Chapter 4

Trauma and Its Effects on Refugee Families

Kylie Agllias and Mel Gray

It is generally agreed in most societies that the right to family life applies to all people, everywhere. Family conjures images of closeness, of kinship, affinity, co-location, and togetherness whether family members are biological or blood relatives or part of the family through adoption, marriage, or de facto relationships between heterosexual and homosexual couples (Bedford & Blieszner 1997). For many cultures, family involves ancestral relationships that assume added significance through forced separation, especially where people are made to leave their place of birth. Forced migration of any sort—for any reason—leads to the experience of absence and loss, and a sense of detachment from family. Such disruptions in family dynamics lead to extreme discomfort as established patterns of behavior and ways of relating between family members are torn asunder for those who leave and those who are left behind alike. Likewise, cultural ties that provide a framework for family life and establish a sense of community and meaning are disrupted by flight and relocation. This is exacerbated in situations of war, where trauma associated with forced migration or asylum seeking is often played out against a backdrop of cultural, political, and historical conflict: “Although all refugees
who have lived through war, internal armed conflict, or [political] repression are labelled on the basis of this specific migration experience, they come from vastly different backgrounds that provide different personal and collective frameworks for interpreting events like separation and trauma and for determining a variety of effective coping strategies” (Rousseau, Mekki-Berrada, & Moreau 2001, p. 41).

When homes and communities are destroyed and residency is lost, family may be all that remains for political refugees experiencing internal displacement and flight. For many, this involves living in refugee camps or even resettlement in a foreign country and mourning the loss of family members due to death and separation or long periods of waiting to be reunited with their family. The long-term, intergenerational impacts have led to historical trauma, especially for indigenous peoples torn from land and kin (Gray, Coates, & Yellow Bird 2010). For many, the refugee experience encompasses changes that are related directly to genocide, war, and the forced separation of families (Weine et al. 2004). This chapter highlights the consequences of political terror and displacement, focusing primarily on their impact on family dynamics in refugee camps and following resettlement in another country. Despite geographical and cultural variances, the literature reveals remarkable consistencies in the experiences of refugee families. The chapter begins with a discussion of the nature and relational consequences of the trauma experienced by individuals and families. Thereafter, these stressors are examined across the stages of the refugee experience, particularly in relation to their effects on family dynamics.

**PSYCHOLOGICAL TRAUMA**

Trauma has been studied most often in relation to the *psychological* impact of *individual* exposure to violence and extreme stress, and, while most agree that it undoubtedly has “a deleterious influence on physical and mental health...[it] does not necessarily lead to psycho-pathology, and may or may not require medical intervention” (Giacaman et al. 2007, pp. 361-362). Thus most studied is the *psychological trauma* that results from excessive stress on the individual’s mental health following a traumatic event. While all traumatic events produce some degree of individual psychological stress, some events, such as sexual abuse, violence, torture, and the destruction or denigration of cultural, ethnic, and religious identity, may result in extreme
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emotional, cognitive, behavioral, and physiological symptoms in the immediate and longer term (Hussain & Bhushan 2009; Ireland 2007). The most common diagnosis given to a severe negative reaction to extreme traumatic events or the repeated arousal of the stress response due to multiple or ongoing stressors and or traumatic incidents in Western mental health treatment environments is post-traumatic stress disorder (PTSD) (Ireland 2007).

U.S. researchers Steel et al.’s (2009) systematic review and meta-analysis of populations exposed to mass conflict and displacement revealed a strong association between PTSD and subjection to torture, in addition to an association between exposure to potentially traumatic events (PTEs) and depression. PTSD, which is typified by intrusive recollections, avoidance of the traumatic stimuli, and disordered arousal, can be seriously debilitating (Ireland 2007). In addition, major depression has been commonly associated with PTSD (Raoul Khouzam, Ghafoori, & Hierholzer 2005). Psychological trauma, particularly PTSD, has also been associated with a number of short-term physical symptoms and long-term illnesses (Banyard, Edwards, & Kendall-Tackett 2009; Hinton et al. 2010; Kendall-Tackett 2009), some of which relate to gender and the type of trauma experienced (Norman et al. 2006).

There is some debate about the accuracy and methodological consistency of contemporary Western research on the particular mental health implications of refugee trauma, torture, and displacement due to complex individual variables and the cumulative effects of stressors at different phases of the refugee experience (Keller et al. 2006). The assessment of individual psychological or psychiatric symptoms, particularly PTSD, has been the most-used measure of the impact of war and conflict-related violence and trauma (Giacaman et al. 2007; National Child Traumatic Stress Network [NCTSN], 2003). Drawing on evidence about the different cultural presentations of mental disorders, recent critiques have highlighted the Western bias of such measures (Giacaman et al. 2007; Hussain & Bhushan 2009). Much of the research on trauma has been conducted in Western contexts and has focused on populations of war veterans and victims of sexual assault. As already mentioned, assessments of PTSD have focused primarily on the individual’s exposure to violence and located the problem within the individual even when political violence was due directly to collectively experienced social disturbances (Giacaman et al. 2007; NCTSN 2003). Giacaman et al. (2007) showed that both individual
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and collective exposure to political violence and trauma had negative impacts on the mental health of adolescents. They explained that collective experiences of violence and trauma also might have different implications for health, mental health, and treatment. One might expect that cultures that exhibited strong community solidarity would experience collective violence differently than individualistic Western cultures (Giacaman et al. 2007). There was also a growing awareness that Western constructions of development, normality, and psychopathology overlooked the diversity of refugee experiences and the resilience of individuals, families, and groups (NCTSN 2003). Additionally, most research has studied refugees who have resettled in Western countries (Hussain & Bhushan 2009), when these refugee populations’ cultural experiences might have been very different from those of people in their destination countries.

More recently, there has been a growing understanding of the effects of trauma on intimate and social relationships. This was particularly so for interpersonal trauma, or trauma that occurred within a relational context, such as rape or persecution due to race or religion (Schwerdtfeger & Nelson Goff 2007). Herman (1997) said that traumatic events called basic human relationships into question: “They breach the attachments of family, friendship, love and community. They shatter the construction of the self that is formed and sustained in relation to others” (p. 51). She found that trauma destroyed the fundamental trust that individuals acquired from their primary attachment relationships, leaving them feeling vulnerable, unsafe, alienated, and disconnected from family and community.

