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The Impact of Trauma on Parenting Experiences of Refugees

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Abstract

The importance of understanding trauma amongst refugees and providing trauma-informed care continues to grow as the number of refugees in the United States steadily increases. Despite the necessity of providing trauma-informed services to this population, a limited number of studies have explored the impact of trauma on this population and how to improve case management. This literature review aims to analyze the relationship between trauma and parenting experiences of refugees within the United States. It also aims to explore the impact of trauma on parenting experiences within this population and how social workers can best provide trauma-informed and culturally competent case management.

Key terms: refugee, trauma, parenting, social work

Introduction

A refugee is defined as “a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, and/or membership of a particular social group, is unwilling to return to or accept protection from their country of origin” (UNHCR, 2021). Due to war and political unrest, there has been a consistent rise in the number of refugees and asylum seekers around the world in recent years. There are currently about 26 million refugees and 3.5 million asylum seekers (Nilson & Jorgenson, 2021). This presents a wide-scale humanitarian crisis, with little infrastructure or will from countries to reduce the number of refugee and asylum requests (Nilson & Jorgenson, 2021).

Refugees are exposed to trauma throughout their lives, which contributes significantly to their decision to migrate to a new country. Trauma refers to the psychological impacts of the experience or threat of violence, injury, and loss (Ocak, 2015). There are a range of events that are considered traumatic, and they can be intentional or unintentional. Examples of traumatic events include rape, physical or sexual abuse, exposure to military combat, torture, incarceration, and/or diagnosis of a threatening illness (Ocak, 2015). The impact of these traumatic events is, in part, determined by the response of the affected person, their family and community, and society. Those who experience trauma, including refugees, are at risk of developing PTSD and other mental health concerns (Ocak, 2015). Refugees who resettle as parents must face the impacts of their trauma while simultaneously raising and supporting a child.

Despite the stunning number of displaced individuals and families, which continues to grow over time, placements and resources for refugees are lacking (Moinolmolki, Ridzi, Cronin & Adan, 2020). There is little infrastructure from countries such as the United States to reduce the number of refugees and asylum requests due to anti-immigration sentiments and xenophobia

during the Trump administration (Nilson and Jorgenson, 2021). This has contributed to a growing gap between refugee needs and resettlement opportunities, meaning this humanitarian crisis has no end in sight (Nilson & Jorgenson, 2021). Social workers need to serve this population of parenting asylees and refugees with trauma-informed care to prevent further traumatization and improve the quality of life for both the parent and child.

Refugees and Trauma

Pre-Migration Trauma

Refugees in the United States experience trauma that aligns with the triple trauma model of migration (Moinolmolki et. al, 2020). This includes trauma pre-migration, during migration, and post-migration. Prior to migration, refugees are often faced with a variety of traumatic circumstances. This can include sexual violence, torture, forced labor, starvation, separation from family members, and several years of living in a refugee camp (Moinolmolki et. al, 2020). These experiences prior to migration can result in symptoms of PTSD, depression, and other mental health problems.

Hepinstall, Sethna, and Taylor (2004) assessed the relationship between traumatic experiences and symptoms of PTSD and depression by interviewing the parents of 40 refugee children aged 8-16 living in London for no more than 5 years. The interviews with parents identified the types of traumatic events that the children had experienced prior to and after migration. Through these interviews with parents, the researchers found that 52.5% of families experienced war or serious threats to their lives prior to migration; 60% experienced violent death of family members; 22.5% experienced temporary separation from a parent; and 22.5% experienced leaving a parent and/or sibling behind (Heptinstall et. al, 2004). Then, the children were assessed for symptoms of PTSD and depression through the Impact of Event Scale and

Depression Self-Rating Scale for Children. The study determined that, in general, pre-migration trauma was associated with higher PTSD scores. The violent death of a family member, specifically, was significantly associated with high PTSD scores.

Pre-migration trauma can include various experiences, which Mhlongo et. al (2018) explored. The association between traumatic events and PTSD in refugees and migrants in South Africa, with a specific focus on sexual trauma amongst women, was also analyzed through this study. To do this, interviews were conducted with 157 adults with a sociodemographic questionnaire, Life Events Checklist, and the Harvard Trauma Questionnaire. Through the interviews, the authors found that 72.26% of participants experienced the unexpected death of someone close, 52.87% experienced physical assault, 49.68% experienced combat trauma, and 24.20% of participants in the study were exposed to sexual trauma prior to migration. The study determined that exposure to sexual trauma was associated with higher risks of post-traumatic stress. The study also identified that, in general, greater numbers of traumatic life events experienced by women were associated with higher odds of PTSD symptoms (Mhlongo et. al, 2018).

