Chapter 1

The Role of Family Functioning in Refugee Child and Adult Mental Health

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Introduction

The mental health of refugees is determined by individual, family, community and wider social influences [1–4]. In this chapter, we focus on the role of family variables in refugees' mental health. Many people flee their country and seek reunification with family members by encouraging those left behind to travel to join them. The stresses they experience in migrating and re-settling may be attenuated by family relationships that may provide an important buffering role, while decreased intra-familial support may exacerbate individual suffering. There are also families in which the disruption to family and community life and experiences of adversity and abuse, sometimes linked to mental health problems, contribute to intra-familial tensions that can escalate into intra-familial violence.

The aim of this chapter is to provide an account of the ways in which the family can play a role in mediating the impact of refugee experiences, as well as increasing resilience in coping with loss and change. We also address the potential for the family to develop strained relationships that lead to the deterioration of function and even dissolution. The association between the quality of family life and mental health is a central theme. We consider the relationship between this range of family experiences and the most prevalent psychological difficulties and disorders associated with refugees' experiences, including grief and bereavement, post-traumatic stress disorder (PTSD) and depression.

We have drawn on a range of empirical studies from many fields including developmental psychopathology, cultural psychiatry, family psychology and social science. However, the relatively small body of work on this topic imposes limitations on the chapter. Research into refugee family relationships and family life has typically been carried out using single informants [5–9], although some has involved multiple members of the same family [10], with some notable exceptions [11, 12]. Few interactional studies have been carried out, apart from the recent studies of infant-parent attachment [13]. Most quantitative studies have measured family factors and variables that are relatively easy to operationalise. Few studies have integrated social anthropological and family perspectives and linked them to mental health, although some qualitative investigations have drawn on these fields [11, 14, 15].

It is useful to consider the functions of the family before discussing how these may change as a result of war experiences, displacement and resettlement. For decades, the role of the family has been understood in functionalist terms with regard to the tasks that the family carries out [16, 17]. These include meeting the material and physical needs of family members by providing a home, food or clothing. This functionalist view also includes the

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provision of child care for rearing the young, and caring for family members when they are sick and unable to work and contribute to the family income. For many refugee families who experience financial hardship, disruption of employment, family separations, losses and legal uncertainty, performing these basic tasks may be a great challenge and sometimes even impossible. In addition, the family also serves to stabilise the emotional state of the parental couple and provide emotional support to the offspring. Achieving this emotional stability and support requires daily conversations, confiding and care, and joint activities that are an integral part of family life. Many shared family activities can be regarded as routines, such as mealtimes, the daily departure for school or work and returning later in the day, and less frequent activities such as visiting extended family and holidays [18, 19]. Family members may also participate in and share rituals that link them to religious practice and beliefs shared by the wider community [19, 20]. Families that come to resettlement countries will experience cultural and language differences and also differences in family organisation and values [21, 22].

Of course, when closely observed, all families are different and reveal their particular family history and experiences, shaped by, and reflecting, their beliefs and practices. These components create the family meaning system that further contributes to the anchoring of family members, as well as shaping, particularly for children and adolescents, their cognitive and social development [23]. The parental couple also brings family-of-origin beliefs and narratives that contribute to the new family meanings or cultures. For families and individuals fleeing organised violence or the threat of violence and persecution, the routines, shared activities and shared meanings that maintain the family are under great threat and may for some be abruptly terminated [24]. Such changes may also take place in the context of the loss of family members because of abduction, detention, killing or involvement in combat, which further strains the family as a functioning unit.

While people have fled violence or persecution for centuries, the twentieth century saw an increased involvement of non-combatants in war and violence [25]. The Second World War was followed by the creation of the United Nations (UN) [26], which was instrumental in defining the term 'refugee' in its 1951 Convention as a person who:

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

There are some related terms that need to be defined. An asylum seeker is a person who has left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded. A refused asylum seeker is a person whose asylum application has been unsuccessful and who has no other claim for protection while awaiting a decision. Some refused asylum seekers voluntarily return home, others are forcibly returned, and for some it is not safe or practical for them to return until conditions in their country change. Refugee status is awarded to an asylum seeker by a receiving country as described in the Refugee Convention. Unaccompanied children seeking asylum (UASCs) are children (under the age of 18 years) who have applied for asylum in their own right, who are outside their country of origin and who are separated from both parents or their previous/legal customary primary caregiver [27].

