

Introduction

This project is designed to investigate how, if at all, refugee parental trauma influences child mental health.

Proposed pathways of intergenerational transmission of trauma include:

- Parental mental health,
- parental behaviors,
- parental and child social support,
- family conflict,
- community involvement,
- Potential biological factors.

We investigate how parental mental and parenting behaviors impact child mental health in refugee populations.

Methods

Data are drawn from the baseline measures of a Hybrid Type 2 Implementation-Effectiveness Trial called the Family Strengthening Intervention for Refugees (FSI-R) at Boston College's Research Program for Children and Adversity.

This study consists of 79 Somali Bantu and Bhutanese families (children and caregivers) and aims to promote resilience and healthy relationships in refugee families. Self report is used data.

Eligibility criteria:

- Somali Bantu and Bhutanese refugees with at least one child between 7-17 years old
- Families who have been in the United States for 3+ months
- Families currently in crisis not included

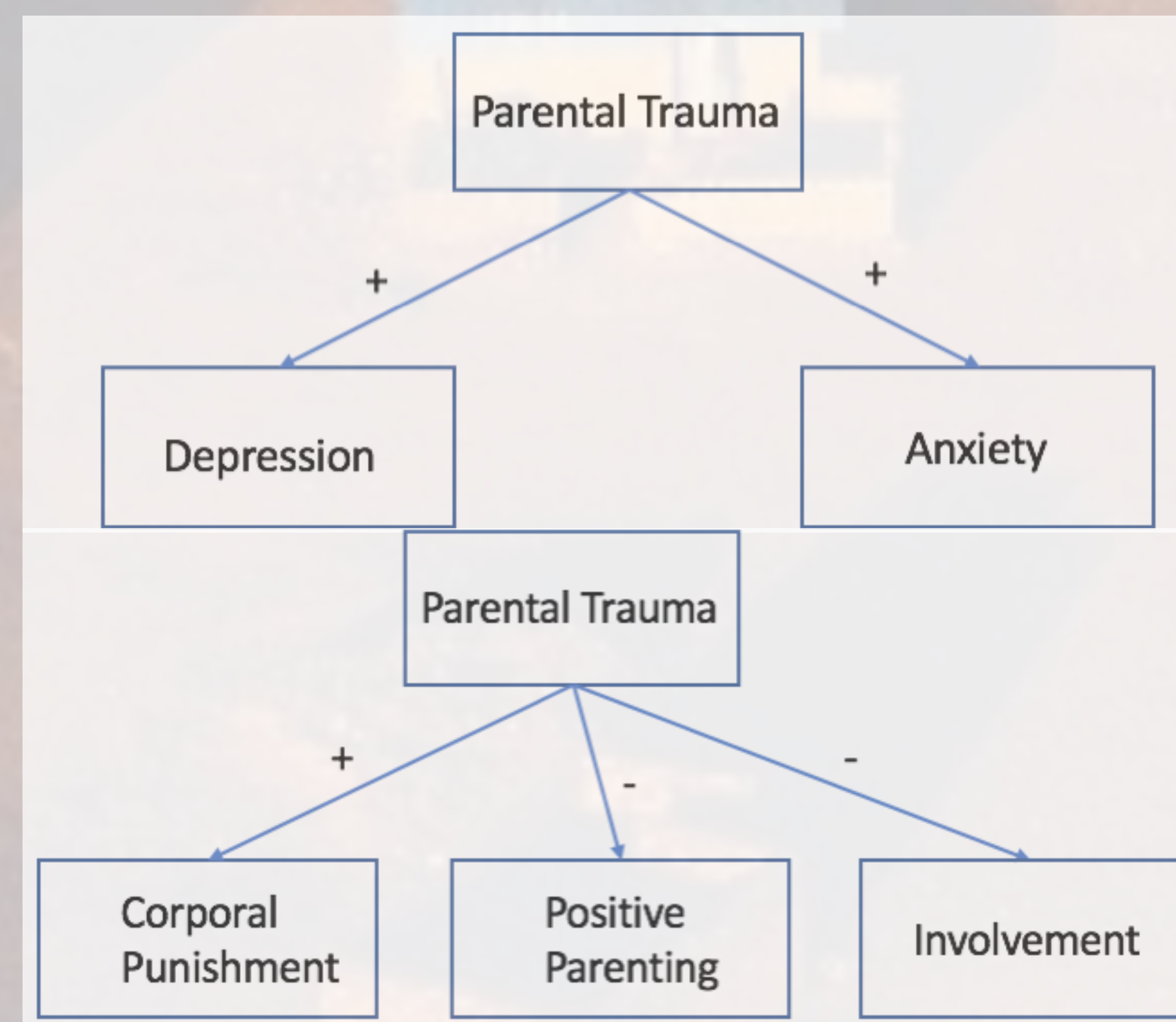
Population	Somali Bantu (37 families)		Bhutanese (42 families)	
	Children (n=88)	Primary Caregivers (n=37)	Children (n=59)	Primary Caregivers (n=42)
Female, n (%)	46 (52%)	32 (87%)	28 (48%)	28 (67%)
Age, mean (range)	12.73 (10-17)	41.32 (31-67)	12.93 (10-17)	40.90 (26-59)
Birthplace, n (%)	Somalia-2 (2%) Kenya-17 (19%) USA-69 (78%)	Somalia-36 (97%) USA-1 (3%)	Bhutan-3 (5%) Nepal-52 (88%) India-2 (3%) USA-2 (3%)	Bhutan-37 (88%) Nepal-3 (7%) India-2 (5%) USA-0
Religion, n (%)	Muslim-87 (99%) Animist-1 (1%)	Muslim-37 (100%)	Hindu-21 (36%) Buddhist-13 (22%) Christian-20 (34%) None-4 (7%) Kirat-2 (2%)	Hindu-15 (36%) Buddhist-9 (21%) Christian-13 (31%) None-4 (10%) Kirat-1 (2%)
# of children in household, mean (range)		5.41 (1-9)		2.24 (1-3)
# of adults in household, mean (range)		1.51 (1-4)		2.31 (1-5)
Years in US (for those not born in US), mean (range)	11.90 (3-17)	13.78 (3-16)	5.39 (1-11)	5.31 (1-11)

