The transgenerational transmission of refugee trauma: family functioning and children’s psychosocial adjustment

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Abstract

Purpose – The purpose of this paper is to explore the role of family functioning in the transgenerational transmission of trauma in a sample of 30 refugee families with traumatized parents and children without a history of direct trauma exposure from the Middle East.

Design/methodology/approach – Based on qualitative analyses of interview material, families were evaluated using theoretically derived dimensions of family functioning and placed in descriptive categories according to family cohesion, family flexibility, family roles, family coping, stressor pile-up, and marital problems. The association between these descriptive categories of family functioning and the child’s mental health as measured by the Strengths and Difficulties Questionnaire (SDQ) was explored using point-biserial correlations, correlations, and multiple regression analyses.

Findings – In all, 22 percent of the variance in children’s SDQ scores could be predicted by whether or not the family experienced a pile-up of stressors and whether or not the family was characterized by role reversal between parents and children. Furthermore, a statically significant association was established between a total measure of adaptive family functioning and lower scores on the SDQ.

Originality/value – These findings suggest that the transgenerational transmission of trauma may be associated with family functioning and have implications for interventions at several levels.

Keywords Refugees, Child mental health, Transmission of trauma, Transgenerational transmission, Family functioning, Traumatized refugee

Paper type Research paper

Introduction

Due to the political situation in the Middle East, a growing number of children are raised in exile by traumatized refugee parents. According to the UNHCR, 51.2 million individuals were forcibly displaced worldwide as a result of persecution, conflict, generalized violence, or human rights violations by the end of 2013, and by mid-2014 Syrians had overtaken Afghans as the largest refugee population under UNHCR’s mandate (UNHCR, 2015). In the EU alone the number of asylum seekers rose to 450,000 in 2013, which was the highest number of asylum applications within the EU-28 since the turn of the millennium (Eurostat, 2015). In light of this, the phenomenon known as the transgenerational transmission of trauma is as relevant as ever in both research and clinical practice. Studies of children of non-western refugees in western countries document that non-traumatized children of traumatized refugee parents are at risk of developing a wide range of psychosocial difficulties (Blankers, 2013; Daud, 2008; Daud et al., 2005; Van Ee et al., 2012). Some questions are, however, largely unanswered: how do refugee parents suffering from severe PTSD handle the daily challenges of parenthood? And how is family functioning related to the psychological adjustment of the children? How do parents perceive the impact of their own traumatic experiences and post-traumatic symptoms on their children? What are the parental coping strategies and how are these related to the psychosocial adjustment of their children? Using a mixed methods design, this study explored...
these questions in a sample of 30 traumatized refugee families from the Middle East with children without a history of trauma exposure.

Within the general research on family functioning and coping strategies several models have been proposed as explanatory frameworks for the ways in which families respond to both normative and non-normative stressors (Segrin and Flora, 2014). Although most empirical research has been carried out with western populations (Olson, 2000), several of the theoretical perspectives and concepts are useful for understanding how refugee families respond to both external and internal stressors.

The Circumplex Model of marital and family systems has been developed and readjusted over almost four decades and has been empirically validated in over 250 studies. The model consists of two central dimensions along which families can be evaluated: cohesion and flexibility (Olson, 2000). Family cohesion refers to the way in which family members relate to each other and covers aspects of family life such as emotional bonding, internal/external boundaries, time, space, friends, and decision making. Family flexibility refers to the extent to which the family system is able to change its power structure, role relationships, and relationship rules in response to situational or developmental stress. Family flexibility covers aspects of family life such as assertiveness/passiveness, control, discipline, negotiation, roles, and rules.

Although this model lacks an explicit focus on cross-cultural differences, the two dimensions seem relevant also to the Middle Eastern families in the present study. Previous research on refugees has found family cohesion to be associated with resilience in both parents and children (De Haene, 2009; Fazel et al., 2012; Weine et al., 2004). Thus, it makes sense to assume that higher levels of family cohesion are a protective factor within the context of refugee trauma. With regard to the flexibility dimension, it is evident that the refugee experience demands a high level of flexibility in order for the family to cope with post-settlement stressors and go through the acculturation process (Montgomery, 2011; Montgomery and Foldspang, 2008). The family system’s ability to adjust its level of flexibility is already according to the Circumplex Model associated with optimal family functioning. Given the uncertainty and uprooting associated with the refugee experience, it makes sense to assume that for refugee families higher levels of flexibility is associated with resilience.

