Hellenic Journal of Psychology, Vol. 4 (2007), pp. 233-256

FROM SYMPTOM TO CONTEXT: A REVIEW OF THE LITERATURE ON REFUGEE CHILDREN'S MENTAL HEALTH

Lucia De Haene[1], Hans Grietens[2], & Karine Verschueren[3]
Katholieke Universiteit Leuven, Belgium

Abstract: In this paper, we aim to review the growing body of research on the psychosocial well-being of refugee children. We start with an overview of the chronological models for the refugee experience that conceptualize the process of forced migration as a long-term adverse context of cumulating risk factors, functioning as a pervasive threat to refugee children's mental health. Next, we briefly summarize the literature on refugee children's mental health as the starting point for a critical reflection on the dominance of the symptom-focused, trauma-centred approach which characterises much of refugee research. Drawing from this, we argue for the pertinence of research on refugee children's mental health from a family perspective. Finally, we propose a model for the refugee family experience, which integrates multiple individual, family and cultural processes, and we organise existing findings on refugee families in relation to six domains of the refugee family life.

Key words: Family perspective, Mental health, Refugee children.

THE REFUGEE EXPERIENCE

The process of forced migration is generally considered to be a pervasive and adverse long-term experience. The long-lasting process of cumulating losses and transitions creates a context of chronic stress that can seriously challenge the mental health of refugees. In refugee research, this cycle of disruptions

Note: [1]Research Assistant of the Research Foundation – Flanders (FWO – Vlaanderen) at the Centre for Parenting, Child Welfare and Disability, Katholieke Universiteit Leuven, Belgium. [2]Centre for Parenting, Child Welfare and Disability, Katholieke Universiteit Leuven, Belgium. [3]Centre for School Psychology, Katholieke Universiteit Leuven, Belgium.
Address: Lucia De Haene, Centre for Parenting, Child Welfare and Disability, Katholieke Universiteit Leuven, Vesaliusstraat 2, B-3000 Leuven, Belgium. E-mail: lucia.dehaene@ped.kuleuven.be

which characterises the refugee experience is commonly organised chronologically in subsequent phases. For each phase, specific stressors that may influence the psychosocial well-being of refugees are identified.

A prototypical conceptualisation of the migration experience from a chronological perspective is the three-phased model of 'pre-flight', 'flight' and 'resettlement' (Fazel & Stein, 2002; Lustig et al., 2004). The 'pre-flight phase' refers to the period in the country of origin, before the refugee flees to another region or country. During this pre-flight phase, several severe risk factors force the future refugees to flee their homes, such as political persecution, torture, violence, war or extreme poverty. Children may face serious disruptions in the stability of their environment: their school education may be interrupted, they may experience severe parental distress, and they may have to cope with losses and the disappearance of close family and friends. The 'flight phase' refers to the journey or displacement to another region or country. This phase entails specific stressors such as deprivation, traumatic stays in detention or refugee camps and powerlessness in the hands of smugglers. Refugee children in this phase may additionally become separated from their parents or caregivers, by accident or by strategy of their parents to ensure a safer future for them. During the third phase, the 'resettlement phase', refugees face multiple stressors related to asylum procedures, such as profound insecurity and loss of control over their future life course. At the same time, they have to cope with acculturation tasks, that is, the process of integrating in a new society which often has different values and different social and gender roles, and with the loss of their homeland. Likewise, refugee children will have to work through the acculturation process and integrate in new school and peer groups.

Papadopoulos (2001) proposes another chronological conceptualisation of the migration process. He describes four phases that constitute 'the refugee trauma': anticipation, devastating events, survival, and adjustment. These four phases broadly fit the aforementioned three-phased model of pre-flight, flight and resettlement. Papadopoulos' second phase of 'devastating events' corresponds with the 'pre-flight phase' in the three-phased model, whereas 'survival' refers to the period of flight. The last two phases of both models are also analogous: 'adjustment' and 'resettlement' refer to the same acculturation period in the host country. However, the first phase in Papadopoulos' model introduces an anticipating pre-traumatic period, which is not explicitly incorporated in the three-phased models. During this anticipation phase, future refugees experience the coming dangers of war,

persecution or poverty and begin to consider the decision regarding fleeing or staying in their homeland.

Both chronological models conceptualise the refugee experience as a severe, pervasive and chronically stressful life period, in which the accumulation of multiple risk factors challenges the mental health of refugees. Furthermore, the stressors outlined in both models emphasise the additional vulnerability of refugee children. Minor refugees face the manifold stressors of war, violence, deprivation and cultural adjustment all of which may affect their development. In this chronically stressful and disruptive life period, many refugee children may have to deal with decreasing intra-familial support, the loss of family members or separation from caregivers. The myriad stressors relating to the process of forced migration are likely to cumulate and interact, thus functioning synergistically to adversely affect the refugee children's psychosocial well-being (Hodes, 2002).

TOWARDS A FAMILY PERSPECTIVE ON REFUGEE CHILDREN'S MENTAL HEALTH

The growing body of literature on refugee children's mental health highlights the severity of the risks implicated in the process of forced migration. Research on the mental health of refugee children reports increased prevalence rates of emotional and behavioural problems (Fazel & Stein, 2002, 2003). More specifically, high levels of Post Traumatic Stress Disorder (PTSD), depression and anxiety disorders are commonly found in refugee children, mirroring the general findings on mental health problems in adult refugees (Goldstein, Wampler, & Wise, 1997; Lustig et al., 2004; Papageorgiou et al., 2000; Sack, Clarke, & Seely, 1996; Servan-Schreiber, Lin, & Birmaher, 1998). Furthermore, many child refugees, who do not explicitly meet the diagnostic criteria of one of these psychiatric disorders, show elevated post-traumatic, depressive, anxiety or somatic symptoms (Lustig et al., 2004). Longitudinal research documents the decrease of psychiatric symptomatology after longer periods of time in the host country, although many symptoms persist over time (Almqvist & Brandell-Forsberg, 1997; Becker, Weine, Vojvoda, & McGlashan, 1999). Thus, research consistently portrays refugee children as being at risk of psychosocial dysfunction and reveals their increased vulnerability for mental health problems.