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The number of people globally of concern to the UN Refugee Agency (UNHCR) has increased since 2010, and by 2018 had reached 68.5 million forcibly displaced people, of whom 25.4 million are refugees and 3.1 million asylum seekers [28]. Over half of the refugees are aged under 18 years. The three top countries from which refugees came were Syria, Afghanistan and South Sudan, and the top receiving countries were Turkey, Pakistan, Lebanon and Iran. While most of the children are cared for in families, there are many unaccompanied refugee children. In 2016, there were 63,300 asylum applications in EU countries from unaccompanied minors. The flow of refugees to Europe is continuing, but at a reduced rate [29]. During the months of January to June 2017, 12,239 refugee children arrived in Italy, of whom 93% (11,406) were unaccompanied or separated. In the same period, 44,300 children with parent(s) sought asylum in Germany, including 5,700 applications from UASCs. These statistics reveal the large number of children amongst the refugees as well as the high proportion of families.

The Refugee Family Experience

The experiences of people who migrate because of fear of persecution or exposure to war, and the ensuing adversities, have been detailed in numerous reports from the last century [25, 26]. Sadly, there is ongoing war in many regions of the world, which results in continuing suffering for refugees [30–33]. Some of the most important influences on refugees' adjustment have been summarised in Table 1.1.

Table 1.1 lists the experiences and adversities that might increase risk for individual refugees' psychiatric disorders and psychological distress, as well as protective factors. The table provides an accessible heuristic representation but simultaneously imposes a static quality on experiences that often arise out of dynamic intra-familial and wider social processes. The discussion here addresses some of these processes from a family perspective.

Pre-flight

Different forms of persecution and exposure to violence may have varied family impacts. In some conflicts, all family members will witness or experience violence, including killings or combat, such as those experiencing bombardment in the Syrian war [33]. Sexual violence may be an intentional aspect of a war against a community [34]. In situations of violent revolutionary social change, as occurred during the Pol Pot Khmer Rouge regime in Cambodia (1975–9), family members were deliberately separated with a view to weakening family bonds. Under Pol Pot, spouses were separated from each other, children were separated from parents and some were taught to spy on their elders to obtain extra favours or were forced to commit atrocities themselves [35, 36]. A high proportion of the refugees fleeing Eritrea are men. In this repressive regime, every Eritrean must serve an indeterminate period of 'national service', with many ending up serving for well over a decade. Eritreans are subject to arbitrary arrest and imprisonment [37].

The decision to migrate is one that will often involve family discussions with a view to assessing the best plan for the flight. There is often sharing of resources and choices made around who migrates and who does not. Conversation may be expanded to include a wider social group and community regarding the risks of travel, the prevalent need for secrecy, and how to manage danger and trust. These decisions are often very stressful and ridden with guilt, which can surface in the post-migration phase as survivor guilt [38, 39]. The

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1.1 Risk and protective factors in the mental health of refugees