The McMaster Model of family functioning was developed within a clinical setting and is the foundation of a specific approach to family therapy. The model draws upon a general systems theory approach describing transactional and systemic properties of the family unit. The model consists of six dimensions of family functionality describing structural and organizational properties of the family along with appraisals of the transactions between family members (Epstein et al., 1978; Segrin and Flora, 2014): problem solving, communication, family roles, affective responsiveness, affective involvement, and behavior control. The McMaster Model of family functioning is based upon a Judeo-Christian value set, but according to the authors it allows “attention to be paid to cultural differences and other issues of cultural relativity” (Epstein et al., 1978, p. 19). Unfortunately the developers of the model do not specify what concepts should be considered culturally relative. With regards to all six dimensions one must assume that cultural variation may have an impact, but inherent in the dimensions: problem solving, affective responsiveness, communication and affective involvement, there is already a theoretical understanding of cultural relativity (Fernando, 2014). The theoretical notion of what constitutes effective problem solving seems independent of culturally embedded conceptions of what constitutes “good solutions.” With regards to affective responsiveness this theoretical concept also seem relatively unbiased in the sense, that the model does not specify what constitutes an “appropriate quality and quantity of affective responses” but allows for the appropriateness to be dependent on the cultural context. Affective involvement as a theoretical concept is perhaps the most universally applicable dimension, as it seems at the heart of what one would universally consider a family to be. With regard to family roles, the distinction between necessary and more impermanent family roles seems relevant; however, an identification of the culturally embedded aspects of the permanent family roles would strengthen the model’s utility, as well as an identification of the less permanent family roles which are connected with the refugee experience. Previous research has identified a phenomenon known as the parentification of children within refugee families (De Haene et al., 2007; Rousseau et al., 2013). This phenomenon refers to a role
reversal in which children display care-giving behavior toward their parents. Furthermore, children in refugee families often come to take on the role of culture broker and mediator between the family and the host society when the family is settled in exile (Hafford, 2010; Rousseau et al., 2011). The final dimension of the McMaster Model, behavior control, is closely tied to the family role dimension, and consequently it suffers from the same lack of incorporation of a culturally relativistic stance.

Hill (1949) presented one of the perhaps most influential models of family adaptation: the ABC-X family crisis model. The model was based on research conducted with families who underwent the stress of separation and reunification during and after the Second World War. The basic assumption of the model is that four interrelated factors can be used to describe the experience of family stress and to predict coping responses: (A) event or situation, (B) the family’s resources, and (C) the family’s perception of the event/situation.

Collectively the A, B, and C factor produce the stress or crisis reaction that is the X factor. In recognition of the fact that families’ stress reactions often persist and develop over time, an attempt has been made at refining the model: the double ABC-X model developed by McCubbin and Patterson in 1982. According to McCubbin and Patterson (1983) the family’s long-term coping should be seen as the result of two stages. The first stage (pre-crisis) can be described by the original ABC-X model; however, the double ABC-X model also features a second stage (post-crisis) in which the following factors are presented: (aA) stressor pile-up (initial stressor event, family life changes, consequences of family coping), (bB) existing and new resources (coping resources), and (cC) perception of X+aA+bB (a family’s post-crisis may involve religious beliefs, a redefinition of the original situation, and endowing the situation with meaning). The double X factor (xX) in the model is the family’s ultimate adaptation to the crisis, which can be either Maladaptation or Bonadaptation. The ABC-X and double ABC-X models contribute to the understanding of family responses to stress by drawing attention to the families’ perception of their situation as an important predictor of adaptation both in short and long term. Furthermore, the double ABC-X model enlightens the theoretical understanding of family stress reactions by pointing to the build-up and potential accumulation of stressors over time. Both models are universalistic in their formulation and seem cross-culturally applicable, although it might be argued that very broad definitions of concepts lowers the utility of the model.

