Aging in Silence: Gaps in Mental Health Support for Older Refugees in the US System

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EXECUTIVE SUMMARY

The United States has long accepted refugees, yet significant gaps in services and policies remain. When older adult refugees are admitted into the country, they struggle in silence and suffer due to mental health challenges from the combination of stressors shaped over a lifetime. Their journey, often marked by unsettling emotions and events, unfolds in three phases: premigration, displacement, and postmigration. These experiences have long-lasting impacts, leaving psychological wounds and scars that later appear in forms of age-related diseases that can deteriorate and debilitate adults' later life. Often arriving with limited to no resources, older adults are more vulnerable because they are limited in their abilities to restart their lives in the United States with limited assistance. With limited social support to express the daunting memories of displacement and loss, resettlement is much more difficult. Older adults have to navigate cultural and language barriers, which can create gaps in receiving treatment for mental health services.

Despite existing literature that acknowledges mental health concerns can have severe consequences, US policies and services fail to meet the needs of older adult refugees. Refugee agencies are limited in funding, which can limit operations and frontline workers' capabilities to assist. Some solutions to improve quality care are:

- Culturally responsive and trauma-informed mental health services
- Expand social welfare benefits and assisted housing.
- Expand federal and state funding for refugee agencies.
- Train and hire bilingual providers.
- Integrate physical and mental health care to provide preventive services.

Together, these solutions focus on older adults and their mental health in order to bridge the gaps in services, promoting effective and equitable support for refugee communities.

TABLE OF CONTENTS

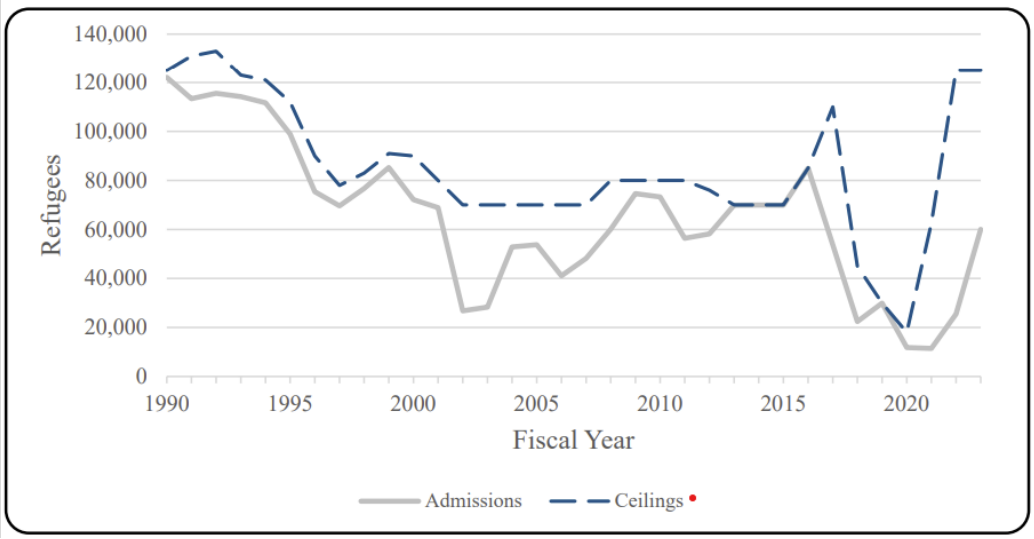
INTRODUCTION

Ethnic minorities in the United States tend to be understudied and overlooked, leaving them to be underserved by policies and systems that fail to address their needs. In the US, a refugee is a person unable or unwilling to return to their country of origin because of persecution or a well-founded fear of persecution on account of: race, religion, nationality, membership in a particular social group or power, or political opinion (Office of Homeland Security Statistics, 2025). Since 1980, the US has admitted over 3 million refugees, and in 2024, about 100,060 refugees were admitted, more than the combined total for 2022 and 2023 (Yap, 2025). Many of these individuals carry traumatic pasts that make adjusting to life in America difficult. Resettled refugees report PTSD, anxiety, and psychological distress because of chronic exposure to trauma (Siddiq et al., 2023). Persons older than 45 years showed a prevalence rate of PTSD of 80% compared to 36.8% for those under 30 (UNCR, 2020). Additionally, some older refugees who settled in the US in their late life are forced to abandon their social support and network, which can lead to isolation, further impacting their mental health (Siddiq et al., 2023). Refugees continue to experience hardships in resettlement, and they do not have adequate support from their community or the government, having difficulty with finding jobs or maintaining financial stability. With a multitude of struggles, this can further impact one's own mental health. Overall, given the large number of refugees who may be eligible for citizenship, it would be best to invest in policies or systems that address the health disparities faced by older refugees, which are critical to providing adequate health and mental care for the aging population.

BACKGROUND

Over the last 10 years, the US has admitted 469,830 refugees, and currently, the most admitted nationalities include the Democratic Republic of the Congo at 23 percent, Burma at 13 percent, Syria at 11 percent, Iraq at 7 percent, and Somalia at 6 percent (Yap, 2025). In 2024, over half of the admitted refugees resettled in 10 US states, with Texas, California, and New York among the most resettled (2025). While settling in the US, refugees are required to apply for lawful permanent resident (LPR) status after one year of admittance, and Green Card holders who are not yet US citizens must apply to be granted lawful permanent residence (Miller, 2024). According to reports, in 2024, about 1.3 million refugees and asylees had LPR status, and 960,000 were eligible to naturalize (2024). Figure 1 shows the number of admitted refugees and the projected ceiling of the maximum number of refugees the US would admit, and sometimes the admitted refugees would be higher than the proposed ceiling (Schofield et al., 2024).