Time in relation to flight	Risk factors for poorer mental health	Protective factors for better mental health
Before flight	1. Persecution 2. Experience of or witnessing violence or combat 3. Loss of family or community members 4. Disruption of family/ community life 5. Child cared for by parent with poor mental health	1. Belief in community cause 2. Planned departure and flight from community 3. Family survival and cohesion
In flight	1. Long arduous journeys 2. Privation (food, accommodation, schooling) 3. Ongoing exposure to violence and abuse (including sexual exploitation) 4. Detention en route to resettlement countries	1. Journeys supported by UNHCR and other organisations, often associated with more rapid entry to safe areas and flight 2. Family union/child continues in care of parents/relatives 3. Ongoing contact with supportive family members and friends, e.g., by telephone or social networking
On arrival in resettlement countries	1. Continual movement in host country, unsettled accommodation 2. Economic hardship 3. Legal uncertainties that can result in threats of deportation or actual deportation 4. Long delays in settling asylum application 5. Detention 6. Age disputes in which UASCs are categorised as adults and only given access to adult services 7. Social isolation 8. Long periods when forbidden to work/unemployed 9. Lack of fluency in language and poor opportunities to acquire new language 10. Persecution and racism 11. Intra-familial tensions, conflict and poor parenting	1. Negotiated entry to resettlement country 2. Rapid resolution of asylum claims 3. Settlement in neighbourhood with high same ethnic/ language density 4. Family union/child continues in care of parents/relatives 5. Ongoing contact with family members, e.g., by telephone or social networking 6. Children successfully negotiate their 'bicultural' and bilingual identity 7. Timely and supported access to services, e.g., health and community welfare organisations 8. Sense of belonging to resettlement country

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decision may relate to the availability of financial resources, the degree of danger to family members and the perceived appropriateness of certain family members, sometimes young healthy males, travelling first.

The extent to which families flee and remain together during journeys is very varied. Not all refugees manage to migrate as an intact nuclear family.

Flight

Some refugees make their own arrangements for their journeys while others negotiate their route with traffickers, but in both cases they often encounter great danger. The adversities include privation from lack of food and water, assaults, the need to sell personal belongings and take on employment to raise funds to pay for the ongoing journey, and often exposure to adverse weather conditions, including rough sea crossings. Arduous journeys were undertaken during the vast movements of people in the turbulent years of war and fascism in Europe and throughout many parts of the world since the Second World War [25, 26]. Well-documented movements occurred during the British de-colonisation of South Asia with the creation of India and Pakistan, and then afterwards associated with the wars in southeast Asia (formerly the French colonies of Indochina: Vietnam, Cambodia, Laos) [26]. Some of the most dramatic and shocking examples were the 'boat people' who left Vietnam during the 1970s and 1980s, setting off in small boats across the South China Sea seeking haven in safer countries [26]. This is reminiscent of the thousands of refugees since 2015 who have tried to cross the Mediterranean to reach European destinations, often in small and sometimes inflatable boats and at great peril [40].

Many refugees travel alone and hope that their families will join them after they have established themselves in the resettlement country. A high proportion of refugees in transit are exposed to violence, including sexual assault [30, 41]. In other cases, close family members have been killed or detained. During journeys, the ability to communicate with family, friends and people-smugglers is very important [42, 43]. Many refugees regard the mobile telephone as a lifeline for seeking help and obtaining information about their onward journey. They can call for help when catastrophe strikes in the Mediterranean and they fear their boat will sink, with the risk of drowning [42].

Those who are under 18 years old (UASCs) form a particularly important group. Their plight is highlighted in view of the high number of losses and separations from parents, carers and family that they may have experienced in their country of origin, and many are orphans as a result of war and organised violence [30, 44, 45]. Attention to their needs was stimulated by the plight of southeast Asia's unaccompanied minors, who fled Cambodia during the 1970s [26]. Since 2015, there has been a dramatic increase in UASCs coming to Europe [29].

Prior to and during journeys, family life and familiar routines may be highly disrupted. Involvement in work and school may cease. Parents or caregivers may be missing or killed. Older children may become carers for younger children. Great effort may be needed to obtain adequate food and water and temporary accommodation. Understandably, this can have massive effects on mood and the ability to cope with strained family relationships, and it challenges parents' ability to care for their children and provide adequate nurture, warmth and stimulating interaction [46].