This body of research on the prevalence of mental health problems in refugee children provides relevant information on the occurrence of characteristic patterns of distress. However, this type of refugee research has been criticised by several authors. An in-depth reading reveals four broad and interlinked domains of criticism, all of which refer to the trauma-centred and symptom-focused character typical of this body of refugee research: (a) the mono-causal perspective on trauma, (b) the necessity of culture-sensitive approaches, (c) the need of a resilience focus, and (d) a shift from an individual towards a family perspective. Below, we briefly present these four domains of criticism.

A reductive perspective on refugee trauma

A frequently mentioned, shortcoming of the research on psychiatric symptoms relates to its exclusive focus on war- and violence-related trauma. Investigating the prevalence of PTSD, which is a central issue in the research under question, assumes that understanding the psychosocial impact of the refugee experience means evaluating the psychological sequelae of war-related, traumatic experiences. Assessing the prevalence of psychiatric symptoms, mostly PTSD symptoms, many refugee researchers have emphasised the importance of the pre-migration experience. Traumatising events such as war, violence, persecution or torture are thus assumed to have a critical and adverse effect on the psychosocial well-being of refugees (Miller, Muzurovic, Worthington, Tipping, & Goldman, 2002; Papadopoulos, 2001).

However, in line with the aforementioned chronological conceptualisations of the refugee experience and the myriad of phase-specific stressors herein identified (Fazel & Stein, 2002; Lustig et al., 2004; Papadopoulos, 2001), researchers have recently argued that this mono-causal perspective on trauma should be replaced by a multifaceted perspective on the process of forced migration and the risk factors it entails. A growing body of research documents the dynamic interplay between pre- and post-migration stressors that operate in a far more complex manner than that assumed by the perspective which solely focuses on the effects of pre-migration traumatic experiences on refugees' mental health (Sack, Clarke, & Seely, 1996; Silove & Ekblad, 2002; Silove et al., 1997). Post-migration risk factors, such as social isolation and unemployment in the host country, stressful and insecure asylum procedures or negative peer relationships of refugee children,

are now recognised as having a significant – or even predominant – effect on the psychosocial functioning of refugees (Almqvist & Broberg, 1999; Lie, 2002; Sourander, 2003). These exile-related stressors may cause new psychological problems or aggravate existing difficulties in refugees. This constellation of pre-migration and post-migration factors is indeed often experienced by refugees as a repetitive cycle of disempowering processes (Bala, 2005). It is, therefore, becoming more widely accepted that the interaction between pre-migration stressors and post-migration risk factors constitutes a core element of the disruptive refugee experience.

A universalising approach of refugees' psychosocial suffering

A second line of criticism concerns the validity claims of western diagnostic categories, implied in trauma-centred and symptom-focused refugee research. Epidemiological research on psychiatric disorders among refugees assumes the cross-cultural validity of western diagnostic entities and thus takes for granted a universal human response to highly stressful events, described by the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD) categories such as PTSD or depressive disorder (Summerfield, 1999). Several authors question this medicalising approach to the psychosocial well-being of refugees on several points.

First, many researchers emphasise the socially and culturally mediated character of illness, health and suffering (Eastmond, 2000; Rechtman, 2002). Assessment in terms of western diagnostic entities fails to take into account the culture-specificity of symptom expression, symptom interpretation, patterns of coping and healing practices. For example, somatic symptoms are the most common clinical expression of distress in non-western populations (Summerfield, 2005). From a western psychiatric perspective, there is a tendency to interpret these as psychosomatic complaints. However, such an interpretation fails to appreciate how somatic symptoms may be situated in multiple meaning systems and may, thus, be culturally coded expressions of distress with no implicit referral to the individual's mind. Indeed, in many non-western cultures, illness and distress are not considered to be situated in the mind of individuals but relate to moral issues or the realm of spirituality. Accordingly, they are understood in terms of disruptions to the social and moral order, under the influence of ancestors and spirits who affect the bodily condition of human beings (Bracken, Giller,

& Summerfield, 1995). In contrast, assessing the incidence of psychiatric symptoms, such as PTSD or depression, means focusing on personal memories and emotions within the mind as a distinct unity. It thus implies an individualising view on psychosocial functioning, cut off from meanings and expressions that occur within social interaction and cultural frameworks (Zarowsky & Pedersen, 2000).

Second, this tendency to neglect culture-specific aspects of psychosocial well-being is considered to be particularly problematic in the context of forced migration. The medicalisation and individualisation of distress leads to a decontextualisation of the refugee experience, which is thus reduced to narrow psychiatric definitions (Losi, 2000). Indeed, the trauma discourse reduces the effects of socio-political violence and atrocities to individual illness and vulnerability (Summerfield, 2005). However, in the process of forced migration, culture and social context are far from epiphenomena; the process of forced migration fundamentally implicates many social, cultural and political factors. Given the multiple stressors involved in the refugee experience, such as war, violence, losses of family and separations, cultural uprooting, acculturation stress and insecure asylum procedures, it is clear that the refugee experience is essentially a profound ecological disruption (Walsh, 1996), in which the distress of refugees always points outwards to the socio-political environment that evoked it (Summerfield, 2005). The essentially ecological, contextualised nature of the refugee experience means that personal meanings and political events are strongly interconnected in the psychosocial functioning of refugees (Bala, 2005). The medicalised character of the notion of 'trauma' decontextualises an experience that is par excellence contextualised.

Drawing on this ongoing discussion on the validity of the trauma discourse, some authors reject the use of diagnostic entities such as PTSD in refugee research, claiming that these categories lack explanatory power and validity (Summerfield, 2003). As an alternative to the notion of PTSD, Eisenbruch (1991) suggested 'cultural bereavement', a new category that can encompass the subjective meanings of trauma and their interrelatedness with cultural coping strategies and symptom explications (Eisenbruch, 1991). On the other hand, authors have argued that the main points of the critique on the trauma concept can be incorporated within the symptom-focused approach, which they consider as a valuable research and clinical paradigm in the field of refugee research (Dyregrov, Gupta, Gjestad, & Raundalen, 2002; Friedman & Jaranson, 1994). An in-depth discussion on the suitability

of the trauma discourse in refugee research is beyond the scope of this article. However, for the purpose of this paper, it is important to note that refugee research should consider the refugee experience as an ecological process, that occurs at the nexus of personal and socio-political dimensions and, consequently, conceptualise issues of refugee health and suffering as socially and culturally mediated phenomena. Refugee research should, therefore, be culture-sensitive and integrate the culture-specific and socially constructed meanings of refugee distress.