Figure 1. Refugee Admittance and Ceilings in the US: Years 1990 to 2023



Source: Schofield & Yap, 2024.

Admittance in the US: From Displacement to Resettlement

To better understand refugees, we need to review the migration journey to resettlement, which typically occurs in three phases: premigration, displacement, and postmigration (Vang et al., 2021). The premigration phase encompasses life before, during, and after persecution or humanitarian crises. While experiences in this phase vary by individual depending on country of origin and timing of persecution, commonalities of themes include the loss of loved ones and forced departure from home to seek safety. These abrupt interruptions of profound events impact mental health and wellbeing and may persist into the displacement phase that compounds trauma onto mental burdens.

During displacement, refugees may resettle in camps, where, despite greater safety, there are risk factors to various harms of violence infiltrating camps and limited resources within camps. There are ongoing concerns about further displacement during settlement in camps and about when admittance to a new country will occur. Thus, the displacement phase is marked by significant uncertainty and anxiety.

The last phase is postmigration, the period when refugees resettle and face added challenges due to racial, cultural, language, and gender differences (2021). This includes adapting to a new life, securing employment, learning a language, or managing a household, while navigating an unfamiliar country. Some refugees benefit from sponsorship by US citizens, groups, or organizations that help register children in schools, find employment for adults, or enroll them in English-language classes. Others receive little to no assistance, making adjustment in the US more difficult. As they adjust to their new country, they still have the psychological scars of their premigration and displacement phase, with challenges often persisting long after arrival.

With the US having a history of admitting refugees, there are still gaps in addressing their needs. There is limited research on the refugee population. Refugees aren't tracked, and later classification as immigrants can lead to inaccurate reporting on refugees, which can limit service providers' ability to assess their clients adequately. Studies using quantitative datasets are limited in their inclusion of social determinants specific to intersectionally disadvantaged groups, and unique intersectional stressors and experiences are typically absent (Tobin et al., 2023). Lack of publications and reporting can lead to misinformed frontline workers and policy blind spots, which can lead to barriers for refugees to receive adequate care and treatment for mental and medical health concerns, leaving populations to feel left behind and dismissed.

As these individuals age, the physical and emotional toll of their migration journey can lead to mental and medical problems. For older adult refugees who arrive in the US later in life, there is little time to establish financial stability, secure long-term employment, build a pension and retirement savings, and establish a network of community. Language and cultural barriers, and medical health concerns due to aging, can get in the way of rebuilding a life, and living in isolation can further burden mental health concerns. However, having to prioritize survival and livelihood affects takes precedence, and refugees neglect their own mental health needs, which can worsen medical concerns.

Understanding the premigration, displacement, and postmigration phases is essential to addressing the unique mental health challenges that may be overlooked in these individuals. With the recent increase in refugee admissions and as more refugee adults get older, the United States needs more competent mental health services

tailored to this population. Without targeted interventions, older refugees risk falling through the cracks of a system that prioritizes youth and work-age adults. As the US population continues to age, the growing older adult refugee population needs to be understood within the broader context of national aging trends, particularly among the racial and ethnic minority groups, including those shaped by forced migration. Compared with their peers, older adult refugees may not be prepared to age successfully into retirement, adequate healthcare, and responsive support systems.

Aging with Dignity in the US and Mental Health Services for Older Populations

The older age population in the US is increasing over time as summarized in Table 1. Between 2021 and 2022, the number of Americans 60 and older increased by 29 percent (U.S. Administration for Community Living, 2024). In 2022, adults 65 years and older are expected to grow by 22 percent by 2040 (2024). By 2060, racial and ethnic minority populations ages 65 and over are projected to jump from 12.3 to 27.7 million, and migration patterns across the country will affect the ethnic and racial composition of the older population in the US (Carr, 2023). The aging population will continue to grow and represent a sizable share of the US population, and there needs to be policies and services that are representative in servicing the needs of older adults. Older adults have a longer life expectancy because of medical breakthroughs, while disproportionately benefiting those with greater social and economic advantages (Carr, 2023). Those who reach age 65 have an additional 18.9 years of life expectancy due to improvements in quality of life, changing the U.S. retirement age over the years (U.S. Administration for Community Living, 2024).

Table 1. Aging Population Trends in the United States

Category	Year(s)	Populations (in millions)	Notes
Women age 65+	2022	31.9	
Men age 65+	2022	25.9	
Total adults age 65+	2022	57.8	Projected to increase by 22% by 2040
Adults aged 60+	2021	60.9	
Adults aged 60+	2022	78.9	29% increase from 2021
Racial and ethnic minority adults aged 65+	2020	12.3	
Racial and ethnic minority adults aged 65+	2060	27.7	Expected to represent more than one-third of older adults

Note. Data compiled from the U.S. Administration for Community Living (2024) and Carr (2023).

In 1991, the average retirement age was 57, and in 2022, it had increased to 61 (2023). By retirement age, the average American would be expected to have a stable career, have purchased a home, have savings, and have retirement to ease into old age. With a purchased home, retirement savings, and a financial safety net, aging individuals have a financial safety net when they are no longer working and receiving income. Instead, they can rely on savings and retirement income to pay off remaining mortgage payments, medical expenses, and basic living expenses such as food and housing. The reality is that not all Americans have a secure retirement plan, including individuals who are uprooted and forced to start over.