Shrestha et. al (1998) explored the impact of torture as pre-migration trauma on Bhutanese refugees in Nepal. Interviews, a checklist of medical complaints, and measures of posttraumatic stress disorder, anxiety, and depression were utilized amongst 526 tortured refugees and a control group of 526 non-tortured refugees. Through these methods, the authors found that the top three most reported torture techniques included severe beatings, verbal threats, and verbal sexual humiliations. It was determined that torture significantly contributed to the development of PTSD, depression, and anxiety amongst this population.

As seen in the previous study, each of these traumatic pre-migration experiences increases the likelihood of refugees experiencing PTSD and other mental health concerns, such as depression and anxiety. Whether the pre-migration trauma is sexual violence or torture, each can be severely harmful to the mental health of refugees. The mental health of refugees can suffer further from trauma during migration as well.

Trauma During Migration

During migration, the journeys of refugees and asylees can be horrific, violent, and full of loss. The migration journey may include staying in a refugee camp for an extended period, which can also be traumatic due to poor living conditions. When crossing the border from Mexico into the United States, for example, various health issues can be traumatic. These health issues may be pre-existing conditions or can be caused by the challenges of traveling long distances. A study by Koleski, Aldulaimi, and Moran (2018) quantified the number of people who crossed the border seen at hospitals. An electronic medical record was used to identify patients that were seen in 2016.

Based on these records from Koleski et. al (2018), 734 patients were seen after crossing the border that year. Of these 734 patients, 235 experienced musculoskeletal trauma, 95 experienced dehydration and breakdown of muscle tissue, 75 experienced infections, 68 experienced gastrointestinal complaints, 42 experienced chronic diseases that were left untreated during crossing the border, and 36 experienced pregnancy-related conditions. There are also serious injuries that can take place while crossing the US-Mexico border, such as injuries from climbing over the border fence and medical illnesses that require intensive care. Crossing the US-Mexico border can also be fatal. According to Humane Borders, a non-profit organization that tracks the deaths of immigrants along the Tucson sector of the border, 616 individuals died

between June 2013 and December 2016. Whether a family of refugees experiences death or medical issues, these experiences can be highly traumatic during migration.

Post-Migration Trauma

After experiencing horrific events before and during migration, refugees continue to experience more hardship while migrating to a new country. Upon arriving in a new country, refugees may feel isolated and experience poverty, depression, discrimination, mental health disorders, and other challenging circumstances. During this time, refugees grapple with new social and cultural frameworks. They may experience feelings of loss, depression, cultural shock, and PTSD. Although migration does not directly lead to the development of mental illness, the stress experienced by it can increase the likelihood (Ocak, 2015).

The living conditions that refugees experience after settling in their host countries can also be traumatic. Refugees may experience poverty and social inequities after arriving in their host country. According to Lukasiewicz (2017), “poverty is a well-known short-term outcome of migration in general and a long-term outcome of forced migration in a global context” (56). In Lukasiewicz’s study, the relationship between asylum, social policies, and poverty is explored based on two studies conducted between 2006 and 2014 with refugees living in Poland. These studies determined that discrimination, low language skills, limited access to education and knowledge of the local market, limited social networks, and the perception of immigration as temporary all contribute towards poor housing conditions and poverty for refugees.

Within the United States, poverty amongst refugees is seen through housing insecurity, inability to purchase basic material goods, dependency on welfare and other support networks, food insecurity, and hunger, living on a day-to-day basis, and being unable to plan for the future. An outcome specific to parenting refugees experiencing poverty includes being unable to fulfill

their children's needs, such as safe housing, clothes, school materials, and school trips (Lukasiewicz (2017)). These experiences of poverty for refugee families can create trauma and contribute to previous experiences of trauma.