Based on the presented theory and research findings regarding family functioning, a number of central dimensions have been identified and serve as the theoretical background for the present study. First, the study is inspired by the overall dimensions of family cohesion and flexibility from the Circumplex Model. Second, the study is inspired by the dimension: family roles from the McMaster Model. Third, the study is inspired by the notion of coping behavior as a response to the family’s perception of their own situation and the impact of the accumulation of stressors over time from the double ABC-X model.

Method

Research questions

RQ1. How do parents perceive the impact of their past trauma history and the current post-traumatic symptoms on their parenting practice and on their children?

RQ2. What theoretically derived dimensions of family functioning and coping can be identified within the interview material?

RQ3. How are the central dimensions of family functioning identified through qualitative analyses related to the psychosocial adjustment of children as measured by the Strengths and Difficulties Questionnaire (SDQ)?

Inclusion criteria

The study included 30 Arabic or Farsi speaking refugee families from Iraq, Iran, Lebanon, Palestine, Syria, and Afghanistan living in Denmark with at least one parent referred for treatment of PTSD-symptoms and who had at least one child without a history of direct trauma exposure aged between four and nine years old.
Exclusion criteria

The study excluded families who had already started family therapy.

Recruitment

Families were recruited via a non-probabilistic sampling strategy in collaboration with five different psychiatric rehabilitation centers across Denmark. Families who met the inclusion criteria were approached by either one of the psychologists at the treatment center or by the first author and an interpreter over the telephone. Families who initially expressed an interest in participating received an information letter, written in their native language, and were subsequently telephoned by the first author and an interpreter. When families agreed to participate, appointments were made and the data collection took place either in the respondents’ homes or at their treatment centers. Unfortunately, not all of the participating treatment centers kept a record of how many families were initially approached, but based on the first author’s records and accounts from the psychologists at the treatment centers, it is estimated that about half of the families who met inclusion criteria declined participation. The reasons given for refusing to participate were either that the parents felt strained by their symptoms or that talking about their situation made them feel uncomfortable.

Measures

The parental qualitative interview. The aim of the parental qualitative interview was to: capture the parents’ accounts of how their own trauma history and current symptoms of PTSD affected both their parenting ability, the particular child in question and the family as a whole; acquire a qualitative understanding of the child’s developmental history and the parents’ perception of their child’s psychosocial adjustment; gain insights into the style of communication within the family unit regarding the parental trauma history and current symptoms; acquire an understanding of the family’s relations with the extended family and social networks in exile and the parental perception of the importance of maintaining ties with the family of origin and with their home country’s culture. In order to address these themes, a semi-structured interview schedule was developed in which the parents were asked open questions about each of the five themes. If answers were short or new themes came up more specific follow-up questions were asked. The interviews lasted between one and two hours.

The SDQ. To measure the psychological adjustment of the children, the study employed the SDQ (parent version with impact supplement), which is a widely used brief screening tool available in both Arabic and Farsi. The questionnaire was chosen to allow findings from the present study to be directly comparable with larger samples and because the psychometric properties of the questionnaire have been researched extensively with good results regarding both validity and reliability (Goodman, 2001; Thabet et al., 2000).

Procedure

Most families were interviewed in their native language by the first author and an interpreter but three families preferred to speak in Danish or English without the presence of an interpreter. All interviews were audiotaped and subsequently transcribed. Data analyses were carried out using the Nvivo 10 software package. For the purpose of this paper selected quotes were translated into English by the first author.

Qualitative analyses

The analytic approach to the qualitative analyses was theory driven and inspired by the thematic analysis (Braun and Clarke, 2006; Joffe, 2011). The aim of the qualitative analyses was to explore the extent to which models of family functioning and coping are applicable within the present sample and to identify the cultural embedment of family functioning without ignoring theoretical or empirical knowledge from previous research. In the first round of coding, each interview was coded incident by incident based on all of the theoretically derived dimensions of family
functioning presented in the introduction. Subsequently groups of codes were integrated into
categories reflecting key concepts. Categories consisting of groups of concepts generated from
collections of codes were then derived from the data. In the second round of coding, the
descriptive categories of family functioning were selected and organized resulting in the
identification of the following central dimensions which could be derived from the initial coding of a
vast majority of interviews: family cohesion, family flexibility, family roles, family coping, stressor
pile-up, and problem-solving skills/conflict level. In the final round of coding, the dimensions
identified above were used as a framework for the final coding in which each family was
categorized in descriptive categories of the presented dimensions of family functioning.
Qualitative analyses were performed by the first author.