A pathologising view on the psychosocial functioning of refugee children

A third line of criticism concerns the focus on the vulnerability of refugee children. Some authors question the pathologising stance of symptom-focused child refugee research, which neglects evidence of the children's resilience despite the experiences they go through (Summerfield, 2000; Weine, 2000). Research on the well-being of refugee children indeed documents their psychosocial resilience (Adjukovic & Adjukovic, 1998; Angel, Hjern, & Ingleby, 2001; Becker et al., 1999; Hjern & Jeppsson, 2005; Kohli & Mather, 2003; Lustig et al., 2004; Rousseau & Drapeau, 2003; Rousseau, Drapeau, & Rahimi, 2003). Drawing from research and clinical practice, authors increasingly stress the remarkable strength and the adaptive developmental trajectories of many refugee children. These findings point to the need to adopt a resilience perspective on the mental health of refugee children, which would examine the protective factors that buffer the adverse effects of forced migration. It seems increasingly important to identify relevant moderating factors at work in the psychosocial functioning of refugee children.

An individualising approach to the mental health of refugee children

A final aspect of the critique on the trauma-centred and symptom-focused refugee research relates to its individualising perspective on the refugee experience. As argued above, the assessment of psychiatric disorders in refugee research reduces the essentially social and political process of forced migration to an individual and psychological one. An important approach in broadening this individualising scope is a family perspective on refugee experiences. A transactional and intergenerational family approach in investigating the effects of forced migration is particularly

relevant in child refugee research. A growing number of researchers argue for the importance of a family perspective on the mental health of refugee children and point to the lack of studies that adopt this perspective (Rasco & Miller, 2004; Samarasinghe & Arvidsson, 2002; Walter & Bala, 2004; Weine, 2000; Weine, Muzurovic, et al., 2004).

Indeed, approaching the psychosocial functioning of refugee children from a family perspective may fruitfully surpass several of the shortcomings of the symptom-focused and trauma-centred approaches. First, the family bridges psychological with socio-cultural levels. Given that the family is the primary ecological niche that performs and reshapes cultural meanings and social practices in everyday interaction, a family approach can offer vital information on the culture-specific meanings of psychosocial well-being and distress. Second, a family perspective may be essential in identifying risk and protective factors and in this way, it can enhance understanding regarding the resilience of refugee children. For example, family variables such as family conflict and intra-familial support have already been documented as significant factors moderating the impact of forced migration on refugee children (Almqvist & Broberg, 2003; Lustig et al., 2004; Rousseau, Drapeau, & Corin, 1998). These studies point to the family as a crucial context that mediates the effects of forced migration, suggesting the need to further study the role of family variables in promoting resilience in refugee children. Family research can elucidate the different types of protective factors that act as buffers to the multiple stressors associated with the refugee experience. As such, family research has significant potential in substantially furthering current knowledge on the key processes in refugee families that promote resilience in refugee children. In this way resilience processes can be identified at both the individual and the family level. Firstly, it may consider family variables, such as parental support, that promote resilience in children. This way of approaching resilience focuses on the relational context of individual resilience. In addition to this, a family perspective can also assess resilience at the family level, through investigating the interactional processes (e.g., family cohesion or communication patterns) through which the family system, as a functional unit, manages crises and disruptive experiences (Walsh, 1996). In other words, our argument for a family approach in child refugee research relates to its capacity to address resilience both at the individual and the family level.

Summarising the above, we have argued that family research can ap-

proach the ecological niche of the refugee family, both as a dynamic context of cultural values and practices and as an influential interactive environment of multiple risk or protective factors. In other words, a family perspective can integrate a culture-sensitive with a resilience-focused approach in research on the mental health of refugee children.

Our discussion to this point has considered the limitations of symptom-focused and trauma-centred child refugee research, in terms of being mono-causal, universalising, pathologising, and individualising. The critique on these four interconnected characteristics of much of current research in this field, clearly points to the need for a systemic approach in child refugee research. A systemic perspective views the process of involuntary migration as a multicausal and multidimensional process and addresses the interplay between internal and external factors in promoting distress or resilience in refugee children (Bala, 2005; Papadopoulos, 2001). Moreover, from a systemic perspective, the process of forced migration is conceptualised as an individual, familial, social, cultural, and political reality through which the relational nature of the event's impact is recognised (Papadopoulos, 2002). More specifically, the discussion converged into the argument on the pertinence of a family perspective on the psychosocial functioning of refugee children. In the literature on refugee children, the family perspective is far less represented than symptom-focused approaches. In the following section, we review existing findings from both research and clinical work with refugee families, with the aim to address the main processes and factors that affect the psychosocial functioning of refugee children.

THE REFUGEE FAMILY EXPERIENCE

In this section, we introduce a model which conceptualises the refugee family experience as a cycle of four disruptive processes, namely marginality, traumatisation, uprooting and acculturation (Walter & Bala, 2004), rather than using the aforementioned chronological frameworks (Fazel & Stein, 2002; Lustig et al., 2004; Papadopoulos, 2001). In this model, understanding the impact of forced migration entails understanding the impact of the cyclical disruptions that are constituted through the interplay between these four processes.

This conceptual framework has several advantages over the chrono-

logical models of forced migration. First, the 'cycle of disruptions' (Bala, 2005) describes four different (but intertwined) processes beyond a chronological perspective. Within these disruptive processes, both pre-migration and post-migration experiences can be taken into account. This non-chronological stance is particularly interesting, as it is in line with the pleas for a non-linear, multifaceted interpretation of the refugee experience in which pre- and post-migration stressors may cumulate and interact. Second, family dynamics and variables situated in the social and cultural context are explicitly implicated in this model.

More specifically, marginality refers both to the family's history of marginality in its country of origin and to the social and cultural isolation often faced by the family in the host country. Traumatisation includes pre-migration risk factors, such as torture, disappearance, persecution, and war. The experience of uprooting is the result of different disruptive processes, such as the profound and disempowering uncertainty and unpredictability which is common during exile, the challenges facing the family's identity in a new cultural environment, the fragmentation of the family during periods of separation, and the family's inability to invest in the future, due to complications in the asylum-seeking procedure as well as to unresolved grief. Lastly, acculturation refers to the attempts of different family members to integrate into a new cultural environment, a process that can lead to disharmonious adjustment profiles and subsequent changes in spousal, parent-child or sibling relationships.

