Bethany G. Roberts

Dr. Jody Jensen

HNRS 400

9 May 2022

Fixing the Faucet and the Floor:

Parental Involvement in Treating First-and-Second-Generation Refugee Children in the U.S.

What is the first step to fixing a broken, flooding faucet? Does the plumber reach for a mop, or a toolbox? Just as laying towels across a floor to mop up excess water will not stop a broken faucet, addressing one generation of trauma in a group cannot guarantee effective treatment for the entire population—particularly when that trauma comes from war, migration, or forced displacement. The ever-growing immigrant population in the United States consists of a substantial amount of refugees; and with the migration of traumatized people comes generations of traumatic effects that often go untreated, only to be revisited and addressed by later generations of refugee descendants.

As of 2019, 44.9 million immigrants make up fourteen percent of the U.S. population, consisting of "22.0 million women, 20.4 million men, and 2.5 million children" ("Immigrants"). While immigrants move to new host countries for a variety of reasons, perhaps the most prevalent at the time of this writing are refugees—more specifically, people forced to migrate due to war. There are a number of programs in place to provide food, shelter, clothing, and healthcare to refugees as they seek asylum in new countries; however, there is a vast and apparent gap in the realm of mental healthcare for refugees. This lack of conversation of the issue—as well as a significant lack of education and programs in place to address the problem—leaves many refugee parents and both first-and-second-generation refugee children with the

adverse effects of trauma for generations to come. Studies show that refugee children and second-generation refugee children are at high risk of PTSD and intergenerational trauma transmission from firsthand immigration experiences and untreated PTSD in their parents, respectively. Increasing parental involvement in refugee children's mental health recoveries through parental involvement—specifically mental healthcare education and culturally informed family therapy—may serve as an effective preventive resource for the psychological needs of refugee children in the United States.

It is essential to address that the term "immigrant" is extremely generalized and addresses a scope much larger than this paper alone; thus, this paper will focus on refugees instead of immigrants in general. Dr. Jacqueline A. Brady et al. define immigrants as foreign-born people living in the United States, including those with refugee standing (524). The term "refugee" will refer to those forced to immigrate to the U.S. "due to a well-founded fear of persecution related to reasons of race, nationality, religion, political opinion, violence, or war" (Brady et al. 524). Refugees are not to be confused with asylum seekers, which refers to "those awaiting an immigration decision about their refugee status" (Fazel et al. 250).

Traumatic effects during the migration process vary among first-generation refugee children, but remain expected and proven nonetheless. Any individual would have a clear need for mental healthcare after experiencing sexual assault, physical and/or verbal abuse, rape, or forcibly leaving their home alone; however, these experiences are not only combined, but also magnified with the migration process that first-generation refugee children endure. Dr. Mina Fazel et al. of Oxford University explore the detrimental effects of such treatment in "Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors." Fazel et al. elaborate:

> Child refugees report harassment, sexual abuse, and physical violence from local people and authorities in host countries. Camps can be extremely unsafe places; rape is not uncommon . . . Children who are not accompanied by an adult carer are especially vulnerable. Some end up living on the streets, whereas others are exploited and abused, having to resort to prostitution or other forms of labour to survive. (253-255)

This extreme traumatic exposure from a combination of both premigration and postmigration conflict results in a multitude of psychological effects in young refugees, resulting in a need for "more effective interventions to support the healthy development of these children" (Fazel et al. 250-251). The main focus of healthcare regarding refugees in the U.S. tends to be for physical needs (food, water, shelter, clothing, etc.) which are important; however, neglecting the psychological wellbeing of refugee children leaves these individuals with untreated adverse traumatic effects that will continue to haunt them for years to come.