A significant body of research has suggested that the development of mental health disorders, particularly PTSD, was associated with a lack of a supportive environment aware of and sympathetic to the refugee experience (Guay, Billette, & Marchand 2006; Kaniastry & Norris 2008; Wu et al. 2009). Some of this research pointed to “social causation,” which suggested that a lack of social support led to psychological distress; other research pointed to “social selection,” which suggested that people with poor mental health would have less opportunity and ability to engage in supportive relationships, and some studies showed a complex relationship between both of these theories (Kaniastry & Norris 2008). However this might happen, current research has suggested that the combination of PTSD symptoms, such as feelings of detachment and angry outbursts, and the associated interpersonal consequences, such as difficulties with intimate
relationships, alcohol, and domestic abuse, might erode the levels of perceived and actual social support given to individuals over time (Kaniastry & Norris 2008; King et al. 2006; Wu et al. 2009). Additionally, PTSD has been shown to increase an individual’s negative experience of social exclusion when compared to people who have not been diagnosed with PTSD (Nietlisbach & Maercker 2009). This might further compound the stress on PTSD sufferers. In fact, Kaniastry and Norris’s (2008) research suggested that when collective trauma was experienced, immediate levels of altruism and mutual support were often high and offered a buffer against initial individual stress responses. However, over time, social support would subside and individuals who continued to suffer high levels of psychological distress might be perceived as irritating or demoralizing, and their symptoms attributed to personal flaws. So at the same time that PTSD symptoms might be making it more difficult for sufferers to interact socially or receive support, the social support might be withdrawn by the very community members who had provided it in the first place (Kaniastry & Norris 2008).

Research has suggested that social support provided by family and friends has a marked effect on recovery and improved physical health outcomes following a traumatic experience (Borja, Callahan, & Rambo 2009; Campbell et al. 2001). However, the relationship between social support and recovery was complex; for example, Borja et al. (2009) suggested that support could be both negative and positive, and even well-intentioned support might be perceived as negative by some. They also suggested that the quality rather than the level or degree of support was more indicative of its therapeutic value.

It is important to view these findings in relation to the support available to refugee families after trauma. Many would be reliant on remaining family members and friends as the primary means of support, that is, those who were most likely to have experienced—and themselves be suffering the effects of—trauma. Steel et al.’s systematic review and meta-analysis showed PTSD rates of between 13 percent and 25 percent in populations exposed to mass conflict and displacement, which suggested a high likelihood that refugee families would have at least one member experiencing extreme reactions to exposure to trauma. It also suggested that refugees would be reliant on new communities for support and validation of their traumatic experiences, at a time when refugees were often portrayed by politicians as queue jumpers, terrorists, and a drain on the settlement country’s
resources. Refugees would be exposed to multiple losses and deprivations during displacement and even after resettlement, since these have been shown to have a potentially cumulative effect on the development of mental health disorders and PTSD (Porter & Haslam 2005; Steel et al. 2009). These stressors are now examined across the stages of the refugee experience, particularly in relation to changing family dynamics.

LIVING WITH CONFLICT, WAR, AND POLITICAL INSTABILITY: THE PREFLIGHT PERIOD

For refugees, the preflight period has been marked most often by loss associated with disruption, destruction, deprivation, danger, persecution, and exposure to traumatic events, such as injury, sexual assault, torture, engagement in combat, and witnessing the torture and murder of others (Brymer et al. 2008). For some, this period of crisis and/or deprivation was prolonged due to the loss of culture, place, and social connectedness that often occurred well before displacement and flight from the homeland (Robertson et al. 2006). In many instances, families were separated from one or more family members before flight, due to incarceration, others’ flights to safety, or unnatural death (Ajdukovic & Ajdukovic 1993; Rousseau et al. 2004). Those left behind, and particularly those left for long periods, might experience feelings of abandonment and betrayal, during a period when traditional family roles and responsibilities might need to be renegotiated and realigned (Rousseau et al. 2004). Other stressors or losses that might impact on family dynamics included loss of capacity due to physical injury, loss of income and status due to the inability to work, forced labor, and the destruction of infrastructures supporting self-employment (Brymer et al. 2008; Steel et al. 2006). Loss of home, too, meant loss of shelter, security, meaning, and identity since, for most people, the home was sacred and a marker of identity: “A home [could] be thought of as a symbol of the self” (Ajdukovic & Ajdukovic 1993, p. 845). However, in many instances, homes had been lost and, as a result, families lived in poor physical environments characterized by overcrowding and a lack of privacy and basic necessities (Ajdukovic & Ajdukovic 1993). Under these conditions, family roles and dynamics might change due to necessity. Families might need to seek assistance when previously they had been self-supporting. Women and children might need to work when this was not previously necessary. Shifts in power and status might occur in shared and newly formed
multigenerational households. Additionally, health and psychological difficulties might be experienced due to limited resources, poor sanitation, and exposure to the elements (Carballo et al. 2004). Steel et al.’s (2006) research with Mandaean refugees in Australia showed that over a third had experienced lack of food and water, and over one-quarter had experienced illness without medical treatment prior to migration. Reproductive health might be affected by reduced access to medical facilities, stress, and poor nutrition. Carballo’s (1991–1994) research with women in Bosnia and Herzegovina showed significantly poorer pregnancy outcomes than prior to war and higher demands for abortion (which might be due to the systematic rape of women in some areas). In most cases, parents (and particularly sole women) would struggle to maintain responsibility and provide support for their families under these conditions, conditions that almost invariably ensured the erosion of family connectedness (Robertson et al. 2006). Often children, too, would experience a reduction in parental support and protection while educational opportunities might be lost due to the destruction of schooling facilities as well as familial instability and ongoing relocation (Ajdukovic & Ajdukovic 1993). Research has shown that children and adolescents’ self-regulation was highly responsive to the emotional well-being of parents and caregivers (Bek-Pedersen & Montgomery 2006; Stauffer 2009). Often children would be living with distressed adults, and this, in turn, could impact upon their capacity to deal with the range of new experiences confronting them (Ajdukovic & Ajdukovic 1993; Stauffer 2009): “It is increasingly recognised that the psychological morbidity related to war and forced displacement is often severe and highly debilitating” (Carballo et al. 2004, p. 465). There is an association between living in political violence and increased rates of mental disorders (Steel et al. 2009). The effects of trauma—which might include depression, aggression, hyper-vigilance, alcohol abuse, illness, and sleep disturbance—have a potentially detrimental effect on family relationships and functioning (Ajdukovic & Ajdukovic 1993; Goodkind 2006; Hsu, Davies, & Hansen 2004). Studies have shown that trauma experienced by refugee parents could have significant impacts on their children and even later generations due to its effects on parenting capacity and expectations of the next generation (Bek-Pedersen & Montgomery 2006; Rousseau, Drapeau, & Platt 1999; Rousseau, Drapeau, & Rahimi 2003). These impacts often commence in the preflight period, and their outcomes might be positive or negative. They are explored in more detail in the discussion on flight and resettlement below.
FLIGHT, REFUGEE CAMPS, AND FAMILY DYNAMICS