Statistical analyses
Significance level was set to \( p < 0.05 \) (two-tailed). Preliminarily, tests for normality, both
Kolmogorov-Smirnov and Shapiro-Wilk, were carried out for the SDQ and the distribution was
found not to deviate significantly from normal. Statistical analyses consist of point-biserial
correlations, correlations, and multiple regression analyses.

Ethics
When the data collection took place at the treatment centers, the respondent families were
offered reimbursement of travel expenses, but no other compensation for participation was
offered. Following written and oral information regarding the purpose of the study, participants
signed a written consent form. All families were offered treatment by the referring treatment
centers regardless of whether they participated in the study or not. The study was reported to the
National Committee on Health Research Ethics in Denmark.

Sample characteristics
The sample consists of 26 two-parent families and four single-parent families. The mean number
of children within the families was 3.3 (SD = 1.62). In 11 families only one parent is traumatized,
these include single-parent families. In these families, only one parent is referred for treatment of
PTSD and the other parent either does not have a trauma history or states that he/she does not
suffer from any kind of post-traumatic symptoms. In 19 families both parents are traumatized and
suffer from severe symptoms of PTSD. At the time of the data collection only four parents had a
job, and in 26 families none of the parents were employed.

Results
Parental perception of the impact of trauma on parenting practice
In 18 families, the parents say that their post-traumatic symptoms affect their children. In some
families the parents describe the traumatized parent’s behavior toward their children as being
negatively influenced when symptoms are bad. These parents describe themselves as short-
tempered, irritable, and impatient with their children, and they describe how they feel incapable of
fulfilling their child’s needs and protecting them from knowledge of the traumatic past:

M: Yes I don’t sleep well, do you know what? Today I didn’t sleep well, I never sleep very long, all the
time I get up and all the bad thoughts they just come to me.
I: I understand but is it something, is it something that the kids ask you about?
M: yes, sometimes, because I yell a little, I am stressed out because and I don’t do it on purpose
because at the same time: the children they have no fault in my situation and my daughter asks: “why
are you yelling?” and I (sobs) I don’t do it on purpose, It is not because I want to blame them or have a
go at them, it is just because I am so tired […] (Family 3).

Parents who believe that their personal situation affects their children negatively often feel guilt
and regret. At the same time, many traumatized parents report a feeling of loneliness and
isolation. They typically report feeling unable to be emotionally close with family members,
especially when post-traumatic symptoms are acute. With regard to the specific impact of parental post-traumatic symptoms on children, a majority of parents do not specify beyond saying that their children are saddened or worried. However, in some cases the parents report that their children suffer from severe anxiety, peer problems, emotional problems, or developmental delays. In 12 families, parents say that children are not affected by their post-traumatic symptoms. These parents emphasize how they make an effort to hide their symptoms and how their children are a source of pride. Among the families in which parents say that their children are unaffected by their personal trauma histories and current post-traumatic symptoms, there is a tendency for parents to emphasize how they care for their children’s physical and practical needs. Very few of these parents mention children’s emotional needs:

M: to the extend that it is possible, we act the way we should as parents I mean I do everything that I can to take care of my children [...] even though I have so much trouble sleeping, I can’t sleep at night, and often times I have to stay up until 1 or 2 o’clock in the morning to try to read or something, and I get really tired and I just want to go and lay down and sleep, but I can’t do that every morning I get up at 6 o’clock to cook breakfast for my children and I send them off to school and I pack their lunches, and all the things which you are supposed to do for your children, I do those things (Family 29).

Within this particular Family (29), the parents both say that their children are unaffected by their own trauma history and post-traumatic symptoms, but later on in the interview, the parents say that their youngest son has been very sad after he has been told the family trauma history, and that his teachers have noticed this. In other families, there is no mentioning of children behaving in a way that may reflect a transmission of trauma. In these families, the parents typically have explicit coping strategies, and/or say that spending time with their children alleviates or reduces symptoms.