In addition to these four core processes, we propose family separation and reunification as a fifth fundamentally disruptive aspect of the refugee family experience. Walter and Bala (2004) include family separation in the process of uprooting, as an additional source of disempowering stress. In our view, however, family separation and reunification should be considered as distinct processes that affect different aspects of family life. The vast majority of refugee families face a period of separation and family fragmentation during their forced migration (Suarez-Orozco, Todorova, & Louie, 2002). Therefore, the experiences of long separations from family members constitute an integral part of refugees' histories, as much as pre-migration traumas (Rousseau, Mekki-Berada, & Moreau, 2001). These intrusive experiences of extended separations and complex reunification complicate the already profound transformations that refugee families undergo (Rousseau, Rufagari, Bagilishya, & Measham, 2004).

The conceptualisation of the refugee family experience in terms of a cy-

cle of five disruptive processes poses the question regarding the effect of each of these processes on intra-familial dynamics. With this question in mind, we review the literature on refugee families and on the impact of refugee family processes on the psychosocial functioning of refugee children. Careful consideration of the research findings on refugee family dynamics reveals a number of central issues in the family functioning affected by their involuntary migration and exile. Each of these domains involves exile-related patterns of distress, family changes and coping strategies. These domains include the following: (a) trauma communication and transmission, (b) acculturation processes, (c) intra-family support, (d) restructuring of family boundaries and roles, (e) family connections with its broader context, and (f) separation- and reunification-specific family dynamics. Using these six domains as a structuring framework, we review relevant findings on the functioning of refugee families, based on both empirical and clinical studies.

Trauma communication and transmission

The first family domain, trauma communication and transmission, involves patterns of intra-familial communication regarding painful war- and exile-related events. These communication patterns often permeate the family's daily life and affect the refugee children's development in various ways (Walter & Bala, 2004). Some researchers have reported the adverse effect that silencing the traumatic experiences has on the psychosocial well-being of refugee children. Almqvist and Broberg (1997) documented strategies of denial in refugee parents, and found that patterns of silencing and denial of the traumatic events often dominate in refugee families. This promotes a coping strategy of suppression of the traumatic memories, which is transferred from parents to children, and governs the communication patterns within the parent-child relationship. This transmission of communication patterns from parents to their children illustrates how coping strategies are not solely individual, parental characteristics, but form an integral part of a refugee family's transactional dynamics (Almqvist & Hwang, 1999).

Almqvist and Broberg (1997) argue that, although these strategies of denial may serve family survival in extremely stressful periods of exile, this short-term adaptive communication mechanism may hinder parental availability and support for the traumatised refugee children, who have been taught to keep silent and protect the parents from knowing how much the

war- or exile-related experiences have affected them. Other researchers have observed the same silencing strategies among Middle Eastern and Bosnian refugee families (Angel et al., 2001; Montgomery, 2004). Montgomery (2004) stresses the undermining effect that parental denial has on the psychosocial well-being of the whole family. The contradiction between 'stories told' and 'stories lived', where painful memories are not explicitly shared but are nevertheless implicitly communicated within the family, threatens family coherence and negatively influences the children's psychosocial functioning, as they are left with their imaginations of 'putative facts' and struggle for meaning and understanding (Walter & Bala, 2004).

Other researchers, however, have documented a more complicated picture regarding the impact of silencing communication patterns on refugee children. First, they suggest that any evaluation of the intra-familial communication patterns should encompass an understanding of the cultural specificity of communication mechanisms and strategies. Summerfield (2000), for example, stresses that many non-western cultures place little emphasis on the process of verbally 'working through' painful experiences. 'Active forgetting' may be a culturally rooted coping mechanism. Disclosure and talking about traumatic events can, thus, have different consequences in different cultural settings (Angel et al., 2001). In families from cultural groups where 'working through' traumatic experiences is encouraged, talking about traumatic experiences will evoke emotional support and concern. Conversely, in cultural groups in which disclosure is discouraged and repressing distress is regarded as adaptive, it is likely that family members will react in a distancing or even contemptuous way towards disclosure.

Second, it seems important to acknowledge that the impact of silencing strategies on refugee children also depends on their developmental stage. Rousseau and Drapeau (1998) reported differing patterns of trauma transmission in two cultural groups. Whereas Central American immigrant parents tended to talk explicitly about their traumatic past, linking their story to its historical and political context, Southeast Asian parents opted for a strategy of silencing their past experiences. These authors furthermore showed how the differences in trauma communication patterns between two cultural groups had a differential impact on refugee children's well-being depending on their developmental stage. The open communication pattern of Central American parents was associated with a greater intrusion in the child's emotional world at younger ages, but led to an adaptive avoidance mechanism of distancing in adolescents. Inversely, the silenc-

ing strategy of Southeast Asian parents had a protective effect on their children's well-being at school age, but an adverse impact on anxiety and depression levels in adolescent girls.

Therefore, evaluating the effect of silencing mechanisms on refugee families requires a thorough understanding of the cultural context in which they function and of the current life circumstances and developmental stage of its members.

Acculturation processes

After arrival to the host country, acculturation is a central task for refugee family members. All the family members are faced with the need to adapt to a new cultural environment, to learn a new language and to adjust to alien cultural values and roles. This complex acculturation process may threaten the internal cohesion of the refugee family (Walter & Bala, 2004).

There is evidence that refugee children usually acculturate faster than their parents, which leads to differential adaptation patterns within the family (Walter & Bala, 2004; Weine, Feetham, et al., 2004). This varying acculturation rate may cause disharmonious adjustment profiles in refugee families. Refugee children acculturating rapidly may serve as a catalyst for the acculturation of other family members and often generate social contacts, introducing the family into the new society. Yet, the children's integration attempts can also lead to parental rejection or to family conflict, causing loyalty conflicts, internalised identity conflicts or distancing strategies, particularly among adolescent refugees (Bala, 2005; Roer-Strier, 1996). The process of integration and the different acculturative strategies used by family members may also lead to changes in family subsystems (Walter & Bala, 2004). For example, gender roles from the homeland may be questioned within the spousal relationship. While fathers are often strict concerning the preservation of cultural values, mothers might be inclined to question the traditional gender stereotypes. This negotiation of gender roles can lead to role conflict and changes in the family hierarchy.

