991, its population was estimated at 7.7 million. Somalis embody the largest ethnic group in Africa (Spitzer, 2007). According to the Central Intelligence Agency (CIA, 2019), 55% of Somalia's population is rural with 71% of its inhabitants being pastoralists, agriculturalists, and agropastoralists. The majority are ethnic Somalis and speak dialects of Somali and practice the Islam religion. Although Somalis are divided into numerous clans, Somalia is one of the most ethnically and culturally homogenous countries in Africa (Abdullahi, 2001).

Family is central to security and identity and Somalis typically live within nuclear families. Somali culture is male centered; however, women contribute in important ways through economic roles and have more freedom to pursue an education, employment, and travel than most other Muslim women. Somali values align with American values in many ways. Somalis have a strong belief in independence, democracy, egalitarianism, individualism, and generosity (Lewis, 2008; Putman & Noor, 1993).

Somalis willfully came to the U.S. as immigrants in the 1920s and settled in the New York area. Somalia and the U.S. established diplomatic relations in 1960. During that decade, students arrived in the U.S. to attend higher education institutions, primarily on scholarships (Putman & Noor, 1993). A 1969 coup replaced the Somali government with military rule and following war with Ethiopia in the 1970s, Somalia looked to the West for aid and support. Civil War erupted in the 1980s, which led to the implosion of Somalia's central government in 1991 and the country's descent into anarchy (U.S. Department of State [DOS], 2016). Small numbers

of refugees were admitted to the U.S in the mid-1980s and these numbers steadily increased throughout the 1990s. In 1991, the U.S. admitted 192 Somali refugees. Over the next six years, nearly 22,000 were admitted (DHS, 1997; Putman & Noor, 1993).

A transitional government was established in Somalia in 2004, and in 2012 it elected a new president, adopted a temporary constitution, and named a new prime minister and cabinet. In 2013, the U.S. acknowledged the new government and in 2015, the Somali embassy re-opened in Washington D.C. The U.S. has been committed to help Somalia strengthen democratic foundations, improve security and stability, and assist the Somali people (DOS, 2016).

Conflict continues in central and southern regions of Somalia among government forces, African Union Mission in Somalia (AMISOM) peacekeepers, and the militant group al-Shabaab. Although government forces and peacekeepers have maintained control of areas in these and other regions, al-Shabaab still controls many rural areas, and amid clashes, more than 50,000 civilians have been killed, injured, or displaced. According to Amnesty International (2017), human rights and international humanitarian laws have been violated by all armed groups involved in the conflict. Reported violations include drafting children as soldiers and abducting, raping, torturing, and killing civilians. At the time of the mentioned Amnesty International report, approximately 4.7 million needed humanitarian assistance, but the conflict hindered aid agencies' access to certain areas.

Purpose and Aims

The purpose of this Interpretative Phenomenological Analysis (IPA) study is to examine how older resettled ethnic Somalis perceive and make meaning related to their health-related quality of life (HRQoL) as they age transculturally in a midwestern region of the U.S. The end goal is to inform refugee focused service providers, program developers, and policy makers

about unmet needs regarding adequate and culturally appropriate support services/resources as perceived by participants and pertaining to their HRQoL, and how to best serve older adult ethnic Somalis to optimize HRQoL throughout the latter years.

Through individual interviews, the primary aim is to not only capture the meaning individuals attach to their perceived HRQoL, but to identify convergent and divergent experiences, meanings, and perceptions across individuals amid the shared phenomenon of aging in a context different from their country of origin. Participants' voices can be used to further interpret the sense-making of this phenomenon in relation to HRQoL and to better understand what factors/resources impact their perception of HRQoL.

Significance

In a technical guidance document prepared by WHO for European Union nations (WHO, 2018), priorities include renewed focus on the "range of individual, social, and structural factors" (p. 24) that impact aging refugees and migrants specifically and are distinct from those experienced by those aging in their countries of origin. Additionally, recent international priorities for WHO (2019) include managing mental health in refugees and migrants, especially in "risk groups" (p. 8) that include older adults. Clearly, to date, there is an unmet need for additional research to explore perceptions of HRQoL experienced by individuals aging in an alternative context in order to ensure provision of adequate, culturally and linguistically appropriate support and health services including mental health care. This study will contribute to this need as well as to the sparse body of extant research focused on older adult Somalis living in the U.S. It will also fill an identified gap in research using Interpretative Phenomenological Analysis (IPA) to explore the meaning older Somalis in the U.S. attach to HRQoL.

The remainder of this document is organized as follows: in Chapter 2 I review literature relevant to the experiences of older resettled refugees in general, as well as older Somali refugees, and introduce the concept of HRQoL; in Chapter 3 I detail the study's design and analysis as guided by Interpretative Phenomenology Analysis and the framework of the World Health Organization's quality of life model; in Chapter 4 I present a narrative and interpretative account of the findings; and in Chapter 5 I further discuss the findings, including the alignment with an established theory, implications, and recommendations for future research.

CHAPTER 2

LITERATURE REVIEW

Older Refugees in the U.S. and Older Resettled Somali Refugees

> A seminal report by the Refugee Policy Group [RPG] (1988) begins with the statement: Of all the persons affected by the rigors of involuntary displacement, it is perhaps the elderly refugee who suffers the greatest hardship. Torn from familiar surroundings and lifestyles and thrust into uncertain circumstances at a time of life when continuity and habit are especially prized, the aged refugee endures a particularly intense sense of desolation and encounters special difficulties in adapting to the hardships of resettlement. (p.1)

Older adult refugees represent a small, but very vulnerable sector of the U.S. refugee population. Their needs often go unnoticed as they remain isolated in their own communities and from the agencies established to serve them (Special Committee on Aging, 2007). The Department of Homeland Security's annual flow report (2019c) documented U.S. refugee arrivals from fiscal year 2016 to 2018. This report characterized arrivals by age groups and showed the contrast between younger and older refugee admittances. In 2018, the U.S. admitted 13,187 (58.9%) refugees ages 0-24 years, 781 (3.5%) refugees ages 55-64 years, and 591 (2.6%) refugees ages 65 years and older. Refugee admissions have, in part, facilitated the growth of the U.S. immigrant population ages 65 and older (Leach, 2009; Population Reference Bureau [PRB], 2013). One projection estimates that this older population of U.S. immigrants will quadruple to over 16 million by 2050 (Leach, 2009; PRB, 2013; Treas & Batalova, 2007).

The definition of aging and "old age" is dependent upon history and culture. Old age may be a privilege or lead to social exclusion; it can be understood and experienced as a regression or a progression (Lagacé et al., 2012). Old age may be marked in either functional terms or formal terms. In functional terms, one is considered elderly when the body loses the strength or mobility to perform certain activities. Within societal debates, the U.S. largely defines old age in formal rather than functional terms. This means that it is determined by an external symbolic event, such as turning 65 years of age (RPG, 1988). Somalis believe it is important to keep the mind and body active, so they will work until they are physically incapable (Mooney & Shepodd, 2009).

Many of the challenges encountered by older refugees are similar to those faced by all refugees, as a result of the traumatic forced flight from their homeland. Some challenges are shared with older immigrants also aging in a foreign culture, and still others are shared with older Americans around the common process of growing old. However, according to the RPG (1988) report, the plight of the older adult refugee is unique, and their challenges are more acute than other older adult populations. The report states the primary distinction between older refugees and older American born persons, or older immigrants that came to the United States at a young age, is that refugees have not had the opportunity to acquire or develop culturally appropriate coping skills that are fostered during the process of socialization. In addition, older adult refugees are not always aware of or have access to services that are intended to support them.

The Refugee Policy (1988) is one of the most comprehensive reports to date that address older refugees' resettlement challenges. Through this work, multiple areas have been identified as being especially difficult for resettled older refugees. Some of these are: financial insecurity; language acquisition; health care; transportation; intergenerational relations; community; and

death and dying. Studies by Lagacé et al. (2012) and Shirazi and Caynan (2016) with older Somalis resettled in Canada and older Somali refugee women in the U.S. respectively, highlight some of the same difficulties.

In exile, refugees have lost the financial security they might have built in their homeland. Although the primary objective for refugee resettlement agencies is assisting refugees in becoming economically self-sufficient, older refugees are often considered unemployable and are not given priority in employment related services. Those who do secure employment are not in the workforce long enough to build sufficient savings, pension, or social security benefits to ensure a comfortable retirement (RPG, 1988). Somali men particularly identified with an inability to earn an income. This was mostly associated with declining health and was considered a loss of social status (Lagacé et al., 2012).

Many challenges faced by older adult refugees originate from and are exacerbated by their limited English language proficiency. Their inability to communicate in English inhibits accessing and understanding the American health care system, learning about their civil rights, navigating public transportation, etc. It essentially prohibits them from fully functioning within an English language dominant society and isolation becomes a concern. (Chenoweth & Burdick, 2001; RPG, 1988). Isolation due to lack of language proficiency is reconfirmed by older Somali women in Canada. Participants identified language barrier as the primary reason for not interacting with Canadian born elders and integrating into their new society (Lagacé et al., 2012).

Aging is naturally accompanied by an increased risk of problems around physical and mental health. Older adult refugees experience similar ailments as American born aging citizens but seem to present with minor physical symptoms more frequently and more acutely than their American born counterparts. They also present with unique symptoms stemming from traumatic

events, such as torture or rape; acculturative stress; survivor's guilt; and changes in climate, diet, and pace of life. After several years in the U.S., many older refugees begin developing health problems that are uncommon in their homeland, but prevalent among older Americans, such as hypertension and high cholesterol levels (RPG, 1988). However, without culturally and linguistically competent care, older refugees may be misdiagnosed, refuse to adhere to treatment plans, or avoid care altogether (Chenoweth & Burdick, 2001).

Depression is the most preeminent mental health illness among older adult individuals; depression, as well as feelings of loneliness, isolation, and adjustment challenges are also common among older adult refugees (Pumariega et al., 2005; World Health Organization [WHO], 2017). Posttraumatic stress disorder (PTSD) prevalence rates vary within each refugee population and has been reported to range from 4% to 86% (Bolton, 2016). According to Mollica et al. (2001), there is reason to believe that distress associated with being a refugee may be chronic in some individuals. This can be attributed to a long history of traumatic incidents, displacement, and different levels of loss. Stress is compounded by the older refugees' approach to mental health care and the American health care system. In some cultures, there is no word for "mental health" and in other cultures, mental health problems are considered shameful. Somali women in Shirazi and Caynan's (2016) study expressed their limited understanding of mental health illnesses and clinicians' lack of cultural competency as barriers to accessing mental health services.

A common challenge faced by all older adults is preserving independence (Chenoweth & Burdick, 2001). Reliable and accessible transportation is essential for older individuals to maintain an independent and social lifestyle. Older adult refugees are often dependent upon family members to provide private transportation; however, if family members are at work or

school all day, they remain confined at home. Walking may not be feasible due to safety concerns regarding crime and poor sidewalk maintenance, great distances, or health constraints (Barrow, 1983). Somali refugees in Canada attributed less walking to winter weather (Lagacé et al., 2012). Public transportation can be limited in many areas, and if available, accessibility may be impossible due to language, psychological, and physical barriers. Research shows that among older adults there is a consistent relationship between access to transportation and life satisfaction. Limited transportation leads to an increased risk of isolation, alienation, and deprivation of social and physical resources among older refugees (Chenoweth & Burdick, 2001; RPG, 1988).

Further feelings of isolation and alienation may occur as a result of intergenerational conflict. One such conflict arises when there is a discrepancy between older refugees' expectations of care and respect from their children and grandchildren and the younger generations' perception of obligatory responsibility to family elders. Intergenerational conflicts are exacerbated by the differential rate of acculturation between the two generations, in which the younger generation generally assimilates language and culture faster than their parents and grandparents. This affects traditional and social roles in which the older adults' reverence as wise teachers is undermined by American strangers and younger English-speaking members of their family and community. In many cultures, it is the elders who pass on cultural values and traditions to their children and grandchildren; however, in a new and unfamiliar culture, older adults may lose this role and be viewed as having very little to offer the younger generation who have abandoned their native language and cultural practices (RPG, 1988). Children and grandchildren often become the older adults' language and culture interpreters and the traditional roles of student-teacher are reversed as older refugees become the student (Hugman et al., 2004).

