

Stressors Affecting Parenting in Refugees and Potential Interventions to Support Healthy Parenting

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June 2021

Abstract

Refugees are at increased risk of psychological distress and mental illness such as PTSD and depression. The mental health of primary caregivers directly and indirectly affects their children. Pre-migratory stressors, such as trauma and violence, are known to increase incidence of child emotional and physical abuse. Post-migratory stressors, such as financial hardship, acculturation, and language barriers can lead to caregiver distress, harsh parenting, and eventually child emotional and behavioral problems. Several parental support interventions are currently under investigation. Some community-based, group parent support education programs show promise in addressing caregiver psychologic distress and improving parenting in refugee populations.

Introduction

Since 1975, the United States has resettled more than 3 million refugees.¹ With refugees using primary care services as much as non-refugees, providers must be prepared to serve and support this vulnerable population.² Adult refugees face increased risk for developing post-traumatic stress disorder (PTSD) and depression, compounded by other post-migration stressors such as acculturation and financial hardship.^{3,4} Research shows that poor mental health of parents and caregivers not only affects themselves as individuals, but also negatively affects the health of their children.⁵ These children are also at increased risk of adverse childhood experiences such as domestic abuse, poverty, and parental/guardian divorce.⁶ Therefore, it is imperative that health systems support refugee parents. This paper aims to first provide an overview of the mechanism of a multitude of factors that affect adult refugees' parenting behaviors, then review potential interventions to support healthy parenting.

History of trauma

Some studies have shown that roughly 40% of refugees suffer from PTSD due to direct or indirect traumatic experiences, including violence and torture.⁷ As Bryant et al. describe, PTSD is associated with harsh parenting, which can then lead to children experiencing greater levels of conduct problems, hyperactivity, as well as emotional and peer relation problems.⁷ This process, in which a parent's response to trauma affects the development of the child, is called intergenerational transmission of trauma. In interviews with North Korean refugees, participants that had experienced significant trauma described feelings of anger, frustration, and being unable to perform daily functions, let alone care for their child.⁸ Severe parent symptomatology and maladaptive behavior increased the incidence of child physical and emotional abuse. Recent investigations detailing the mechanisms of intergenerational transmission of trauma suggest it is via decreased parental emotional availability, impaired family

functioning, insecure attachment, and poor intra-family communication.⁹ Thus, when health care systems care for refugees, it is important to screen for a history of trauma and violence and offer resources not only to those directly exposed, but to the entire family.

Post-migratory factors

Stressors affecting parenting are not limited to the pre-migration and migration stages, but post-migration can also have a significant impact on parenting through a variety of mechanisms.

Refugees arrive to the United States with extremely limited resources. The Migration Policy Institute reported that the median household income for recent refugees -- meaning having arrived in the last five years -- was only 42 percent of the median for U.S.-born households.¹⁰ One can imagine the stress of arriving in a new country and needing to begin working in what is often a low wage, labor-intensive sector due to having little education or education not recognized as valid in the United States. Financial stress is therefore found to exacerbate primary caregivers' psychological stress, leading to hostile parenting, which can then affect children, leading to child emotional and behavioral problems.¹¹

The level of acculturation of the primary caregiver likewise affects parenting and family functioning. Lu et al. analyzed acculturation of refugees in Australia through four different dimensions: English proficiency, self-identity (feeling welcomed to the new country, free from discrimination, etc.), social interaction (ability to make friends, talk to neighbors, etc.), and self-sufficiency to participate in life in the new country (know how to find a

job, use public transportation, etc.).¹¹ Of those dimensions, low caregiver self-identity and English proficiency showed indirect effects on children's wellbeing through increasing caregiver's psychological distress which then contributed to hostile parenting.¹¹

Conversely, adapting to a new country and perceptions of American culture can deter refugee mothers from healthy child care practices that they value. For example, in interviews with 10 refugee mothers from East and Central Africa, the women stated that they breastfed their babies less than they would have in their home countries.¹³ Along with a perceived stigma of breastfeeding in the United States, they also pointed to the demands of having to work at a job and the low-cost of formula compared to their home countries as playing roles in their choice to feed formula to their babies.¹³ Even though mothers valued carrying their babies in traditional African wraps -- stating that it helped bonding -- they carried their babies less due to the need for car seats and potentially opted for strollers due to the perception that few mothers in the U.S. carried their children.¹³