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Resettlement

The arrival of refugees in safe countries may have been negotiated by an international agreement for their resettlement. This will significantly smooth their reception, as facilities for accommodation, legal and language support and rapid granting of refugee status will enable the bread-winners to seek work and permanent housing. However, since around 2000, such programmes have been less available and there is an increasing harshness towards refugees [47]. This has been provoked by the bombing of the twin towers on 9/11 [48], the consequences of austerity for the welfare state, and the European refugee crisis, beginning with large inflows of refugees in 2014–15 [49–51]. Many countries are reluctant to accept asylum seekers and develop harsh regimes to deter them [52]. One notorious example is Australia, which has offshore detention centres [53]. Many refugees, including families, live in temporary camps or temporary accommodation without employment or adequate schooling and facilities for rearing children. In many countries, there are policies to deport asylum seekers. In 2017, across the European Union nearly half (46%) of first-application asylum decisions resulted in positive outcomes, but the proportion of such outcomes is variable across the continent [29]. Financial hardship, social isolation that may arise because of dispersal policies, and lack of fluency in the language of the host community add to the stresses that impact on family life.

These cumulative experiences during pre-flight, flight and resettlement phases impact on mental health, and the vast majority of studies document an association between asylum-seeking or refugee status and higher levels of psychiatric symptoms and prevalence of disorder. An early meta-analysis of studies carried out in Western countries found a prevalence amongst refugees of post-traumatic stress disorder (PTSD) of 9% (99% Confidence Intervals (CI) 8–10%) and 5% (4–6%) for major depression amongst adults and a prevalence of 11% (7–17%) for PTSD amongst children [54]. A larger global study of 81,866 refugees and other conflict-affected persons reported an unadjusted weighted prevalence rate for PTSD of 30.6% (95% CI, 26.3%–35.2%) and for depression of 30.8% (95% CI, 26.3%–35.6%) [55]. When looked at longitudinally five years after settlement, the prevalence rate of psychiatric disorder appears elevated compared with non-migrant peers [56]. These studies produce generalisable data, but the meta-analytic methodology averages out rates, and specific processes that may give a more nuanced understanding to study findings may be lost.

Refugee Family Processes

Case example – Disruption in attachment and its impact

Rona is a 10-year-old Iraqi Kurdish girl. She was referred by her school with concerns regarding her quiet withdrawn behaviour and constant complaints of headaches and stomachaches. Rona often expressed her physical symptoms in a very dramatic way by crying out loud, wailing and becoming hysterical. Teachers described her behaviour as very similar to the way her mother expressed her distress, as witnessed by school staff. Despite Rona's appearance as very bright, she was failing academically due to lack of concentration.

Rona lives with her mother and two sisters, one two years older than her and one two years younger. Her parents separated a few years after migrating to England. Her father had a mental breakdown and became violent towards her mother. This was explained in part by his inability to support the family. He lives near the family and children to support the family. Her mother has suffered from depressive disorder for many years. She was

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prescribed anti-depressants, but did not take them for fear of becoming out of control and not being able to look after the children and because of her beliefs regarding medication interfering with her brain functioning. She experienced somatic complaints not attributed to disease.

Rona's mother described experiencing very traumatic events associated with their escape from Iraq. She described fleeing to the mountains whilst pregnant with their third child, a pregnancy that she did not want to continue. She describes trying to abort the baby by hitting her stomach, punching herself and going without food. She had hoped that the stress would bring on a natural termination of the pregnancy. During the journey, additional traumatic events included privation of food for days with very little shelter and witnessing deaths and the mass destruction of villages. Her mother narrated the story in a very fragmented way and became overwhelmed in the telling process, and during that process her mental state became fragile. She was visibly shaking, crying and repeating that she could not bear her life; she was only living for the children. She could not acknowledge what the then two- and four-year-old children had witnessed and experienced and its possible psychological impact. She explained that as they were small they would not remember anything. For Rona's mother, nothing could be worse than what they had experienced during their escape from the war. Now that they were in a safe country, the children should not be having any problems. For her to accept that the children could have difficulties would mean a failure of her parenting, and she refused to accept that Rona was having difficulties. Her mother's (as well as her father's) distress contributed to the lack of emotional availability of the parental figure(s) in Rona's life. In the absence of the extended family, the impact on children's mental health becomes more fragile. Rona became the identified child who exhibited parental distress and lack of emotional availability. It is often the children's distress that brings the parents into contact with professional services.