Intergenerational conflict, expressed within different surrogate terms, such as social value and status loss, has been noted as a human experience in other qualitative studies on older refugees aging in a country very different from their own (Dubus, 2010; Lewis, 2009; Shemirani & O'Connor, 2006; Tan & Ward, 2010). These experiences are also conveyed by older Somali women in the U.S. and Canada (Lagacé et al., 2012; Shirazi & Caynan, 2016).

Many older adult refugees dream of returning home. Most will never return; therefore, it becomes very important to maintain strong ties to their ethnic community, as well as establishing new relationships within their American community (RPG, 1988). A feeling of homesickness is recognized in Colomer's (2013) report, as well as in a study of older Somali refugees in Finland (Mölsä et al., 2014). There is an initial homesickness over what was lost or left behind and once it becomes evident that return is impossible, there is a mixture of psychological reactions that amplify homesickness. Refugee and immigrant identity fuses together memories, images, and performances from the homeland culture and from the host country. Older adults seek comfort and direction from their culture and have an increased interest in their "cultural history, community identity, and attachment to place" (p. 20). However, it cannot be assumed that older refugees have an attachment to place in their host countries, particularly if they encounter discrimination. Their cultural heritage and personal identity are emotionally connected to a distant place and it is with this understanding that they are entering old age in a foreign land. If an immigrant or refugee identifies with their current environment as a significant part of their community and they are emotionally attached to it, then they are less likely to feel displaced, homesick, excluded, and lonely (Colomer, 2013).

Aging in an unfamiliar culture and a distant land can also threaten the security of a "good death" (Cottrell & Duggleby, 2016). In many traditional societies, older adults succumb to death

in their own home surrounded by family, which is in stark contrast to some older refugees' perception of death in the United States. Most older refugees fear dying in a medical facility, separated from family, surrounded by medical equipment, and with restrictions that may discourage cultural rituals around death. The prospect of death can be frightening for older refugees, because it means departure without the customary ceremony and separation from ancestors in their homeland (RPG,1988).

The stressors of aging coupled with traumatic pre-and post-migration experiences and the challenges of resettlement increase the likelihood of poor health outcomes among older refugee populations (Sadarangani & Jun, 2015). The mentioned varied challenges of resettlement are presented in detail to demonstrate how such factors can have multiple, interconnected effects on physical, mental, and social functioning. These three domains of functioning make up the concept of health-related quality of life (HRQoL) (Centers for Disease Control and Prevention [CDC], 2018).

Health Related Quality of Life

Since the World Health Organization (WHO) defined health in 1948 as not only the absence of disease, but also the presence of physical, mental, and social well-being, quality of life has gradually become more significant in health care practice and research (Testa & Simonson, 1996). In the 1970s, quality of life research dramatically escalated, and the term became more prevalent in medical reports. However, without an acknowledged uniform definition of the concept of quality of life, evaluating it was problematic (Kirchengast & Haslinger, 2009). Therefore, in 1991, WHO began to develop a standardized and transcultural definition of quality of life and in 1993 defined it as:

> An individual's self-perception in the context of their culture and value systems, and their personal goals, standards, and concerns. It is a broad-ranging concept that includes negative and positive dimensions and is affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs, and their relationships to salient features of the environment. (WHOQOL Group, 1995, p. 1405)

The CDC (2018) expanded the definition to also include the community level and presents it as an individual's or group's perceived physical and mental health. Both definitions are indicative of a view that quality of life is a subjective assessment and is nested in a cultural, social, and environmental context. Since health-related quality of life (HRQoL) focuses on perceived health, it is not an objective measure of a condition or disease, but rather an evaluation of unmet needs and the impact of a disease or an intervention on quality of life. Testa and Simonson (1996) assert that while an objective measurement establishes a person's health status, one's self-perceived health is what transforms the objective measurement into actual HRQoL experienced. The CDC (2018) adds that "self-assessed health status is a stronger predictor of mortality and morbidity than many objective measures of health" (para. 6) and with advancements in medicine, as one factor, leading to longer life expectancies, health outcomes can no longer be based just on the preservation of life, but also the quality of life.

Kirchengast and Haslinger (2009) point out that old age is associated with physical changes, as well as disease and other vulnerabilities and therefore posed the question, "What does this mean for quality of life during old age?" (p. 37). Prior research has supported the notion that aging, and the process of aging reduce HRQoL among older adults in general; however, the authors list other contributing factors that impact HRQoL in older adults, such as

socioeconomic position, depression, marital status, and social relations. Nesterko et al. (2013) identified similar factors associated with HRQoL in immigrants residing in Germany, like health status, employment, education, access to health care, cultural differences, involvement in public life, and socioeconomic status. Castañeda et al. (2015) argue that immigration itself must be recognized as a social determinant of health and therefore, a factor related to HRQoL.

De Vries and Van Heck (1994) examine how refugees' experiences can impact each of the HRQoL domains. The physical health domain includes basic needs such as nutrition, clean water, sanitation, and security. Without these provisions, irreversible health effects can occur. Refugees often lack one or all these essentials at various points prior to resettlement. Other aspects of physical health, such as pain and discomfort, a diminished interest in sexual activity, and interrupted sleep can all be symptoms of trauma and posttraumatic stress disorder experienced by refugees. Inadequate sleep is an independent risk factor for common diseases, increased mortality, and impaired brain function (Eriksson-Sjöö et al., 2012). A history of psychological trauma is a contributing factor to an increased risk of hypertension, diabetes, and cardiovascular disease (Kinzie et al., 2008).

Due to extensive losses that refugees experience, grief is a central aspect of the psychological domain. Many refugees also experience a loss of dignity. Levels of education and professional positions are disregarded as individuals become identified as a fleeing homogenous group and lose control of their lives and independence. Another aspect of the psychological domain that is common among refugees is guilt or survivor's guilt which is rooted in powerlessness; the lack of power to protect and save others. Uncertainty about the future, hopelessness, worry, shame, homesickness, lack of trust, and frustration are still other aspects of the psychological domain that De Vries and Van Heck (1994) mention as common among

refugees. The social domain of quality of life refers to one's interpersonal relationships and social roles (Kuyken et al., 1994). Among refugees this domain can be affected by the destruction of social networks, the loss of family members, the restructure of familial roles and status, and the loss of community status.

Decreasing quality of life has been associated with increases in depression, symptoms of chronic disease, and degree of physical limitation (Ruo et al., 2003). Brenes (2007) found increases in anxiety and depression were associated with decreases in the physical health, social functioning, and mental health domains of HRQoL. For older Somalis in the U.S., the additional acute and chronic stressors associated with aging in general and refugee or immigrant status are likely to present additional threats to quality of life and associated mental and physical health outcomes. Little is known about the overall quality of life of Somali refugees who have resettled in the U.S. (Redko et al., 2015). Kuyken et al. (1994) remind us that the definition of quality of life and the factors that affect it vary across cultures. There is not only diversity among cultures, but within cultures and this should be acknowledged. Therefore, there is a need to recognize older adult refugees as a specific group in this study, even more specifically, older ethnic Somalis resettled in the U.S.

CHAPTER 3

RESEARCH DESIGN AND METHODS

This research was in part inspired by a qualitative pilot study I conducted with refugee service agency providers who emphasized the need for focus on older resettled refugees. The methodology for this study is guided by Smith et al. (2009) who provide a detailed and step-by-step manual to conducting an experiential qualitative study.

Interpretative Phenomenological Analysis (IPA)

In this study, I utilized the qualitative approach of Interpretative Phenomenological Analysis (IPA). IPA originated in the field of psychology and is a methodology concerned with an intimate exploration of personal experience. It is intended to examine how individuals make sense of significant life experiences and the meanings linked to these experiences (Smith et al., 2009). Dilthey (1976) (as cited in Smith et al., 2009) interprets a person's point of awareness of a lived experience as the birth of an experience rather than just experience. Smith et al. describe this distinction as a "hierarchy of experience" (p. 2) and explains that an experience is made up of separate parts and conjoined by a common meaning.

IPA is influenced by three approaches: phenomenology, hermeneutics, and idiography. Phenomenology was developed by philosopher, Edmund Husserl and is concerned with one's consciousness of something and how one perceives or makes sense of the object of that consciousness. Further developed by philosophers, Heidegger, Merleau-Ponty, and Sartre, phenomenology focuses on the understanding that the meanings individuals attach to their

experiences are unique to them related to one's worldview and relationship with others (Smith et al., 2009).

Hermeneutics is the theory of interpretation (Smith et al., 2009). Just as individuals attempt to make sense of personal experiences, researchers strive to make sense of or interpret these experiences as they are disclosed by their participants. This is referred to as double hermeneutic (Smith & Osborn, 2003). As Smith et al. acknowledge, hermeneutics is explained through the ideas of three theorists: Schleiermacher, Heidegger, and Gadamer. Within the framework of IPA, Schleiermacher's ideas suggested that interpretation requires skill, including intuition, and that the interpretative analyst can present an added perspective to the participant's understanding. According to Heidegger, the intersection of phenomenology and hermeneutics allows the examination of a phenomenon as it appears as well as what might be latently connected to it below the surface. Heidegger also suggested that interpretations are based on preconceptions; therefore, in IPA, it is important for the analyst to integrate reflexivity around biases and prior knowledge into the analysis. Gadamer added the idea that although interpretation may be influenced by a held understanding of the past, it should be more strongly influenced by the present period in which the analysis is performed (Smith et al., 2009).

Idiography relates to the specific or the particular; whereas, human subject research frequently generalizes outcomes to a population or group, IPA is focused on the detailed analysis of single case studies and then carefully and inductively establishes group generalizations (Smith et al., 2009). Arguments against generalized outcomes presented by Smith et al. describe such approaches as informed by probabilities and averages without the intimate input from the individuals who provided the data (p. 30). Although individuals can provide a personal perspective on a phenomenon, idiography is not an emphasis on an individual's characteristics,

but rather an individual's relationship to, or engagement with a phenomenon (Smith et al., 2009, p. 29). The focus is on meanings and processes, rather than outcomes (Finlay, 2011).

The participants in this study share the common phenomenon of entering the U.S. under refugee status and aging in a vastly different environment and culture from their homeland. As older adults, they navigate a daily stream of experiences related to aging. As older former refugees resettled and aging in an unfamiliar world, they bring an acute awareness to specific parts embedded in the aging experience and those related to immigration that cumulatively impact their perceived HRQoL. Smith et al. (2009) explain that by utilizing IPA, individuals' experiences and perceptions can be understood by exploring the meanings participants place upon them. In addition, Clarke and Borders (2014) assert that IPA is most effective in understanding underserved populations. Refugees are an underserved population and within that population is the sub-group of older refugees who are even more invisible. Many studies within Somali refugee populations focus on younger individuals or the population as one group. In this study, IPA is a suitable approach for giving older Somalis a unique opportunity to reflect on their worldview and what is important to them regarding HRQoL.

World Health Organization's Quality of Life Model

The World Health Organization has advanced the field of HRQoL around which this study is framed. In 1991, the World Health Organization Quality of Life (WHOQOL) project was initiated to develop a cross-cultural quality of life assessment and establish a standardized and global definition of HRQoL (WHOQOL Group, 1995). This task was embarked upon in response to several considerations. First, although assessments were utilized to measure the impact of disease, none expressly assessed quality of life, which was described as an omitted dimension in health care (Fallowfield, 1990); second, most health status measurements were

developed in one cultural setting and not always adapted and validated for use in other settings; and third, as medicine focused largely on disease and symptom abatement, the need for a more holistic approach in health care was evident (WHOQOL Group, 1994).

The original WHOQOL assessment was the result of a collaborative and iterative process taken on simultaneously by multiple field sites around the world and guided by the needs of health professionals, researchers, and individuals from the general population (WHOQOL Group, 1995). One stage of the WHOQOL development involved concept clarification during which researchers agreed upon some of the quality-of-life constructs' characteristics. First, although the subjective nature of the quality-of-life concept is its defining feature, there are levels of inquiry that range from reports of objective functioning, such as hours of sleep or degree of mobility to global evaluations of functioning (e.g. 'How well do you sleep?') to personal evaluations of satisfaction or dissatisfaction (i.e. positive and negative) with various aspects of life. The WHOQOL group argue that although reports of objective functioning are important health status data, the global and personal evaluations of "behaviors, states, and capacities" (p. 1405) best inform quality of life. Second, quality of life is a multi-dimensional construct and at a minimum includes physical, psychological, and social dimensions. The WHOQOL group argue that these three broad domains are "universal values across cultures" (p. 1405). However, Kagawa-Singer et al. (2010) stress the importance of identifying determinants within and across cultural groups that give meaning to those shared values. This is all reflected in the theory of HRQoL which states that the theory is significant for measuring an individual's perceived HRQoL and is made up of various, multi-dimensional domains that are affected by determinants specific to culture and population group (Peterson & Bredow, 2013).

