Evidence-Based Family Interventions for Trauma-Affected Refugees

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Family connections are crucial for trauma-affected refugees from collectivistic cultures. Evidence-based family interventions are consistently promoted to support a host of mental and relational health needs of families exposed to traumatic stressors. Exposure to multiple traumatic stressors and life adversities are often unavoidable before and during the process of migration. After resettlement in a new country, cumulative daily stressors, additional exposures to traumatic stress over time, poverty, and acculturation stress place refugee families at risk for serious negative mental health outcomes and relational challenges. The overwhelming consequences of exposure to displacement and traumatic stressors demand multilevel systemic interventions that are culturally responsive while also addressing individual, family relational, and community health needs.

Keywords: family ; mental health ; refugees ; traumatic stress ; culture ; displacement ; intervention

1. Introduction

Forced displacement estimates exceeded 89.3 million people globally by end of 2021 and is expected to be even higher in the future with new and ongoing global conflicts [1]. The full impact of the COVID-19 pandemic on displacement is yet to be determined. United Nations High Commissioner for Refugees (UNHCR) data showed that arrivals of new refugees and asylum-seekers were sharply down in most regions, which is likely a reflection of how many people were stranded as a result of the pandemic. Forcibly displaced and stateless people are among the most adversely affected groups around the world and continue to face increased food and economic insecurity as well as challenges in accessing health and protection services [1]. Climate change is also driving displacement and increasing the vulnerability of these populations [2]. Many are living in climate “hotspots” where they typically lack the resources to adapt to an increasingly inhospitable environment. The dynamics of poverty, food insecurity, climate change, conflict, and displacement are increasingly interconnected and mutually reinforcing, driving an increasing number of people to search for safety and security [3]. It is also important to note that children account for an estimated 41 per cent of all forcibly displaced people [1].

Forced displacement disrupts the entire community and family structure of migrant and refugee populations [4]. Exposure to multiple traumatic stressors and life adversities are often unavoidable before and during the process of migration [4]. After resettlement in a new country, cumulative daily stressors, additional exposures to traumatic stress over time, poverty, and acculturation stress place refugee families at risk for serious negative mental health outcomes and relational challenges [5][6][7]. The overwhelming consequences of exposure to displacement and traumatic stressors demand multilevel systemic interventions that are culturally responsive while also addressing individual, family relational, and community health needs [8].

Most refugees belong to collectivistic societies that value family connection and interdependence [9]. Family unity and cohesion represent an important indicator of individual mental and relational health in collectivistic cultures [8]. Where there is forced displacement because of human rights violations, organized violence, natural disasters, and climate change in their home countries, refugee families are stripped from their natural contexts and resources and face multiple and enduring losses [8].

The COVID-19 pandemic further exacerbated existing mental and relational health issues; specifically, it created more barriers for refugee families to stay connected when they were geographically separated [10]. Resettlement communities around the world have a sociopolitical and moral responsibility to create infrastructures to support these families. Most importantly, mental health professionals have a critical role in developing and testing interventions to effectively address the mental and relational health of various refugee populations. Despite the overwhelming challenges to survival, these communities have tremendous resilience, and researchers know historically that when families are provided with opportunities to heal, they recover and thrive in their new countries of resettlement [8].

In 2015, Slobodin and de Jong published a systematic review of family interventions for refugees [4]. This work documented the impact of traumatic stress on individual mental health, the need to interrupt the intergenerational transmission of psychopathology and violence related to trauma exposure, and the need to support family and community healing [4]. Slobodin and de Jong's study [4] reported that only six experimental studies met their inclusion criteria of family-based interventions, with four being school-based interventions and two being multifamily support groups. They went on to underscore the shortage of research in this area and discussed the challenges of drawing clear conclusions regarding the effectiveness of family interventions for trauma-affected immigrants and refugees. They also called for future trials to go beyond individual-level Post traumatic Stress Disorder (PTSD) treatments and called for a greater focus on family-level processes that incorporate relationships, communication, and resilience.

2. Working with Displaced and Minoritized Refugee Families

Displacement can be life threatening for refugee families. Three common stages of migration (i.e., premigration, during, and post migration) are often linked with the development of cumulative traumatic stress among forcibly displaced communities [4][11] often resulting in deleterious mental health and relational maladjustments [12][13]. In premigration, severe traumatic events such as political turmoil leading to mass violence, wars, genocide, human rights violations, as well as natural disasters and climate change have forced people to migrate and seek safety [2][14][15]. During migration, refugees often continue to be exposed to traumatic events through forced displacements both inside and outside their home countries for years [3]. Refugees continue to live in harsh conditions in refugee camps and have to deal with uncertainty and the ambiguity of hope during migration. In post migration, refugees arrive in resettled countries with additional stressors such as family separation, a lack of social support, a lack of employment and language skills, transportation difficulties [16], and limited support from local authorities [13][17]. Additional migration experiences include acculturation stress, severe poverty, living in high crime neighborhoods, and most importantly, living with untreated mental health after exposure to severe adversities before and during their resettlement [18][19][20]. Cumulative traumatic stress at premigration, during, and post migration is associated with psychological and relational consequences such as depression, anxiety disorders, adjustment disorders, PTSD, complicated grief, psychosis, suicide [5][6][7][12][19][21][22][23][24][25][26], the comorbidity of mental health disorders [12][13], the comorbidity of mental health and physical health issues, substance abuse, the disruption of family functioning (e.g., the disruption of couple relationships and parent–child relationships) [6][16][24][27][28][29][30], and the intergenerational transmission of traumatic stress among refugee families [31][32][33].