Hypotheses

Hypothesis 1a: Parental trauma increases parental depression and anxiety.

Hypothesis 1b: Parental trauma increases corporal punishment parenting.

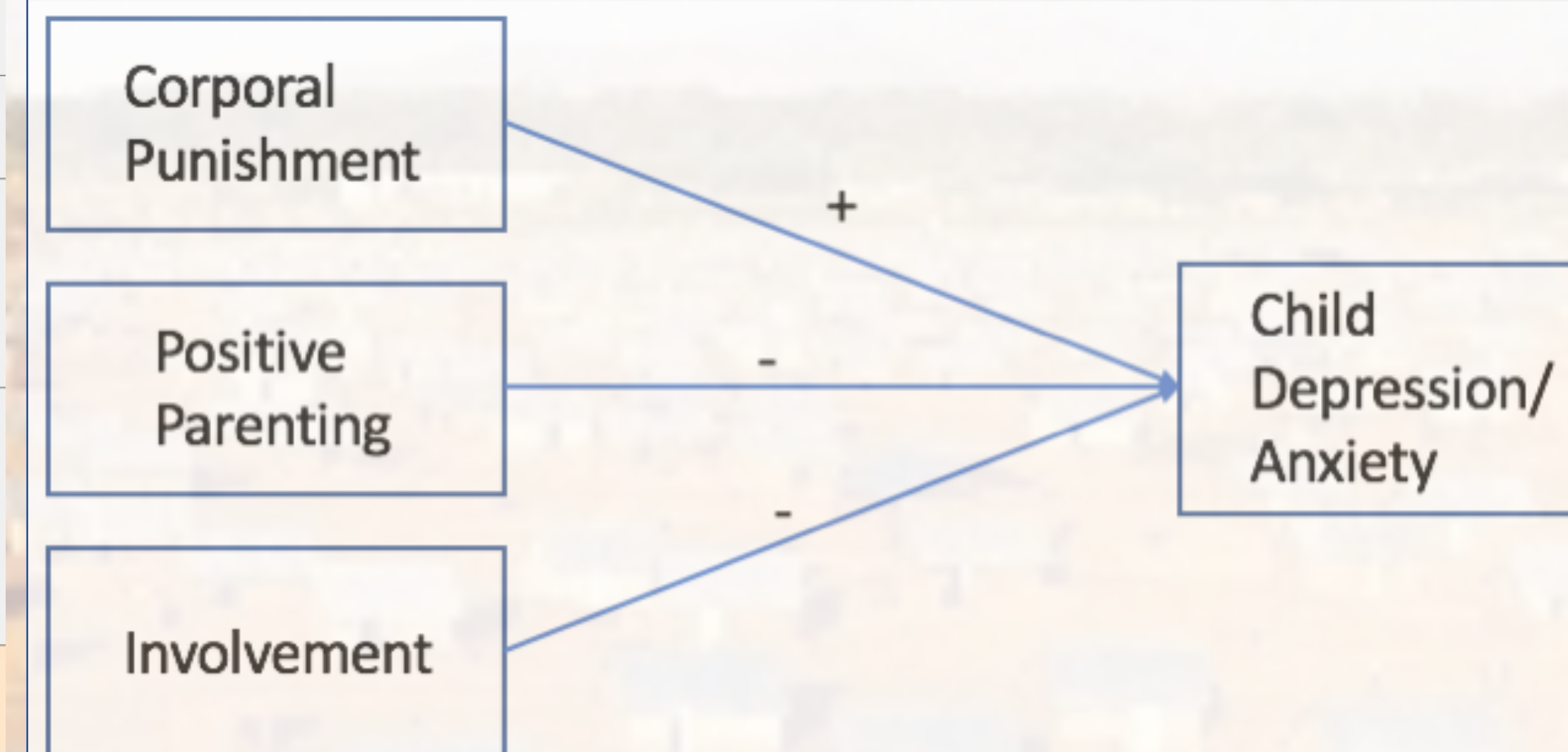
Hypothesis 1c: Parental trauma decreases positive parenting behaviors.



Hypothesis 2a: Positive parenting behaviors decrease child depression and anxiety.