When resettling in the US, refugees often arrive with very little or no assets and financial means. In 2024, 75 percent of admitted refugees were under 35 (Yap, 2025). Based on the reports from the last three years, those over the age of 55 make up an average of 5 percent of admitted refugees, but the numbers continue to grow from 1,350 individuals in 2022, 2,970 in 2023, and 4,910 total number of admitted refugees over the age of 55 in 2024 (2025). Unlike the average American, these individuals do not have a purchased home, savings, or retirement, for some had to abandon their homes in their native country to escape for safety. Some of them cannot take their savings or assets with them, which can make living in the US and aging with dignity more challenging and less equitable. Unlike many older adults in the United States who may rely on retirement savings, homeownership, or support from social networks, older refugees often arrive with none of these foundational supports. Forced to start over, they face the daunting task of rebuilding their lives from scratch and navigating a new country. This economic precarity is compounded by the lingering trauma of migration, displacement, and loss, making the pursuit of aging with dignity especially challenging while dealing with mental health. To address the mental health needs of older refugees, understanding is needed for both the systemic barriers they face and the enduring emotional impact of their migration journey.

THE HEALTH TOLL OF DISPLACEMENT: TRAUMA AND MEDICAL ILLNESS AMONG REFUGEES

Social or environmental factors can accelerate aging, and when exposed to stress, one can become more susceptible to a range of health issues in later life that can make

aging harder. The oxidative stress models propose that age-related disease can result when the body's balance of pro-oxidants and antioxidants tilts to favor pro-oxidants, which can damage healthy cells, and these imbalances can increase the risk of neurodegenerative diseases such as dementia, cancer, heart and blood vessel disorders, and inflammatory disease (Carr, 2023). High cumulative stress is positively associated with increased reports of negative physical health outcomes, and some of this stress may be a combination of financial stress and perceptions of deprived opportunities (Haight et al., 2023). In a 14-year longitudinal study on the effects of adversity on older adults, stress is positively associated with accelerated aging and health deterioration, strongly affecting mobility limitations (Levinsky et al., 2021). Therefore, stress can slow down some of the body's normal functioning and can physically cause harm. While stress is a normal part of human functioning, being exposed to constant stress can make aging harder while dealing with health issues and having to afford medical costs, which can add more worry. Oxidative stress is linked to social factors, and years of exposure to acute and chronic stressors can overwhelm one's cardiovascular, immune, and central nervous system and bring about disease and premature death, shortening life spans (Carr 2023). For older adults, it may not be ideal to live the remainder of their lives managing health complications while dealing with stress.

Older adults are more susceptible to health problems because the natural process of aging slows some of the body's normal functions, such as cell repair and healing. Stress can only make the process of aging worse by further slowing these processes, making older adults more prone to infections, illnesses, or diseases.

However, older adults must monitor their mental health just as much as their physical health. Analysis among older adults shows that depression risk increases after age sixty-five because each passing year brings more physical and cognitive health problems, which can cause distress, and the stress of managing health and the disruption to one's daily routines and activities can intensify feelings of sadness, anxiety, and hopelessness (Carr 2023).

Refugees often experience stress during pre-migration, displacement, and post-migration phases that can contribute to oxidative damage in the body because of the long-term exposure to stressors. Prolonged exposure to trauma or feelings of uncertainty can possibly make them more susceptible to diseases and health complications in older age. Multiple stressors over time create cumulative, compound stress, and this may accelerate the onset of age-related illnesses, causing medical issues to emerge earlier than expected. For refugees who experienced forced migration in later life, age-specific factors may compound the mental health impact and psychological distress that are induced by forced migration, such as dementia, depression, and unrecognized alcohol abuse (Virgincar et al., 2016). Additionally, chronic physical illnesses, disability, and nutritional deficiencies compound psychological stress, and resources and treatment may not be available during enforced migration periods (2016). The age of migration and increased length of stay among foreign-born adults are both factors that contribute to mental health disparities (Siddig et al., 2023). For refugees who have settled in the US for a good duration, as they age, they might be more likely to be diagnosed with medical problems earlier in their adult life or have a worse prognosis than their similar-aged cohorts. Foreign-born adults are both

factors that contribute to mental health disparities (Siddig et al., 2023). For refugees who have settled in the US for a good duration, as they age, they might be more likely to be diagnosed with medical problems earlier in their adult life or have a worse prognosis than their similar-aged cohorts.

Pre-migration Phase Stress Factors:

The premigration phase is the beginning of each refugee's experience of their migration journey, and this journey is filled with events that trigger feelings of worry, stress, and anxiety. During this phase, some refugees experience breaches of trust and betrayal from their government, community, or even family members, such as family members turning them in to protect themselves from oppression (Vang et al., 2021). Bhutanese refugees experienced betrayal of having their citizenship stripped away from their country and being forced to leave (Frounfelker et al., 2020). Hmong refugees who fought as soldiers in the post-Vietnam War remained in Laos to fight as their military leaders abandoned to Thailand for safety, risking their family and themselves to violence and harm (Vang et al., 2021). The history of war and instability in the Democratic Republic of Congo has led to millions of people dying from diseases and malnutrition, and survivors have been assaulted, tortured, and sexually terrorized (Wachter et al., 2016). Though the premigration phase differs across refugee groups, the consistent pattern is one of profound psychological threat, marked by betrayal, violence, and instability that undermine refugees' well-being long before displacement begins.