The period of flight was primarily characterized by hardship, instability, unpredictability, and a loss of control (Brymer et al. 2008; Hsu et al. 2004). Flight was often an unplanned response to an escalation of life-threatening events in the home country (Valtonen 2008). Forced displacement or ethnic cleansing was often a method aimed at destroying collective symbols, identity, and a sense of “belonging” (Carballo et al. 2004). Unfortunately, often the processes employed to support refugees during flight and asylum were just as dehumanizing (Marfleet 2006). Such processes were underpinned by global ideologies that viewed waves of refugees as “elemental forces threatening inundation and which require[d] containment and redirection’ (Marfleet 2006, p. 193). During the period of flight and temporary settlement, the most basic needs of families would be reliant on the decision and priorities of external sources, the degree to which would be determined by the type of temporary settlement arrangement (NCTSN 2003). In many cases, flight was within the country of origin and people were said to be “internally displaced.” These families would experience many of the same issues discussed below in relation to those who reside externally in refugee camps. However, they would often be at considerable risk of further danger, persecution, and relocation because they remained under national jurisdiction without the protection of the United Nations High Commissioner for Refugees (UNHCR). Displacement made previously independent people reliant on external forces and humanitarian aid, and they might be denied input into decisions about this process (Carballo et al. 2004). This was particularly so for the poorest families, who were more likely to have localized support networks and kin, and few resources to make their flight more bearable (Marfleet 2006). Carballo et al.’s (2004) research with 1,500 displaced and nondisplaced persons, who had been exposed to the war in Bosnia and Herzegovina, highlighted the disempowerment associated with war and displacement. The first of two major themes “was the repeatedly referred-to sense of powerlessness felt by displaced people, which reflected their loss of family, property and all that might have offered them a belief in future return and reconstruction of their lives” (Carballo et al. 2004, p. 468). The second theme illuminated the negative impact of war, and particularly displacement, on self-esteem and a sense of self-sufficiency (Carballo et al. 2004). Feelings of powerlessness and low self-esteem could have
deleterious impacts on decision making and increase dependency on others (Carballo et al. 2004).

In some countries, such as Australia and the United Kingdom, asylum seekers were subject to detention or restricted temporary residency while their claims for asylum were processed. Steel et al.’s (2006) study of Madaean refugees in Australia showed that detention was a highly stressful experience. Refugees reported stress related to the application process; poor physical conditions, such as overcrowding, boredom, and being woken in the night; interpersonal problems, such as abuse, conflict, and witnessing violent acts; and poor access to adequate healthcare. Detention and temporary residence contributed to risk of PTSD, depression, and mental health–related instability. Longer periods of detention and restricted temporary residence were associated with increased severity of mental health disorders and the persistence of symptoms following release (Steel et al. 2006).

Most refugees would be relocated temporarily to a refugee camp in a bordering country that might have limited resources or capacity to assist to the extent required. In some protracted situations, residence in a refugee camp might be for decades. The processing of refugees prior to their settlement in a refugee camp, while necessary, might be considered deleterious to autonomy and self-control. Marfleet (2006) suggested that camp authorities often had pervading assumptions that refugees were mostly “helpless” and “emptied of self-will” at the same time as expecting them to be responsive to, and grateful for, humanitarian agendas into which they had little or no input. It was often expected that refugees would take on a subordinate role within the camp hierarchy. Resistance in the forms of “uprisings” and “ration fraud” were not consistent within these predetermined scripts (Marfleet 2006).

One might expect that refuge would bring some relief from preflight stressors and trauma, a time to regroup and begin healing. However, evidence suggests that refugee families continued to be exposed to violence and attempted or committed suicide during their time in detention and refugee camps (Brymer et al. 2008; Carballo et al. 2004; NCTSN 2003). Overcrowding, restricted movement, and stigma were reported as very real problems for families in refugee camps (Giacaman et al. 2007; Horn 2009). Rahman and Hafeez’s (2003) study showed that female refugees rated financial concerns and concerns for their children’s futures as highly problematic during this period. This evidence was supported by a meta-analysis that showed that displaced people
and refugees living in refugee camps had higher rates of PTSD and depression than those who had resettled (Giacaman et al. 2007; Steel et al. 2009). One study of 1,000 school-age Palestinian children showed that 34.1 percent of the sample met the diagnostic criteria for PTSD, with this rate rising to 50 percent for those living in refugee camps (Khamis 2005). Rahman and Hafeez's (2003) study of 297 young Afghan mothers residing in a refugee camp reported that 36 percent had a mental disorder, with 91 percent of these having suicidal thoughts in the prior month, while 34 percent felt depressed and almost 25 percent had experienced chronic anxiety (Carballo et al. 2004). This suggested that stressors experienced during displacement and while living in refugee camps not only delayed recovery from mental disorder, but also increased susceptibility to mental illness. Further, the consequences of psychological distress placed a considerable burden on family and social networks, to the point where people might start to distance themselves from the person experiencing symptoms (Kaniastry & Norris 2008). At the same time, displacement often stripped refugee families of the structures and relationships that might have supported them in the new context (Valtonen 2008). Children might be separated from their parents and caregivers during flight, and unaccompanied minors reported "significantly higher rates of trauma exposure and associated depression, anxiety, and posttraumatic stress symptoms than [did] accompanied refugee minors" (Derlyun & Broekaert, in Brymer et al. 2008, p. 626). Separation required the reconfiguration of family roles, including shifts among parents, children, and extended family and perhaps even reliance on external sources to fulfill parenting, household, and employment duties (Rousseau et al. 2004). Even relationships that remained intact throughout the preflight and displacement period might be affected by the magnitude of the traumatic events the family was undergoing (Stauffer 2009). The interplay of trauma, loss, separation, and conditions within refugee camps could seriously impair parents' ability to supervise and attend to their children's needs (Brymer et al. 2008). Rahman and Hafeez's comments about the Afghan mothers in their research illustrated the multiple and often conflicting roles that women faced in refugee camps: "Young mothers are a vulnerable group with little political voice, yet there are at the forefront of the repatriation process, expected not only to rebuild their lives but also to provide care and some semblance of a nourishing environment for their children, who represent the future of the country. This is a demanding task, and poor physical or mental health in these mothers might be
expected to have adverse consequences on their children's physical and psychological development” (Rahman & Hafeez 2003, p. 392).