Post-migration can also occur due to factors beyond poverty and living conditions. In the study by Hepinstall, Sethna, and Taylor (2004), the parents who were interviewed also discussed post-migration trauma. Based on the interviews, 67.5% of parents reported being worried about the welfare of their family in their home country; 62.5% experienced language problems; 47.5% experienced housing problems; 45.0% experienced feelings of isolation and exclusion; 45.0% experienced insecurity about asylum applications; 40.0% experienced financial difficulties; 37.5% experienced worry over their family's current safety, and 30.0% experienced worry about physical illness in their families. Between 20 and 25% of parents also reported serious concerns about discrimination, cultural differences, and family relationships. Financial difficulties were the category of concern after migration that was associated with higher depression scores among the children who participated. Higher PTSD scores amongst the children who participated were reported for post-migration experiences of insecure asylum status. This may be due to the children living amongst parents with higher anxiety about deportation (Hepinstall et. al, 2004).

Experiences of PTSD Amongst Refugees

Due to the various traumatic experiences faced by refugees, they may develop symptoms of Post-Traumatic Stress Disorder. Betancourt et. al (2012) investigated the trauma history profiles, psychopathology, and associated behavioral and functional indicators among war-affected refugee children. Through the study, a sample of 60 war-affected refugee children were interviewed and clinically assessed. The results of the interviews and assessments indicated that there were "...high rates of probably posttraumatic stress disorder (30.4%), generalized anxiety

(26.8%), somatization (26.8%), traumatic grief (21.4%), and general behavioral problems (21.4%)” (Betancourt et. al, 2012). These mental health concerns can have a significant impact on the lives of refugees, especially those that are raising children.

Narratives of Central American Refugees

Refugees from Central America, for example, also experience trauma before, during, and after migration. In recent years, there has been a significant increase in the number of unaccompanied minors from the Northern Triangle of Central America, which includes El Salvador, Honduras, and Guatemala. Unaccompanied minors are individuals below the age of 18 who have fled their countries without a parent or guardian. These unaccompanied minors are fleeing their countries in the Northern Triangle of Central America due to extreme poverty and gang violence.

Tello, Castellon, Aguilar, and Sawyer (2017) aimed to gain awareness of the journey experienced by 16 unaccompanied refugee minors from Central America who arrived in the United States. According to Tello et. al, “impoverished living conditions and gang violence are the major factors leading unaccompanied minors to leave Central America. Even though the journey to the United States is filled with grave danger, children are fleeing Central America because of their dire living conditions” (p 361). El Salvador, Honduras, and Guatemala have experienced prolonged drought which has caused food insecurity and has affected agricultural labor. Due to this, 50% of the Guatemalan population experiences chronic undernutrition, and over half of the population in Honduras and Guatemala live in poverty. There are also high rates of youth unemployment. Gangs in Central America were also able to gain control, partially due to drug demands in the United States.

The 16 unaccompanied minors who shared their narratives discussed the factors that contributed to them fleeing their countries of origin. Three main reasons included helping the family financially, to escape gang violence and death, and to escape a sense of powerlessness. They also discussed their journey to the United States. Participants either rode above trains or through the assistance of a smuggler, also known as a coyote. The train is often referred to as “La Bestia” or “the beast” due to how deadly and dangerous it could be. Participants also shared accounts of physical and emotional trauma on their journey to the United States. They reported feeling physical pain due to freezing temperatures, injuries due to days of walking on desert terrain, and limited access to food and water. Emotional pain was also reported through being exposed to physical and sexual assault, as well as death (Tello et. al, 2017).

In terms of life in the United States, the participants stated they felt a sense of faith in God’s protection and guidance. They also reported feeling worried about the future in terms of providing for their families. Some shared worries about their family’s safety in their country of origin/ Participants also mentioned receiving help from people in the United States, which provided them with hope and guidance. Another theme that was brought up by participants was their view of themselves. Some participants reported feeling that their life was going nowhere, stating that their American dream had become their nightmare. Others viewed themselves as survivors of pain and sacrifice (Tello et. al 2017). Central American refugees face various experiences of trauma before, during, and after migration. Each of these experiences can take a toll on the mental health of these individuals, which can present additional obstacles as parents.

The Impact of Trauma on Parenting

The lives of parenting refugees can be significantly impacted by experiences of PTSD, depression, anxiety, and other mental health concerns. These concerns, specifically trauma and

PTSD, can have a negative impact on the parenting experiences of refugees. Moinolmolki et. al (2020) state that "...many refugee parents are at a higher risk for experiencing Post Traumatic Stress Disorder... this, plus the loss of social support networks upon resettlement, places refugee parents in unfavorable circumstances for parenting" (p. 7). Refugees must face the impact of their trauma and PTSD, along with challenging circumstances that local resettlement regions are struggling to support (Moinolmolki et. al, 2020).