**Parent/child role reversal**

In families where parents are aware of the impact of their suffering of children, the parents are often characterized by a feeling of helplessness and role ambiguity/reversal is often seen. In these families, children’s response to parental sadness is to try to comfort the parents by offering emotional support and by caring for them in a manner that mirrors typical parental care-giving behavior such as offering food, comfort, or physical proximity. In the literature, this is often referred to as children becoming parentified. In five families parent/child relationship appear to be enmeshed, the parents do not just want to parent their children: they want to be close to their children in an encompassing way, which may challenge the child’s individuation process:

I: mm yes, so the next thing that I wanted to ask you about is your thoughts on how much you want to tell him (son) about your childhood, when he grows up?

M: Everything.

I: aha, okay interesting [...].

M: I want to be his everything, I want to be his friend, his female friend, his mother, father, brother, sister [...] so it is necessary that he hears everything, that he knows everything about me (Family 19).

In other families, older siblings seem to have almost parent-like relations with the younger siblings. While it may be possible that within some families younger children might benefit from the care they receive from older siblings (Hafford, 2010), it seems plausible that the young children’s display of care-giving behavior toward their traumatized parents is problematic. Especially, because it seems to be associated with decreased parental emotional availability and responsiveness toward the child.

**Family cohesion and flexibility**

In 20 families, parents explicitly say that family cohesion is important to them and emphasize how this is an asset and a source of strength and protection, from both the perceived dangers and challenges associated with life in exile, but also how family cohesion serves as a buffer or a way of protecting children from being negatively affected by parental suffering. In some families parents say that the family is the only place where they are able to function and that family cohesion and emotional support is what enables them to carry on:

I: How does it affect one as a parent to live with these posttraumatic symptoms?
M: Even though I have all these complaints and this pain in my body and mind then I still have a little strength left and this little strength that I’ve got left I use it with my kids and with my husband, there are others who have much more strength to function with children, husband and a house and who can handle going shopping and going to work. There are some who have the strength for that, but I don’t, I only have the strength to function at home (Family 17).

At the other end of this dimension, family cohesion seems to be challenged by the parental suffering in ten families. In these families the traumatized parent(s) typically experiences loneliness and isolation when symptoms are acute:

   F: and I can tell you (mother’s name) I can’t talk to her, she gets stressed out easily and cries (mother starts to cry as he says this) and when I see her crying who am I supposed to talk to? I go to the beach and talk there […]

   I: because you don’t want it to affect your family?

   F: yes, when I am in pain, I don’t tell anyone about it, but she (mother’s name) she thinks that I go because I want to smoke, but when I feel bad then I’ll smoke a couple of cigarettes, even though I’m not supposed to, I know people who use drugs (Family 8).

With regard to family flexibility, 18 families seem high on this dimension. What this refers to is that they seem to have adapted well to challenges such as having to move several times, coping with uncertainty with regard to the destiny of the extended family in the country of origin or other common challenges associated with life in exile. These parents often stress ongoing dialog as a way of helping children navigate within both the family system and the Danish society:

   I: are there things, which you worry about regarding your children’ s future?

   M: it is my perception that as long as I do my best and protect them, and I am honest and open with them, and talk to them and tell them what relations should be like […] it should not be like I just tell them “this and that is forbidden and you can’t do that […] that is no good, but if I am a person who discusses things openly with them, then things will turn out good”.

   I: yes.

   M: And I want to, even when they become adults, even when they grow up, then they must respect rules and the law […] it should not be like, the boy grows up and thinks: “now I am an adult, so I decide for myself what to do: no- they need to obey the rules and the law in this country, in school as well in general” (Family 7).

This mother stresses how family cohesion and ongoing parent/child dialog are important aspects of her parenting strategy. However, the fact that she sees the dialog as an open discussion can be interpreted as if she is flexible in her thoughts on what things her children are allowed to do as long as they respect the laws and codes of conduct within society. Families categorized as low on family flexibility showed no signs of adaptation to major changes and/or expressed severe frustration related to life in exile.