One study of 1,000 school-age Palestinian children showed that family ambivalence, or the child's experience of anxiety in the home, was the most significant environmental or parenting predictor of PTSD (Khamis 2005). These children were more likely to report feeling “anxious, tense and nervous in situations involving . . . patterns of interaction such as speaking, discussing and communicating” (Khamis 2005, p. 91). Research has also shown that parental PTSD contributed to poor adult-child relationships and increased parental aggression (Lauterbach, Bak, et al. 2007), and that negative life events might be significant contributors to lessening parent-child attachments (Waters, Merrick, Treboux, Crowell, & Albersheim in Stauffer 2009): “Because refugee parents have fewer choices than immigrants, they often have less ability to protect their children, potentially compromising children’s basic trust in them” (NCTSN 2003). Changes in parental roles and physical and mental health were likely to impact upon parental engagement, discipline, and attachment (Spencer & Le 2006). Research showed that maternal experiences of trauma, particularly PTSD, could affect prenatal attachment patterns, which might, in turn, contribute to the intergenerational transmission of traumatic symptoms (Schwerdtfeger & Nelson Goff 2007). Additionally, there was some evidence that lower levels of parental and peer support in childhood increased the likelihood of developing PTSD in later life (Lauterbach, Koch, & Porter 2007). However, attachment problems were not only confined to children. Adult separation anxiety disorder, “where adults experience[d] intense anxieties about separations from, and exaggerated fears about harm befalling, close attachment figures” (Silove et al. 2010, p. 169) were associated with PTSD in a group of war-affected Bosnian refugees resettled in Australia (Silove et al. 2010).

The social arrangements during displacement and residence in refugee camps often affected social, occupational, and life roles. For example, work skills might not be transferrable to the new context, which might mean unemployment or underemployment and an accompanying change in social status (Carballo et al. 2004). For example, Hsu et al. (2004) suggested that the importance of family, and the gendered hierarchy inherent in Southeast Asian cultures, could be disturbed when single mothers needed to take over the primary caregiver and breadwinner roles within the family. In traditional Southeast Asian families, men were often viewed as superior to women, and their position was
one of authority and financial support (Hsu et al. 2004). However, this might be challenged by the new conditions. Children were more likely to work in refugee camps due to necessity, and child labor has been linked to increased likelihood of PTSD in a study of Palestinian school-age children (Khamis 2005): “Displacement exaggerates unequal relations of gender, and camp regimes usually further emphasise such differences, as external authorities make assumptions about gender relations which are consistent with their own expectations and with their preference for liaison with male authority figures” (Marfleet 2006, p. 208). Women often had considerable power in the domestic (and sometimes political and social) spheres that might be stripped during their residence in refugee camps, and they might be viewed as secondary to their male partners. For example, they might no longer have control over the food they served or the ways they parented (Marfleet 2006). Environmental pressures might mean that women must take on new roles in order for the family to survive economically and socially (Hyder, Noor, & Tsui 2007). However, these new arrangements might be viewed as contributing to moral decay by some sectors of the community, who might exert pressure on women to continue traditional roles (Horn 2009). In contrast, Szczepanikova’s (2005) study of gender relations between Chechen refugees residing in a refugee camp in the Czech Republic found that changes in work roles might not affect refugees’ ideal notions of femininity and masculinity. They found that femininity remained associated with the domestic sphere and masculinity with honor, honesty, and protection of the family even when roles changed (Szczepanikova 2005). So while camp conditions might have necessitated the role of financial support being transferred to the adult female, this was often regarded as an additional and secondary role, which resulted in additional, rather than different, pressures being placed upon some women. There was evidence to suggest that such circumstances might contribute to many male refugees feeling less self-worth, as if they had failed to protect their families, and that they had lost control in many aspects of their lives (Hyder et al. 2007; Szczepanikova 2005). However, this did not necessarily mean that men would adapt to new roles within the domestic sphere, and some would find this extremely difficult (Szczepanikova 2005). In some cases, the dynamics associated with one partner being overburdened and the other feeling undervalued might contribute to intimate partner violence. Women were highly susceptible to physical and sexual violence in refugee camps, and several investigations have
revealed the widespread vulnerability and abuse of women by other refugees and camp officials (Horn 2009; Marfleet 2006; Szczepanikova 2005). Additionally, a high incidence of intimate partner violence has been repeatedly shown in refugee camps (Horn 2009; Hyder et al. 2007; Szczepanikova 2005). Women who have been separated from kin might be protected no longer from men within the camps and from their own partners (Horn 2009; Marfleet 2006; Szczepanikova 2005). Isolation from family meant that women might not have a safe place to go or representatives to help resolve the problem (Horn 2009). Some speculated that men experiencing poverty and boredom might use violence as a way to alleviate this stress and regain control within their families (Jewkes in Hyder et al. 2007). Additionally, women might not report violence to authorities, and authorities might not be trained to respond adequately (Hyder et al. 2007). Szczepanikova’s (2005) research with Chechen refugee women showed that the continued danger to the lives of male partners, the shortage of male partners, and traditional notions of honor and respect embedded within the marriage contract meant that women tolerated male behaviors in refugee camps that previously they might have challenged or reported to authorities. Additionally, people witnessing violence might not report or seek help due to suspicions that authorities would remove women from the family following domestic violence (Horn 2009).