A shorter version of the original assessment has been converted into more than 50 languages using the WHO method of forward and backward translation followed by a rigorous review process by linguist groups (WHOQOL Group, 1995). However, until recently, it had not been translated to Somali. A few examples of adaptations in the Somali version include the concept of quality of life, which was too vague and was instead expressed as standard of life; when asking the question, "Do you have enough energy for everyday life," the word "energy" was replaced by the word "training" since energy in the Somali language is more closely associated with electricity; and in the question, "How often do you have negative feelings such as blue mood, despair, anxiety, or depression," there was no equivalent expression for blue mood, so it was removed from the question (Redko et al., 2015).

In addition to the short version, an OLD add-on module was developed and filled the gaps in the original version to make it more relevant to older adults. Facets that were added to the OLD version are sensory abilities, autonomy, past, present, and future activities, social participation, intimacy, and death and dying. The WHOQOL group assert the purpose of all versions of the quality-of-life assessment is to evaluate the impact of service provision, and health and social care systems, and to identify areas that can be improved to optimize quality of life (Power et al., 2005). Although I did not administer any version of the WHOQOL assessments to participants, they guided the development of my questioning route, including possible probes, and provided insight into semantics. See Appendices A and B for the demographics' questionnaire and interview guide, respectively.

Sample and Recruitment

Prior to participant recruitment, I was introduced to the director of a small Somali service agency who was willing to assist me in my recruitment and data collection goals. She is a former

Somali refugee and served as a gate keeper into the community to which I needed access. Participants were purposively selected which is required to conform with IPA methods and to ensure participants share the phenomenon being explored (Smith et al., 2009). Initially, participants were recruited one weekday morning during the first week of February 2020 at a local café as they gathered to collect vouchers from an organization that collaborated with several Somali cafes to offer monthly meal discounts to older Somalis. The director assisting me, made an announcement to the group and introduced me and my research proposal. Volunteers self-identified as meeting the inclusion criteria and provided their name and telephone number on a sign-up sheet with an expectation of being contacted within a week. Additionally, referrals were made by participants (snowball sampling) and gatekeepers/cultural brokers.

The inclusion criteria for this largely homogeneous sample are as follows: male and female ethnic Somali persons; arrived in the United States under refugee/asylee status at least 5 years ago (2015 or earlier); 60 years of age and older. Somali cultural brokers clarified that Somalis identify as "old" as early as age 55 (H. Mohammed & M. Samatar, personal communication, December 2019); therefore, to compromise between the U.S.'s formal definition of senior at age 65 and the Somalis' cultural definition of senior around age 55, I decided upon 60 years of age as the lowest cut-off point. Discussions with refugee resettlement agency employees informed me that refugees enter what is referred to as a honeymoon period upon arrival (T. Mrosko, personal communication, May 2015). Refugees are assisted in finding shelter, food, employment, health care, and other immediate needs within the first few months and are usually very hopeful about their new life. After this initial euphoric period, refugees are likely to experience culture shock and disillusionment as they negotiate adaptation to their new environment; finally, there is a period of adjustment and then integration or mastery (Black &

Mendenhall, 1991). These stages are based on the U-curve adjustment model developed by Lysgaard (1955). Although the length of stay in each stage varies by individual, the U-curve of cross-cultural adjustment suggests that adjustment and integration are the lengthier stages and that integration/mastery may not begin until at least the fourth year after resettlement (Black & Mendenhall, 1991; Oberg, 1960). This supports my rationale to recruit participants who have been resettled in the U.S. for at least five years. Characteristics that excluded participants were acute terminal illnesses, cognitive impairment, and unmanaged severe mental health disorders that were determined through observation and health centered inquiries on the demographic survey.

I initially identified a sample size of twelve individuals. Smith et al. (2009) explains that there is not one decisive sample size required to conduct IPA. The decision is largely dependent upon the richness of data gathered from participants. Smith et al. point out that professional doctorates may also think in terms of the number of interviews, rather than participants, and suggest between four and ten interviews. These authors warn that larger numbers of participants or interviews do not equate to a more scholarly level of work. A landmark study by Guest et al. (2006) suggested approximately 12 interviews were sufficient to develop overarching themes. As a result of referrals from initial participants in combination with my efforts to ensure a balanced sample regarding sex, a total of 16 participants agreed to be interviewed. Based on Guest et al., this number could reasonably be considered adequate to fully explore the experience of interest.

Role of Language Interpreters and Translators

Due to the language barrier between participants in this study and me as the researcher, working with an interpreter was essential. Brämberg and Dahlberg (2013) warn that in cross-language studies the presence of an interpreter can threaten a participant's spontaneity and

openness; therefore, a qualified interpreter for qualitative interviewing is one who is "experienced in verbal translation and who shares a cultural background with the person being interviewed" (p. 241). The authors also point out the importance of matching interpreter and participant on characteristics such as ethnicity, gender, class, and age. The interpreter for this study, identified by the agency director, was a 61-year-old male, ethnic Somali who tutored English and other courses at the agency. He arrived in the U.S. as an asylum seeker.

Prior to the interviews, a local professional Somali translator service was recruited to translate the written participant consent form and interview guide. Both documents were then reviewed, by the previously mentioned Somali director and the interpreter employed in this study, for target language comprehension. The interview guide was translated to Somali and back translated to English as recommended by the WHOQOL Group (1995). Back translation is a method utilized to allow comparison with the original text to ensure the equivalence of meaning between the source and target texts (Brislin, 1970; Lopez et al., 2008).

Pre-interview discussions with the interpreter emphasized the study's purpose, the anticipated interview session process, and role expectations. As Brämberg and Dahlberg (2013) point out, it is crucial that interpreters understand the context of the interview questions, as well as qualitative interviewing. Interpreters must also understand the importance of receptiveness and support for the participant's responses, and when probing or follow-up questions are asked, interpreters should not interrupt, but listen even when there is repetition (p. 244). During interviews, verbatim translation in the first-person is recommended (Brämberg & Dahlberg, 2013; Essén et al., 2000). The interpreter for this study skillfully upheld these guidelines and recommendations.

Interviews were conducted through the interpreter who translated from English to Somali when directing questions and statements to participants, and Somali to English when directing participant responses to me, the interviewer. As the interviewer, I held eye contact with the participant rather than with the interpreter to forge a more intimate exchange. Although the interpretation should be as accurate and as close to verbatim as possible, the authors stress that the emphasis should be on translating meaning. Lampert (1997) describes interpreters as simultaneously engaging in two cultures and bridging the planes of understanding. The interpreter in this study often reminded me that word for word interpretation and translation was impossible due to the source and target languages differences; therefore, according to Molina and Albir (2002), he engaged in "oblique" procedures to adjust both languages to "produce an equivalent communicative effect," including meaning (p. 502). In addition, the interpreter preferred to interpret small units of continuous dialogue rather than a sentence by sentence or whole conversation approach.

The interpreter should be viewed as a research instrument (Brämberg & Dahlberg, 2013). Like the researcher and the participant, the interpreter produces data and informs its analysis (Squires, 2008; Temple & Young, 2004). Therefore, to maintain consistency in interpretation and thereby strengthen reliability, the number of interpreters should be limited to just one or two (Brämberg & Dahlberg, 2013; Wallin & Ahlström, 2006). In addition to the primary interpreter, the director served as an interpreter on two occasions. The participants in those interviews had a personal connection with the director and indicated a higher level of comfort with her as the interpreter.

Both interpreters welcomed participants with an air of hospitality and respect. I observed affable interactions and a genuine concern for the participants emotional and physical comfort

during the interviews. One notable example is when the interpreter informed me that if the line of pursued inquiry were to continue, the participant may become emotionally upset. Although the participant insisted on continuing her story, the interpreter was mindful of her well-being. There were rapport building conversations between the participant and interpreter prior to the interviews and continued personal conversations afterwards, which sometimes led to an exchange of contact information. The interpreter even provided participants' transportation to and/or from the interview site when necessary.

In addition to conversations with participants, the interpreter and I engaged in debriefing sessions after most interviews. These consisted of casual observations within the participant's dialogue, explanations around culture that added context to the dialogue, similarities and differences among participants' stories, and additional context around the current lived-in community. Information from these debriefings were documented as memos and considered in the analysis. Many of these conversations took place over tea and samosas in a local Somali cafe. During this time, the rapport between me and the interpreter grew as we also learned more about each other. I frequently showed my appreciation for his work by providing tea or coffee, samosas, and appropriate breaks between interviews to support his well-being.

Pilot Interviews

Three pilot interviews were conducted using in-depth, semi-structured, one-to-one interviews. The interviews included one male and 2 female participants to test the semantics and comprehension of the interview guide. The interviews were not included in the data corpus due to either an incomplete interview or failure to meet all the participant inclusion criteria. As a result of these interviews, and in collaboration with the interpreter, I reframed the wording of the first five questions to form a clearer inquiry. The first question, "How do you describe yourself?"

was reworded as, “When you meet someone for the first time, and you are sharing things about yourself with them, what might you say?” Although not as parsimonious as the original question, the meaning is more precise. The second inquiry, “Describe what you do in a typical day” was more readily understood when phrased, “Describe your activities during a typical day, from the time you wake up until the time you go to bed.” Following recommendations from the Redko et al. (2015) quality of life study within this community, I referred to quality of life as standard of life. The third question, “How would you describe health-related standard of life?” was altered to “What is most important to you in making your standard of life good?” When asking about mental health, participants were more receptive to the term, emotional health. Spirit and morale were also used interchangeably with emotional health. The fourth and fifth questions, “What affects your physical health/emotional health?” became “What kinds of things have caused changes in your physical health/emotional health?” In addition to wording modifications, the pilot interviews served as useful practice runs for working with an interpreter. They also illuminated the need for further discussions regarding interpreter protocol and scheduling interviews around prayer times.

Data Collection

The proposal for this study was approved by Kent State University’s Institutional Review Board. As with the pilot interviews, in-depth, semi-structured, one-to-one interviews were conducted. According to Smith et al. (2009), this is the most appropriate means of collecting data for an IPA approach that offer a “rich, detailed, first-person account” of experiences (p. 56). All interviews were held in a quiet, private space over a one-month period between February 15 and March 13, 2020.[1] On average each interview lasted 70 minutes. Prior to the start of the first

[1] All interviews were completed prior to the U.S. government’s declaration of the pandemic, COVID-19, as a national emergency, and prior to widespread shutdowns and stay at home orders.

interview, the interpreter signed a confidentiality agreement to ensure participant anonymity and confidentiality. Preceding each interview, the interpreter reviewed the consent form with the participant, which among other information, highlighted the assurance of confidentiality and the right to withdraw from the study at any time. The interpreter then obtained their written informed consent and provided them with a Somali translated copy. Although there were no anticipated risks for the participants greater than those encountered in ordinary daily life, the copy contained contact information for local Somali support agencies and the national suicide hotline number in case of adverse post-interview emotional reactions that require professional intervention.

A consent to audio record interviews was granted by each participant and following guidelines by Smith et al. (2009), all interviews were simultaneously recorded on two digital recorders. Additional data were collected as participants' demographic survey responses, contextual information shared by the interpreter, and reflexive memos on each interview. All documents containing participant information, as well the audio recordings were de-identified and assigned the number of the sequence in which the interview took place. Additionally, participants signed an acknowledgement of receipt for the $25 cash incentive awarded at the conclusion of the interview.

Data Analysis

In preparation for data analysis, each audio was uploaded from the digital recorders onto my personal computer and then to the Express Scribe Transcription Software Pro v 8.26 (2021). One copy of the application was loaded for my use to transcribe the audio's English spoken parts and a second application copy was loaded onto a laptop for the interpreter's use to transcribe the Somali spoken parts and subsequently translate it to English. All interviews were conducted before the first transcription was initiated. Within 24 hours of completing each interview I

listened to its audio recording, and on a designated Word document I logged observations of the participant's appearance and nature, a few demographic descriptions, the interview setting, initial, brief interpretative thoughts, reactions to the interview content, reflections on my performance as the interviewer, interactions with the interpreter, and a posteriori knowledge.