Roer-Strier (1996) describes how immigrant parents develop different strategies to cope with acculturation conflicts. The author documents three prototypical coping strategies used by parents who are faced with cultural differences within their family. The 'kangaroo strategy' refers to a uni-cultural parental style that promotes the conservation of traditional values and roles. Here, immigrant parents consider themselves the primary socialisation agents

of their children. The level of acculturative stress within these families is relatively low: the family manages to maintain cohesion and experiences minimal cultural changes. The 'cuckoo strategy' concerns a culturally disoriented style in which the family tends to disqualify itself as an important socialisation actor in the host country. However, these parents tend to maintain their traditional view on adaptive development and are likely to reject the influence of the host culture. Lastly, parents using the 'chameleon strategy' acknowledge the cultural differences between their homeland and their host country, but encourage the child to integrate both in its development. This type of family may maintain contact with their former culture while establishing family cohesion within the new culture. These three different coping strategies among immigrant parents in turn influence the child's acculturation process. While a child from parents who operate with a 'kangaroo strategy' may experience serious loyalty conflicts and become the family's scapegoat when trying to adopt values of the host society, a child within a 'chameleon' family can more easily learn to negotiate between two different socialisation agents and benefit from the relative advantages of both (Roer-Strier, 1996).

It is clear from the above, that the refugee family becomes intensely engaged in a cultural transition that may cause value conflicts between the family and institutions, between family members, as well as intra-individual, internalised identity or loyalty conflicts (Bala, 2005). These conflicts at the community, family and individual level may increase the level of family stress and aggravate the family members' struggle with exile-related stressors such as unemployment, social isolation and uncertainty over the outcome of asylum-seeking procedures.

Intra-familial support

Intra-familial support forms a third domain of refugee family dynamics. The support and responsive caregiving within the refugee family is an important factor in the mental health of the refugee child (Fazel & Stein, 2002; Hodes, 2002). Indeed, during the process of forced migration, refugee parents often show diminished responsiveness towards their children. While the children's need for support may be increased, the parents' ability to offer sensitive caregiving is often restricted, due to their preoccupation with resident insecurity, grief and chronic distress (Bala, 2005; Walter & Bala, 2004). Analysing clinical case studies, Almqvist and Broberg (2003) described how traumatised Kosovar mothers developed a damaged representation of their

self as a nurturing mother. Due to their inability to prevent their children from witnessing traumatic events of violence and rape, the mothers were unable to view themselves as protective parents. In addition, the role of their children as situational triggers for the mothers' flashback memories led to a complete disengagement of these mothers from caregiving behaviour. These case studies show how strong relational dynamics may damage the capacity of refugee parents to engage in supporting behaviour towards their children. Since parental support, proximity and responsiveness are vital protective factors for the children's psychosocial well-being, it is clear that this diminished parental sensitivity enhances the adverse effects of forced migration on the mental health of refugee children.

Restructuring of family boundaries and roles

The fourth refugee family domain affected by the process of forced migration concerns the family's boundaries and roles. The profound changes the family faces during its flight and exile often lead to a redefinition of roles and relationships in a changing family structure.

We have already described the (re-)negotiation of gender roles between partners during the acculturation process. These negotiations extend beyond the spousal relationship: all family members, including the children, may experience challenges to patriarchal structures from their culture of origin, leading to a restructuring of the family hierarchy (Walter & Bala, 2004; Weine, Feetham, et al., 2004). Furthermore, refugee children may take up many household activities and fulfil parental roles towards siblings. Parents often view their children as their future hope and thus burden them with heavy family obligations. It is clear that boundaries between parental and child responsibilities are crossed in these situations and that the 'parentification' of refugee children may constitute an important dynamic in refugee families. Walter and Bala (2004) describe several parentified roles undertaken by refugee children, such as the 'care provider' and 'the perfect representative of the culture of origin'.

Both of the structural changes described here, namely changes in a patriarchal family hierarchy and new, parentifying role definitions for the child refugee, can profoundly influence the mental health of refugee children. Parental conflict on gender roles may lead to increased family stress and diminished parental availability, whereas parentification mechanisms may interfere with the socio-emotional development of refugee children. However,

it seems important to note that, although parentified roles of refugee children can indeed threaten the child's self-image and capacity for proximity-seeking behaviour (Cassidy, 1988; Moss & Dubois-Comtois, 2004), the huge family obligations refugee children often face may also be a source of strength and resilience. For example, Rousseau, Drapeau, and Platt (1999) showed how parental expectations towards their children had a protective role during adolescence. Adolescents, as they were seeking to compensate in their own future for their families' hardships, experienced family obligations as a motive for responsibility and personal growth (Rousseau et al., 1999).

Family connections with its broader context

A fifth important domain of the refugee family life is the establishment and maintenance of links with the family's broader context. Within this domain, we can distinguish two different sub-domains that relate to issues regarding the transnational family and to issues regarding social support and social isolation in the host country.

The first sub-domain relates to the contact with family members in the home country. For many refugee families, the sense of staying connected to their larger family network is of vital importance (Almqvist & Hwang, 1999; Eastmond, Ralphsson, & Alinder, 1994). Keeping contact through letters and phone calls or sending money to family members who were not able to emigrate are often crucial issues for the refugee family (Weine et al., 2004). These strategies of maintaining bonds with the extended family can facilitate the establishment of a sense of familial and cultural continuity.