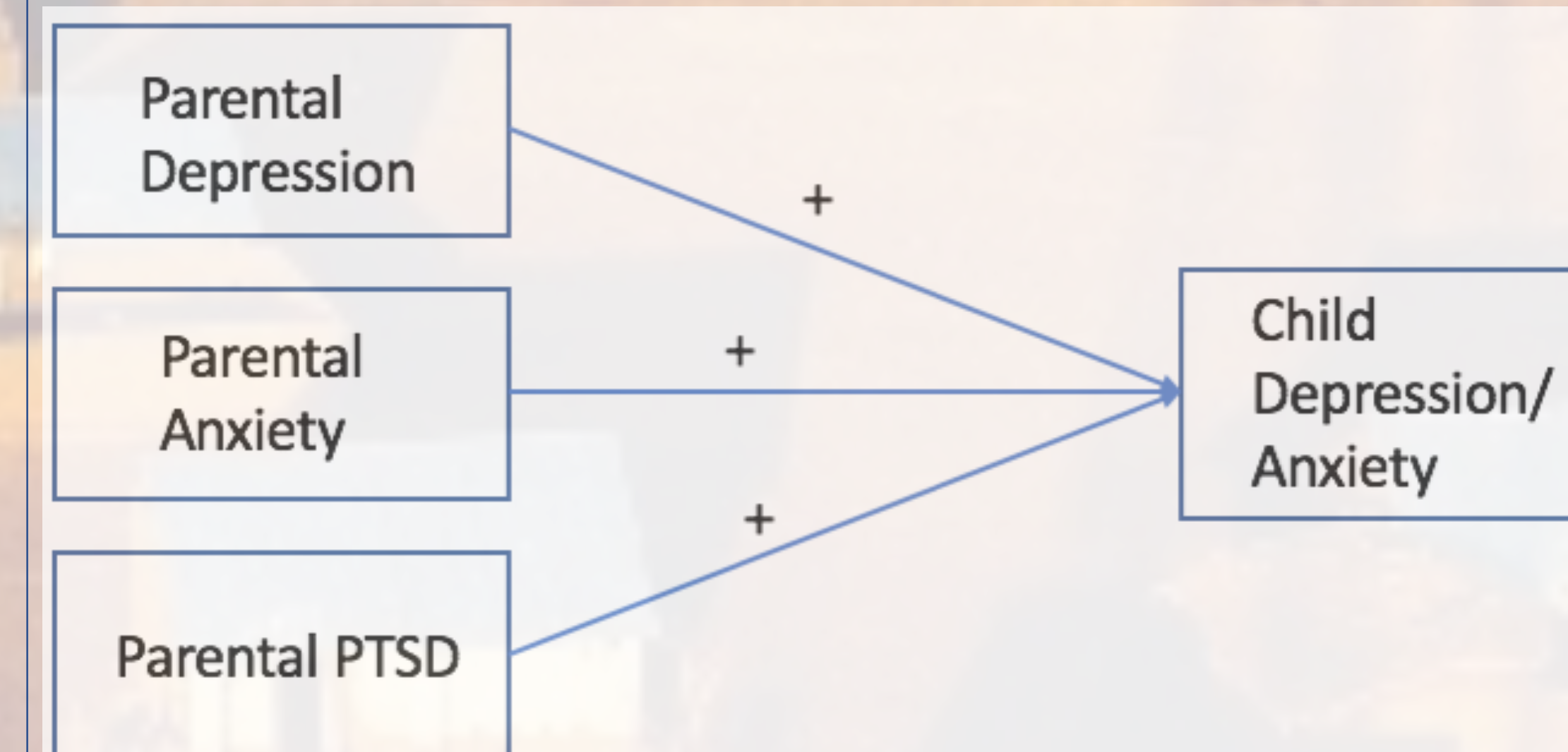
Hypothesis 2b: Corporal punishment parenting behaviors increase child depression and anxiety.

Hypothesis 2c: Parental involvement decreases child depression and anxiety.