Banyard, Williams, and Siegel (2003) explored the impacts of complex trauma and maternal depression on parenting. A sample of 174 women was gathered, half of whom had been victims of child sexual abuse and half that had no officially documented history of abuse. The women were assessed for their trauma history and parenting outcomes through interviews about current and past mental health symptoms, relationships, and experiences with trauma. In terms of trauma exposure, the participants were screened for sexual abuse, childhood physical abuse or assault, witnessing harm or violence as a child, partner violence in adulthood, adult sexual assault. The results were summarized in a trauma composite. Mental health symptoms, specifically maternal depression, were screened through the Trauma Symptom Inventory. Protective factors were identified through interviews about social support, age of parenting, spirituality. Parenting outcomes were explored through the Conflicts Tactics Scale for physical punishment, the CTSPC Neglect Scale for neglect of child, and questions about parenting satisfaction and reports of child abuse.

Based on these measures, the study found that "overall, higher levels of trauma exposure on the composite were related to decreased parenting satisfaction, reports of neglecting behavior, and reports of protective service involvement, or a child having been abused, as well as more severe physical discipline behaviors" (Banyard et. al, p. 341). The traumatic experiences during

childhood and adulthood had a negative impact on parenting outcomes. Maternal depression was also a risk factor for parenting and demonstrated the connection between traumatic experiences and parenting. Parenting refugees who have fled their countries of origin have likely experienced high levels of trauma, which can have a similar negative impact on parenting skills and outcomes.

Bryant et. al (2018) explored the effect of refugee caregivers' previous trauma and levels of ongoing stressors on current PTSD and how this influences parenting behavior and the child's psychological health. The participants included 411 primary caregivers who were refugees and had at least one child. There were three waves of data collection. Waves 1 and 3 allowed for face-to-face interviews, whereas data for wave 2 was collected through phone interviews. The face-to-face interviews collected data about demographic and migrating unit factors, including PTSD, trauma history, postmigration stressors, parenting styles, and the children's psychological difficulties. The Post-Traumatic Stress Disorder-8 and Harvard Trauma Questionnaire Trauma Events Module were utilized to assess PTSD in participants. Parenting styles were assessed for warmth and harsh dimensions of parenting style through the Child Rearing Questionnaire. The children's psychological difficulties were assessed through the SDQ22.

Through these assessments and interviews, the study found an association between PTSD and the children's reported emotional difficulties. It also identified that PTSD in refugees is "...associated with harsh parenting styles, leading to adverse effects on their children's mental health" (Bryant et. al, 2018, p. 254). Both studies, which included participants who were not refugees and those who were, demonstrated a negative impact of trauma on parenting outcomes. Trauma had an impact on parenting skills, such as leading to more harsh parenting. Harsh parenting included negativity, use of physical discipline, and rigid enforcement of rules. The use of harsh parenting negatively impacted the children's psychological well-being, as shown through reported

emotional difficulties for children whose caregivers experienced symptoms of PTSD (Bryant et. al, 2018).

Parenting Challenges for Refugees

In addition to the trauma faced by refugees who are parents, there are a variety of other challenges that they must face. Through migrating to a new country, these caregivers must adapt to an entirely new way of life. This creates a range of obstacles, which adds to the difficulties faced by these families.

Moinolmolki et. al (2020) aimed to determine the needs of newly resettled refugee parents by exploring the obstacles they face. The study gathered 24 participants from Somalia, the Democratic Republic of Congo, or Bhutan above the age of 17 with at least one child. The participants had recently resettled in the United States within the last 10 years. The participants were broken up into three focus groups and data was collected through open-ended discussions with each focus group about their parenting experiences in the United States. Based on these discussions, participants reported various challenges. These challenges included limited financial and cultural resources, cultural dissonance, and shifts in power dynamics/helplessness in parents.