Prior to transcribing each audio recording to a printed interview record, I again listened to the recording to re-familiarize myself with the data. Following the transcription of each interview, further interpretative thoughts on the interview content and participant, and reflections on the interview process were added to its existing memo corpus. IPA requires a transcript to include all words that are spoken by every contributor to the interview. Meaningful non-verbal utterances, such as laughter or distinct pauses should be noted in brackets; each line of the transcript should be numbered; and wide margins should be created to allow for coding and commenting (Smith et al., 2009). The transcription layout for this study also included the interview's identifying sequence number, interview date, time, and duration, and sex and age of the participant. The layout identified contributors as I (Interviewer), P (Participant), and Interpreter in instances where the interpreter added context to the dialogue.

A cross-language interview and the utilization of an interpreter adds complexity to the process of transcription. The interpreter and I worked at a similar transcription pace. He followed the same document layout as described and translated as he transcribed rather than first transcribing in Somali followed by translation into English. Frequent communication was held throughout the transcription process to address questions and note progress. Following the interpreter's completion of English translated transcripts, a second translator recommended by the formerly used Somali translation service, reviewed the translated documents while listening to its corresponding audio recording and made edits where necessary, along with any appropriate

explanations, in a contrasting text color. I then reconciled each of the interview documents I transcribed with its corresponding translated document reviewed by the second translator into a final transcript ready for further analysis. This method pertains to an epistemological approach that includes translators as part of the data production process (Temple & Young, 2004) and to ensure accurate translations of meaning. The full transcription and reconciliation process took place over a 10-week period and was completed in June 2020.

Smith et al. (2009) have developed a set of guidelines for the analytic process in IPA; however, they stress that it is not a linear nor rigidly prescriptive process and allows ample room for flexibility and creativity. Smith et al. describes the analysis process as iterative and inductive, moving from the idiographic to the shared and from the descriptive to the interpretative (p. 79). The authors also suggest working through the steps of the process one case at a time.

The first step taken, as outlined by Smith et al. (2009), was to read the final reconciled transcript of the interview multiple times to immerse myself in the data. I listened to the audio recording once more while following along with the transcript. It is suggested that this approach may provide new insights. Each review included the continued strategy of documenting emergent observations, reflections, or thoughts related to content, context, language use, emotions, and early interpretations (Pietkiewicz & Smith, 2014). As Smith et al. state, my aim was to create a broad and thorough set of exploratory comments around the data (p. 83). These exploratory comments were created within the wide margin of each transcription document by utilizing the new comment feature under the review heading in Microsoft Word (2016).

Smith et al. (2009) suggest three components of exploratory commenting: descriptive comments; linguistic comments; and conceptual comments. According to the authors, there is no prescription on how the text should be divided and then commented upon, because some parts of

the interview will be richer than others and require more comments (p. 83), and could relate to a broad paragraph, as well as a couple of sentences. As I developed comments, each component was differentiated by text color (e.g., linguistic comments were green). As part of the data, these distinctions made for an easier review of comments. Descriptive comments describe content, and within this element I was concerned with understanding what was important to the participant through key words, phrases, and explanations (p. 84). As the analysis progressed, my goal was to more deeply understand the participant's relationship with those things of importance (p. 88). Linguistic comments focus on language use, such as "pronouns, pauses, laughter, repetition, tone, articulation, and metaphors" (p. 88). As a cross-language study, this element was at least partially dependent upon the interpreters and translators who added data by deciding what meaning to assign to the participants' words as they interpreted and translated from the source language to the target language. As I moved from descriptive to interpretative commenting, I engaged with the data on a conceptual level. Conceptual commenting, as described by Smith et al., requires time for "discussion, reflection, trial-and-error, and refinement" of my ideas (p. 88). On this level, I shifted my focus to more abstract and overarching ideas of understanding derived from my own experience and knowledge. These experiences and knowledge, as well as biases and preconceptions were annotated within my memos. Smith et al. emphasize that these stages of commenting can be performed synchronously or in separate iterations, and in conjunction with other strategies of exploratory noting. I found myself naturally commenting synchronously on content and linguistics, with a separate iteration of conceptual commenting.

In the next step of analysis, the focus was on my comments as I began to further develop them into emerging themes. This entailed fragmenting the data into parts, and as Smith et al. (2009) explain, my aim was to capture an understanding of the "part and interpret in relation to

the whole, as well as interpret the whole in relation to the part" (p. 92). An additional iteration resulted in suggested themes within each interview. These themes were added in black, bold text within the comments to which they applied. A separate document was created for each interview to illustrate emergent theme headings followed by all applicable blocks of comments for each theme. Each block of comments was identified by its location within a transcript according to interview number, page number, and line numbers. I then looked for relationships between themes and compiled conceptually similar ones together under a descriptive name. This strategy was yet a higher level of interpretation.

Following the completion of one participant's transcript as presented, I proceeded to the next transcript. Smith et al. (2009) advise to bracket the ideas formed around the previous case to preserve each participant's individuality and to allow new themes to emerge with each subsequent case. The completion of all transcripts yielded a list of 66 emergent themes. These themes and corresponding comments were transferred to a single Word document and then printed as a hard copy from which to begin identifying patterns and relationships between themes. This involved additional margin notes and reconfiguring themes into groups based on those patterns and relationships. Through this iterative process, I reduced the number of emergent themes to thirty. As more emergent themes were discarded, included as part of another theme, or transformed into a super-ordinate theme or sub-theme, the list was reduced to the final ten--three super-ordinate themes and seven sub-themes.

The layout used in the previous step assisted me in the next step of looking for connections across cases. Smith et al. (2009) suggest this strategy may help the analyst move to a more theoretical level as themes that are recognized within cases are also shared across cases (p. 101). The identification of comments by interview number allowed me to quickly determine

themes that were most recurrent across interviews. Smith et al. note that in larger sample studies, such as this study, a super-ordinate theme is considered recurrent when it is represented in at least half of the interviews. This was determined by simply counting the number of interviews represented under each super-ordinate theme and its sub-themes (See Appendix C). This step was also conducive in finalizing the super-ordinate and sub-themes previously mentioned, as well as a higher order stream of interpretation that connects the themes. Analysis took place from July 2020 to November 2020. Further interpretation transpired while writing the findings and was completed in March 2021 following three iterations, each providing a more developed level of interpretation.

Establishing Quality

Yardley (2000) (as cited in Smith et al., 2009) introduced four core principles for evaluating the quality of qualitative research. The principles were developed out of discontent among qualitative researchers whose work was continually assessed according to the criteria for validity and reliability in quantitative research. The differences between qualitative and quantitative research in areas such as researcher-participant relationships, nature of data collected, and the definition of generalizability make assessment of qualitative research using quantitative criteria problematic (Yardley, 2015). The principles presented by Yardley are based on common criteria across differing qualitative methods and therefore broad enough to be applied to all types of qualitative research.

Sensitivity to context. This principle was first demonstrated by my choice to interview members of an underserved population and a hard-to-reach sub-group, as well as my awareness of the need for a gatekeeper and cultural broker in accessing the sample population. My relationship with participants and interpreters were strengthened by building rapport, showing

empathy, concern, and respect, recognizing participants as experiential experts, and appreciating the interactions during and outside of interviews. Participant responses such as words of appreciation for interviews, comparisons of my nature to a Muslim's kindness, and even invitations to join the Islam faith are perceived evidence of my sensitivity to context. Quality is further established in the utilization of a primary interpreter who is similar to the study's participants. The study is limited to two interpreters. The secondary interpreter participated in only two interviews where she was specifically requested. This principle continues into the analytic process as well. The interpretative nature of IPA demonstrates a sensitivity to context along with the use of participants' verbatim excerpts to support interpretations.

Commitment and rigor. Commitment sometimes overlaps with sensitivity to context in the attention given to participants during data collection. Commitment refers to diligence, patience, and creativity demonstrated in the iterative nature of the analysis process. Rigor applies to the meticulousness of the study, from participant selection, to interview attentiveness, to careful analysis. It also applies to the accuracy of interpreted and translated data prior to analysis, as in the decision to employ a second translator to reconcile audio recordings to corresponding transcripts already once translated. Guided by Smith et al. (2009), I carefully adhered to the principles and processes presented by the authors to develop a higher quality study. Constant supervision by my committee chairperson was also a component of enhanced quality.

Transparency and coherence. Transparency refers to the details and clarity with which the research process is documented. It is demonstrated in this study through a reflexivity journal, the detail with which the methods are cited, and a repository for audit trail files which include but are not limited to the proposal, reflective notes, interview schedule, demographics survey, signed agreements, interview audios, transcripts, analysis notes and commenting, and the final

report. Reflective memos and notes produced throughout data collection and analyses provide an insight to information learned and meanings taken from the data while illustrating trustworthiness (Birks et al., 2008). Coherence can be thought of in numerous ways, including the degree of consistency with the underlying principles of IPA. This was ensured by again adhering closely to the guidelines of Smith et al. (2009) and are detailed in this write-up.

Impact and importance. The final principle refers to the aspiration of the researcher to tell the reader something interesting and useful with the potential to make a change. As Yardley (2015) explained, the importance of achieving the preceding principles is so one's research can have an impact. This principle can be met in part by building on what is known in extant literature and practice and taking it a step further to answer relevant questions in society. Fulfillment of this principle can be seen in the findings and discussion sections.

CHAPTER 4

FINDINGS

Participants' Demographic Characteristics

Among the 16 ethnic Somali participants, nine were male and seven were female residing in different areas of the same municipality. Their reported ages ranged from 64 years to 88 years with a mean age of 74 years. Two participants were married and presently living with their spouses. Most of the remaining participants were either widowed due to the conflict or married and involuntarily separated from a spouse still living in Somalia or a neighboring host country. Only one participant was currently employed, one was previously employed in the U.S. for fifteen years, and the remainder were never employed following resettlement. All but three participants reported monthly income; the mean value was $835. The number of years since resettlement in the U.S. ranged from 6 years to 28 years with a mean of 17 years. In response to a question about current health status, all but one participant reported two or more chronic conditions. The most common diagnoses were hypertension, hyperlipidemia, and undefined gastric upset. Other conditions included type 2 diabetes mellitus, arthritis, allergies, asthma, and moderate disability from injuries sustained during conflict violence.

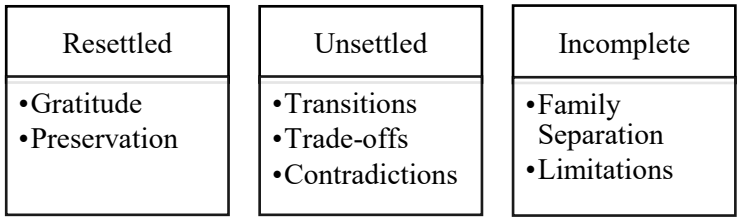
Qualitative Analysis

In my analysis of the interview transcripts, I identified three super-ordinate themes. Following, I present a narrative and interpretative account of the themes including, their definitions, descriptions, relationships, and impact on HRQoL. Excerpts from the interview data

provide illustrative examples of participants' perspectives. See Figure 1 for super-ordinate themes and corresponding sub-themes.

Figure 1

Super-Ordinate Themes and Sub-Themes Developed from Participants' Accounts



Resettled. Resettled describes a sense of emotional relief or peace of mind following the acquisition of basic human needs identified by participants as: safety, security, peace, housing, food, income, and healthcare. Participants viewed these acquisitions as resources provided by the U.S. government. They arrived in the U.S. with very little except their experiences and hope for a better life than what the Somalian conflict brought; therefore, these are resources that were lost or diminished with the conflict and the period between flight from Somalia and resettlement in the U.S. In this context, resettled is a more complex concept than the dictionary definition of movement to a new place to start again. Resettled also encompasses the sub-themes, gratitude and preservation. Gratitude represents the response to replenished human needs which affect overall health. Preservation alludes to attempts to retain specific characteristics and resources and maintain a healthy quality of life in an unfamiliar setting.

***Gratitude*.** Participants were eager to voice their gratitude to the U.S. for resettlement. Some sentiments illustrated general feelings of gratitude, while others associated resettlement with specific opportunities and benefits, such as health and healthcare, income, and other basic needs that potentially provide a sense of rootedness, rather than displacement, and ultimately a

favorable quality of life. One of two participants who were employed after resettlement reflected upon obtaining employment soon after arrival to the U.S.