Untreated PTSD generates enough risk within the victim alone; however, the confirmed transmission of trauma from refugee parent to child expands the ramifications of the migration process from one generation to the next. Ph.D. student Obianujunwa Anakwenze and Dr. Andrew Rasmussen of Fordham University explore the effects of intergenerational trauma transmission in their 2021 study "The Impact of Parental Trauma, Parenting Difficulty, and Planned Family Separation on the Behavioral Health of West African Immigrant Children in New York City." Anakwenze and Rasmussen address that untreated PTSD in refugee parents transmits to second-generation refugee children in the form of "harsh, overprotective, and role-reversing parenting styles, which in turn causes higher levels of child conduct problems, hyperactivity, emotional problems, and interpersonal problems" (Anakwenze and Rasmussen

458). Anakwenze and Rasmussen's study further shows that refugee parents' posttraumatic symptoms do predict this externalizing behavior in their children; furthermore, the children of both forced and voluntary migrants are most vulnerable to negative psychological effects when separated from their parents for over a year during the migration process (464). The longer that trauma goes untreated from each generation to the next, the more challenges victims face once trying to trace their trauma back to the original source and begin treatment. Thus, the need for refugee mental healthcare exists not only for first-generation refugee children, but their immediate and future descendants as well.

Despite the continually growing population in need refugee mental healthcare**,** the need and the treatment thereof prove to have little discussion in current academic and medical realms. Anakwenze and Rasmussen explain that "there is little research on the impact of parents' trauma-related symptoms on children's wellbeing in the general immigrant literature" (458). In their 2006 study "Mental Health Service Utilization by Ethiopian Immigrants and Refugees in Toronto," Dr. Haile Fenta, Dr. Ilene Hyman, and Dr. Samuel Noh note that despite the large amount of diversity in Canada, "there are surprisingly few empirical investigations of mental health service use by minority immigrant populations" (Fenta et al. 926). Anakwenze and Rasmussen, as well as Fenta et al., are compile only two of a group of studies identifying the need for refugee mental healthcare and encouraging others to address the topic; furthermore, Fenta et al.'s study was published in 2006, whereas Anakwenze and Rasmussen's study appeared in 2021. This timeline shows that over fifteen years have passed, yet there is still little discussion on the topic of mental healthcare in refugee populations and the treatment thereof.

Besides addressing mental healthcare services in immigrant populations, immigrant mental health service utilization itself is extremely slim—meaning that the few resources that *do*

exist are rarely used by refugees, but why? Fenta et al. address a multitude of hypotheses explaining the lack of mental health service utilization among immigrants, including differing views of mental illness, a recognition for mental illness paired with a reluctance to seek treatment due to "cultural . . . and linguistic barriers," and racism during interactions with the healthcare system (Fenta et al. 926). Of these conflicts, the most common roadblocks to immigrants' mental health service utilization are cultural differences, religious beliefs, and discrimination immigrants face within the healthcare system (Fenta et al. 931). These findings show a two-sided relationship between refugee and host country, particularly a relationship in which both sides face the result of miscommunication or misinformation to some degree. Fenta et al. indirectly address both sides of this relationship through explaining cultural differences and religious beliefs that immigrants hold, as well as the discrimination that the host country's caretakers administrate to them. Overall, this information indicates that mental healthcare services for immigrant populations in the U.S. contain staff who are culturally uninformed of the immigrants they take care of. Further exploring the need for educating healthcare professionals is the topic of another study, but will be addressed again later.

Despite the notable gap in immigrant mental healthcare research, studies show proposed and currently engaged solutions. A number of these treatment options especially concern social support systems and parental involvement, often hand-in-hand.

Fazel et al. "specifically recommend the enhancement of *community self-help and social support,* helping the provision of appropriate cultural, spiritual, and religious healing practices, and support, particularly for young children (0-8 years) *and their carers*" (262, emphasis mine). Fazel et al. do not only address young children affected by immigration trauma, but the parents taking care of these children as well; additionally, these practices are to be both appropriate and

culturally informed. Mental healthcare solutions targeting refugee children must provide a balance of culturally informed treatment for parent and child, as it would be ethical to take the refugee's original religion and culture into consideration when administering mental healthcare services. Such education and inclusion would ease the tension created by the earlier mentioned cultural differences between the refugees' culture and medical treatments available in the U.S., increasing the rate of refugee mental healthcare service utilization.