**RESETTLEMENT AND FAMILY DYNAMICS**

In the previous sections, we noted that the greatest threat to the refugee family was not trauma itself but the erosion of family bonds, the renegotiation of family roles, and the mental health stressors that resulted from trauma and dislocation. Recovery from trauma, and trauma-related stressors, required the establishment of safety and stability, making sense of the trauma story, and reestablishing trust within the family and between social systems. During resettlement, a number of factors created and buffered additional stressors within the family system. Unlike migrants, refugees did not have the luxury of choice or time to plan physically, emotionally, or psychologically for the resettlement experience. The majority of refugees came from regions—such as the Middle East, Africa, and Asia—that were vastly different from the industrialized nations in which they were resettled, such as the United States, Canada, Australia, and the Nordic countries. This meant that rapid and deep cultural change—including the renegotiation of
values, cultural practices, and beliefs—were required in response to the demand of the resettlement process (Valtonen 2008). Challenges included mastering a new language, finding employment and educational facilities, adapting to the new culture, adjusting to new foods, experiencing exclusion or discrimination, and coping with the psychological legacies of trauma and displacement. Indeed, Valtonen (2008) suggested that the family system would undergo "another" type of role metamorphosis in response to these challenges and the new settlement conditions. During resettlement, it was not uncommon for refugees to experience culture shock—a situation where physiological and psychological stress was experienced due to the absence of familiar cues—as they tried to negotiate the meaning of two different cultures. Porter and Haslam's (2005) meta-analysis showed that the sociopolitical aspects of the resettlement context played a significant role in long-term mental health outcomes for refugees. Recovery required a responsive resettlement environment as well as support for trauma-related mental health conditions.

The new country offered opportunities, risks, and challenges to the family system. However, most families continued to experience stress and mental health issues related to the legacy of war and displacement for some period of time. Many families were living with vulnerable family members who had been affected physically or emotionally by war and displacement. The symptoms and behaviors associated with PTSD and depression—as described previously—might continue to impact interpersonal relationships. However, trauma and trauma responses could be located, understood, and determined through a different cultural lens where problematic symptoms might not correlate with Western diagnostic criteria, leaving refugees vulnerable to misdiagnosis and delays in treatment and support (Hsu et al. 2004). However, more than mental health issues persistently affected resettled families. Carolan's (2008) research showed that higher rates of infant morbidity and mortality continued among sub-Saharan African refugee women after resettlement, suggesting that physical conditions might persist for some time.

The family remained the anchor of emotional adjustment, meaning making, and cultural identity during the initial resettlement period. Ager and Strang's (2008) investigation of refugees in the United Kingdom found that proximity to family and social bonds with the cultural group were essential to feeling "settled" in the new country. Rousseau et al.'s (2001) work suggested that "the presence of family
members sometimes seems to transform adversity into a source of strength, perhaps in aiding the rebuilding of a meaningful universe” (p. 157). However, Montgomery’s (2008) study of young Middle Eastern refugees eight to nine years after migration showed that nearly 20 percent had been attacked, and 40 percent had witnessed an attack on another, person since arrival. The majority had experienced some form of discrimination, including teasing, derogatory remarks, and refused entry. This meant that the family and, indeed, the cultural community served as protection against the internalization of prejudice and discrimination (Valtonen 2008), but most families were not intact on arrival. Additionally, dispersal policies in some resettlement countries contributed further to family and community separation and social exclusion during this period. Western concepts and definitions of family also had implications for family bonds during resettlement. For example, Southern Sudanese people described family as genetic or blood relatives and kin or tribal members (Stoll & Johnson 2007). Some cultures practiced polygamy, and others did not differentiate between sons and daughters and nephews and nieces. When Western concepts were applied, families and communities might be separated and required to resettle in different locations, which obstructed the healing process (Weine et al. 2008)

Worrying about those left behind or in different asylum locations and waiting for reunification could affect the settlement process (Valtonen 2008). Family members were often scattered around the globe, resulting in infrequent communication and emotional distress. Even the separation of family members who would not be reunified in the new country could lead to guilt and sadness. Older parents might have been left without younger generations to care for them. Fear for family remaining in the war-torn countries might be very real and impact the refugee family’s ability to move forward as shown by Nickerson et al.’s (2009) study that showed higher levels of PTSD, depression, and mental health-related disability in refugees who had family remaining in their homeland (Iraq). Porter and Haslam’s (2005) meta-analysis also reported that refugees showed much better mental health outcomes when the political conflict in their place of origin had been resolved. The impact of ongoing conflict could not be underestimated, because this analysis showed higher levels of mental health outcomes for refugees resettled externally, compared to refugees resettled internally in countries where conflict continued. Additionally, “for refugees who have had traumatic experiences, extended separation from
family members may serve as a continuing link to an unbearable past, which translates into painful episodes of reliving experiences associated with news or lack of news from the family" (Rousseau et al. 2001, p. 41).

Delays in reunification—often after long waits in the first country of asylum—might be experienced as distressing and disappointing. As mentioned previously, the reconfiguration of family roles might commence when family members were initially separated, and this continued or needed to be readjusted once more while awaiting reunification in the settlement context. Rousseau et al.'s (2004) research with Congolese refugees resettled in Montreal showed that they experienced feelings of isolation and powerlessness during this period, and some even questioned their desire to live. The families in Rousseau et al.'s (2004) study employed three different strategies or positions to sustain them until reunification: Some families anticipated change and disruption but readied themselves for this change by "anchoring" themselves to culture and tradition; some families relied on notions of permanence and resisted change within the family system; and some found solace in accepting the predictability of future change and loss. Regardless of the response to ongoing separation, the loss of extended family had the potential to bring the nuclear family closer together or it might provide the impetus for permanent separation (Rousseau et al. 2004). Marriages were more prone to break down during long periods of separation (Rousseau et al. 2001).