The experiences witnessed during the premigration phase constitute significant psychosocial risk factors that can have enduring impacts on mental health and well-being because they are extremely traumatic and upsetting. Individuals may experience family loss, such as the death of a spouses or a child. Younger individuals can lose one parent or be orphaned. These painful events can leave a lasting impression on refugees, such as distress and grief, that some survivors describe as psychological symptoms similar to depression, anxiety, and PTSD (2016). Forced migration and prioritizing survival do not allow individuals to have time to process feelings of grief, betrayal, or abandonment, leaving unresolved feelings and lingering thoughts that may be buried and compartmentalized for periods of time. Collectively, premigration phase lays a foundation of psychological distress that refugees carry into later phases of displacement and postmigration.

Displacement Phase and Trauma:

During the displacement phase, feelings of instability and loneliness arise as individuals flee their homes and seek safety (Vang et al., 2021). There's uncertainty about the danger of having to make quick decisions for survival. However, quick decisions sometimes mean being forced to leave your home and your job behind. Additionally, it means leaving behind the support network and community to ensure the safety of the individual and their family, which can lead to feelings of loneliness. Loneliness can come from loss of loved ones, losing support networks, and not being able to rely on the government for help. Individuals must rely on themselves to survive, which can be a lot of pressure, yet they don't have anyone to turn to for help processing their emotions.

Bhutanese refugees remarked that they felt isolated from their native country, without a home to return to, yet also outsiders in the US because of cultural differences, further emphasizing feelings of alienation (Frounfelker et al., 2020).

Those seeking refuge are often at risk of displacement traumas, which are a multi-systemic and multilevel phenomenon that recognizes the importance of timing, or the age at which an event happens, that significantly shapes and molds a person's resources, abilities, and weaknesses in responding to threats to their well-being (Siddiq et al., 2023). Afghanistan women refugees in refugee camps risked themselves to vulnerable health conditions, preterm labor, spontaneous abortion, physical and sexual trauma, and infectious disease (Worabo et al., 2024). Though these camps are supposed to be a safe haven, they pose many risks, and the uncertainty of danger persists as refugees are trapped with little to no safety. Refugee camps for Maya refugees in Mexico were suspected by the Guatemalan government as guerrilla bases, leading the Mexican government to deport refugees back to harm (Garcia, 2006). There is a 'limbo state' in which they may have resided in a refugee camp in a country for many years prior to arriving in the US, which may contribute to unstable social networks (Siddiq et al., 2023). The limbo state during the displacement phase, though physically safer away from the conditions they fled, is marked by persistent uncertainty about survival, future resettlement, and potential threats to survival.

Feelings of instability persist even after individuals settle into refugee camps, due to the uncertainty about what will happen afterwards, which can contribute to a limbo state. In addition, without a stable social network, there are few, if any, trusted outlets for support to discuss the struggles of settlement and migration in which one can

confide. Some factors that influence the displacement phase are familial loss, instability, loss of social status, and isolation, which contribute to loneliness (Vang et al., 2021). When there are so many factors experienced within a short time frame of forced migration and persecution, it's no surprise that the psychological stress would greatly impact one's physical health.

Post-migration phase: Challenges that impact mental health

The last phase for refugees is often a last resort to escape harm in their native country, but it is marked by new challenges and barriers in resettlement. When refugees decide to relocate, they must leave their native country behind. Sometimes, they leave behind their relatives, their community of support, and any social networks. They also leave their homes that they or their families have worked hard to maintain and build. Furthermore, this is the uprooting of one's life, leaving jobs or careers behind, and a culture that they have been used to for most of their lives. Even so, this is a quick uprooting after witnessing so many traumatic events that one does not have time to process the migration and resettlement. Resettlement gives the idea of hope and stability away from the harms of violence and persecution, but the reality is that some refugees struggle after their settling in their new country. Resettled refugees experience a high prevalence of mental health-related issues, such as depression, psychological distress, anxiety, and post-traumatic stress disorder (PTSD), compared to their native-born counterparts (Siddiq et al., 2023). The traumas that forced refugees to flee do not simply disappear upon resettlement.

Their journey continues as they navigate their new life, start over from scratch, and attempt to create a new normal in their new country. However, the psychological scars persist, leading them to be susceptible to mental concerns. Older adult refugees face heightened vulnerability to mental illness due to the intersection of aging and prolonged trauma (2023). Forced migration can disrupt and reduce their social networks and quality of social support, leading to social isolation, grief, and mental health challenges (2023). Even in a new country away from immediate harm, isolation away from family and loved ones remains deeply impactful, as many lack trusted relationships through which they can process grief and the emotional toll of migration. The culminating factors experienced during the premigration and displacement phase greatly affect physical health, and symptoms of these concerns are more pronounced, making older adults more susceptible.

Assessing data of Vietnamese-origin older immigrants and refugees in the Houston, Texas area revealed that many experienced similar health conditions of older Americans but reported higher rates of depressive symptoms and cognitive impairment, with the three common conditions comorbid with arthritis and hypertension being depressive symptoms, diabetes, and cognitive impairment (Miyawaki et al., 2024). Participants also reported several physical disabilities that were significantly associated with depressive symptoms and loneliness (2024). The stress of displacement and resettlement can compound these health issues, as serious physical conditions often exacerbate mental health challenges, which in turn can further deteriorate physical functioning. By understanding the mental and physical implications of refugees' journey

to the US, we can provide better policies to mitigate these serious health consequences.