Parents and caretakers are not the only ones expected to participate in finding a solution. Anakwenze and Rasmussen suggest using their findings to identify immigrant children displaying externalizing behavior to "empower *social service professionals and health care providers* to strategically offer *parenting support* and other preventive resources to families that are at highest risk of intergenerational trauma transmission" (464, emphasis mine). Social service workers and healthcare staff are logically the most likely to interact with refugee children in the U.S. postmigration; thus, their inclusion of addressing the trauma and the transmission thereof within refugee populations should be expected. Anakwenze and Rasmussen specifically identify the need for parenting support as a resource for immigrant families with intergenerational trauma transmission, indicating that these vital individuals serve as the primary source of care, education, stability, and comfort for their children.

One notable solution involving both parental involvement and culturally educated professionals is the Boston Children's Hospital Trauma and Community Resilience Center (BCH TCRC), a recent development addressed in Dr. Jacqueline A. Brady et al.'s article "Refugee and Immigrant Core Stressors Toolkit to Care for Newly Arrived Children in a School Nursing Setting." This center "is staffed by a multidisciplinary team of researchers, clinicians (i.e.,

psychologists and social workers) and educators, most of whom have appointments at Harvard Medical school" (Brady et al. 523).

The BCH TCRC references the Four Core Stressors Framework, which identifies the main stressors that affect "newly arrived children post-migration to the United States: trauma, acculturative stress, resettlement stress, and social isolation" (Brady et al. 523). These factors align with the aforementioned, more detailed studies conducted by Fazel et al. and Anakwenze and Rasmussen: trauma which has been proven to occur firsthand through the immigration process itself, or through intergenerational trauma transmission; stress which occurs during the immigration process and resettling into a new host country; and social isolation that refugee children experience when separated from their parents for a year or more.

Using the Four Core Stressors Framework, the BCH TCRC developed the Refugee and Immigrant Core Stressors Toolkit (RICST), which is "an evidence-informed web-based screening tool for assessing the strengths and needs of newly arrived children and families" (Brady et al. 523). Brady et al. focus on implementing the RICST with school nurses to identify and assist immigrant children, but overall recommend using the RICST "as part of a screening and referral process to improve the emotional and physical well-being of newly arrived children" and clarify that doing so "would require coordinated, interdisciplinary teamwork between school systems and community providers" (529). School system faculty and community staff are already using the RICST this way, as indicated in greater detail in Brady et al.'s study. These providers must communicate and collaborate to effectively treat immigrant children and their trauma; within this growing team of workers, further discussion and education on refugee trauma and the treatment thereof proves vital in promoting effective treatment.

School systems and community providers are not the only team members who learn from the RICST when treating refugee children. Parental involvement in the treatment of first-generation trauma reception or intergenerational trauma transmission in refugee children is vital to successful treatment. Using the case of "Jasiel," Brady et al. walk through examples of the RICST's screening and recommendation process. Most—if not all—of the prescribed RICST interventions involve Jasiel's mother implementing recommended treatment at home (525-527). These recommendations include resettlement agencies and in-home therapy for both Jasiel and his mother, generating a healthy relationship "between home and school team," and coordinating with Jasiel's mom to include "an assets-based approach focusing on strengths" within the home (Brady et al. 525-6). Nearly every step of the mental healthcare process includes solutions involving Jasiel's primary caretaker. This shows that working with Jasiel's mother is a key factor in treating Jasiel himself.

The necessity for parental involvement is further confirmed through the study of externalizing behavior in refugee children. Anakwenze and Rasmussen explain their use of the Child Behavior Checklist (CBCL), a widely used and highly trusted source for evaluating children's behavior, to conduct their study (461). According to Anakwenze and Rasmussen,

> The Externalizing Scale is comprised of 32 items representing forms of bothersome behavior at several levels of severity (e.g. "showing off or clowning," "physically attacks people," "sets fires"); parents respond with "not true," "somewhat or sometimes true," or "very true or often true." (461)

Anakwenze and Rasmussen recommend identifying this externalizing behavior in immigrant children to allow social workers and healthcare providers to treat immigrant families and offer preventive resources to specifically combat intergenerational trauma transmission (464).

Logically speaking, those most likely to identify the externalizing behavior in their children are the parents or caretakers themselves. The results of the Externalizing Scale in the CBCL are not only used to treat the children directly, but the immigrant families as a whole. Including the parent or caretaker of the refugee child in mental healthcare programs requires not only identification of externalizing behavior, but the proposal and collaborative execution of treatments as well.