In refugee and immigrant families, children and adolescents tend to learn the host country's language faster than the parents. This can set them up to serve as "brokers" for their parents/ caregivers in both language and cultural situations. Studies have looked into how language and cultural brokering can affect the primary caregiver -- child relationship. Roche et al. surveyed Latino youth about language brokering in three different situations: home (bills, insurance forms, etc.), school (parent-teacher conferences, report cards, etc.), and community (post office, government

office, etc.).¹² They found that school and community language brokering exerted neither a positive nor negative effect on parenting processes. However, language brokering in the home was associated with less parent-child closeness and less parental knowledge and authority over youth behaviors such as when they do their homework, watch TV, and informing parents where they are going or who they are hanging out with.¹² The authors of the study suggest this may be due to the fact that adolescent children lack the skills to handle complicated financial documents and that having to interpret these documents is stressful for both the adolescent and the parents. The stress can produce conflicts, erode trust between parent and child, and undermine the child's sense of competence. Additionally, parents' reliance on their children for these interpretations may adultify them prematurely which can lead to decreased parental knowledge and authority over youths' behaviors, further damaging family functioning and wellbeing.¹²

Family Interventions: Under Investigation

The Centers for Disease Control and Prevention (CDC) states that "supporting parents, and caregivers who act in the role of parent, is a critical public health priority".⁶ As detailed in previous sections of this paper, refugee families are particularly vulnerable and in need of support. There is scant evidence for validated family support interventions for refugees at this time, but several are currently being studied.^{14,15,16} We will discuss some of these interventions under investigation.

The organization War Child Holland developed a program named Caregiver

Support Intervention (CSI) which aims to: *"Strengthen parenting by lowering stress and improving psychosocial wellbeing among refugee parents, while also increasing knowledge and skill related to positive parenting"*.¹⁷ CSI is a nine-session weekly group intervention, with groups offered separately to men and women. The first four sessions focus on caregiver wellbeing, with the following four sessions focusing on parenting in adversity, and the final session including a review and close of the intervention.¹⁷ Each session is also accompanied by teaching on a relaxation or stress management technique. In a two-arm pilot randomized controlled trial (RCT) with Syrian refugees in Lebanon, Miller et al. recruited 78 families (151 parents) to test the feasibility of the study prior to conducting the definitive RCT (which, at the time of writing, is currently underway).¹⁴ They found that 68% of women and 57% of men attended all nine sessions, with 95% and 86% respectively attending at least seven of the nine.¹⁴ Although assessing the effect on parenting was not an aim of the feasibility study, they found that those in CSI group reported "increased parental warmth and responsiveness, decreased harsh parenting, lowered stress and distress, and improved stress management".¹⁴

In another feasibility and acceptability study of a pilot parenting intervention, the University of Minnesota and the Karen Organization of Minnesota designed an intervention to specifically aid Karen refugees from Burma.¹⁵ The program, named the Refugee Family Cohesion Program, targeted parents of adolescents with the goal of promoting *"family cohesion and communication through parental education and skill building to address*

adolescent behavior and promote adolescent sense of belonging and positive identity".¹⁵ The program consisted of six sessions lead by a social worker and community health educator that covered topics on parenting in the United States, basics of adolescent development, communication skills, forms of discipline and their impact, addressing harmful teenage behavior, and an overview of the education system and its associated resources. In total, they recruited 50 caregivers representing 46 families, of whom 62% of the total participants were women, with an overall attrition rate of 14%.¹⁵ Participants similarly reported improved family communication, family satisfaction, and parent self-efficacy directly after the intervention as well as at the 9-month follow up.

Conclusion

Refugee families need our support. Psychological distress of primary caregivers through traumatic events or the stresses of settling in the United States can negatively impact parenting, which then increases the risk of emotional and physical abuse as well as emotional and behavioral problems in their children. Locally, the International Family Medicine Clinic at the University of Virginia has the Family Stress Clinic (staffed by behavioral health experts) and a psychiatry team led by Dr. Richard Merkel as resources for refugee patients experiencing psychological distress and mental illness, such as PTSD. In the Charlottesville area, the International Rescue Committee aids refugees in resettlement, finding employment, education, as well as family support. They offer classes and resources for learning English, financial literacy, cultural orientation, and parenting.¹⁷ As

demonstrated in this paper, all of these services are necessary and important in developing healthy families.

The number of refugees arriving to Charlottesville is set to grow from the historic lows seen during the Trump administration,¹⁸ so future efforts to support refugee families should be prepared to delegate some services to other community members,¹⁶ mobilize the current resettled refugee population to act as a support for new arrivals²⁰, and adapt supportive programs to reach both mothers and fathers as is feasible.^{14,21} As evidence grows for the efficacy of community-based, group parenting programs, the adoption of such programs may be of great benefit to local refugee families.

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