BEYOND RESETTLEMENT: POLICY PERSPECTIVE

The Refugee Act of 1980 established the Federal Refugee Resettlement Program to provide effective resettlement for admitted refugees and to assist them in achieving economic self-sufficiency after arriving in the US (Office of Refugee Resettlement, 2022a). Currently, the Office of Refugee Resettlement (ORR) oversees the program, providing funding to states and local agencies for services and programs like offering cash and medical assistance and supporting long-term resettlement services up to five years, such as employment services, case management, and English language training (Office of Refugee Resettlement, 2025). The federal government recognizes that older refugees have unique needs and challenges compared to other age groups, and ORR provides funding for specific programs and services. ORR partners with the U.S. Administration on Aging to identify aging and resettlement networks to collaborate at the state and local levels to ensure services are accessible to those in need (Office of Refugee Resettlement, n.d.). However, services vary depending on funding and availability of programs to address health and mental needs identified by refugee agencies and nonprofits in various cities. Some services include access to senior community centers, transportation, home care, and activities and services that support overall physical and emotional health, helping integrate older adult refugees into new communities and supporting independent living (Office of Refugee Resettlement, n.d.).

There are many efforts to assist the refugee population, with nongovernmental organizations (NGOs) and nonprofits providing services to refugees settling in the US. In the fiscal year 2014-2015, about 11,977 older adult refugees nationwide received services (Office of Refugee Resettlement, 2016). These numbers are for those over the age of 60 who have recently arrived in the US and do not include refugees who have long settled in the US. Additionally, the data does not capture older adult refugees who are served outside of federal funding. There may be limitations in tracking older refugees' post-resettlement outcomes at the federal level, or the number of refugees served may not be shared from refugee agencies to federal agencies. Thus, the number is not representative of all older adult refugees residing in the US, and some individuals may be falling through the cracks and not receiving adequate services. Even so, refugee agencies do their best to continue with operations to help their refugee clients.

At the local level, nonprofits and NGOs conduct most outreach to older adult refugees and provide services. Some examples include community-based mental health care, such as outpatient care, supported employment and housing, case management, and counseling, which are available, but little emphasis has been placed on prevention, early screening, treatment, and mental health resources tailored to the needs of the broader refugee population, particularly older adults (Siddiq et al., 2023). With aging adults in mind, preventative measures are needed to address mental health concerns at early stages to reduce the risk of more severe outcomes, such as the early onset of age-related disease.

The True Cost of Agency Operations

Even with the assistance of federal funding, many refugee agencies and nonprofits still face financial challenges. Many organizations remain underfunded and rely on alternative sources to sustain their operations. According to one survey, about 84 percent of organizations received individual donations, 72 percent rely on philanthropic donations, and 60 percent of organizations receive faith-based funding (American Immigration Council, 2021). In contrast, only 42 percent of respondents received federal funding, 38 percent state funding, and 35 percent local government funding (2021). This uneven distribution limits an organization's ability to reach its targeted audience, provide services, and connect them to resources. While survey respondents said they would be open to certain types of government funding, some sources, such as ICE and the Department of Homeland Security, were the least favorable, but funding restrictions make it difficult to effectively serve clients (2021). No restrictions were specified, but this feedback suggests that some refugee agencies and nonprofits would prefer that federal agencies align with their goals. Thus, this conflict could lead to hesitancy to approach the federal government for funding and grants when refugee agencies need additional funding to remain functioning. If several refugee agencies choose to operate independently without federal assistance, the federal audits conducted may be less accurate in assessing refugees' needs, ultimately hindering the development of meaningful policies and programs.

Despite the US having one of the oldest and largest refugee resettlement programs in the world, it still faces challenges in addressing mental health for older adult refugees (Capps et al., 2012). Street-level bureaucrats, such as case workers and

community informants from refugee agencies, play a critical role in bridging gaps between refugees and essential services. By fostering trust and cultivating relationships, these frontline actors enable refugees to access available resources, such as medical and mental health services. As refugees settle in the US, a case worker or community informant can help with the transition of resettlement while navigating challenges and uncertainty.

Besides offering guidance and services to refugees, sometimes case managers monitor and document their clients for possible signs of mental or medical health concerns. Many factors to consider when making referrals to older adult refugees include age, background, and language, to ensure they receive a provider who best meets their needs. A culturally competent provider can increase client satisfaction by being culturally aware and sensitive to clients' backgrounds (Govere et al., 2016). Having providers who are culturally sensitive in their healthcare and social service approaches can minimize feelings of alienation and discomfort among refugees (Nisa et al., 2024). However, cultural sensitivity alone is not enough to build refugees' trust in their service providers. Shared language is sometimes needed because language can minimize miscommunication. An interview with a case manager at a refugee agency serving Afghanistan, the Middle East, and North African refugees in California expressed frustration in identifying specific community-based resources that matched their clients' backgrounds and language (Siddiq et al., 2023). Having providers who share the same language as refugees can make communication easier, but there are few frontline workers who are bilingual.

Already difficult to find a service provider who meets a client's background and needs, case managers are stretched thin to find the client multiple resources just to access the mental health services they need. While the overall rates of mental illness for many refugees and immigrant groups are, on average, lower, they are far less likely to receive care because of accessibility, worsening the consequences of mental health (Simmich et al. 2014). Cultural and language barriers are among the many factors preventing care. Other barriers to accessing mental health support include transportation and costs (Siddiq et al., 2023). Older adult refugees arrive in the US without their own vehicles or reliable transportation, and they still must navigate to seek care while finding a provider who can meet their specific concerns, discouraging older adult refugees from seeking help and accessing it.