Parental involvement proves to be fruitful in treating externalizing behavior in children. In his March 2014 article "The Rational Positive Parenting Program for Child Externalizing Behavior: Mechanisms of Change Analysis," Dr. Oana Alexandra David explores the effects of cognitive-behavioral parenting programs on children's mental health. David acknowledges evidence that improved parenting styles result in improved child behavior (33). Furthermore, the results of his study show that while there are a variety of factors at play when treating children's psychological needs, "improved parenting" and "reduced parental distress" prove to be particularly effective (David 21). Such involvement would require providing education with parents about mental health and treatment, as well as collaboration on ensuring improved parenting methods in the home. David writes that

> a theoretically informed cognitive package, incorporating focus on both intermediate but also evaluative core beliefs of parents is needed before addressing child management strategies for better long-lasting outcomes. (34)

This coincides with the culturally-informed practices implemented by the BCH TCRC, as well as the parental involvement Anakwenze and Rasmussen encourage. Brady et al. emphasize that the Boston Children's Hospital Trauma and Community Resilience Center concentrates on "culturally-responsive and trauma-informed training" (523). This places significant emphasis on

workers who are informed and considerate of the immigrants' cultures while offering assistance and mental healthcare strategies, a move that proves to be essential to combat the cultural differences that conflict with mental healthcare awareness and strategies.

This parental involvement can be further implemented and encouraged through mental healthcare education, as well as culturally informed family therapy. First-generation refugee children should receive mental healthcare treatment as soon as possible, and so should first-generation refugee parents. Administering mental healthcare education—with an understanding of the refugees' personal religious and cultural beliefs—would encourage awareness of what mental health is and how to address it effectively with therapy and in-home social practices. Culturally informed family therapy addresses not only the mental healthcare needs of first-and-second-generation refugee children, but their parents as well. Implementing this practice will treat the trauma at its source, combatting intergenerational trauma transmission.

In conclusion, refugee children have a substantial need for mental healthcare services in the United States. Whether experiencing trauma firsthand as first-generation refugees or receiving its destructive effects through intergenerational trauma transmission as second-generation refugees, these children are at high risk of depression, anxiety, and other psychological issues. There are not many studies on the mental healthcare of immigrants; however, those that have been made have been carefully conducted and strongly supported with clear evidence that there is a need for more mental healthcare services for these refugees. While this demand for intervention is vast and requires an array of answers to even address the problem, one solution includes parental involvement through the use of mental healthcare education and culturally informed family therapy. Through further education from culturally-informed workers as to what mental illnesses are, as well as training in better parenting and

home treatments in collaboration with school programs and social workers, refugee parents can play a substantial role in improving the mental health of their children.

Works Cited

Anakwenze, Obianujunwa, and Andrew Rasmussen. “The Impact of Parental Trauma, Parenting Difficulty, and Planned Family Separation on the Behavioral Health of West African Immigrant Children in New York City.” *Psychological Trauma: Theory, Research, Practice, and Policy,* vol. 13, no. 4, May 2021, pp. 457–66. *EBSCOhost,* https://doi.org/10.1037/tra0001011.

Brady, Jacqueline A., et al. “Refugee and Immigrant Core Stressors Toolkit to Care for Newly Arrived Children in a School Nursing Setting.” *Journal of School Nursing,* vol. 37, no. 6, Dec. 2021, pp. 523–31. *EBSCOhost,* https://doi.org/10.1177/10598405211045688.

Fazel, M., Reed, R. V., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: Risk and protective factors. The Lancet, 379(9812), 266 –282. https:// doi.org/10.1016/S0140-6736(11)60051-2

Fenta, H., Hyman, I., & Noh, S. (2006). Mental health service utilization by Ethiopian immigrants and refugees in Toronto. Journal of Nervous and Mental Disease, 194(12), 925–934. https://doi.org/10.1097/01.nmd .0000249109.71776.58

“Immigrants in the United States.” *American Immigration Council*, 21 Sept. 2021, www.americanimmigrationcouncil.org/research/immigrants-in-the-united-states#:~:text=In%202019%2C%2044.9%20million%20immigrants,million%20children%20who%20were%20immigrants.