> So America gives that opportunity, two jobs, easy, you can make two checks [inaudible], you can make $300, $300 a week. After 6 months you can make one other job $400 [inaudible] keep. There's nowhere else in the world you come yesterday, broke from the plane landed, and you have two jobs today. You cannot find this opportunity anywhere else in the world. You cannot tell me. I know how the world functions. I travel. Not possible [laughter].

Many participants arrived in the U.S. with significant healthcare needs. Adverse psychological and physical conditions largely resulted from a combination of traumatic incidents experienced during the conflict, and extreme conditions experienced during flights to safety and life in exile. Some perceived the care received in the U.S. as lifesaving.

> I went into the bushes to go to Ethiopia. We walked long distances without food, clean water, and resting areas. And we came there, thirst, malaria, malaria all the time, everywhere lions in the wild. By the time we are walking in wooded areas, every kind of animal can attack us, no safety. All night you have to pay attention to yourself [crying out as if attacked by a lion], because the lions are the killers in the woods, in safari, and they are too much, and it is not easy. Then after that I get what they call gastric because of the hunger. Before I came to the U.S. I become gastric. After that government [Ethiopia] take me there, still I was vomiting, vomiting, vomiting soon as I came, and I used a little bit medicine at the same time, but still vomiting. Then I came to U.S. and they gave to me prescriptions, medicine in U.S. Then I get food and get medicine. America's

> nice. I was almost dead, but U.S. government gave me a hand, give to me here food. I got medicine, I got milk, everything. Then I said, U.S. is the best.

Another participant attributed improvements in emotional and physical health to safety, security, and peace in the U.S., which presented stark contrast to the violence in Somalia.

> Peace is the test. There's no peace, then you get your body gastric, [high] blood pressure, diabetes, everything. There's no peace; all the time terrifying. The best place in the world is where you get safety. Imagine if you are terrified every night and all night and days all the time, what time you will die you are thinking about. I love here, U.S. and I am 16 years right here [slumps in his chair as if to relax and sleep]. I'm in a safe place. Then I just relax.

These two excerpts clearly illustrate the contrast between traumatic stress associated with experiences prior to resettlement and the perception of peace, safety, security, and ready access to essential healthcare in the U.S. The earlier excerpt illustrates how the participant is grateful to the U.S. for providing essentials necessary for life and satisfactory health (e.g., medicine and food). The latter excerpt demonstrates understanding of the possible health outcomes associated with continuous stress. The perception that the U.S.is an anomaly, a country of plentiful resources, is discernable in these participants' accounts, although in these two instances, acquired benefits are defined solely by comparison of current U.S. conditions with life threatening conditions experienced prior to resettlement. In contrast, in the earlier excerpt regarding employment, the participant asserts that the U.S. offers better conditions than "anywhere else in the world."

Another participant also offered a broader comparison of the U.S. with other regions, although this was supported with specific examples from Somalia:

> America is one of the most developed countries. They have the health. Always save the life of health. When I was in Africa, we don't get enough care, health-wise. No opportunities we have for all the people. Always we are sick—teeth, eyes, ears, legs, everything is become older.
>
> But according to government services exists here, like medicines, prescriptions, like food stamps, like whatever income it is, here is much resources for my age. I have a family in Somalia who cannot afford or provide what I have here in U.S.

Expressions of gratitude to the U.S. related to fulfilled basic needs of food, shelter, healthcare, and income, along with the interrelated health benefits of safety, security, and peace were continually accompanied by appreciation for the U.S. in general, or the U.S. government in particular. This illustrates how participants attributed the conditions in their new environment to larger, unseen powers rather than relying on personal agency or community resources. This is also evident in the language used when benefits gained were described as "gifts," and recipients were described as "beneficiaries." This tendency toward external attribution may originate in religious beliefs that were reinforced by perceived lack of control over the circumstances that precipitated their resettlement and the significant losses incurred.

Preservation. Due to material and intrinsic losses, participants attempt to prevent further loss through the preservation of meaningful attributes with which they arrived, and the maintenance of health through acquired essentials upon arrival. This was first apparent in efforts to preserve identity. Participants introduced themselves not as U.S. citizens, but as Somalis living in the U.S. The U.S. was described as a "second home" while Somalia remains "inside" them. For most participants, identity as defined through external factors such as employment and

status can now only be preserved through recollections of the past. This was explained as emotionally beneficial when participants "remember when they used to be something back home."

Preservation also refers to health maintenance. Participants engage in social and spiritual activities to facilitate the regulation of physical and emotional HRQoL domains.

> Those things regulate my health quality of life. If I miss that, it affects me, because if I stay alone at home, I might get sick, or maybe I feel depression. So that is a kind of medication—to talk to the people, to say hello, watch TV [together], say your prayer, read the Quran; all those are medical for my physical and my emotional inside. It is important to socialize and meet other people. That makes me feel peace and happiness, and those activities that I do in my daily schedule, otherwise I become ill if I stay home for long periods of time.

The analogy of social and spiritual activities as medicine exhibits an awareness of strategies to maintain emotional and physical well-being and illustrates the interdependence of HRQoL domains. This also demonstrates participants' reliance on continued traditional activities from Somalia to feel a sense of comfort.

Social interactions are mostly with other Somalis similar in age. This exclusivity is primarily due to language barriers; however, it is also a strategy to preserve the Somali community. In the following excerpts, three participants mentioned gathering at one another's homes, meeting at Somali-owned cafes, sharing meals and tea together, and spending afternoons together at adult daycare centers.

> …I go to socialize where the Somali people come together, as a peace or morale, or less emotional place. That's what I do from the morning until I go to bed. I socialize with people close to me…My healthy quality of living changes through my socialized activities…
>
> I just enjoy she [daughter] brings me there. There's adult center; we just enjoy talking to each other and socialize, men and women. Then we eat together and we become happy for that day. Sometimes it's very nice to be 5 or 6 women together. We enjoy socializing and eat together. Yes, very happy. I sleep well that night.
>
> It is very nice to be social, even if you are sick. You have to try, go to tea, talk, they'll talk also, you listen…Then maybe you become healthy, because emotionally maybe you laugh, or you listen to people. You were getting headache, or bones, or pains, or whatever. When you socialize, maybe you get fine; you get healthy. It's another mood, another situation, and you become fine.

Each excerpt demonstrates how frequent socializing positively impacts HRQoL. These social activities, however, take place in encapsulated environments created to emulate their homeland communities. It illustrates that although the participants physically live in the U.S., emotionally they remain attached to Somalia and choose to move within Somali circles. Despite the integration of social activities into daily routines, for those participants living without family nearby, loneliness was identified as one of the most difficult challenges in the U.S. One participant described loneliness as an illness worse than hypertension as well as a cause of hypertension. Ironically, living within a populous Somali community has allowed them to create their own isolation from the larger community.

In addition to small social groups, participants utilize Somali news sharing applications that are available to join by cellular phone. The format is presented much like an audio conference and allows participants to engage in conversation and glean information about current events affecting Somalia. This approach serves to connect Somali communities globally, preserving a collective identity while separated from their homeland, and alleviating anxieties associated with this separation. Rather than embracing the host community in which they live, this represents a disconnect from the U.S. and a symbolic reach for sources that connect them back to Somalia.

As observers of Islam, participants described the multiple daily prayer times as opportunities to come together and socialize. Therefore, practicing faith was identified as another vehicle to social connection, as well as a means of health preservation, particularly emotional well-being. When asked about the maintenance of their emotional well-being, participants overwhelmingly acknowledged faith as a coping strategy. It was suggested that Muslims do not need mental health professionals, because their faith provides emotional protection and strength.

> Anything that comes to us, emotion or physical, comes from God. So we believe one God and we pray for Him. I don't have any complaints, but I continue worshipping Him at all times and that maintains my emotional situation.

Daily prayer, reading the Quran, and the use of tasbih prayer beads contribute to emotional stability.

> I don't have that problem [emotional ill-health], because I'm connected to the Quran and tasbih right here and I pray all the time. Before I finish one round [tasbih bead counting], I just feel sleep. I collapse. People eat tablets to get to

sleep, but in Muslim, just you read that two times or three times, you feel sleep, finish.

In addition to daily spiritual rituals, Islam requires individuals to care for the whole body. Therefore, along with striving for emotional well-being, Muslims must take care of their physical health in ways that include healthy diets, cleanliness, exercise, seeking healthcare, and adherence to healthcare recommendations. Even the act of prayer was described as physical exercise. It requires kneeling, bending, and stretching and while "staying close to God," is perceived to improve body function.

Claims of emotional well-being in the two previous excerpts are contradicted by descriptions of how they utilize faith to manage emotional stress. It is suggested that acknowledgement of psychological ill-health, particularly, is an acknowledgement of distrust in Allah. The fear of betrayal might also extend to their homeland or heritage and account for the effort to preserve their identity, social connections and activities, and religious practices. These are attempts to maintain a continuity of life in the U.S. as it was in a peaceful Somalia. Collectively, the retention of familiar features from home represents efforts to regain some semblance of control following the chaotic upheaval of conflict.

Unsettled. Whereas resettled represents the formation of a stable foundation in an unfamiliar environment, the Unsettled super-ordinate theme presents an ambiguous state of mind; a straddling of two worlds; and an attempt to reconcile the past with the present which exist in very different countries and contexts. This theme was initiated from a participant's account of older Somalis who were first to resettle here and who had to leave family behind.

I believe the [Somali] immigrants, first immigrants, the responsibility and the baggage they come with, and the need also is the part of frustration when they

become older. Because the first immigrants, they carried there that family members they left back home. Their support, they send money, they have to take care of them, they have to help their children, they have to worry about them, and they're not settled.

The state of unsettledness is an imbalance between expectations and needs, and the objective world. It is reflected in the sub-themes, transitions, trade-offs, and contradictions, which mostly depict participants' perceptions of how being unsettled affects HRQoL.

Transitions. A transition is the passage from one state to another. In this study, the meaning includes adaptation to the new and different. Throughout the interviews I observed participants who remain stuck within transitions between their past and present and Somalia and the U.S. Arrival to the U.S. introduced a barrage of navigable transitions.

They don't know the highways; they don't know the smallest things. They don't know the culture. You know, they call it culture behavior problems. So everybody has that, culture shock.

Culture shock is unsettling and provokes stress. Although the initial shock passes, ongoing challenges keep transitions in limbo. Some commonly expressed challenges associated with this sub-theme include feelings of homesickness, the intolerance of a colder climate, and idleness. Indications of homesickness were detected in phrases such as, "when I feel back home" and "I become emotional for that [life in Somalia]." Participants were not only homesick for friends and family, but also for Somalia's perceived health-centric qualities.

…because everything is fresh. Milk is fresh, meat is fresh. They didn't have this many years ago, a fridge. They don't have frozen food. You go to the land or the plantation, you have banana, you have mango, you have the…everything is

> fresh, you take it. The land, it's not over-populated. No more cars, no more people, so it's nice. Only you hear the birds singing. We don't any streets that have a lot of trash and buses and chemicals. Emissions-wise, there are a lot of emissions over here. Yes, we walk around in Somalia. Everything is smelling good; you're feeling nice. Nothing is bothering you. Then when you come back, your emotional, your physical is nice when you come home. We get a lot of diseases here because we don't do that, and most of the foods has the flavors [additives] over here. Over there is clean. Everything is fresh.

This also demonstrates transition to a different post-resettlement stage. The notion that the U.S. has everything plateaus, and appreciation for pre-conflict Somalia and what was left behind surges. This excerpt can be compared to a stage of grief where a deceased individual becomes the object of pre-occupation and is memorialized in a positive light.

Another environmental difference between Somalia and the U.S. to which most seem to have not yet adapted is the colder climate. It was identified as one of the most challenging elements of life in the Midwest U.S. One participant mentioned that if the U.S. had perpetual summers, there would be no desire to go back to Somalia as some Somalis have because they could not endure the long, cold winters. Participants perceived the cold climate as having a negative effect on all domains of HRQoL and was attributed to the onset of asthma, allergies, aching bones, and increased isolation.

> The weather bothers me if it is cold, so I stay all night, all day at home. That also gives me stress. I stress that way, because when you become aged in the U.S. it's too hard. When you're aged in Somalia, you can go around…the weather's nice. Here it becomes cold and you are inside by yourself.

This excerpt, spoken by a participant who lives alone, assumes a double meaning. Not only does it describe how cold weather restricts social activities, but it also describes a state of mind that reflects the loneliness experienced in the absence of their homeland's familiarity. It alludes to oppressive components beyond their control that make adaptability to the U.S. more challenging.