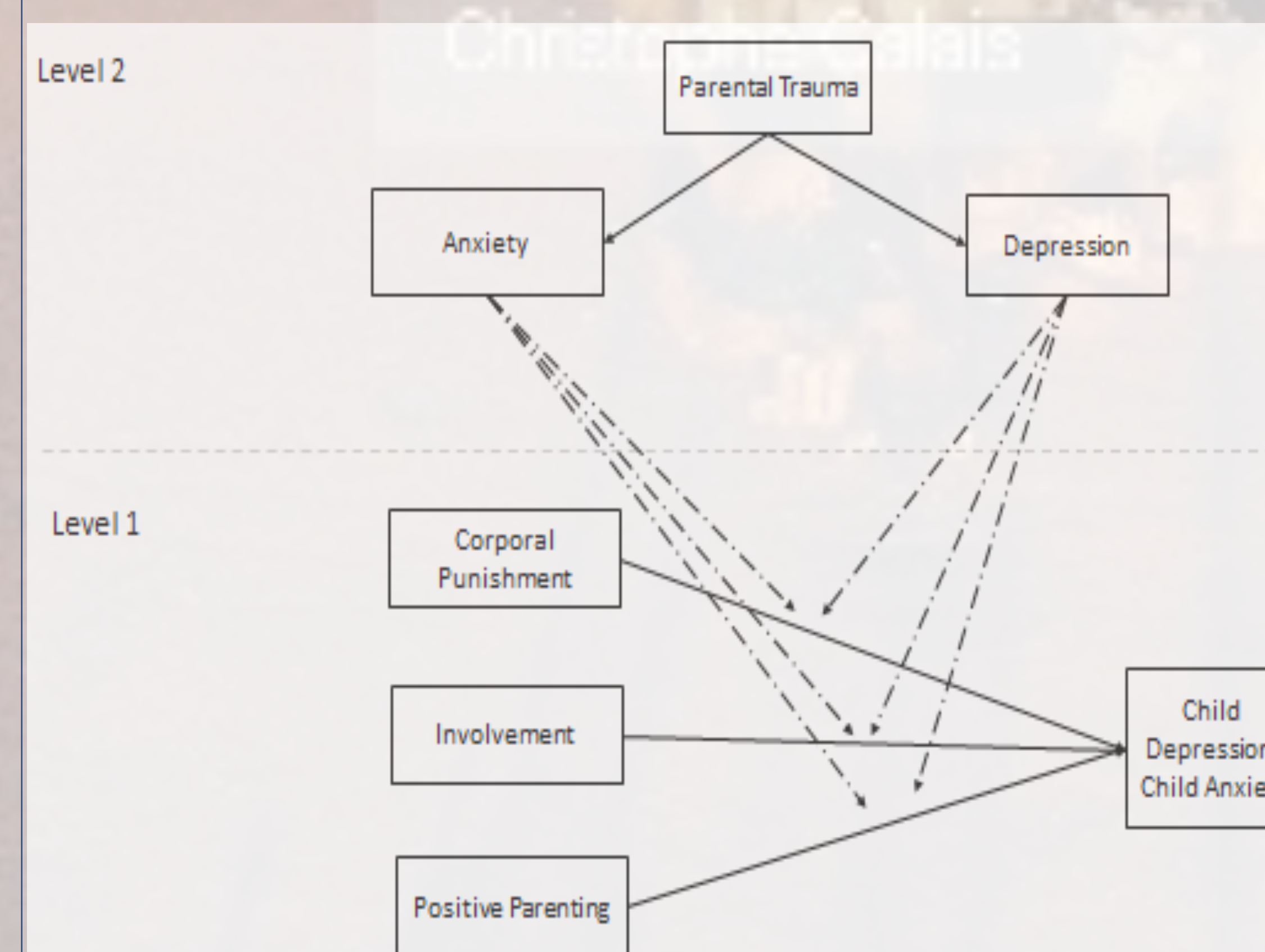
Hypothesis 3a: Parental PTSD increases child depression and anxiety.

Hypothesis 3b: Parental depression and anxiety increase child depression and anxiety.



Hypothesis 4a: Parental mental health moderates positive parenting behaviors and child depression and anxiety.

Hypothesis 4b: Parental mental health moderates corporal punishment parenting behaviors and child depression and anxiety.



Discussion

Confirmation of hypotheses would speak to importance of support mechanisms for refugee families who may struggle with prior trauma and acculturation stress, and its impact on their mental health and consequently on their family dynamics.

Implications include:

- Early screening for mental health issues
- Early screening of home environment including monitoring parenting behaviors,
- Referrals to community resources that may help parents improve their own mental health and develop healthy parenting strategies that cultivate positive child mental health outcomes

Diversity, Equity & Inclusion

Refugees are disproportionately impacted by mental health issues, yet due to cultural and structural barriers, they also have less access to mental health care.

In order to address and solve these issues, people from a range of interdisciplinary fields including psychology, biology, public health, community health, and social work must work together to create solutions.

Applicable to other populations and low resource settings.