Second, social support and social isolation have been shown to be major factors in the psychosocial well-being of refugee family members. Social support for the refugee family in the host country constitutes a vital protective factor in the psychosocial functioning of refugee children (Farhood, 1999; Hodes, 2002; Lustig et al., 2004). Therefore, it seems crucial that the refugee family develops strategies for drawing on a social network. Other refugee families in the host country that share similar experiences, often provide an important source of social support. This 'community of fate' forms a vital support group and point of reference (Eastmond et al., 1994; Hjern & Jeppsson, 2005). However, creating such supportive social network seems to be a difficult task for the refugee family, since social isolation is reported to be a major source of exile-related stress (Miller et al., 2002). Throughout the process of forced migration, the refugee family becomes isolated from its broader social network

and, therefore, loses many of its external sources of support. Thus, family members have to re-establish social contacts in their new environment in the host country. Refugee parents often complain about the loss of social roles and their marginal position in the host society. They are often preoccupied with establishing a valued social position in their new society, through learning the language or employment (Weine, Feetham, et al., 2004). These tasks may be complicated by the disempowering insecurity of asylum-seeking procedures, which often result in intense family distress (Sourander, 2003). The question of how to find opportunities for meaningful citizenship is at the core of refugee family members' experiences in the host society (Bala, 2005; Summerfield, 2005). It seems evident to note that the coping strategies refugee family members develop in this family domain will also be profoundly influenced by the host society's attitudes towards their integration.

The difficulties refugee parents experience in rebuilding social networks and social status reveal the far-reaching social isolation they often face in host countries. This seclusion may profoundly affect the well-being of refugee children. Indeed, the isolated position of the refugee family creates an extraordinary dependence on family support in refugee children. Due to the lack of external sources of support, refugee children show an increased need of parental availability and support (Hjern et al., 1998). Yet, as stated above, this parental responsiveness and caregiving behaviour may be diminished during the process of forced migration. While being a crucial protective factor in buffering the impact of forced migration, sources of social support may thus be relatively scarce for refugee children. Because of the lack of both parental and external support, refugee children are often left without sufficient containing relationships.

In clinical work with refugee families, issues of social support and isolation are therefore vital in promoting the well-being of refugee children (Hjern & Jeppsson, 2005). An extended social network may facilitate possibilities for refugee children to seek support outside the family unit. At the same time, increasing the social network and the social status of refugee families may decrease parental preoccupation with social seclusion and therefore make it possible for them to provide responsive and supportive caregiving to their children.

Separation- and reunification-specific family dynamics

A final domain of the refugee family life is its engagement in separation- and reunification-specific family dynamics. A large number of refugee families

face, at least temporarily, separation and reunification. Refugees often experience these processes as predominant stressors (Lie, 2002; Miller et al., 2002). The family separation and reunification indeed profoundly complicates the refugee family experience. The impact of pre-migration stressors is aggravated by a separation that causes prolonged grief over uncertain and ambiguous losses: absent members cannot be considered 'really' absent because of the great risks they are considered to be under and the uncertainty about their fate (Rousseau et al., 2004). Furthermore, family roles must be reconfigured, given the changing family structure during both separation and reunification.

Thus, it is clear that refugee families dealing with processes of separation and reunification will have to cope with marginality, traumatisation, uprooting and acculturation in a complicated and fragmented manner. Dealing with past experiences and adjusting to a new culture is often put on hold due to the prolonged separation and then may suddenly be precipitated by the reunification of family members (Rousseau et al., 2004). The fragmented family then needs to find strategies to re-establish family continuity and internal cohesion, such as remaining rooted in tradition or spirituality, negotiating role changes for parents and children or making their history of losses the thread through the family narrative (Rousseau et al., 2004).

In this review of findings from research and clinical work with refugee families, we discussed six interwoven domains of the refugee family life. Two additional perspectives on the mental health of refugee children permeated and complemented this family approach. Firstly, throughout the description of refugee family processes, we encountered the culture-specificity of intrafamilial dynamics. Research on refugee families inevitably encounters culturally-rooted rearing practices, communication patterns and social values. Thus, the integration of a family perspective with a culture-sensitive research approach seems plausible and particularly relevant. Secondly, this review addressed several coping strategies used by family members in different domains. In this way, the description of refugee family dynamics broadened the focus from a purely medicalising, pathologising view on refugees' mental health towards an emphasis on protective processes and resilience. Throughout this review, we described protective factors at both the individual and family level, thus highlighting the potential of refugee family research to address resilience on a twofold level, namely as contextual factors in individual resilience and as interactional processes at the system level of the family unit.

CONCLUSION

In this paper, we reviewed the research and clinical literature on the mental health of refugee children. The vast majority of research on the psychosocial well-being of refugee children focuses on the assessment of psychiatric symptomatology and psychological distress. However, listening to critical voices in the literature towards this symptom-focused research approach, we questioned the suitability of trauma-centred research in documenting the mental health of refugee children. We argued for a systemic perspective that approaches the refugee experience as a multidimensional process and addresses the dynamic interplay between psychological, familial, social, cultural and political factors, which in turn affects the distress and resilience of refugee children. More specifically, we proposed a theoretical shift towards a family approach.

Following this shift, we reviewed the literature on refugee children's mental health from a family perspective. We organized the research findings within six interlinked domains of the refugee family life. This review showed how research on the mental health of refugee children from a family perspective can complement symptom-focused research. The relational dynamics in a refugee family provide significant heuristic frameworks by which results from symptom-focused research can acquire a broader and contextualized meaning. In this way, the psychosocial functioning of the refugee child becomes situated in core processes of the refugee family, such as trauma communication, acculturation or parental support.

However, this review also highlighted the lack of research on the processes of family resilience and other core processes in the refugee family life. Further research addressing key processes in refugee families is, therefore, highly recommended (Rasco & Miller, 2004; Steinglass, 2001). Such an approach on refugee children's mental health encompasses the psychological, familial and cultural meanings of their psychosocial functioning and may offer significant insights for clinical work with refugee children. Indeed, the findings from the research and clinical work with refugees presented here not only offer interpretative frameworks for understanding the psychosocial distress and well-being of refugee children, but also have important implications for clinical practice. For example, they provide a strong argument for organising the clinical support to refugee children within their family context. Family support and family therapy make it possible to address the relational nature of the impact of forced migration (Bala, 2005; Hjern & Jeppsson, 2005; Weine, Feetham, et al.,

2004). Within the context of family work, psychosocial problems of child refugees can be understood and treated with respect to the meaning and function they have within the context of family dynamics. Moreover, clinical work with refugee families opens up possibilities of promoting the well-being of refugee parents. In dealing with issues of strengthening the social network of refugee parents and supporting their efforts to utilize community resources, in addressing grief processes at the nexus of political and intimate life or in drawing on functional problem-focused coping styles within the family, clinical work may enhance the psychosocial well-being of refugee parents and in this way, increase their resources for caregiving and supportive behaviour towards their children. Therefore, the proposed shift from an individualising symptom-based to a family perspective carries important directions for clinical work with refugee children and enables us to address the pervasive impact of forced migration in its multidimensional, culture-specific and systemic nature.