Pahud et al.'s (2009) study revealed that refugee families viewed family reunification as a major achievement or milestone in the resettlement process, and this alleviated the stress linked to separation from loved ones. Rousseau et al.'s (2001) research also showed that the negative mental health effects caused by separation decreased when refugees were reunited with at least some family members. However, reunification was not a simple process of joy and relief, but one that also involved losses and significant realignment. Rousseau et al. (2004) suggested that "memories of the person and the relationship [were] reconstructed during the absence of the missing person during the wait, sometimes through idealization, guilt, doubts about fidelity, fears of abandonment, the need to be supported and sustained by the long distance relationship or, conversely, the need to become independent, to make the solitude bearable" (p. 1096). Reunion might bring challenges to self-identity, as parties came to the realization that they had changed over the period of separation. It also had the potential to unleash old memories and revisit losses associated with the old
country and bring finality to the idea that settlement in the new country—with its opportunities and disappointments—was permanent (Rousseau et al. 2004).

Beliefs about permanency, secure accommodation, and economic opportunity (or access to work and the ability to maintain socioeconomic status) contributed to better refugee mental health outcomes (Porter & Haslam 2005; Steel et al. 2006). Similarly engagement in school or university was an essential component to young people’s feelings of acceptance and usefulness in the new country (Pahud et al. 2009). While preflight trauma was a major signifier of children’s mental health disorders, migration stressors mediated longer-term mental health adjustment. For example, Montgomery’s (2008) study of young Middle Eastern refugees eight to nine years after migration showed that a number of conditions affected externalizing and internalizing behaviors, including preflight traumatic events, witnessing an attack, discrimination, moving schools, and stressful experiences after arrival. However, attending school or work, having Danish friends, being of faith, language proficiency, and increased mother’s education all had positive effects. Secure and comfortable housing was essential to settlement because it provided an opportunity to establish “home” and community connections (Ager & Strang 2008). Employment and education were key components of integration for the refugee family, because both provided opportunities to meet others, develop language skills, and foster economic independence and self-reliance (Ager & Strang 2008). The new country often offered employment opportunities that might not have existed in the country of origin, particularly for women (Hsu et al. 2004). However, the non-recognition of previous qualifications might result in underemployment and a change of status and income for some families, particularly men. Stoll and Johnson’s (2007) study of Sudanese men in Canada showed substantial underemployment and lower than national average wages even though most men were employed full time. They also showed that more educated refugees and those with higher predisplacement socioeconomic status had lower mental health scores, which might suggest greater losses associated with displacement and resettlement. Rousseau et al. (2004) noted Congolese women’s greater engagement, and flexibility, in relation to employment due to the stimulation and socialization it provided, compared to the men, who were more likely to mourn the loss of skill and qualification recognition in their new employment. Some shifts in employment
roles between parents might result in marital disharmony and stress, although, over time, adaptation seemed to occur (Valtonen 2008). According to Valtonen (2008), during this period, “members of a family often take actions that are not privately beneficial, but which will be best for the economic well-being of the family unit” (p. 126). Weine et al. (2004) showed that this focus on economic success, multiple jobs, and conflicting schedules often resulted in less family time for the resettled family and might require fathers, grandparents, or extended family members to take a greater parenting role. Where family members were unable or unwilling to shift roles, there might also be considerable conflict and disparity in the allocation of work, particularly in families where women were expected to do household chores and, out of necessity, engage in paid work (Rousseau et al. 2004). For some men, the new engagement with household chores and childcare could create a sense of loss and failure and become a source of disillusionment in the new country (Rousseau et al. 2004). Exposure to employment and education might also influence gender relationships, with men sharing the breadwinner role with their wives and children for the first time. Additionally, exposure to Western notions of gender equality might result in some female members challenging patriarchal norms within the family, requiring the family system to become more flexible and egalitarian (Weine et al. 2004). Parents might be faced with decisions about how to parent when their young people have new knowledges, freedoms, and risks in the resettlement country. Weine et al.’s (2006) study of parents of adolescents showed that core family beliefs were adapted in the new context to meet these new demands. For example, some parents might become more actively involved in their children’s new lives and give them more responsibility, while others might increase control in order to protect them from perceived risks in the new country.

Economic survival was of paramount importance in the early stages of resettlement, particularly for single mothers, who might have been widowed during the conflict. Staying connected with extended family members was also important for these women, who needed to reconstitute a new form of family in the absence of a partner (Weine et al. 2004). Many refugee families also supported family members in the country of origin or were saving for reunification, which created the impetus to work long hours and put a strain on the family’s resources. For example, Stoll and Johnson’s (2007) study of Sudanese men resettled in Canada revealed the economic strain associated with providing
for immediate family, saving to sponsor relatives to the new country, and sending money to family in Africa, something they referred to as the "global breadwinner role." Financial demands contributed to role strain that had a negative effect on social adjustment. However, psychological adjustment was not affected by the global breadwinner role. This suggested that this role was an important and positive way of maintaining individual pride and family continuity. Indeed, saving for reunification with family members living abroad could be an important strategy in adjustment and family well-being. Sending money home often helped to alleviate guilt and stay connected with extended family (Weine et al. 2004).

Social isolation could be a significant barrier to successful adjustment to the settlement context, with certain family members being more susceptible to isolation and loneliness. Social isolation resulted from poverty, language difficulties, lack of education, and psychological problems for some refugees. Robertson et al.'s (2006) study found that older women and those with larger families, who had higher pre-flight exposure to trauma, experienced less opportunities for social inclusion during resettlement: "The sequela of torture go well beyond physical and psychological trauma. Torture experience interferes with the capacity and ability of survivors to function in social and economic spheres" (Hsu et al. 2004, p. 294). Older people might have less access to social support due to their limited participation in the economic or educational sphere. Poor language skills could marginalize particular members and also limit access to information, which might mean that refugees relied more heavily on extended family and community members for support and guidance. However, Pahud et al.'s (2009) study showed that some refugees were reluctant to call on other refugees because they were aware that they were facing their own hardships, and this could place enormous strain on a limited number of nuclear family members.

