Understanding the mechanisms of transgenerational mental health impacts in refugees

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The trauma experienced by refugees has transgenerational mental health impacts.[1,2] A study by Richard Bryant and colleagues[3] in *The Lancet Public Health* provides evidence about the specific mechanisms by which these impacts might occur.

Bryant and colleagues[3] studied more than 400 families who had come to Australia as refugees, primarily from Afghanistan, Iraq, and Iran. They investigated the associations between exposure to trauma, parental post-traumatic stress disorder, parenting style, and children's psychological difficulties. They used path analyses to investigate direct and mediating effects over time. Around a quarter of parents met criteria for likely post-traumatic stress disorder, and children of those parents experienced increased psychological distress. These effects were mediated by harsh parenting style and post-migration stressors. The study provides one of the largest prospective studies of refugee families, and is one of the first studies to investigate the mediating effects of parenting style.

Only 6·7% of refugee children scored in the psychological difficulties range on the parent-rated Strength and Difficulties Questionnaire (SDQ).[4] This proportion is lower than the 10·1% estimate for the Australian population[5] and estimates of up to 13% in Australian refugee children.[6,7] However many of the studies[5–7] produced these estimates using an SDQ cutoff score of 17, compared with the score of 20 used by Bryant and colleagues. All of these might be underestimates: parents typically under-identify emotional problems compared with adolescent self-reports, and refugee parents might particularly under-report their children's psychological difficulties.[6] Reduced stressors after resettlement seem to be protective for children's wellbeing[7] and, in this study, no participants had experienced the mandatory detention imposed on some refugees to Australia. The SDQ might also be insensitive to specific psychological impacts of trauma in refugee populations.[8]

Silove points out[1] that the story of refugee mental health should not be seen as uniformly negative. Three quarters of refugee parents in this study did not have post-traumatic stress disorder. This wide spectrum of outcomes underlines the opportunity for effective intervention. Bryant and colleagues' findings highlight particular groups of young people at risk. The greatest differences from population norms occurred in emotional and peer problems, particularly in young women, rather than in conduct problems and hyperactivity. Hence, target areas for intervention could include identification and treatment of parental post-traumatic stress disorder; a focus on protective parenting styles; and strategies for responding to emotional distress and improving peer relationships of children and adolescents, particularly for girls.

For more on **population norms** see http://www.sdqinfo.com/g0.html

Health care for refugee families should sit within a broader context. Protective factors for the mental health of refugee children include a strong sense of cultural and ethnic identity, broader community integration, access to opportunities for economic and social participation, and the avoidance of stigma and discrimination.[2,7,9] In many developed countries the two goals of strong cultural identity and broad community integration have sadly become seen as increasingly incompatible. Until recently, Australia's approach to multiculturalism valued the maintenance of a strong ethnic and cultural identity, seeing this as normative and helping to define the broader Australian sense of community.[10] However, more recent political and social trends have threatened this delicate balance.

Finding a compassionate response to the global refugee crisis has caused debate in many developed countries. Ideally, evidence regarding refugee mental health should provide some empirical common ground in these debates. Studies such as that by Bryant and colleagues continue to build the evidence. Mental health problems affecting some refugee families, left untreated, will leave a legacy of individual and transgenerational suffering, community impact, and economic cost. Developed countries such as Australia have the social and financial resources to respond. Do we also have the will to respond to the emerging evidence?

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