**Parental coping strategies**

Active coping. In ten families, parents report active coping strategies for protecting their children against the impact of their suffering. Active coping strategies refer to parents explicitly mentioning that this is what they do, to protect their children. In families where only one parent is traumatized, the parents typically describe how the traumatized parent withdraws from family life either physically or with regard to responsibility and parenting when symptoms are acute. This strategy of withdrawal and distraction is also very commonly described in families where both parents are traumatized. Often parents say that they have explicit strategies for distracting their children, and keep them unaware of their own symptoms, either by telling their children that they just have minor physical problems, or by keeping busy with household chores and telling their children that they are too busy to interact with them. Other parents describe how they send their children to the playground, let them watch TV, and/or they change the subject and or try to engage their children in play or other activities:

   I: Do the children ever ask questions that you find difficult to answer?

   M: when we feel that he (father) is feeling very unwell, it often happens that he is very sad, that he is introverted and depressed, and when he is feeling like that, then I take my children away, my eldest
son, he understands a little, so he asks questions like, “what is this?” and then I tell him: “dad is feeling a little unwell, but you mustn’t worry about it, he will get better soon” and then I take them to another room, and then I talk to them or we play games, or I pick up some toys and we play with that, and I try to distract them from their father’s illness (Family 12).

Hopelessness/helplessness. A few parents within the study report a general feeling of helplessness/hopelessness and a genuine lack of problem-solving and coping skills. This is often seen in the families who experience a pile-up of stressors and it is often combined with perceived racism:

M: I have to take care of the two older children, who are not doing so well and I have to take care of the two smallest who are also not doing so well and it is like I have got more than I have energy for […] more than I can handle […] and at the same time, when I ask the social services for help, then I get a “no” in response and of cause I am under a lot of pressure and very marked by it, and then I ask myself: “why do I get a no, is it because I am a foreigner? It is like they forsake me, I mean when I got the first rejection they said that it was because I already had a roof over my head already had a home, and I said.” “I know that, but it is that home that is causing me problems, because I have lived there for 18 years in the same apartment” So I want to blame the authorities for this problem that just gets worse and worse for my children and for the entire family, because we ask for help and we don’t get the help we need in order to switch apartment (Family 1).

Parents in these families are very inflexible and generally feel as if they have no opportunities for helping themselves and their children. The lack of agency and autonomy causes frustration, and they typically have a great deal of anger toward the authorities.

Mixed coping. In 12 families, parents report mixed coping strategies. When asked, these parents report some strategies for coping with their traumatic symptoms while parenting their children, but these parents also say that often times they feel as if their existing strategies are inadequate. These parents are often overwhelmed and thus their coping strategies vary with their symptoms:

I: Okay so you say that you have been highly affected by your situation, but do you have the feeling that you can support each other?

M: no, not always, there have been periods of times where we have had a lot of problems […] there is a limit to how much one can take.

I: I see.

M: I am pressured by thoughts and frustrations that I carry around and I have been very irritable and I have been getting angry easily, so I felt like I couldn’t stand it all […] but with time things got better (Family 15).

Marital problems, physical abuse, and family conflicts

In nine families parents describe marital problems ranging from reoccurring arguments to severe chronic conflict. In two families mothers describe that their husbands have been physically violent toward her and the children. In four of the families, the parents have chosen to live apart and say that the separation was necessary as the father’s behavior and post-traumatic symptoms were affecting the children too much. In six families, the parents directly attribute the marital conflicts to their own trauma histories and/or current post-traumatic symptoms. This can be seen in the following excerpt:

I: […] if you were to give advice to other parents with a history of trauma, and who have children the same age, what would that be? What do you think is important?

M: hmm my best advice would be, if both parents are traumatized, and if they have marital conflicts and fights then my best advice would be that they should not live under the same roof, they should move away from each other […] and those who suffers from PTSD can either be very soft or very strict towards children […] When you have been through trauma then you will either be too soft towards the children or you will be way too strict and almost push the children away from you […] (Family 2).