In terms of limited financial and cultural resources, participants reported having difficulty with developing community resources and finding adequately compensating occupations and vocational training to support their families. Many of the participants mentioned feeling as if they lacked the cultural resources to navigate their child's school system (Moinolmolki et. al, 2020). The parents also reported fear of Child Protective Services separating or taking away their children, due to a lack of cultural knowledge about appropriate disciplinary actions. Cultural dissonance was described as a conflict between cultural values during their parenting transition, due to the lack of cultural competency of their child's school system and the influence of school culture on

their child's behavior (Moinolmolki et. al, 2020). Many participants reported feeling unsure about how to effectively discipline their children due to this cultural dissonance. Participants also reported a shift in parent-child power dynamics due to the children adapting to the culture, language, and system more rapidly than the parent(s). The participants stated this made them feel more helpless in parents, which led to them resorting to a more laissez-faire style of parenting that later put their children at risk for negative influences in their environment (Moinolmolki et. al, 2020). The parents that participated in the study reported a need for better communication, respect, and informational/educational resources. Many parents emphasized a need for better communication and respect between them and their children as well.

Refugee parents also face a range of issues related to poverty. According to a study on challenges faced by refugee parents by Stewart et. al (2014), "financial constraint posed obstacles to childcare, family activities, and education. Recent immigrants are more likely to experience poverty, poor housing, low literacy levels, and unemployment within five years of migration" (p. 1153). Each of these concerns pose additional stress for refugees adjusting to a new country. In addition to those poverty-related challenges, many of these families may face discrimination, culturally insensitive services, and language barriers. Each of these challenges is in addition to the impact of trauma on parenting experiences.

Providing Support to Parenting Refugees

Cultural Humility and Trauma-Informed Care

Due to the impact that trauma can have on both the parenting refugees and their children, social workers must provide culturally competent, trauma-informed services to refugee individuals and families. According to Potocky and Naseh (2019), cultural humility within social work requires a commitment to self-evaluation and self-critique, a commitment to correct power

imbalances, and a commitment to developing a partnership with those who advocate for others. When working with the refugee population, social workers must encourage individuals or families to maintain their heritage culture while engaging with the new culture, rather than fully discarding their former values and norms. Social workers must be knowledgeable about the characteristics of ethnic groups, how members of an ethnic group are influenced by their environment through family, groups, organizations, their community, and society. This includes an understanding of the impact of stereotyping, racism, xenophobia, and individual and institutional discrimination. It is also important for social workers to know what certain ethnic groups have faced historically (Potocky & Naseh, 2019).

It is also imperative that social workers provide trauma-informed care. Miller et. al (2019) define trauma-informed care as an approach that "...recognizes the pervasive impact of trauma on children's development or health, applies this knowledge of trauma and its consequence into practice, and actively seeks to prevent re-traumatization" (2). The principles of trauma-informed care include promoting physical and psychological safety, building trusting relationships with clients and families, providing peer support, supporting and fostering agency, and promoting intersectionality. 10 ways that social workers can utilize trauma-informed care with refugees include practicing a strengths-based approach, creating an immigrant-friendly environment, promoting trusting relationships within the environment, asking for permission to discuss difficult subjects, recognizing the impact of trauma on the developing brain, and recognizing the various manifestations of trauma, treating trauma-related disorders appropriately, recognizing the trauma of other family members of the client, knowing local resources and making sure they are trustworthy, recognizing that trauma may not end after migration, and advocating for patients in

all ways possible. Through doing this, social workers can prevent re-traumatization and promote the well-being and health of the individuals and families being served.

Parenting Education Amongst Refugees

Social workers can utilize specific interventions to work with refugees who are parents. These interventions may allow them to improve their parenting skills and prevent separation from their child. Lindstrom Johnson, Elam, Rogers, and Hilley (2018) aimed to assess the impact of trauma-informed parenting interventions on positive parenting practices, negative parenting practices, parenting stress, children's internalizing problems, children's externalizing problems, and trauma symptoms. This study conducted six meta-analyses to do so. The parenting interventions that were reviewed focused on children aged 5-10 with various types of trauma. These forms of trauma included exposure to intimate partner violence or family conflict, child maltreatment such as physical or sexual abuse and neglect, PTSD, and community violence exposure. The interventions utilized trauma-informed care through Cognitive Behavioral Therapy for example, and they lasted between 3 to 20 weeks.