Children and adolescents tended to renegotiate and acculturate more readily than their parents, due to rapid language acquisition and greater cultural exposure and acceptance. This is not to say that adults were less willing or able to change, rather that there might be less incentive or rationale for changing values and practices that had served them adequately in their home country, particularly if there were few perceived alternatives. This could cause significant changes and even conflict in intergenerational relationships as young people negotiated two cultural spaces more readily than the older generations.
Family members might need to rely on children and young people to translate language and cultural norms, and this might be experienced as a burden by the younger generation (Weine et al. 2004). Hinton et al.’s (2009) study found that nearly half of the Cambodian refugees surveyed had directed a severe anger attack or outburst at a nuclear family member in the past month that had resulted in somatic arousal and trauma recall. The stimulus for these angry outbursts was often an inability to communicate with children due to linguistic differences. Traditional methods of discipline, such as physical punishment, might not be acceptable in the settlement country (Valtonen 2008), and traditional medicinal treatments might be viewed as unacceptable by the new culture (Hsu et al. 2004). Additionally, Western culture granted children considerable power and authority in relation to their parents that might be inconsistent with prior parenting practices (Rousseau et al. 2004). The parental bond was sometimes affected by reduced involvement and discipline in the settlement context. For example, Spencer and Le’s (2006) research showed a connection between parental refugee status, reduced ability to engage with and support their children, and the incidence of Vietnamese youth engaging in serious violence (including violence within the family).

Parental exposure to trauma might also provide protective factors during the resettlement period, when a form of overcompensation contributed to the nurturing of, and investment in, the young person’s well-being and success (Bek-Pedersen & Montgomery 2006). Children provided hope for the future in the resettlement context. In what might be viewed as an unexpected finding, Rousseau et al.’s (2003) research with Cambodian adolescents found that those whose families were more exposed to preflight violence were more likely to experience positive social adjustment and fewer mental health difficulties after resettlement. Rousseau et al. (2003) explained this finding in relation to Cambodian parents’ high expectations for their children in the new country and also the young people’s felt obligation toward their parents. However, Weine’s (2004) research also shed light on the disappointment that arose when children experienced difficulties: “When looking at their children’s lives, parents try to find positive experiences and outcomes that would take their minds off memories of trauma and loss. The problem is that when they encounter the problems that their children are having dealing with urban America (i.e., gang violence), it again reminds them of traumas” (Weine et al. 2004, p. 154). Additionally, children might take on too much responsibility for their parents’
happiness. In Rothe’s (2005) research, over a third of children and young people reported feeling guilty about what had happened, with young people sometimes reframing their parents’ decision to emigrate in terms of giving the younger generation a better future.

The experience of children and young people could not be distinguished from the recovery from the trauma of war and dislocation. Rothe’s (2005) study of Cuban children, up to six months after relocation in the United States, showed the majority continued to experience symptoms of PTSD, such as somatization, reexperiencing, avoidance, acting out, and regressive behaviors. The mental health of parents also had the potential to affect the children in their care (Bek-Pedersen & Montgomery 2006), and the trauma story had a large impact on family cohesion. The communication—or withholding—of the trauma story affected the mental health and emotional responses of children and young people in both negative and positive ways. The overprovision of detailed and traumatic information might be deleterious to the young person’s mental health, but withholding information might also have adverse affects. Weine et al.’s (2004) study of Bosnian refugee families in Chicago reported that some family members refrained from speaking about negative memories of the past due to the physical and emotional pain that resulted and also for fear of causing distress to others. Children were often perceived as primarily focused on their new lives and uninterested in memories from the past, and some adults felt that a positive future was more likely if they avoided or erased such memories. Talking about the previous trauma experience was also avoided in some instances to avoid bringing evil into the future (Lin, Suyemoto, & Nien-chu Kiang 2009). However, Lin et al. (2009) suggested that avoiding communication for too long led to an insular and detached experience that was detrimental to family and social relationships. When young people overheard family stories, heard traumatic information in the heat of intrafamilial conflict, and/or gained their information primarily from peers, this could lead to confusion and mistrust (Lin et al. 2009). However, young people might want information about their heritage, including the trauma story. Adolescents from the Middle East residing in Denmark suggested that parents had an important capacity to influence the young person’s synthesis of the family story in relation to understanding their current resettlement process (Bek-Pedersen & Montgomery 2006). This was reiterated by Weine et al.’s (2004) study that showed that expressing emotions and sharing experiences could be a positive experience that helped to rebuild trust within the family.
and community. Communication about the culture and birthplace, as well as the maintenance of language and religion, were deemed very important ways of strengthening family by parents in this study. Consistently, research has shown that developmentally appropriate and thoughtful communication of the trauma story between the generations was important for the maintenance of family integrity and cohesion (Bek-Pedersen & Montgomery 2006; Lin et al. 2009; Weine et al. 2004).

CONCLUSION: RECOGNIZING LOSS AND SUPPORTING THE CHANGING FAMILY

The losses associated with internal conflict, flight, temporary residence, and then resettlement that have been described in this chapter may seem insurmountable. Over time, however, most refugee families settle in their new country and have successful and fulfilling lives. There is growing recognition that the reception refugee families receive in the resettlement country has an impact on the way in which loss is experienced and healing occurs, and that refugees are not merely passive victims with psychological impairment but active participants in the resettlement process. So it is important to understand the mechanisms that support refugee families during the resettlement period and those that make family adjustment more difficult. First, refugee families resettle in a political context that is often at odds with their healing and adjustment processes. In many Western countries where resettlement programs fulfill international humanitarian commitments, politicians simultaneously use campaigns of fear and distrust as a political lever. They try to incite fear of the “other” and the “alien” among populations with mixed tolerance for immigration by using the language of difference, criminality, and invasion. Many governments have responded to community anxiety through laws and policies that detain and deport asylum seekers and regulate the lives of refugees. Societal beliefs also have an impact on grieving processes that are not fully appreciated in Western society, resulting in “disenfranchised grief,” that is, “the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported” (Doka, in Corr 2002, p. 39, authors’ emphasis). It results when: (1) refugee families are disempowered; (2) public recognition of their traumatic experiences is lacking; and (3) Western societies do not distinguish between refugee families and immigrants such that the reality of the torture, trauma, and dislocation they have
suffered is denied. In such circumstances, their grief and loss are overshadowed by expectations that they would readily integrate, assimilate, and become productive members of their new society (Lin et al. 2009).