In order to understand the ways in which past and ongoing adversities, as well as protective factors, may interact with family processes, the subsequent sections explore specific family experiences and their links with specific forms of psychopathology.

Separation and Loss

Refugees experience the loss of many aspects of their lives. First, there is often the loss of close family members, either through death, injury or separation. Death and separation from relatives causes intense sadness, pain and a sense of loss [57]. Where there has been death, the surviving family's responsibility is to dispose of the body in the appropriate culturally sanctioned way [58]. For many bereaved people, performing appropriate death rituals facilitates grieving and social mobilisation that may help to achieve some level of acceptance and closure.

Cultures and religions have very diverse ways of understanding death and its consequences. The cultural shaping of bereavement and the detrimental effect of inadequate funerary rituals have been graphically described [59–61]. One example of cultural difference is the genocide of Pol Pot in the 1970s and its impact on death, which affected many refugees. Hinton and colleagues explain that 'Cambodians worry that the Pol Pot dead are not reborn and that they wander the earth in a purgatory-like state, and moreover they believe that those who have not attained rebirth may only do so through the merit-making of their relatives or through suffering while wandering the earth, with suffering having the power to eliminate demerit' [60]. This has implications for interventions, as psychological recovery and healing requires the performance of appropriate rituals to enable rebirth and lay the soul to rest [59, 62].

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Funerary rites may be impossible for many refugees to carry out while in transit. Family bereavement also cannot be fully experienced and the death rituals cannot be performed by those whose relatives have 'disappeared'. This produces a state of 'frozen bereavement' [63], or ambiguous loss [63, 64], which may be associated with persistent complex bereavement disorder. Documented accounts from Central and South America, when there was military dictatorship and thousands of people were killed, poignantly illustrate this. As one mother said: 'There are many families in Argentina destroyed by this, just like us. We have gone through 37 years of not knowing. To have a relative disappeared is a wound that does not close until the person appears again' [65]. Full grieving for the 'disappeared' is not possible because of the hope that the person will re-appear. During this time, life is 'suspended', as new relationships cannot be formed and re-marriage is not possible without the formal certification of the death of the spouse. Relatives of family members who have been killed may experience guilt about their survival while other family members perished [38, 66].

For those who survive conflict and journeys, a strong sense of loss may arise because of the cessation of contact with loved ones. Many refugees have travelled across the world to find safety in a country with prospects of a settled family life and opportunities for children. During the twentieth century, contact with those in the country of origin would have been by letter and then later in the century by telephone. The rise of the internet and widespread use of mobile telephones has substantially changed this. Telephone ownership and use is high amongst refugees [43].

When looked at from a cultural perspective, refugees often travel to countries with very different cultures, languages and religions to their own. This can add to the sense of loss, or 'cultural bereavement' [67]. In coping with cultural bereavement, the sense of loss may be mitigated by the new meaning and sense of purpose that arises in the new country [24]. Feeling connected to the new country is associated with better mental health [68]. A key challenge for families is to adapt to the new community and re-create family relationships and meanings in their lives with renewed hope. Most achieve this with some level of success, which explains why, for many refugees, depression and associated hopelessness reduces over time [69–71].

However, there are others for whom pre-migration adversity, losses and resettlement stressors are overwhelming. This can result in continuing depression, hopelessness, self-harm and suicide. Suicidal behaviour and suicide is more prevalent amongst refugees than in host community populations [72, 73], with a higher risk for those refugees with low family and social connectedness [74].