The interventions led to outcomes for both parents and children. As for the parents, only three studies examined negative parenting and four examined parental stress. Parenting stress was shown to be reduced in the four studies, For the children's outcomes, sixteen studies indicated "a moderate to a large decline in internalizing" and nine of the studies "[indicated] moderate to large average declines in trauma symptoms" (Lindstrom Johnson et. al, 2018). Although this study did not provide much information about parenting outcomes, it demonstrates the importance of parenting interventions for children.

A potential concern for parenting refugees includes separation from their child after arrival in their new country. Through this separation, these parents may become involved in the child

protection system, which may only add to the stress and trauma they have experienced. A study by Williams (2012) aimed to explain why refugee parents were involved in the South Australian child protection system while highlighting the need for parenting education as an early intervention amongst the refugee population. According to focus group participants in a study conducted by Williams (2008), there was a lack of knowledge regarding state authorities and systems such as child protection, police, schools, healthcare, and the power of agencies to intervene in their lives. Refugee families must receive information about this, including universal definitions of child welfare and child maltreatment that transcends north-south paradigms.

Williams et. al define parenting education as “the process of providing parents and other primary caregivers with specific knowledge and childrearing skills, to promote the development and competence of their children” (116). Parenting education is critical for refugee children and their families. Despite this, this right to education is not always fulfilled and child-welfare-centered education is nonexistent. Even when refugee families receive parenting education, the existing models of education are limited in promoting self-efficacy for the parents (Williams, 2012). Programming and services for these families are much needed, and proper education can promote positive resettlement transitions and child welfare amongst refugee families.

Caregiver Support Intervention

A variety of interventions may be utilized amongst refugees and other populations in need of parenting education, yet not all are successful in improving the parents’ skills and ability to care for their child. Miller et. al (2020) explored the use of the Caregiver Support Intervention amongst conflict-oriented parents of children aged 3-13. According to Miller et. al (2020), “parenting interventions generally prioritize the acquisition of parenting knowledge and skills, while under attending to parental stress and distress” (1). The Caregiver Support Intervention model was

created to strengthen parenting through lowering stress and improving psychological wellbeing, as well as through increasing knowledge related to positive parenting. This intervention model defines positive parenting as nurturing, consistent, authoritative, and non-violent. To determine the effects of the Caregiver Support Intervention model, focus group data from participating parents was used. The CSI model was implemented in Gaza and with Syrian refugees in Lebanon, and focus groups were held with participants following the implementation.

In Gaza, poverty and unemployment are common. Access to medical care, water, and electricity is scarce. In addition, “the deprivations of everyday life are punctuated by intermittent shelling from Israel” (Miller et. al 2020, p. 4). Three groups of women and three groups of men were recruited, all of whom had a child between the ages of 10 and 15. Each group of men and women had between 10-12 participants. Focus groups were conducted with each group 2 weeks after the last session of CSI. Based on these focus groups in Gaza, engagement was high, and the stress management exercises were highly valued by participants. The participants described feeling calmer and better able to respond to their children in supportive, nurturing ways. Participants also reported a reduction in harsh parenting and an increase in parental warmth. This was reportedly due to a session on positive parenting, through which the adverse effects of harsh parenting were described.

The Caregiver Support Intervention was also implemented amongst Syrian refugees in Lebanon. These refugees had experienced a prolonged, devastating war and a range of traumatic events. According to Miller et. al (2020), high levels of stress amongst Syrian refugee parents were reported. Through implementing CSI, engagement was high yet there was reluctance from the men to try the stress management exercises. The women appeared enthusiastic, yet the men were hesitant to participate. Both male and female participants viewed the frustration and anger

management techniques positively, however. The focus groups also determined that the male participants believed they had no role to play in raising their children below the age of 5, beyond providing income and shelter. The findings from these focus groups in Gaza and Lebanon suggest that parenting interventions that aim to strengthen parenting must also address caregiver wellbeing. The Caregiver Support Intervention, for example, proved to be effective in terms of prioritizing caregiver wellbeing while providing knowledge about parenting skills.

Conclusion

Within the United States and around the world, there is a growing population of refugees – all of whom have experienced high levels of trauma. These traumatic experiences can lead to the development of PTSD and other mental health concerns such as depression and anxiety. For parenting refugees, this can have a negative impact on their parenting experiences with their children. Social workers can serve the population of parenting refugees through effective parenting interventions, trauma-informed care, and culturally competent services. In doing this, social workers can greatly improve the lives of refugee families and bring hope and healing to a population in need.

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