REFERENCES

Ajdukovic, M., & Ajdukovic, D. (1998). Impact of displacement on the psychological well-being of refugee children. *International Review of Psychiatry, 10*, 186-195.

Almqvist, K., & Brandell-Forsberg, M. (1997). Refugee children in Sweden: Post-traumatic stress disorder in Iranian preschool children exposed to organized violence. *Child Abuse & Neglect, 21*, 351-366.

Almqvist, K., & Broberg, A. G. (1997). Silence and survival. Working with strategies of denial in families of traumatized preschool children. *Journal of Child Psychotherapy, 23*, 417-435.

Almqvist, K., & Broberg, A. G. (1999). Mental health and social adjustment in young refugee children in a follow-up three and a half years after settling in Sweden. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 723-730.

Almqvist, K., & Broberg, A.G. (2003). Young children traumatized by organized violence together with their mothers: The critical effects of damaged internal representations. *Attachment and Human Development, 5*, 367-380.

Almqvist, K., & Hwang, C. P. (1999). Iranian refugees in Sweden: Coping processes in children and their families. *Childhood, 6*, 167-188.

Angel, B., Hjern, A., & Ingleby, D. (2001). Effects of war and organized violence on children: A study of Bosnian refugees in Sweden. *American Journal of Orthopsychiatry, 71*, 4-15.

Bala, J. (2005). Beyond the personal pain: Integrating social and political concerns in therapy with refugees. In D. Ingleby (Ed.), *Forced migration and mental health. Rethinking the care of refugees and displaced persons* (pp. 169-182). New York: Springer.

Becker, D. F., Weine, S. V., Vojvoda, D., & McGlashan, T. H. (1999). Case series: PTSD symptoms in adolescent survivors of "ethnic cleansing". Results from a 1-year follow-

up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 775-781.

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995). Psychological responses to war and atrocity: The limitations of current concepts. *Social Science and Medicine, 40*, 1073-1082.

Cassidy, J. (1988). Child-mother attachment and the self in six-year-olds. *Child Development, 59*, 121-134.

Dyregrov, A., Gupta, L., Gjestad, R., & Raundalen, M. (2002). Is the culture always right? *Traumatology, 8*, 3-10.

Eastmond, M. (2000). Refugees and health: Ethnographic approaches. In F. L. Ahearn (Ed.), *Psychosocial wellness of refugees. Issues in qualitative and quantitative research* (pp. 67-87). New York: Berghahn.

Eastmond, M., Ralphsson, L., & Alinder, B. (1994). The psychosocial impact of war and violence: Bosnian refugee families and coping strategies. *Refugee Participation Network, 16*, 7-9.

Eisenbruch, M. (1991). From post-traumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees. *Social Science and Medicine, 33*, 673-680.

Farhood, L. F. (1999). Testing a model of family stress and coping based on war and non-war stressors, family resources and coping among Lebanese families. *Archives of Psychiatric Nursing, 13*, 192-203.

Fazel, M., & Stein, A. (2002). The mental health of refugee children. *Archives of Diseases in Childhood, 87*, 366-370.

Fazel, M., & Stein, A. (2003). Mental health of refugee children: Comparative study. *British Medical Journal, 327*, 134-134.

Friedman, M., & Jaranson, J. (1994). The applicability of the posttraumatic stress disorder concept to refugees. In J. Marsella, T. Borneman, S. Ekblad, & J. Orley (Eds.), *Amidst peril and pain. The mental health and well-being of the world's refugees* (pp. 207-227). Washongton, DC: American Psychological Association.

Goldstein, R. D., Wampler, N. S., & Wise, P. H. (1997). War experiences and distress symptoms in Bosnian children. *Pediatrics, 100*, 873-878.

Hjern, A., Angel, B., & Jeppsson, O. (1998). Political violence, family stress and mental health of refugee children in exile. *Scandinavian Journal of Social Medicine, 26*, 18-25.

Hjern, A., & Jeppsson, O. (2005). Mental health care for refugee children in exile. In D. Ingleby (Ed.), *Forced migration and mental health. Rethinking the care of refugees and displaced persons* (pp. 115-127). New York: Springer.

Hodes, M. (2002). Three key issues for young refugees' mental health. *Transcultural Psychiatry, 39*, 196-213.

Kohli, R., & Mather, R. (2003). Promoting psychosocial well-being in unaccompanied asylum-seeking young people in the United Kingdom. *Child and Family Social Work, 8*, 201-212.

Lie, B. (2002). A 3-year follow-up study of psychosocial functioning and general symptoms in settled refugees. *Acta Psychiatrica Scandinavica, 106*, 415-425.

Losi, N. (2000). Understanding the needs of the displaced: Some elements on the Kosovo case. In C. Becker (Ed.), *Psychosocial and trauma response in war-torn societies. The case of Kosovo* (pp. 11-20). Geneva: International Organization for Migration.

Lustig, S. L., Kia-Keating, M., Knight, M. W., Geltman, P., Ellis, H., Kinzie, J. D., Keane,

T., & Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 24-36.

Miller, K. E., Muzurovic, J., Worthington, G. J., Tipping, S., & Goldman A. (2002). Bosnian refugees and the stressors of exile: A narrative study. *American Journal of Orthopsychiatry, 72*, 341-354.

Montgomery, E. (2004). Tortured families: A coordinated management of meaning analysis. *Family Process, 43*, 349-371.

Moss, E., & Dubois-Comtois, K. (2004). Attachment at early school age and developmental risk: Examining family contexts and behavior problems of controlling-caregiving, controlling-punitive, and behaviorally disorganized children. *Developmental Psychology, 40*, 519-532.

Papadopoulos, R. K. (2001). Refugee families: Issues of systemic supervision. *Journal of Family Therapy, 23*, 405-422.

Papadopoulos, R. K. (2002). Refugees, home and trauma. In R. K. Papadopoulos (Ed.), *Therapeutic care for refugees. No place like home* (pp. 9-39). London: Karnac.