In two families, the mothers say that the conflict and physical abuse existed before the father’s traumatic experiences, but that the conflict has escalated after the father developed post-traumatic symptoms. Finally, in one family the mother says that the marital conflict is caused by disagreement over child rearing practices. In eight families, the parents express
helplessness and a general lack of problem-solving skills and a dysfunctional style of intra-family communication. In these families the conflicts between the parents seem to be a part of a larger pattern of conflicts between family members:

M: so (name of eldest daughter) she goes to the bathroom and then she can spend an hour there and I ask her to come out and she says: “no, leave me alone” and there has been this period of time, where (name of eldest daughter) she had a very difficult time and it was difficult to handle her [...] also her relationship with her father, that relationship was really troubled [...].

I: do the older children know about their father’s situation, I mean do they know about the things which he experienced in his country of origin?

M: not much [...] I don’t know what he has told them, and I asked (name of eldest daughter) what he has told, but she didn’t want to tell me and I don’t like to ask him (ex-husband) about what he has told them, because I don’t want to remind him, so I don’t know exactly what he has told them.

I: but what about you, have you told them any thing about the reason why he is ill?

M: no (Family 1).

**Stressor pile-up**

Within 14 families, parents describe that their primary concern and worries are not just caused by their traumatic past and current post-traumatic symptoms. These families experience a pile-up of stressors, caused by various others factors. These factors are one or a combination of the following: serious physical illness, financial problems, worries about the extended family in the country of origin, worries about residency permits/citizenship in Denmark, having a disabled child, the family’s housing situation (many families are unhappy with their current housing situation or have had to move several times after the arrival in Denmark). A majority of parents within these families say that the problems they experience in everyday life matters more to the well-being of their children than the parental traumatic past.

**Summary of qualitative analyses**

Based on the qualitative analyses, a number of central dimensions of family functioning were identified within the interview material. The following dimensions were selected because it was possible to categorize all families along these allowing for a test of the associations between these and the children’s scores on the SDQ: family cohesion: high vs low; family flexibility: high vs low; family roles: presence vs absence of role reversal; family coping: active coping, hopelessness/helplessness and mixed coping; stressor pile-up: presence vs absence of stressor pile-up; and marital problems: presence vs absence of marital problems and/or family conflict.

**Results of statistical analyses**

In order to test the association between each of the dimensions of family functioning and the children’s psychosocial adjustment as measured by the SDQ, point-biserial correlations were calculated between the SDQ and each of the family functioning bivariate variables. For the family coping dimension, the data were dummy coded in order to allow for separate tests of the association between each of the three categories and the children’s SDQ scores. Results can be seen in Tables I.

The point-biserial correlations were not significant with the single exception of that between the stressor pile-up variable and the SDQ. All nine of the correlations, however, were all in the expected directions (Table II).

In order to further explore the associations between the dimensions of family functioning and children’s psychosocial adjustment a multiple regression analysis was carried out. Due to the sample size of 30, the possibilities were limited to the inclusion of only two predictors (Field, 2009, p. 222). The two strongest of the family functioning variables were included in this analysis, namely whether or not the family experiences a pile-up of stressor and whether or not there had been role reversal between parents and children. Taken, thus, together, neither of these two predictors was statistically significant ($p > 0.05$) but the overall model was significant
Finally, all the dichotomous variables except the mixed coping variable were combined into a scale measuring total adaptive family functioning, based on the theoretical assumptions presented in the introduction. The reliability of this scale proved to be satisfactory (Cronbach’s $\alpha = 0.61$). A correlation between this scale and the children’s total difficulties scale was carried out, and the result was significant $r = 0.39$, $p = 0.034$, thus confirming the association between adaptive family functioning and positive mental health characteristics in children.

### Discussion

The results of the present study have implications for assessment and interventions at several levels. The findings from the qualitative analyses shed light on the parental perception of the transgenerational transmission of trauma within non-western refugee families.

From an individual clinical perspective, it seems highly important to address the parental feelings of guilt, personal incompetence, and social isolation within the family system experienced by almost two-third of the traumatized parents within the present sample. These parents demonstrate a very depressive view of their own parenting ability, which in itself may become a
self-fulfilling prophecy. These parents seem to give up before even trying and to react to children’s needs with withdrawal and self-blame. Many of these parents express a lack of problem-solving skills and coping strategies. This may constitute a threat to the long-term adjustment of children, as the children may not be able to develop coping strategies of their own or they may inherit/mirror their parents’ hopelessness/helplessness attitude. Thus individual psychotherapy with traumatized refugee parents should be targeted at enhancing the parental perception of agency and assisting the parent in developing coping skills to counter the effects of symptoms on their parenting ability. These coping strategies could be inspired by the strategies, which were described by the more resilient parents within the present sample.