Case example – Survivor guilt and its impact on mental health

A Syrian female survivor came to the UK with her children and husband. She repeatedly attempted to take her life by trying to jump off bridges, hang herself, and various other forms of suicide attempts. During an interview with the adult mental health team, she said that it was not worth living while all her extended family members were being killed in Syria. Her mental health and attempts to take her own life arose because she was a survivor and unable to endure the guilt of living. In this case, the social structures and belief systems (such as religious and cultural) that often help individuals to manage adversity could not support her mental anguish, highlighting her underlying susceptibility to mental health difficulties, and her experiences as a refugee brought these to the forefront. The survivor may be tormented by what actions could have saved other family members, even if such actions were impossible to carry out.

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Attachment

The attachment dynamic is fundamental in understanding family relationships and child development. Refugee experiences, as described above, include threatening events that will activate the attachment dynamic between child and caregiver or parent [57]. For this reason, refugee children who are separated from their parents may show increased anxiety [75], and this is apparent in pre-school children [76]. Attachment is less likely to be secure when parents are depressed [77]. Refugee children may also show insecure attachment, including disorganised attachment, when their parents have PTSD [13], shown to be related to frightening, threatening and dissociative parenting behaviour. Refugee parents may be preoccupied with and communicate their own distressing cognitions (related to grief, depressive cognitions or PTSD), which can interfere with their ability to attend to their infants' emotional needs [78]. The refugee parents may find it hard to separate from their children, for example, for nursery or school, having experienced the world as a dangerous place, and this can be communicated to the children. An attachment perspective investigating the long-term effects of the Holocaust showed that parents found it hard to separate from their children, yet at the same time they wanted them to be successful and take up all available opportunities [79].

The attachment dynamic also operates for older children, adolescents and spouses. The parent or spouse serves as a 'secure base' or attachment figure. This is consistent with substantial research showing that adult and adolescent refugees who are settled with family members are less distressed [2, 68, 80]. Secure attachment in adults is associated with lower levels of PTSD symptoms following trauma [81]. The refugee experiences described above can increase an adult's wish to seek proximity to their attachment figure, a role taken on by spouses or intimate partners. While separation anxiety disorder is usually regarded as occurring in children, it has been reported in adult refugees who came to the USA after experiencing war in Bosnia [82].

Violence Exposure, PTSD and Family Life

It has been established that the strongest predictor for the onset of PTSD in refugees is the proximity to violence, the extent of personal threat and the duration of exposure [2–4]. However, there are many other influences on this link, and the family may play an important role in protecting against PTSD and influencing the severity of PTSD symptoms. These influences need to be considered in relation to the life cycle and maturational processes.

Infants who experience exposure to violence may develop PTSD, which is observed using age-specific techniques. A study of infants from Iran showed post-traumatic functioning through play assessment: infants who experienced prolonged separations from their fathers because they were imprisoned and whose mothers had poor mental health had high levels of distress [83]. In many conflict settings, both children and parents experience exposure to traumatic events. Parental PTSD and anxiety may increase child PTSD and anxiety [84, 85]. The mechanism is likely to be through communication of emotion and reduced ability to contain and reassure the child [86]. The quality of parent-child interaction, including between fathers and children, is negatively affected by PTSD [87]. On the other hand, some studies suggest that PTSD may be associated with relatively good social function, so that parents are able to continue in their role as carers for their children [88].

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Nevertheless, PTSD may be relatively stable, with some people, including infants, experiencing PTSD symptoms over many years [69, 71, 83].

Threatening events may increase PTSD intensity in family members. Most of the studies on this subject have been carried out with individuals, but nevertheless it is clear that some events will be understood and experienced as threatening by all family members. These include threats of deportation and possible return to the country that the family came from [89]. Detention is associated with the deterioration of mental health, including PTSD [90–94]. Additional examples of increased threats are the re-experiencing that occurs when people with past war trauma are exposed to reminders of this by hearing about or seeing further violence, for example, on television or in news reports.

A consistent finding on protective factors for mitigating PTSD is the presence of attachment or supportive figures that reduce PTSD, anxiety and depression [4, 68]. Children who experience war or violent events whilst in the presence of their parents or attachment figures may be protected against the risk of developing PTSD [95]. Interestingly, this also applies to UASCs who are fostered with families and who are placed in higher-support living arrangements rather than in low-support arrangements [96–98]. In the more supportive settings, the level of PTSD symptoms was lower.