Cold weather is a factor also attributed to idleness. The exercise enjoyed by walking outdoors is made difficult by winter weather conditions and cold temperatures. Therefore, the maintenance of better physical and emotional health through exercise is disrupted. Although some participants walk indoors during the winter months, they agree that walking was naturally part of their daily routine in Somalia and allowed them to sustain better physical health year-round.

> …when I was in Somalia or Africa, I used to walk. Walking, walking all the time, sweating, walking. That was kind of an exercise. But here, mostly it's wintertime, people have cars, so I become like them. Just I go. I'm sitting here, I'm sitting at home, sitting in the car, sitting all the time. So that kind of situation give me physical problem for cholesterol, blood pressure, all this resulted. But in Africa you are walking all the time and you have enough space to walk.

The transition from an active lifestyle to a sedentary lifestyle again is restrictive and presents a barrier to perceived good HRQoL. There is also a health transition from infectious diseases in Somalia to more non-communicable diseases in the U.S. which are perceived as consequences of idleness.

Overall, this sub-theme represents a transition away from the gratitude for resources and benefits that were bestowed upon them and focuses on unfavorable conditions that were forced

upon them. There is seemingly again a lack of control over these conditions that attribute to circumstances of perceived confinement which may feel like a perpetuation of restrictive experiences in exile prior to resettlement.

Trade-offs. This sub-theme differs from the transitions sub-theme as it exposes a struggle to reconcile the best of both Somalia and the U.S. Most participants agreed that the receipt of basic needs in the U.S., such as income, healthcare, medications, safety, and peace, is the primary incentive to remain here. Otherwise, a peaceful Somalia is the preferred place of residence, due to family, climate, familiarity, and a general feeling of well-being. The overwhelming perception was that an optimal HRQoL could be achieved with access to frequent travel between the U.S. and Somalia. Or as one participant suggested, the continued receipt of monthly U.S. social security benefits and other resources while living in Somalia would be ideal.

As physical health was discussed with participants, it became clear that although they value the advanced and specialized healthcare available in the U.S., participants feel Somalia offers more general health benefits that stem from the natural environment. After all, despite acquiring peace and safety, many participants received new diagnoses of chronic illnesses once resettled in the U.S., perceived as a result of a substandard environment and sedentary lifestyle more so than as a function of aging. One participant offered an example of how Somalia lends itself to better health:

> Sometimes I think if I might go back to Somalia, which has fresh food and fresh climate, I might be better than today. There are some aged people in the U.S. saying some aged people left from the U.S. to there. They get a lot of medicine [metaphorically], maybe sun, too much sun over there. Medical D. Too much D over there. Vitamin D. Then when they were here, they were walking with sticks

> or wheelchairs. They went [to Somalia]; when they stay one month, they threw away one stick. And when they were three months, they threw away the next one. They were walking over there, and they came back to U.S. and they are here now, and they walk normally. So when a person comes with sticks and a wheelchair, it's better to go to Somalia to get more Vitamin D and come back. One aged person right here, he suggested to us go to Somalia, stay ninety days and come back, and you'll become perfect because you have sweating, sweating, sweating [walking and exercise in warm climate].

This excerpt demonstrates the belief that Somalia's environment provides natural medicinal qualities. It was mentioned that aging individuals in Somalia are "healthier than U.S." residing individuals. Therefore, only a visit to Somalia can restore perceived good health. In contrast, upon initial arrival to the U.S., it was here that health was restored. Through resettlement, participants traded Somalia's natural health benefits for advanced U.S. healthcare; however, advanced healthcare alone does not translate to an improved HRQoL. Emotional health included trade-offs as well. Participants described all the available benefits and resources that give them peace of mind in the U.S; however, they expressed sadness and worry for what was left behind, particularly family. All resources and benefits gained from the U.S. come at the expense of losses from home. Shelter and income were two other mentioned acquisitions that cost them the loss of property and other assets, as well as an established livelihood and imagined future. There was no opportunity to consider these gains and losses beforehand, nor time to negotiate and accept compromise; therefore it seems participants are still entangled in this process.

In contrast to the transitions sub-theme that revered Somalia for beneficial features, this theme presents a modest acceptance of conditions in the U.S. while still weighing the pros and

cons of both existences. This excerpt however seems to portray Somalia in an illusory light where healing occurs. Here, the participant alludes to it as a place that would only temporarily be visited. In this instance, like Allah and the U.S. government, Somalia is presented as a larger, more abstract being or power. However, just as participants were involuntarily pushed towards exile and resettlement, there is now an acknowledged, voluntary pull to the U.S. and to the benefits only available here that contribute to HRQoL.

***Contradictions*.** The final sub-theme of super-ordinate theme, Unsettled, is a fluctuating collection of thoughts and perceptions related to HRQoL. This state characterizes a sense of 'I'm okay, but I'm not okay.' Contradictions is a product of the trade-offs sub-theme. Due to the trade-offs mentioned, participants are conflicted in what is best for their HRQoL. Although this is noticeable in the trade-offs theme, there are distinct contradictory statements made in comparisons of health and aging in the U.S. versus Somalia.

The ambivalence is clear as participants explained it is better to live in the U.S. where resources are plentiful, but family is still in Somalia where environmental health benefits outweigh those present in the U.S., and even though resources are plentiful in the U.S., there are other challenges, therefore Somalia is a more tranquil place to live. Statements of belonging in the U.S. and expressions of loyalty to Americans were countered with visions of returning to Somalia to live and work. Claims of "no problems" in the U.S. were opposed by statements that cited problems:

> There's no problem over here [U.S.] if you become aged…If you are Muslim [in Somalia], you are [inaudible] because your next of kin keeps you healthy and your demands are limited. You're not demanding anything, but here you have more demand. You need more. More money, more cars, more life, more food,

more cakes, more and more. It's a problem. If I don't have anything, so it's another problem.

This participant conveys that aging well in the U.S. is financially difficult. Needs outpace assistance (i.e., Supplemental Security Income [SSI]), rendering it insufficient. However, even as some participants continued to voice a desire to one day return to their homeland, they concurrently made it clear they would return to the U.S. after a short-term visit. Despite an insufficient monthly salary, the income is too valued to lose with a permanent return to Somalia. This sentiment may also be a result of refugees from low-income countries resettling in high-income countries.

The most salient contradiction referenced the availability of healthcare. One of the resources most appreciated in the U.S. is advanced healthcare. Conversely, despite the need for improved healthcare in Somalia, care as experienced in the U.S. is largely perceived as unnecessary in Somalia.

> We don't have any problem also here [U.S.]; no problem over here. We have peace here, we have health here, we have prescribed medicine, we have everything here. And our emotional right here is good, and this is nice.
>
> Healthy place, Somalia, without any medication. Aged person in Somalia does not need much medication, because the country is a healthy country. Because there's no pollution. Everything is organic. I never taste [synthetic medication]. When I came here 18 years ago, I was still a grand [aged person], but I never used any medicine prescribed by a doctor. Right here, soon as I came to the U.S. I have prescribed medicine, medicine, to another medicine, to medicine.

> You'll never take any medicine if you go there [Somalia]. Nothing. Do you think that if our country becomes peace, many people will leave from U.S., especially aged people, because they feel there fresh air, fresh milk, organic food?
>
> My emotional will be changed if I stay in Somalia. It will be fantastic to see my old friends, and part of my separated family to be socialized again, but what I lose is the prescribed medicine, housing, food, all of those.

This is an explicit depiction of the participant's sense making process as to which living situation supports the optimum HRQoL. The needs are clear, but the impossibility of obtaining it all leaves two incomplete options and indecision. Similar inconsistencies were observed when participants, for instance, reported their emotional health as "good" and made conflicting statements about how memories connected to the war are frequent and "still we have bad pain [emotional] in our bodies." Contradictions surface as participants attempt to work it out aloud, creating a conflicted push and pull. As previously stated, these contradictions may in part stem from viewing the U.S. government as they view Allah, an unseen power, and their hesitancy to voice a complete distrust when it has also provided benefits. It may also stem from an attachment to their homeland and an unwillingness to emotionally betray it.

Incomplete. The third super-ordinate theme describes a definitive absence of people, materials, and perceived self-value. It represents loss that has a substantial impact on HRQoL. Incomplete is the last of three themes that began with opportunities to feel rooted and well in an otherwise unfamiliar context, followed by a state of constant unsettledness regarding quality of life. Incomplete descends into a realization of forced loss and sacrifice that are seemingly beyond

reach and out of their control. This theme includes two sub-themes, family separation and limitations.

Family Separation. Family separation is the most poignant consequence of the conflict and resettlement. It is discussed in the context of death, distance, tension, and sadness. It is a loss that fractures familial structures and social networks and adversely affects emotional health, which impacts physical health. As one participant emphasized how living among family is healthy and social connections start with family, the interpreter aptly commented, "That's the problem of the civil war. Everyone went somewhere."

Most participants mentioned the death of family members due to the conflict. Parents, spouses, children, and siblings were killed by "barbarians" within Somalia. Others lost family during flights to safety. A child died from pathogens in unpasteurized milk supplied by a farmer. An aging father died after reaching a refugee camp due to exposure to the elements and malnutrition during the journey. Most participants expressed that to expound upon the experiences of death due to the conflict was too emotionally difficult.

> We cannot talk about it, it's a huge paragraph, long stories. They killed. My older brother died over there. My cousins, at least minimum 5 people, 5 of my cousins, plus my ex-husband, plus his brother and his cousins, about 4 or 5, were deceased for that civil war. It's a long story. I cannot. I cannot.

"It's a long story" was also code for, "it's too painful to recall." There were a few detailed stories of violence recounted by participants which provided a glimpse into the rebels' brutality, but mostly there was an avoidance. The stories shared were in response to their current HRQoL and an attempt to create context, whereas the silence seems to serve as self-protection against a past that remains strongly present.

Family is the most valued asset in Somalian culture, but participants had little control over keeping their families together as they were assigned resettlement. Participants talked about the physical separation and distance from family members.

> All of us have family (who are in danger) and we think, due to the civil war torn of the country and through Somalia we have a lot of families, everybody has a lot of families. No one has seen their family. When I was coming to the U.S., they [other family members] couldn't pass, so they remained there in Kenya. Part of my family, by the time we were flying to the U.S., some of them could not pass, so they will be behind.

This excerpt exhibits how typical it is to arrive in the U.S. with a separated family unit. As participants traveled to a more hopeful destination, they simultaneously experienced grief for those left behind. They are now geographically out of reach from one another. Despite hope for eventual reunification, participants explained how the resettlement process is not easy, nor expedient and prolongs family separation. Frustration overwhelmed one participant's tone as seven years have passed with no family members admitted. Although participants can talk to family and friends by telephone, it is not always possible with intermittent service in Africa. In addition, as one participant stated, "it is not enough," nor the same as meeting in person.

Misconceptions by family members in Africa create an additional and emotional separation, which produces stress and tension. Participants described a customary obligation to help family members left behind; however, due to a limited income, they are unable to send ample funds. This is difficult for those in Africa to understand, because their perception of the U.S. is a 'land of wealth and plenty.' One participant explained the tension this creates:

> [If] I go back to Somalia, people think I'm rich and they ask me to give them something, but I don't have anything. They never believe that. They think I am rich. If you hear the word, U.S., they think you are rich. If that conflict comes up it depends on the income or the resources. If you don't give them anything, everybody hates you. Doesn't matter if it's relative, daughter, uncle, brother, niece, nephew, they hate you. Even if you die, they don't worry anything about it, or they never become sad, because you never helped them. I used to help the people when I was customs officer, 'now you become broke. Why you become so broke? You are citizen in the U.S., and you are not helping the families. Why? You become U.S. person; you are rich…You don't have a good heart. I don't know what happened to you. You become an American and that's it?'

Family in Somalia likely feel betrayed by their more fortunate U.S. resettled family and participants feel wrongly judged by Somali family who seem incapable of understanding. It has become a different conflict, but still with wealth and resources as points of contention that continue to pull families apart. Participants are accustomed to helping each other as a collective society; however, as residents of the U.S., it is no longer possible. Just as some participants felt helpless in saving family members from the violence and other dangers of the war, and keeping their families together in exile, this too symbolizes helplessness. In contrast, the one participant who is employed, and can sufficiently help family abroad, commented on how gratifying it is to be able to do so and is something that brings great happiness.