Therefore, it is imperative that human service workers educate and campaign against ideologies, policies, and practices that contribute to social exclusion, racism, and intolerance of refugee families. It is also important to recognize that integration is more than the provision of services to assist with health, housing, and employment. Valtonen (2008) says that it is "about substantive citizenship which would allow for unimpeded and full participation ... long-term prospects for self-development, and the attainment of meaningful and productive roles in the life of the community and society" (p. 188). Indeed, Pahud et al.'s (2009) research with refugees in New Zealand revealed the importance that refugees placed on becoming self-reliant, building strong family bonds, and making a socially responsible contribution to society. A key component of integration, then, is about citizenship and social connectedness that require the "maintenance of cultural identities and networks, while at the same time encouraging a positive relationship between refugees and the host society" (Ager, in Watters, 2001, p. 1711). It is about supporting those things that facilitate social and economic success, such as language proficiency, safety, and stability (Ager & Strang 2008).

As mentioned previously, there is growing recognition that refugee trauma does not just affect the individual but impacts on the family and the community. Evidence suggests that resettlement processes that include extended family members and promote family and community cohesion were more likely to contribute to psychological and social adjustment (Stoll & Johnson 2007; Weine et al. 2008). Hence, there is an increasing focus on interventions with refugee families, groups, and communities in addition to individual psychological or mental health treatment services. One of the key themes in the research and literature about working with refugee families, groups, and communities is the promotion of self-determination. This is where families and communities are encouraged and assisted to voice their current concerns, needs, strengths, priorities, and desires, and where this information is used to inform interventions, policies, and practices in the resettlement country.

A sound example of this is Weine et al.'s (2006) work that highlights the processes through which core beliefs were adapted and applied in
### Table 4.1
Factors Influencing Family Dynamics

<table>
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<tr>
<th>Family dynamic</th>
<th>Pre-migration</th>
<th>Displacement</th>
<th>Resettlement</th>
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<tbody>
<tr>
<td>Membership</td>
<td>Loss of members due to incarceration, displacement and or death.</td>
<td>Loss of family members left behind, and separated during flight. Might be some reunifications. Might be the loss of contact with members left behind due to incarceration, displacement, risks inherent in contact, and death.</td>
<td>Loss of family members left behind, and separated during flight. Might be some reunifications. Might be the loss of contact with members left behind due to incarceration, displacement, risks inherent in contact, and death.</td>
</tr>
<tr>
<td>Rules, rituals, and expectations</td>
<td>Families might be forced to change rules, rituals, and expectations due to religious persecution and ethnic cleansing. Disruption to daily living, including loss of housing, lack of privacy, food, and medical attention affect the rules, rituals, and expectations of families.</td>
<td>Disruption to daily living, including loss of housing, overcrowding, and lack of privacy. Rules and regulations in refugee camps might not be consistent with family rules, rituals, and expectations.</td>
<td>Threatened loss of cultural identity and pressure towards assimilation. Greater exposure of children and young people to the dominant culture. Vulnerability of women to different notions of gender. Men might face a loss of identity as the main breadwinner.</td>
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<tr>
<td>Family roles</td>
<td>Gender roles</td>
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<td>Might change due to loss of family members.</td>
<td>Might change due to loss of family members.</td>
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<td>Children might no longer go to school.</td>
<td>Women might need to take on breadwinner roles.</td>
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<td>Women and children might need to take on breadwinner roles.</td>
<td>Children might need to take on parental roles.</td>
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<td>Children might need to take on parental roles.</td>
<td>Women might not have extended family to negotiate on their behalf or keep them safe from violence.</td>
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<td>Men might have less opportunity to work and need to take on more caring roles.</td>
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<td>Women might need to work to support family.</td>
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<td>Families might be subject to the gender role expectations of authorities.</td>
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<td>Awareness might be raised about different gender expectations.</td>
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<td>Young women might have educational opportunities not previously available.</td>
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<td>Families might be subject to the gender role expectations of settlement country.</td>
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<th>Displacement</th>
<th>Resettlement</th>
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<tbody>
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<td>Communication</td>
<td>Communication between separated members infrequent or non-existent.</td>
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<td>Communication between separated members infrequent or non-existent.</td>
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<td>Communication patterns might change in response to new living conditions, e.g., overcrowding and lack of privacy.</td>
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<td>Some women might be restricted from talking about sexual assault within the family for fear of dishonoring family.</td>
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<td>Children might act as interpreters for parents and other adults.</td>
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<td>Children might act as interpreters for parents and other adults.</td>
<td>Parents might talk about the homeland and traumatic events—children might experience this as a pressure to succeed in settlement country.</td>
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<td>Parents might never talk about the homeland and traumatic events—children might experience this as secrecy.</td>
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</table>
resettlement. The resultant Family Beliefs Framework reminded workers that core family beliefs must be identified and understood in order to work in socially and culturally appropriate ways. Additionally, work with the refugee family involved recognizing and taking steps to address barriers to participation, such as work schedules, transport difficulties, and socioeconomic considerations. Being culturally sensitive is more than employing people from similar ethnic and cultural backgrounds. It recognizes the heterogeneity of refugee families and communities, and guards against the use of workers from similar cultural backgrounds as translators or agents of the dominant treatment paradigm (Watters 2001). Cultural sensitivity recognizes the interrelationships among body, mind, family, community, history, and ideology, and promotes holistic, responsive, and adaptive service provision. It challenges ideologies that see the maintenance of ethnic identity and social bonds as a threat to social cohesion. In fact, “social adjustment is feeling comfortable in, and accepted by, the new majority culture while retaining pride in one’s own cultural origins, thus exhibiting intercultural competence” (Stoll & Johnson 2007, p. 621).

In conclusion, while cultural sensitivity is important, the battle for the fair and equal treatment of refugees is political. It requires human services workers to take a stance and to promote the rights of refugees and their families. As noted by McClaren (1994), “justice needs to be continually created and constantly struggled for” (p. 55). In this regard, Baltra-Ulloa (2012) promotes a “critical multiculturalism” that leads to a framework for practice that involves inter alia a form of engagement in the here-and-now situation, in which a “learner stance” is taken in a process of mutual learning and acceptance. Often, working cross-culturally is uncomfortable. The cross-cultural setting is unfamiliar and is likely to remain so, since one can never know everything about someone else’s culture. Ultimately, cross-cultural practice is political in that it is inherently about assuring and restoring human rights.

REFERENCES