Mental health professionals working with refugees need to be aware that refugees encounter multiple stressors across all system levels (i.e., individual, family, and community) over prolonged periods of time [8] and suffer from mental health complications due to their comorbid nature [6][12][13][16][24][27][30][34]. At the individual subsystem, exposure to traumatic events during migration leads to extreme stress responses in the brain of affected refugees [35][36][37][38][39]. The amygdala dominates brain functioning and leads to the fragmentation of memory systems as the brain is wired to activate the implicit sensory, physiological, cognitive, and emotional aspects of the traumatic events (associated with the amygdala) without connecting those memories to the context, time, space, and chronology of the events (associated with the hippocampus) that are processed in the prefrontal cortex of the brain [35][36][37]. This fragmentation of memory systems often results in posttraumatic stress symptoms. Individual symptoms of PTSD include re-experiencing, arousal, avoidance, and negative cognitive and affective changes after experiencing life-threatening events or witnessing the life-threatening events of significant others [40]. Trauma-affected individuals tend to isolate themselves, be on guard and hypervigilant, and utilize fear-based coping and avoidance in their daily functioning and relationships [41]. Moreover, trauma survivors may continue to be impaired emotionally, behaviorally, cognitively, biologically, and spiritually long after experiencing the traumatic events [42].

At the family subsystem, exposure to trauma and prolonged family separation during migration disrupts refugees' family processes [43][44]. Traumatic stress affects not only individuals, but also their families and communities [45][46][47]. The adversities experienced in one system level affects all others as they are interrelated in an ecosystem [8]. These horrifying experiences often impair the individual's ability to maintain healthy relationships with their family, especially with people who are close to them such as their partners and children [47].

In couple relationships, traumatic stress affects the intimacy and marital satisfaction of trauma-affected individuals. The inability to control one's emotional and behavioral reactions in response to traumatic memories can lead to anger outbursts [41][48] and all forms of family violence [49][50][51][52]. Specifically, anger outbursts experienced by trauma-affected partners frequently result in intimate partner violence [41][48][53]. This violence is harmful to their relationship as a couple and can be transmitted to subsequent generations as well [54].

In parent–child relationships, trauma-affected parents may employ corporal punishment as a form of child discipline; however, they may not be able to differentiate between punishment as discipline and punishment resulting from their inability to control their anger outbursts [55]. These relational patterns between parent and child are pathways to the intergenerational transmission of traumatic stress among refugee families [31][32][33][43][50][54][56][57]. Having limited to no access to trauma treatment and parenting supports, trauma-affected parents cannot perform their parenting roles adequately [57][58]. As a result, their children are at risk of adverse mental health and relationship consequences such as aggression, low self-esteem, low emotional adjustment, and impulsivity [55][59][60][61], as well as poor school performance, poor peer relationships, violence and delinquency, substance abuse, anxiety, depression, and PTSD [50][51][52][62]. This intergenerational transmission continues to pass on if there are no proper interventions to disrupt its cycle.

Notably, not only do family members, and particularly parents, children, and spouses, influence each other through their adverse experiences; they also influence each other through their strengths and resilience [45][62][63]. Family bonding, a form of family resilience through shared values and interdependence, is a powerful resource for trauma treatment [64]. Moreover, fostering resilience at multi-system levels (i.e., individual, family, and community) is crucial in trauma treatment since resilience in one level affects the other levels too [65][66]. Thus, involving family members in individual and relational trauma treatment is strongly recommended [45][46][47][67].

At the community subsystem level, the resources and support offered by resettlement countries define how fast refugee individuals and their families recover from adversities and cumulative traumatic stress [13]. Local authorities usually fail to provide multi-systemic mental health support to newly resettled refugees [13][17]. Specifically, schools, the main social organizations that work directly with refugee children, often underestimate the complexity of daily stressors that affect their ability to learn and acquire knowledge [68]. At home, witnessing harsh labor conditions, poverty, emotional dysregulation, anger outbursts, and domestic violence between their parents and other family members disrupts the development of refugee children. Child labor is also very common among refugee children and youth, because their labor is often necessary to sustain family functioning. At school, refugee children are prone to being victims of and/or a part of gang violence and delinquency, experiencing discrimination, substance abuse, and a lack of study motivation, and have a lack of educational role models and supports [8][51][68]. All these factors underscore the need for specific systemic interventions to be effectively developed and deployed across all system levels within resettled refugee communities.