There are low reports of mental illness for these groups because of cultural stigma, shame, distrust of professionals and service providers, or lack of access, possibly leading to the belief that these individuals do not need service. Yet limited providers and accessibility further frustrate both case workers and refugees, and this can deepen feelings of isolation and uncertainty for refugees, compounding the stress they already carry from displacement, trauma, and the challenges of resettlement. Additionally, funding levels are insufficient to maintain the staff and services necessary to carry out the work of refugee agencies and nonprofits. Frontline workers are constrained and pressured to ensure that refugees' needs are met while meeting federal and state guidelines to secure funding for operations, leaving caseworkers burdened by the anxiety of oversight and the weight of discretionary decisions (Fee, 2018). Despite their limited capacity, case managers and frontline workers take on the

stress of working with multiple clients and caseloads while de-stigmatizing mental health and overcoming cultural barriers.

Language: Lost in Translation and Mental Health Divide

Frontline workers from refugee agencies are faced with handling large caseloads, familiarizing themselves with local resources, being knowledgeable about the latest policies and procedures, and, all the while, being sensitive to refugees' cultures and traumatic backgrounds (Kotovics et al., 2018). If workers or client managers aren't fluent in the refugees' native language, communication can be difficult, leading to misunderstandings between the street-level worker and their client. As mentioned earlier, case managers want to match service providers who can speak the same language as their clients to avoid misunderstandings and confusion. The use of medical jargon can be difficult for refugees to understand and translate, making it more challenging to navigate services (Rose et al., 2023). Even street-level workers who speak the same language found it difficult to express mental health concepts, and language barriers are already compounded by poor mental communication and fear among refugees of being misunderstood and misdiagnosed (2023). Discussion around mental health can be hard between frontline workers and refugee clients when communication is not clear, possibly leading to further confusion regarding the concept of mental health for refugees.

When interviewing South East Asian refugees, it was recognized that there is no definition for mental health, and professionals noted that if their clients cannot recognize mental disorders and cannot understand psychiatric terms, they cannot correctly

understand, express, or seek help for their mental illness, further explaining that elderly refugees demonstrated lack of recognition and understanding of depression (Lee et al., 2010). From a cultural perspective, the problem of having such narrow definitions of illness and treatment is compounded by the fact that those immigrating to Western contexts do not understand mental illness within such a framework (Simmich et al., 2014). Older adult refugees might not be able to communicate their mental health concerns if they have any because they are not able to identify them themselves, which can further complicate communication with their case managers and service providers. On the other hand, if professionals heavily rely on medical and psychiatric terms, then it can limit cultural exchange and understanding between frontline workers and clients. Even so, the lack of understanding of the mental health concept adds work to case managers, who have to actively look for signs of possible mental health concerns to be able to make referrals.

Confusion isn't limited only to language barriers and miscommunication. Sometimes, refugees are directed to websites that pose challenges for older adults due to low computer literacy and language barriers, leaving them in need of long-term assistance from their case workers (Nisa et al., 2024). Computer literacy adds another layer of older adult refugees having to navigate to receive services, and they are expected to navigate these websites on their own if they are limited to social support and assistance, leading to delays in receiving mental health services and frustration. This can further discourage clients from seeking them out. For many, the pathway to receiving services is inaccessible or inequitable, leaving gaps in care.

Cultural and Mental Health Stigma for Barriers to Effective Care

In the US, concepts of mental health are more accepted today and normalized, but in some parts of the world, they are still indifferent. Differences in cultural views of mental health can prevent refugees from seeking help and services, especially when they need mental health services to help with depression or PTSD. In exploring mental health among Middle Eastern older refugees, it was reported that older adult refugees hold their stress in because of stigma, cultural values, religiosity, not wanting to burden the family, and mental health not being emphasized in their home countries contributed to their silence (Siddiq et al., 2023). The cultural view that talking about mental health is a burden can cause more stress, leading them to bury any underlying feelings and thoughts. As these mental burdens continue to be concealed, they eventually show in other ways, such as anxiety, depression, or possibly early onset of aging diseases. Educating on the long-term effects of mental health can prevent or mitigate some of these outcomes. However, mental health education sometimes ignores the older population, sometimes choosing to focus on a younger audience. It can be forgotten that older adults have their own specific issues concerning mental health related to their age.

The stigma of mental health varies across cultures. In Asian cultures, mental health is viewed as a sign of weakness, and in Ethiopia, mental health is associated with supernatural causes that can limit one from seeking evidence-based psychiatric care (Ahad et al., 2023). Frontline workers must be mindful of these cultural views to provide responsive, respectful care that builds trust between frontline workers and clients, reducing barriers to mental health care. Sometimes, gender and culture

compound in mental health stigma. In some Arab communities, mental health was particularly heightened among refugee men, leading them to suffer in silence and be unwilling to talk about distressing events or past trauma with family or close friends (Siddiq et al., 2023). This is the perception of Arab men as stoic, with emotional control and strength (Ahad et al., 2023). However, cultural perceptions can prevent individuals from recognizing that they need help and can make engagement between frontline workers difficult. This underscores the importance of training in cultural competency, fostering community partnerships to build trust, and promoting inclusion and healing.

Refugees and US Systemic Barriers

To provide service rooted in culture, further understanding of the postmigration challenges of refugees challenges and their integration in US society. Language barriers were predictors of depression in older adults, including their perceptions of pressure to learn English and possessing low English competency, and when comparing immigrants and refugees, English competency had a greater effect on stress for refugees (Wrobel et al., 2009). In postmigration phases, having to navigate language barriers can bring on more stress for refugees, especially when they have low English competency. Low levels of language competency in resettlement contexts are associated with poor health outcomes and represent significant barriers to healthcare access (UNHCR, 2020). In relation to medical terms lost in translation, miscommunication can delay services and frustrate refugees, especially when they require them. Refugee agencies do their best to encourage refugees to take English learning courses because they understand the gravity of language barriers to accessing

services and public assistance. However, older adult refugees might be less likely to take English-learning courses because of other barriers, such as transportation, and navigating a new world can be wearying.