The most emotionally fraught dialogue took place around family separation and the longing for reunification. For most participants, emotional health is connected to family, and family separation negatively impacts mental health. One participant identified family separation

as the only emotional hurdle and stated that daily affirmations around hope of reunification eases the sadness. For others there is "complete sorrow" in the absence of family.

> If you are in homeland and you have your wife, your kids, whatever you have, your morale is high and that affects your health. Then it's a positive-wise. When you're in U.S. and you don't have those things, the quality of effect of your health quality changes. The only thing I'm demanding from the U.S. government, I would like to have my wife in the soil of the U.S. She has no papers to travel. She has no money to come over here. And there's no ability to come over here. Even myself, my brain and my heart bothering that. Whenever you see some family living together and you are single, you become mad, emotionally, because you would like to have, but you don't have it. So it changes a little bit your morale or emotional.

This excerpt illustrates the emotional difference between family union and separation. In addition to sadness with separation, there is a detection of guilt and fear. It is possible there is no equivalent Somali word for guilt, and could be nested, along with fear, in the meaning of worry. Guilt is likely rooted in the inability to care for family as they could if they were together, and as the emotion felt by participants resettled in a safe and resourceful country while family in Somalia remain vulnerable. Fear remained unspoken; however, the participants' advanced ages could mean they will never again be reunited with family left behind. This participant appeals to that abstract, higher power, the U.S. government, for a solution to the separation from his spouse, and his grief. Hope, along with faith, seems to be a stabilizing factor for mental health in the contrasting presence of uncertainty.

Limitations. Losses such as a homeland, shared culture, common language, status/role, and assets, led to a list of participants' identified needs as immigrants in the U.S. They are lost elements that have not yet been regained and may never again be gained by an older resettled refugee in the U.S. Lack of these resources were depicted as limitations to achieving an optimal HRQoL. Some participants recognized the natural aging process accompanied by anticipated health decline as a limitation to the best quality of life; however, the most mentioned restrictions were minimal English language proficiency, inadequate income, unemployment, absence of assets and properties, and a perceived diminished self-worth.

Many participants identified the lack of English language skills as one of the most impactful limitations. The one participant who spoke with me without the assistance of an interpreter also claimed to speak here for the entire Somali community.

> Language is the key. Language is very [emphatically] important. So when you have no capacity of the language, you have problems, your sickness, or your secrets, you cannot explain yourself, you have to tell somebody else. Some maybe feel culturally ashamed, maybe you cannot experience, maybe you think this person interpreter is not the right person I can tell these things. You hide so many issues because of these scareds.

As alluded to in this excerpt, the inability to explain, express, and comprehend creates frustration, anxiety, and fear. Inadequate English language skills limit inclusion and participation outside of the Somali community, preventing a more diverse social support circle. Although participants voiced a desire to converse with U.S. born counterparts, the language barrier is perceived as impenetrable and another factor of isolation. As a factor in HRQoL, it was explained that the language barrier impedes communication in healthcare settings and with or

without an interpreter there can be challenges. The interpreter for the interview recounted an incident where a young U.S.-born Somali interpreter misconceived the meaning of some of the language used by an older Somali patient, which led to a misdiagnosis. Participants indicated trust in their American doctors but prefer Somali speaking practitioners. Lack of English proficiency likely adds to feelings of an incessant reliance upon others, just as they are reliant on the U.S. government for resources. It also keeps them on the outside of the larger community, a feeling they are presumably already familiar with as immigrants in a very different environment. Once again, they are not in control and depend on other influences for help and guidance.

English language proficiency was also identified as a requirement for employment in the U.S. According to participants, employment leads to a more active, purposeful lifestyle as well as more income and the acquisition of assets, all of which were perceived necessary for a positive HRQoL. Although many essentials are subsidized, after monthly expenses have been covered, there is inadequate support for other necessities, such as over-the-counter health supplements that a physician might recommend. There is little discretionary income for simple pleasures and most importantly, for "tourism" [travel]. A participant explained that if a person has a means or resources, "morale is high" and travel is possible, but without it there is nothing and "morale is low." The lack of funds to travel to Somalia to visit family was the most lamented limitation.

> I would like to see my friends, or socialize people, or relatives back home. I don't have enough money to go there. By the time I pay the rent, finished. I just live survival. I am living as aged person.

The financial inability to travel clearly leaves participants feeling confined and unfulfilled. They are reduced to sustenance living, not a life of freedom to enjoy more than a stagnant existence

perceived to be reserved for a homebound "aged person" possibly just waiting to die. This participant does not identify as such an aged person, but financial limitations have repressed the possibility of being anything more. Subsequently, a satisfactory HRQoL has also been repressed.

Financial instability hinders ownership of large assets or properties. Most of the participants permanently lost their homes, property, and other assets due to theft and destruction. They arrived in the U.S. with nothing and have been unable to accrue enough money to purchase large assets here. Most participants have not held a job in the U.S. and therefore have no retirement plans, only a supplemental security income. They feel excluded from opportunities to improve their standard of living and gain additional resources through investments and ownership which is impossible on a small and limited income. Participants talked specifically about owning homes, and land development. A participant who once hoped for a plantation estate in Somalia explained that one must be able to save money and purchase a home with a flower garden, which would improve quality of life. There was also discussion around the absence of assets to leave as an inheritance.

> Whenever you age in Somalia, you might have properties, you might have stuff, you might have something to leave behind, so your children or grandchildren can inherit from you. But when you're aging here, you're just a refugee and have nothing, no property, so if you die you are not leaving anything behind.

This is an allusion to the diminished self-worth that followed the loss of everything in Somalia. The loss of belongings, community status, and familial roles. None of these have been regained at a level equivalent to that in Somalia. Participants live in a country viewed as wealthy, but ironically, they were wealthier in some sense there than they are now in the U.S. This participant described resettled Somalis as "just" refugees with no perceived uniqueness, or individual

importance, and nothing to contribute at death. Another participant implied different feelings of self-worth in reference to community involvement.

> I am aged person here. If I would be [in] Somalia, people may be giving to me that job description for aged person, giving the people warnings, giving them information, giving the people peace processes, giving many goods. But right here [U.S.] I am aged person, and I don't know what to do. I just stay. If I would be there [Somalia] I could be active. I could give shelter for many people, advise them as a wisdom, giving to them information for the youth, but at this time I'm just an old, aged person.

In Somalia, they would be recognized as invaluable and more than "just an old, aged person" with nothing to offer. This excerpt illustrates a perceived existence of insignificance in the U.S. Just as the rebels devalued their victims' lives, the participants feel devalued as older members of this American society. A different participant explained that Islam teaches its followers to be community leaders and altruists. According to this excerpt, in the U.S., they are denied the opportunity to achieve that community-based role outside of the Somali community. This symbolizes another level of unfulfillment. All of the limitations mentioned impact the three primary domains of HRQoL. Despite the many life-saving benefits participants feel they gained when arriving in the U.S., there are still so many crucial resources absent that could improve their HRQoL.

When I asked about Somali agency services, there was no awareness of current senior-specific programming. Some noted that at one time there were local groups who arranged outings for Somali seniors but have since been discontinued. The lack of programming only adds

to perceptions of unimportance and invisibility. Subsequently there was a considerable amount of appreciation expressed for the interviews.

> It is good for the heart…asking questions, what do you want, what do you need. Those questions are very healthy for our heart. Need is something that you need, but what do you want is something extra. And I will say to you, thanks again.

CHAPTER 5

DISCUSSION

The purpose of this research was to better understand how older ethnic Somali refugees resettled in an area of the Midwest U.S. perceive and make meaning related to their HRQoL as they age in a context very different from their country of origin. The purpose is intended to elucidate what resources and interventions should be considered by community service agencies, program developers, and policy makers to enhance HRQoL for current and future resettled, older Somali populations. Analysis of interviews with 16 participants resulted in three developed super-ordinate themes, Resettled, Unsettled, and Incomplete, along with sub-themes that portray these perceptions and sense-making efforts.

The findings in this sample indicate that HRQoL is linked to the gain or restoration, maintenance, and loss of resources that influence the sustainability of a favorable quality of life within physical, psychological, and social domains, as well as the perception of control over those gains and losses. A favorable HRQoL is dependent upon the preservation of resources that are threatened and the gain of resources that are equivalent or superior to those lost. Participants made clear which resources facilitating the best HRQoL were gained since arriving in the U.S., those they continually attempted to preserve, and those lost in resettlement. They were undecided regarding order of importance between resources gained in the U.S. and resources left behind in Somalia. Although the three identified super-ordinate themes appear to suggest a process moving from resettled to unsettled to incomplete, there is no linear progression through stages based on resources, but rather a layering of perceptions that exist simultaneously.

These findings are significant because as previous studies have shown, health-related quality of health is a predictor of mortality, hospitalization, and healthcare costs (Chern et al., 2002; Dorr et al., 2006; Harada et al., 2017; Tsai et al., 2007) and informs planners and policy makers where to allocate resources to alleviate the burden of impaired HRQoL (CDC, 2018). However, due to differing perceptions of HRQoL across cultures and even sub-groups within cultures (Kuyken et al., 1994), this study brings awareness to older resettled Somalis' perceptions, and places this group at the table of discussion regarding HRQoL.

In contrast to the current study, recent studies concerning refugee HRQoL have been quantitative and do not focus exclusively on Somalis, older refugees, or those living in the U.S. In addition, different assessment instruments were utilized resulting in measurements of varying HRQoL dimensions and variables. Gottvall et al. (2020), Grochtdreis et al. (2020), and Hossain et al. (2020) assessed HRQoL among distinct nationalities of refugees living in camps or resettled in countries outside of North America. Although respondents older than 60 years were few and results were aggregated with younger ages, authors found a positive correlation between risks of problems in each dimension and increased age, as well as an association with older age and lower HRQoL. However, unlike this study, the authors noted it was not possible to explore other factors that might impact HRQoL, such as social exclusion, cultural values, and family separation. These studies cannot be equitably compared or generalized to the current study, but they identify a trend with increasing age that introduces a possible expectation of HRQoL in older Somali refugees.

The current study largely expands on the quantitative work presented by Redko et al. (2015) who developed and validated a Somali WHOQOL-BREF in the same population and municipality as the participants in this study. Researchers administered the HRQoL assessment

to respondents which included older Somalis, but results were aggregated, and no comparisons were made among sub-sets such as age groups. In addition, it is unknown what percentage of the sample was represented by older adults. Although Redko et al. found that psychological and environmental domains contributed most to overall HRQoL, it was beyond the scope of their study to explore influential factors within domains. Through a qualitative approach, the current study was able to better identify and understand aspects of HRQoL, within a particularly vulnerable sub-set [older refugees], that were not previously quantitatively derived.

Studies that have explored factors affecting resettlement and refugee health specifically in older adults have done so with the purpose of identifying unmet health and social needs (Gautam et al., 2018); needs and challenges of integration (Chenoweth & Burdick, 2001); and influences on single domains of HRQoL (Mölsä et al., 2014). Similarities among these and the current study's findings include participant reports of language barriers, isolation, loneliness, idleness, and family separation. Mölsä et al. found additional factors associated with a lower quality of life among Somali refugees in Finland such as homesickness and low monthly income due to unemployment which are also congruent with findings in the current study.

The concept of aging out of place has been captured in a fairly large number of qualitative inquiries including Dubus (2010), Lewis (2009), Curtin et al. (2017), and a systematic literature review by Sadarangani & Jun (2015). However, to my knowledge, none specifically explore HRQoL, nor include Somalis. Other qualitative studies and reports that examine older refugees aging in the United States include populations of Cubans (Perez, 2013), Vietnamese women (Chu & Leasure, 2010), and Cambodians (Becker & Beyene, 1999). Although these studies do consider quality of life, they do not specifically examine HRQoL. However, they do present similarities, as well as some differences, to the current study through narratives about

aging in the U.S. Similar to the findings presented in the Resettled theme, Cuban exiles and Vietnamese women expressed gratitude to the U.S. for providing refuge and advanced healthcare. They cited the U.S. government as the provider of these and other beneficial resources. Despite government assistance, like the Somali participants, they were unaware of existing local aid services. Similar to narratives within the Unsettled theme, Cambodians spoke about residing in an in-between space of two worlds. This is depicted by Somali participants as they became stuck within transitions between aspects in Somalia and the U.S. due to an emotional attachment to their home of origin. Cubans described this as well, and like the Somalis idealized a peaceful Somalia, participants in the Cuban study idealized a pre-revolutionary Cuba and expressed hopes of returning home. Contrary to the current study, the Vietnamese participants described a feeling of overall contentedness with their life in the U.S. Although Somalis cited many positive aspects of American life, their narratives, in terms of HRQoL, did not reflect a state of robust contentedness. Finally, within the Incomplete theme, transnational family separation is discussed in a recent study with Somali refugees by Grace (2018) and, like the current study, touches on the shame and guilt felt by those resettled in the U.S. when unable to provide for family members left behind.