3. Family Interventions Implemented with Trauma-Affected Refugees

A few notable evidence-based family interventions have been adapted for implementation with trauma-affected displaced populations. The interventions have focused on parenting [58][69][70][71][72], multifamily groups [73][74][75][76], and school-based approaches [77][78][79][80][81]. Family-based interventions have proven to be effective in treating traumatic stress and disrupting the intergenerational transmission of traumatic stress among various contexts, but it is difficult to track broad-based effectiveness among refugee populations due to the paucity of family interventions [4]. Most importantly, there is still a lack of culturally adapted or tailored interventions for different ethnic minority refugee populations since most of the evidence-based interventions are based on western and white Euro-American populations [42][46][82].

4. Known Barriers to Advancing Mental Health and Systemic Treatments

Design challenges have been pervasive in developing and testing both individual and relational treatments within displaced communities. Gold standards inherent in RCT designs (e.g., control groups, recruitment, blind assignment, statistical power, retention/attrition, dose levels), also create challenges to the effectiveness and superiority of trials and often slow behavioral-based translational sciences. There have been increasing calls to expand researchers' conceptualization of the scientific process to encompass more critical and ethically informed frames that also include deep collaboration with members of the targeted communities [83]. For example, Critical Participatory Action Research (PAR) models specifically incorporate social justice, empowerment, and liberation as part of the scientific endeavor [83][84][85]. The adoption of culturally tailored multi-informant and multi-method research (quantitative, qualitative, and mixed-method approaches) would expand researchers' capacity for developing, implementing, and testing interventions with greater potential for uptake and sustainability within displaced refugee communities [86][87][88][89]. Key researchers in this entry also recommended including qualitative studies such as case study methods [78], ethnographic methods [75][76], and community-based participatory research methods [73] along with RCT designs in future research to enhance the effectiveness of family interventions that address mental health and family functioning among diverse displaced refugee families.

Another barrier is the poor resettlement infrastructure in host countries. Considering that the largest percentages of displaced people (86 percent of refugees worldwide) resettled into middle- and low-income countries, limited and often

inadequate public and mental health institutions are available to support the resettlement process [3]. Similarly, inadequate infrastructure is also part of the refugee experience in high-income countries [42]. A lack of state policies to systematically assess mental health needs and provide support to resettled families significantly compromises successful family adjustment. For example, a national study conducted by Shannon et al. in the U.S. with 44 refugee health coordinators exploring the mental health training of refugee health coordinators and the systematic screening of refugee mental health reported that they believed it was possible to administer a brief mental health screening during early resettlement meetings; however, only half of the coordinators had received any mental health training [90]. These coordinators identified PTSD and major depression as their top concerns related to refugee mental health and requested training on the mental health needs of arriving refugees. They linked mental health screening with positive referral outcomes for refugee populations. Similarly, a lack of training and awareness of professionals in primary and secondary educational institutions, along with a lack of trained mental health professionals and community health workers, exacerbates concerns and a lack of healing post resettlement. Among the studies reviewed in the paper, Mohlen et al. also highlighted the need to train professionals (i.e., social workers and teachers) who work directly with refugees [81] while Puffer et al. suggested training lay providers who are community members to ensure the sustainability of intervention implementation [72]. Beyond individual assessment and mental health, other studies [58][59][70] documented the broad need for parental support post resettlement as parents feel poorly equipped to navigate new legal, educational, and labor systems.

In addition to the need for greater emphasis on both evidence-based and practice-based interventions for resettled refugee communities (e.g., parenting groups, relational health, peer support), an emphasis on institutional programs that enhance professional capacity, the trauma-focused training of health providers, and community-based refugee centers would go a long way in promoting successful adjustment [91]. Slobodin and de Jong highlighted the need for the implementation of intervention in community settings such as schools, women's health clinics, or primary care clinics, rather than solely clinical settings, in order to increase the accessibility and cultural responsiveness of mental health services among trauma-affected and displaced refugee families [4].

Most studies in traumatic stress treatment have primarily focused on symptom reduction rather than other aspects of human relationships, such as parent–child relationships, couple relationships, sibling relationships, and both familial and community relationships. Specifically, trauma-affected refugees experience complicated grief and other comorbidities related to mental and relational issues [42], so researchers advocate for trauma treatments that incorporate multiple systemic factors (i.e., relationship, identity, meaning-making, and community supports) that affect refugee families during resettlement [92]. Several key researchers in this entry suggested the inclusion of additional variables in future research in the area of family intervention implementation science: (1) family mental health and functioning along with individual treatment [71]; (2) the cultural components of specific ethnic minority refugees [79]; and (3) timing (e.g., developmental time, family life cycle, time since exposure to trauma, and time of resettlement) [75].

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