Even though nearly three-quarters of recent older immigrants cannot speak English fluently or have limited proficiency, compared with just one-third of older immigrants who arrived decades earlier, there still seems to be a gap in services accessible to those whose first language isn't English (Carr, 2023). In 2022, 25 percent of older adults identified as racial or ethnic minorities (U.S. Administration for Community Living, 2024). There is an ongoing need to improve the provision of providers, frontline workers, and services that address cultural and language gaps. Overall, refugees have been characterized as being "multifaceted and multidimensional", for it involves a mixture of dimensions and perspectives, ranging from psychological and socio-political to financial, cultural, and historical, covering the entire span of time (Papadopoulos, 2018). Each refugee group has different experiences and a political context, shaped by varying histories of racism, conflict, or religious division.

A review of resettled refugees originating from Afghanistan and Iraq had a higher risk of mental disorders than those from other countries (Geneva: World Health Organization, 2023). This could be the country's history of political instability and violence that individuals experienced. Another review reported that migrants from African and Caribbean countries of origin, where most of the population is categorized as Black, had a significantly higher risk of psychotic disorders, which may be driven by structural and institutional racism and disproportionate levels of poverty, social

exclusion, and discrimination experienced by ethnic minority groups in destination countries (2023). Individuals who experience trauma may experience more comorbidities, but their associated mortality rates may be lower because of developing resilience in facing cumulative adversity due to cultural values (Levinsky et al., 2021; Chen et al, 2015). The context of refugees' countries of origin matters, adding complexity to addressing these groups across the pre-migration, displacement, and post-migration phases. In the US, refugees' resettlement experience may be compounded by racism and systemic barriers, which can further limit their access to services and public assistance, risking them to further isolation when they most need help.

When analyzing refugees and mental health, the literature remains limited for this population, especially for older adult refugees. The scarcity of evidence is characteristic of deficiencies in interventions for ethnic minority populations and may be attributed to the specific challenges of conducting such evaluations with refugee populations (Murray et al., 2010). The gap in providing services to these groups can lead to fragmented and inconsistent findings due to underrepresentation. Moreover, accurate reporting of refugee demographics is complicated by shifting classifications over time. Individuals initially designated as refugees may later be classified as immigrants due to naturalization, leading to inconsistencies in data collection and longitudinal tracking. Accurate classification can enable service providers to deliver more culturally sensitive, trauma-informed care that considers refugees' unique experiences and needs.

BRIDGING THE GAPS IN POLICY AND PRACTICE

Despite federal recognition of older refugees' unique needs, current systems remain fragmented, underfunded, and ill-equipped to address the intersectional realities of aging, trauma, and cultural displacement. By drawing connections between stress, cumulative trauma of forced migration, and the migration phases of refugees, there can be better advocacy and pathways to supporting the need for mental health in order to mitigate and provide early treatment of medical health concerns. Table 2 summarizes key structural and psychological challenges facing older refugees, along with proposed policy and practice interventions. The solutions emphasize culturally responsive care, improved funding mechanisms, and integrated service delivery for equitable support. By synthesizing insights from the available literature and current policies, I contribute a practical framework for advancing mental health equity and services among aging refugee populations.

With greater focus and emphasis on age-specific mental health services, there will be more tailored services to better address the needs of older adults, while also providing culturally responsive care. In services that highlight grief, financial insecurity, and family care support, community-based resettlement practitioners can shape innovative programs that advocate for resources specific to refugees (Wachter et al., 2016). Admitted refugees aged 40 years parallel their resettlement experience to those aged 60, having similar difficulty integrating in the US and understanding new systems, leading to gaps in services (Maleku et al., 2022). This can lead to a greater need for public and cash assistance among refugees in this group due to disrupted financial and home security in their native country. However, there are limitations to cash assistance

that show greater benefit to those who are able to work, are younger, are obtaining an education, and have some level of English competency (LoPalo, 2019). Even so, state and federal funding for cash assistance helps alleviate some financial concerns, as some programs have limited timelines for assisting refugees of all ages.

Refugee agencies of all kinds are underfunded, and they should receive more federal funding to keep operations going. However, in early 2025, federal funding was paused, defunding the entire refugee resettlement infrastructure in the US government, leaving many organizations across the country reeling with how to provide vital services to newly admitted refugees (Bustillo, 2025). This forces refugee agencies to rely on public donations and sponsorships for funding when those funds are already limited. Even so, passionate organizations continue to provide essential assistance to those in need. Having service providers who are culturally competent and speak the same language as refugees, while providing mental health services that focus on preventive care for these specific clients, can greatly improve the health of older adult refugees. Providers need to understand the economic stress that newly arrived refugees typically face, as they are often low-income and do not make a living wage, and refugees sometimes experience the frustration of constantly being referred when providers do not have culturally-relevant care (Im & Swan, 2021). The stress of navigating resettlement does not always allow refugees to have the capacity to process grief and trauma.

Table 2. Key Challenges Facing Older Refugees and Proposed Solutions.