The long-term effects of PTSD include the effects on offspring. In a study of survivors of the Khmer Rouge regime in Cambodia (1975–9) and their adolescent daughters, parents with PTSD had daughters who scored high on anxiety [99]. Maternal role reversal was shown to mediate the relationship between the mother's and the daughter's symptoms. Another study of survivors of the Ukrainian atrocities of genocide and starvation in the 1930s investigated second- and third-generation offspring [100]. The emotions transmitted included fear, mistrust, sadness, shame, anger, anxiety and decreased self-worth. There was also stockpiling of food and high value placed on food. Many of these features have been found in the offspring of Holocaust survivors, including overprotection, anxiety and disordered eating [101].

For a long time, the main explanation for intergenerational transmission of PTSD and anxiety was located in communication and modelling, but in recent years attention has turned to epigenetic mechanisms as a source of trauma transmission, with accumulating evidence from studies with Holocaust survivors [102–104]. One influential study showed that parental PTSD had an effect on DNA methylation of the exon 1F promoter of the glucocorticoid receptor (GR-1F) gene, and this has an effect on the neuroendocrine system [103].

Culture Change, Exile and Reconstitution of Family Life

There are numerous influences on mental health in the resettlement phase that change over time and that have an impact on family life (see Table 1.1). One of the most important is that refugees who arrive in resettlement countries and claim asylum are usually unable to apply for work and obtain work permits, and in the absence of private savings they are forced to depend on state benefits. This can impose financial hardship on the family, which itself is a cause of considerable stress [105]. In addition to the financial consequences, being out of work can have negative effects on self-esteem and increase social isolation, a sense of purposelessness and tensions between spouses. Pre-migration stressors, such as war trauma,

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Case example – Loss of social status and financial security

Faizal, aged 12 years, lived with his parents and 2 older brothers. Both parents were from the Middle East, where they were both professors in mathematics in a well-established university. Faizal was referred for aggressive behaviour in school, lacking in concentration and not doing very well academically. His older brother obtained a place to study medicine in the UK but was struggling with depression, although his middle brother was managing academically. The family was very distressed, as both parents were finding it difficult to get a job in the UK. His father was trying to do some teaching in college but found it degrading, as the UK system of teaching was very different to that of the Middle East. He was preoccupied with what was happening in his country of origin and the number of academics being imprisoned and killed. This generated conflict for the father, who was relieved at his and his family's refugee status but also anguished by his own loss of professional status in the UK, as well as feeling helpless with regard to his former colleagues in his country of origin. This preoccupation had a significant impact on family dynamics, as Faizal's father became emotionally unavailable and his mother became depressed. There was an emphasis on the boys achieving well academically, which contributed to further pressure in the home.

are also associated with lower take-up of employment [106]. Some refugees with professional backgrounds, such as doctors, scientists or engineers, may find great difficulty in obtaining employment using their qualifications, and this process of de-skilling leads them to experience a sense of loss of role and disempowerment. Many men find it hard to contribute to child care. There may also be significant changes in family gender roles. Women may be the heads of households and be responsible for household income, as they are often separated from their spouses who are involved in combat, detained or killed. These changes can contribute to family tensions and affect the adjustment of children, as illustrated in this case vignette.

This case emphasises the loss of social class and privilege and the effects of having to rely on state benefits. Survivor guilt also added to their distress, as they got frequent feedback from their country about colleagues who were killed in bombings or imprisoned. This vignette is consistent with the findings of a Quebec study of adolescent refugees, who were predominantly not war-exposed [107]. A higher prevalence of disorder was found amongst the refugee group than amongst the non-refugee comparison group, and interestingly this occurred amongst the male adolescents and much of it was accounted for by conduct disorder. Difficulties were associated with paternal unemployment of more than six months and single-parent, mother-headed families. The authors suggest that there was less confidence amongst fathers and less authoritative parenting by mothers in single-parent households. These processes which strained family relationships reduced warmth and increased the criticism and conflict that may be associated with parental preoccupation, depression or PTSD and the disruptions of routines, social isolation, financial hardship and overcrowding, which are all risk factors for the development of conduct disorder [108–111].