In a little more than one-third of the families in this study, the parents say that children are not affected by their personal trauma history and current post-traumatic symptoms, the qualitative analyses did, however, reveal that in some cases these parents’ accounts are inconsistent, as parents may say both that children are unaffected and then later on in the interview describe incidents in which it seems evident that children are indeed affected by parental suffering. Furthermore the parents who did not report any influence of trauma and post-traumatic symptoms on their parenting ability often seemed to focus very narrowly on the fulfillment of the child’s physical and practical needs. These finding should not be interpreted as a lack of resilience within these families, but it may indicate that the parental perception and narrative account of how children are doing may not be the best approach to measuring psychosocial adjustment in children. The reasons chosen for using the parental version of the SDQ was the age range of the children recruited for the purpose of another study, and thus future research should employ a self-rating measure of children’s psychosocial adjustment, as previous studies point to a limited degree of cross-informant agreement between self- and parent assessment of mental health problems (Montgomery, 2008). Within the present study, a correlation analyses of the association between the parental perception of whether or not the child was impacted and the children’s SDQ scores revealed a non-significant correlation of \( r = 0.223, p = 0.236 \), the lack of association further strengthens the need for an additional measure of children’s psychosocial adjustment within future research.

At the family level, the high level of marital conflict found in the present sample should be a focus point within family therapy targeted at preventing the transmission of trauma. Although the individual correlation between the children’s SDQ total difficulties score and marital conflict was not statistically significant within the study, this is most likely caused by the limited statistical power of the present study, as the link between marital conflict and psychological maladjustment in children has been established within several populations including refugee families (Davis and Cummings, 1994; Fazel et al., 2012), and there was a clinically meaningful mean difference in the SDQ total difficulties scores between the children in families with marital conflict and the children in families without familiar conflict (see Table II).

Furthermore, family interventions with refugee families should focus on potential role reversal or role ambiguity, as the study confirms the existence of this problem within almost one-third of families, and the results of the multiple regression confirm the association between role reversal and children’s psychosocial adjustment as measured by the SDQ. Therapeutic interventions should be targeted at increasing parental awareness of the way in which they express feeling toward or in the presence of children. Within the present study, it appears as if many parents are so absorbed by their own grief that they fail to notice how their children are adopting care-giving behavior toward them. These parents should be encouraged to find different sources of comfort and children should be reassured that the parental suffering is not their responsibility. Although the finding is not statistically significant, the results of the present study confirm the finding from studies of the transmission of trauma with other populations that having two traumatized parents is negatively associated with psychosocial adjustment in children. This finding is important when assessing the need for interventions at the family level.

Regarding family flexibility and cohesion, the results of the study points to a confirmation of the hypothesis that higher levels of both cohesion and flexibility are associated with lower level of psychosocial maladjustment in children. Future research should explore this association further.

At a community or societal level, the finding that the pile-up of stressors within families is the strongest predictor of psychological maladjustment in non-traumatized children of traumatized
refugee parents has important implications. The stressors within the present study are comprised of one or a combination of serious physical illness, financial problems, worries about the extended family in the country of origin, worries about residency permits/citizenship in Denmark, having a disabled child, or the family’s housing situation. The negative impact of parental worries about the extended family in the country of origin points to the effect of global politics on child development. The negative impact of parental financial problems and worries about residency permits/citizenship in Denmark has important national political implications, and points to the potential implicit or unintended consequences of immigration policies. At the community level, the negative impact of physical illness and of having a disabled child points to the need for interventions at the community level, offering physically ill parents and parents of disabled children support in dealing with their daily chores in addition to interventions targeted at the post-traumatic symptoms.

Limitations

The both limited sample size and the use of a non-probabilistic sampling strategy constitute major limitations of the present study. The families who declined participation may possibly constitute a subpopulation suffering from additional problems than the consequences of traumatic experiences.

References


Further reading


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