Problem	Description	Proposed Solution
Lack of Age-Specific Mental Health Services	Most programs prioritize youth or working-age adults, overlooking older refugees' trauma and aging-related needs.	Fund culturally responsive, trauma-informed mental health services tailored to older adults, including geriatric screening and counseling.
Disrupted Retirement Security	Forced migration erodes savings, pensions, and homeownership, increasing financial vulnerability.	Expand eligibility for SSI, Medicaid, and housing support; offer financial literacy and benefits navigation.
Underfunded Community-Based Organizations (CBOs)	CBOs provide frontline support but face unstable funding and limited staffing.	Expand federal and state funding for CBOs; simplify grant processes and support capacity-building.
Cultural and Linguistic Barriers	Language gaps and stigma hinder access to care and trust in providers.	Train and hire bilingual, bicultural providers; expand interpreter services and culturally competent care models.
Cumulative Trauma and Accelerated Aging	Chronic stress from migration phases contributes to early onset of age-related illness.	Integrate physical and mental health care; invest in preventive services and resilience-building rooted in cultural strengths.

Note. Adapted by the author from sources including Siddiq et al. (2023), Carr (2023), and the Office of Refugee Resettlement (2025)

DISCUSSION

The lives of refugees are not simple and are often filled with many challenges and burdens to overcome. The literature suggests that the premigration, displacement, and postmigration phases do have long-lasting impacts due to trauma exposure, disrupted

social networks, and chronic stress that intersect with age-related health decline. The compounded vulnerabilities are magnified for older adults due to aging, making them susceptible to early-onset age-related diseases and structural barriers that limit the effectiveness of support systems. Current systems do not meet their needs because federal funding is insufficient, and agencies are constrained in their capacity to provide services. Additionally, resources are limited too, leaving many older adult refugees alone to deal with their health concerns. Cumulative stressors and unprocessed trauma do contribute to long-term mental health conditions that adversely impact later-life medical health concerns. Refugees who are considered working adults are more likely to find means of resources and receive help because they're less likely to have a debilitating health condition that hinders their ability to get around and secure a job as a means of income. Older adults with mobility issues are less likely to gain access to services and maintain a job, which makes them more prone to stress. US systems need to recognize the unique needs of older refugees to better address the barriers that affect their health outcomes.

The US has structural issues that further restrict access to care. Language is one of the main barriers to receiving care and a predictor of refugees' mental health. All the while, systemic racism and marginalization further exacerbate cumulative health burdens, contributing to elevated risks of distress and social alienation. The social structure creates gaps that contribute to fragmented care and inconsistent support across communities.

There are plenty of refugee agencies across the US that advocate for refugees and provide services. These agencies recognize the types of concerns that refugees

need assistance with. Nonetheless, due to funding constraints, operations are at risk, leading to gaps in the provision of sufficient care and treatment to this vulnerable population. Based on the literature found, there is a need to tailor mental health outreach for older adult refugees, for both those who have arrived in the US in their adult age and those who have aged into older adulthood. However, the limitations in tracking lead to wider gaps and underrepresentation for older refugees. For services that better meet the needs of older refugees, there needs to be more culturally responsive, trauma-informed care that is accessible. Overall, the literature reveals that older refugees face a convergence of trauma, aging, and structural barriers that shape their mental and physical health outcomes. Addressing these challenges requires coordinated policy action between the federal government and refugee agencies that focuses on sustained funding and culturally grounded approaches that recognize the complexity of refugees' lived experiences across the migration continuum. Simultaneously, the US and refugee agencies provide services and policies that are sensitive to systemic barriers and social structures.

After reviewing the available literature, more research focuses on youth and working adults, likely because more refugees in those age groups are admitted (Yap, 2025). However, it can limit the support for older refugees, undermining their needs and skewing available services instead. Working adults and youth have the advantage of time to integrate themselves into the US in the postmigration phase. If there were research or data on older adults' death rates or life expectancy, then those numbers could be compared to other non-refugee cohorts. They can also reveal the severity of mental impacts on health outcomes.

LIMITATIONS

There are limitations in obtaining data for refugees: the federal website only lists data from 1997, and the data doesn't differentiate age groups until later reports, such as 2003 (Office of Homeland Security Statistics, 2025). In addition, it's impossible to obtain longitudinal data specifically on refugees, which can make it hard to report on this population. Despite the growing number of older refugees resettled in the United States, research on their mental health experiences remains limited. Most existing studies focus on younger populations or general refugee integration, leaving older adults underrepresented in both data and discourse. This lack of data should not be interpreted as a lack of need. On the contrary, it underscores the urgency of investing in age-inclusive, culturally responsive research that centers the lived experiences of older refugees, which can help improve service providers and justify funding for refugee agencies.

CONCLUSION

Taken together, the available literature demonstrates that older refugees face layered vulnerabilities shaped by trauma, aging, and systemic barriers. The complex trauma needs more inclusive and culturally knowledgeable practitioners and frontline workers if they are to be successful in treating their clients with diverse backgrounds, such as refugees. An intersectional approach to health and aging recognizes that statuses such as race, ethnicity, gender, and age are fundamental determinants that shape exposure to health risks and access to health-promoting resources (Tobin et al., 2023). The cumulative experiences of refugees need to be understood to provide an accurate

narrative for better treatment and mitigation. With fragmented tracking, systems fall short in giving special attention to older adult refugees. Improved language access, stable funding, and more research on this population are needed to better identify the focus for policymakers and refugee agencies. Ultimately, supporting older adult refugees requires recognizing the full complexity of their migration journey to design systems that honor their resilience while providing equitable access to mental treatment to give them a quality-of-life postmigration.

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