Many refugees seek asylum in countries that are culturally different from the one they came from. This gives rise to an awareness of cultural and ethnic difference. By ethnicity is meant a combination of race, religion, cultural history, family organisation and values, attitudes to work and employment and more local cultural influences, including dietary practice [112]. Awareness of culture and ethnicity is often heightened by migration and the encounters of refugees with the host society. Refugees need to negotiate and decide the

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extent to which they adopt the culture and values of the host society and the extent to which they retain or distance themselves from the culture of origin [21, 113, 114]. The process of acculturation and acquisition of the new language and culture of the host society is usually different across generations. Children and adolescents who are in school or college learn very quickly. Parents, who may be isolated and not working, may struggle to learn the language and feel less adept at judging culturally appropriate behaviour and establishing age-appropriate norms for their children. Residing in an area with a clustering of immigrant communities may enable refugees to feel familiar and safe, although it could reduce the adaptation process to the host country. The differential rates of language acquisition and acculturation may set up tensions that can lead to intergenerational conflict. However, adolescent children are aware of culturally shaped parental expectations and may try to maintain loyalty to their culture of origin as well as adopting the culture and ways of the host community [7]. They become bicultural and bilingual and may adapt their behaviour to the setting they are in [22, 115]. For this reason, there is no simple link between rates of offspring acculturation and parental acculturation and adjustment [116].

In resettlement, the process of family reunification may invoke relational complexities in coping with cultural change and adaptation. Re-uniting engenders many feelings. While there may be a yearning to restore the family to its earlier state, the situation may generate anxiety about how the other family members have changed and what reunification will mean [11]. During long separations, spouses may have had very different experiences. Some, often men who have been combatants, may have been detained, sometimes tortured, and migrate after their wives and children have arrived in resettlement countries. In this situation, wives may have started to acquire autonomy as heads of households and language fluency in the new country [11, 117]. The arrival of fathers may strain marital and family relationships. The newly formed family will need to negotiate new routines and the extent to which it will follow traditional customs or those of the host society. A further source of tension between spouses can be the difficulty of attaining intimacy, especially after women have been sexually abused. For women, assault often brings great shame and guilt, which they may feel cannot be shared with their spouse for fear of rejection and divorce [117]. Sometimes this distress is communicated through their bodies as medically unexplained symptoms [118] (see first vignette).

The strains in refugee families may result in violence, a topic that has been poorly researched. Available studies suggest that it could have a prevalence of 30–50% [5]. Risk factors for this include individual war trauma associated with psychiatric disorder including depression and PTSD, family structural variables including single-parent families, strained parent-child interaction, financial adversity, and cultural influences including patriarchal beliefs [5]. It appears that a risk accumulation model provides the best explanation.

While much of this section and earlier sections concern refugees' psychiatric and social difficulties, it is important to bear in mind that as time elapses most families will become settled, and many will experience satisfaction with their new life and will be able to see benefits. Many individuals experience 'post-traumatic growth' in which past adversities enable them to develop strengths that help them to become more resilient. 'Post-traumatic growth' is more likely to occur in the presence of a high level of family and social support and a positive outlook about the new country and planning [119–121].

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Conclusion

This chapter has outlined the varied ways in which the family is affected by war, threat of violence, migration and resettlement. The family may be a buffer against these adversities. However, in some circumstances, relationships become so strained that conflict and violence can arise, and in this circumstance there will be a further detrimental effect on mental health. Over time, most refugee families in resettlement countries become less distressed, but PTSD and associated protective and fearful behaviours in parents may be communicated to offspring. Most families show surprising resilience and some show post-traumatic growth.

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