Due to the previously mentioned studies' findings and other literature, there was nothing particularly surprising regarding specific losses and challenges affecting participants' perceptions of their HRQoL in this study. However, what was surprising is that many of the same losses and challenges are described in RPG's 1988 report on older refugees. This leads to the impression that little change has occurred in national and local immigration policy and programs to mitigate these common challenges, or the negative impact precipitated by them. In

addition, some of the same challenges can be seen across different refugee groups in various European and western-culture countries.

Although this study was framed around WHO's Quality of Life model, the findings can be further explained by the Conservation of Resources (COR) theory (Hobfoll & Schumm, 2009). As previously stated, to attain a favorable HRQoL, the necessary individual and community resources must be accessible and as shown in the findings, participants identified the most salient resources. The COR theory suggests that resources are fundamental components to determining individuals' appraisals of events and defining how individuals cope with those events (p. 133). The presence or absence of resources in this study determined how participants perceived their HRQoL following the event of forced migration and during the event of aging transculturally. Using religion as one resource example, their spiritual belief and practice served as strategies to emotionally cope with the events.

The focus of COR theory is on responses to events that affect resources. Resources are defined as objects, such as land ownership or the Quran; personal characteristics, such as self-worth and English language skills; conditions, such as family reunification or climate; and energies, such as income and knowledge. Responses are activated when there is a threat of resource loss, actual loss of resources, or lack of resource gain. Hobfoll and Schumm (2009) point out that a threat of loss or actual loss is especially stressful due to an individual's diminished coping capabilities in the face of future challenges. COR theory proposes that resources are interrelated and changes in one resource affects the availability of other resources. According to participants in this study, if they had better English language proficiency, they could obtain employment, which would provide an income for travel to visit separated family members and to purchase a home with land to enjoy, both of which affect psychological health.

Proficient English language skills would also allow better communication with healthcare providers to avoid miscommunication and possible misdiagnoses which affect physical health. And finally, English proficiency would facilitate relationships with U.S. born English speakers and expand their social network. The theory also proposes that loss is more powerful than resource gain, and initial loss results in more vulnerability to the negative impact of ongoing resource challenges (p. 134). Those already lacking resources will be more susceptible to loss spirals, such as the poor and powerless, which are two characteristics with which participants in this study identify.

The findings in this study depict a stronger emphasis on resource loss than on gains and can be explained by the principle that resource gains do not hold the same powerful impact as losses. The Resettled theme includes a response of gratitude for the gain and restoration of resources lost through the conflict and immigration that affect health. Participants also reacted to the threat of resource loss through actions to preserve individual identity, health, social networks, religious practices, and the larger Somali community. The Unsettled theme is comprised of the undecided weight given to gains versus losses that impact health. And the Incomplete theme is entirely made up of losses that burden health. The COR theory additionally explains in part why these older participants, despite an average of 17 years in the U.S., continue to struggle. Unlike their younger counterparts, older refugees have not experienced as many gains, such as English language skills, employment, and education, that lead to even more gains. Instead, they seem to primarily remain in a loss spiral that also includes naturally occurring losses of health and insults to HRQoL with increased age. This observation highlights the ongoing need for resource gains rather than just those provided to newcomers. Although different nationalities may identify different needed resources, the similarities among various refugee groups in the aforementioned

studies suggest that immigration should be a key social determinant of HRQoL and other measures and that resource losses as well as crucial gains should be considered in resettlement policy and programming.

Limitations

The primary limitation of this study is conducting interviews in another language with the assistance of an interpreter. According to Plumridge et al. (2012), the use of an interpreter will inevitably result in the loss of some control over the interview. There is a reliance on the interpreter, particularly with accuracy in relation to the interpreter's queries and the participants' responses, and it may be difficult to recognize when there are unaddressed misunderstandings in either. Misunderstanding a query is a potential challenge particularly in semi-structured interviews where there are spontaneous questions not previously reviewed on the interview schedule. Inaccuracies might occur if the interpreter is unable to capture every word of the participant's response. In addition, this could result in missed probing opportunities to gain more in-depth information. There is also the potential loss of meaning in the interpretations between English and Somali (Kapborg & Boterö, 2002). That said, there were processes put in place to mitigate the impact of these compromises. As explained in the methods section, there were two series of transcriptions, one in English and one in Somali translated to English, taken from the audio-recordings. Each English translated version was reconciled with its audio-recording by a second translator who did not participate in the interviews. The original English transcripts and the English translated transcripts were then also reconciled and formatted for analysis. This process enhanced the assurance of accuracy and increased the study's validity. An additional possible limitation in working with an interpreter, particularly one from the community, is a participant's distrust in the interpreter's ability to maintain confidentiality, resulting in withheld

or disingenuous responses. There was no indication of this; however, it cannot be eliminated as a possibility.

Another possible limitation in this study might be identified by some as a cohort effect. However, although not all participant characteristics can be purposively matched, the nature of IPA sampling typically results in a homogenous sample. Therefore, exploration of differences based on cohort effect is not generally a feature of IPA. There are of course differences within this study's largely homogenous sample. For example, participants' mean age upon arrival to the U.S. was approximately 58 years and, except for two of the youngest participants, were never employed after resettlement. The two who did obtain employment reported a few differing experiences, based on financial security; however, one task of IPA is to aggregate shared meanings of essential experiences. Therefore, potential variations generated by a possible cohort effect would be more appropriately explored within a different study design.

Implications

Due to the nature of qualitative research, the findings can mostly only be generalized to its study participants, but as seen in the literature, although there are differences in resource needs across and within different refugee groups, there are also similarities, regardless of group, host country, or study purpose. This study's results can validate other studies' findings through similarities, introduce new information through differences, and help expand the limited research corpus focused on older refugees resettled particularly in Western societies to inform resettlement organizations, service agencies, program developers, and policy makers.

Public health response options based on these findings include a community assessment and further development of public health partnerships to acknowledge resources that impact older refugees' HRQoL and that can be influenced at population, individual, and organizational

levels. Due to financial limitations at the federal, state, and municipal levels much of the response work would be more efficiently accomplished by collaborating with grass roots and non-profit organizations. Collaboration between public and private organizations, as well as the targeted refugee community itself, is also more apt to bring successful, long-term programs utilized by the population for which it is intended.

Public health efforts at the state and local levels can explore strategies to improve accessibility to available health-related resources and establish resources that do not exist. Programming at this level might include transportation to nearby farmer's markets for locally grown produce; frequent day trips to local attractions and events, or settings that more resemble their homeland than does the busy urban setting; established green spaces and community vegetable and flower gardens; employment and volunteer opportunities; and travel programs to visit family abroad.

Since English proficiency is a resource with a broad impact, another strategy might be to develop English classes specifically for older Somalis. Although English as a Second Language (ESL) and other English language learning classes are available for refugees in this study's community, it is possible the classes are not tailored to older persons' unique needs. Chenoweth and Burdick (2001) note that older refugees may experience embarrassment when making mistakes alongside younger students. Older persons with little education in their homeland or who are illiterate in their first language, may view learning a new language as impossible. In addition, psychological trauma can have an adverse impact on language acquisition (Gordon, 2011). Chenoweth and Burdick (2001) recommend designing a language class that is more than a learning experience, but also a time for older refugees to gather for meals and recreational activities. A portion of this time could also occasionally be used for professionals to provide

education pertaining to physical and psychological health. Chenoweth and Burdick suggest a program like this could be carried out by a local organization with government funds.

This study's findings could additionally strengthen lobbying arguments for resources supporting HRQoL at all government levels. The current U.S. government administration issued an executive order in February 2021 (U.S. Office of Press Secretary, 2021) to rebuild and enhance refugee resettlement programs. Although broad and vague at this point, there is specific mention of women and children as vulnerable, but no reference to older refugees. This is an opportunity to give voice to older refugees and the importance of attaining a favorable HRQoL in the U.S. by contacting state and federal legislators on appropriate committees. Concerns such as sufficient income and family reunification can be addressed here.

In terms of clinical implications for community healthcare providers who attend to older Somalis' overall health, it is important for them to be aware of an individual's past experiences and current challenges and how they affect HRQoL. In other words, holistic care and cultural competence pertaining to older Somalis can provide much insight into early diagnoses of diseases and mental illness related to these past and present factors and prevent further insult to their HRQoL. In reference to psychological health services, Mölsä et al. (2014) note that previous research supports the absence of "culturally insightful healing practices for refugees" (p. 503); therefore, education would be beneficial for practitioners in this area of healthcare.

Recommendations for Future Research

To my knowledge, this is the only study that uses IPA to explore HRQoL among older ethnic Somali refugees resettled in the U.S. Since the participants in this study live in an urban setting with a large Somali presence, additional qualitative research focused on older U.S.-Somalis might examine similarities and differences in HRQoL between those resettled in rural

versus urban settings; those resettled in areas with large versus small Somali populations; and those living in more temperate regions of the U.S. versus regions with extreme climate differences from their homeland. Other resources mentioned by participants, rather gained or lost, could be further explored separately to gain a deeper understanding of how that single resource alters HRQoL. Each domain of HRQoL could also be independently examined in this population. I recommend exploring spirituality as a domain. Another HRQoL comparison could be explored between older Somalis and their U.S. born counterparts living within the same area to determine where resources can be shared between the groups and where they should be adapted for Somalis. In addition, a minority group of Somalis called Bantus have also resettled in the U.S. It would be advantageous to compare the perceptions of HRQoL between older ethnic and Bantu Somalis with an aim to observe how experiencing a marginalized existence prior to exile influences HRQoL in resettlement, rather than assuming their needs are identical to ethnic Somalis or other older African refugees. These recommendations are all an effort to facilitate greater resource gains than losses among this vulnerable Somali population to allow for a favorable HRQoL.

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Appendix A

Demographic Survey

What is your approximate age? _____

What is your gender? ____M ____F

What is your marital status? _____Single _____Married _____Divorced

_____Separated _____Widowed _____Living as married

What is the highest education you have received? _____None at all_____Primary school

_____Secondary school _____Tertiary school

Are you employed? _____YES _____NO

How many years have you lived in the U.S.? _____

Are you currently ill? _____YES _____NO

If yes, what do you think is the problem?

Appendix B

Interview Guide

1. When you meet someone for the first time, and you are sharing things about yourself with them, what might you say?
2. Describe your activities during a typical day, from the time you wake up until the time you go to bed. PP: How do your activities contribute to your standard of life?
3. What is most important to you in making your standard of life good?
4. What kinds of things have caused changes in your physical health? PP: What, if anything, would you change that would make your physical health satisfactory?
5. What kinds of things have caused changes in your emotional health? PP: What, if anything, would you change that would make your emotional health satisfactory?
6. Describe your social relationships and participation. PP: What would you like to be different about your social relationships and participation?
7. How do you think aging transculturally impacts your health-related standard of life? PP: What is different about aging in the U.S. from aging in Somalia?
8. How do you attempt to maintain a healthy standard of life? PP: What allows you to do this? What prohibits you from doing this?
9. What support do you feel you receive or do not receive in living a healthy life? PP: What else do you need to live a healthy life?
10. What else would you like to share that I have not asked about?

Appendix C

Occurrence of Themes Across Interviews

Themes	Interview																Totals
	I1	I2	I3	I4	I5	I6	I7	I8	I9	I10	I11	I12	I13	I14	I15	I16	n=16
Resettled																	
Gratitude	√	√	√	√	√	√	√	√	√	√	√	√	●	√	√	√	**15**
Preservation	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	**16**
Unsettled																	
Transitions	√	√	√	√	√	√	√	√	√	√	√	√	√	●	√	√	**15**
Trade-offs	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	**16**
Contradictions	√	√	√	√	√	√	√	√	√	√	√	√	√	●	●	√	**14**
Incomplete																	
Family Separation	√	√	√	√	√	√	√	√	√	√	√	√	√	√	●	√	**15**
Limitations	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	**16**