Papageorgiou, V., Frangou-Garunovic, A., Iordanidou, R., Yule, W., Smith, P., & Vostanis, P. (2000). War trauma and psychopathology in Bosnian refugee children. *European Child and Adolescent Psychiatry, 9*, 84-90.

Rasco, L. M., & Miller, K. E. (2004). Innovations, challenges and critical issues in the development in ecological mental health interventions with refugees. In K. E. Miller & L. M. Rasco (Eds.), *The mental health of refugees. Ecological approaches to healing and adaptation* (pp. 375-416). Mahwah, NJ: Erlbaum.

Rechtman, R. (2000). Stories of trauma and idioms of distress: From cultural narratives to clinical assessment. *Transcultural Psychiatry, 37*, 403-415.

Roer Strier, D. (1996). Coping strategies of immigrant parents: Directions for family therapy. *Family Process, 35*, 363-376.

Rousseau, C., & Drapeau, A. (1998). The impact of culture on transmission of trauma. Refugees' stories and silence embodied in their children's lives. In Y. Danieli (Ed.), *International handbook of the multigenerational legacies of trauma* (pp. 465-484). New York: Plenum.

Rousseau, C., & Drapeau, A. (2003). Are refugee children an at-risk group? A longitudinal study of Cambodian adolescents. *Journal of Refugee Studies, 16*, 67-81.

Rousseau, C., Drapeau, A., & Corin, E. (1998). Risk and protective factors in Central American and Southeast Asian refugee children. *Journal of Refugee Studies, 11*, 20-37.

Rousseau, C., Drapeau, A., & Platt, R. (1999). Family trauma and its association with emotional and behavioral problems and social adjustment in adolescent Cambodian refugees. *Child Abuse and Neglect, 23*, 1263-1273.

Rousseau, C., Drapeau, A., & Rahimi, S. (2003). The complexity of trauma response: A 4-year follow-up of adolescent Cambodian refugees. *Child Abuse and Neglect, 27*, 1277-1290.

Rousseau, C., Mekki-Berada, A., & Moreau, S. (2001). Trauma and extended separation from family among Latin American and African refugees in Montreal. *Psychiatry, 64*, 40-59.

Rousseau, C., Rufagari, M. C., Bagilishya, D., & Measham, T. (2004). Remaking family life: Strategies for re-establishing continuity among Congolese refugees during the family reunification process. *Social Science and Medicine, 59*, 1095-1108.

Sack, W. H, Clarke, G. N., & Seely, J. (1996). Multiple forms of stress in Cambodian adolescent refugees. *Child Development, 67*, 107-116.

Samarasinghe, K., & Arvidsson, B. (2002). 'It's a different war to fight here in Sweden' – The impact of involuntary migration on the health of refugee families in transition. *Scandinavian Journal of Caring Sciences, 16*, 292-301.

Servan-Schreiber, D., Lin, B., & Birmaher, B. (1998). Prevalence of post-traumatic stress disorder and major depressive disorder in Tibetan refugee children. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*, 874-879.

Silove, D., & Ekblad, S. (2002). Editorial. How well do refugees adapt after resettlement in Western countries? *Acta Psychiatrica Scandinavica, 106*, 401-402.

Silove, D., Sinnerbrinck, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression and PTSD in asylum-seekers: Association with pre-migration and post-migration stressors. *British Journal of Psychiatry, 170*, 351-357.

Sourander, A. (2003). Refugee families during asylum seeking. *Nordic Journal of Psychiatry, 57*, 203-207.

Steinglass, P. (2001). Forced relocation: A family researcher/clinician's perspective. Commentary on "Trauma and extended separation from family among Latin American and African refugees in Montreal". *Psychiatry, 64*, 64-68.

Suarez-Orozco, C., Todorova, I. L., & Louie, J. (2002). Making up for lost time: The experience of separation and reunification among immigrant families. *Family Process, 41*, 625-643.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine, 48*, 1499-1462.

Summerfield, D. (2000). Childhood, war, refugeedom and 'trauma' three core questions for mental health professionals. *Transcultural Psychiatry, 37*, 417-433.

Summerfield, D. (2003). War, exile, moral knowledge and the limits of psychiatric understanding: A clinical case study of a Bosnian refugee in London. *International Journal of Social Psychiatry, 49*, 264-268.

Summerfield, D. (2004). Cross-cultural perspectives on the medicalisation of suffering. In G. Rosen (Ed.), *Posttraumatic stress disorder. Issues and controversies*. Chichester, UK: Wiley.

Summerfield, D. (2005). "My whole body is sick...my life is not good": A Rwandan asylum seeker attends a psychiatric clinic in London. In D. Ingleby (Ed.), *Forced migration and mental health. Rethinking the care of refugees and displaced persons* (pp. 97-114). New York: Springer.

Walsh, F. (1996). The concept of family resilience: Crisis and challenge. *Family Process, 35*, 261-281.

Walter, J., & Bala, J. (2004). Where meanings, sorrow, and hope have a resident permit: Treatment of families and children. In J. P. Wilson & B. Drozdek (Eds.), *Broken spirits. The treatment of traumatized asylum-seekers, refugees, war and torture victims* (pp. 487-519). New York: Brunner-Routledge.

Weine, S. (2000). Survivor families and their strengths: Learning from Bosnians after genocide. *Other Voices, 2*, 1-12.

Weine, S., Feetham, S., Kulauzovic, Y., Besic, S., Lezic, A., Mujagic, A., Muzurovic, J., Spa-

hovic, D., Zhubi, M., Rolland, J., & Pavkovic, I. (2004). Bosnian and Kosovar refugees in the United States: Family interventions in a services framework. In K. E. Miller & L. M. Rasco (Eds.), *The mental health of refugees. Ecological approaches to healing and adaptation* (pp. 263-293). Mahwah, NJ: Erlbaum.

Weine, S., Muzurovic, N., Kulauzovic, Y., Besic, S., Lezic, A., Mujagic, A., Muzurovic, J., Spahovic, D., Feetham, S., Ware, N., Knafl, K., & Pavkovic, I. (2004). Family consequences of refugee trauma. *Family Process, 43*, 147-160.

Zarowsky, C., & Pedersen, D. (2000). Rethinking trauma in a transnational world. *Transcultural Psychiatry, 37*, 291-293.