In The Wake Of 1974: Psychological Well-Being And Post-Traumatic Stress In Greek Cypriot Refugee Families

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Abstract

This study examines the health of Greek Cypriot refugee families who suffered the traumas of displacement and death of family members. Thirty refugee and twelve non-refugee families (N=118) completed ten self-report inventories assessing their resources, coping styles, well-being, and post-traumatic stress. Results indicate that the resources of social support, education, income, and family adaptability, and coping through support-seeking, positively predicted adaptation to war trauma. Twenty-two per cent of the refugee family sample and none of the non-refugee family sample exhibited PTSD, and 94% of these subjects were women. A model of family adaptation is presented, and implications for clinical intervention and public policy are discussed.

Introduction

As witnessed in Cyprus, and more recently in the former Yugoslavia and Afghanistan, armed conflicts dramatically disrupt and irrevocably change families' lives. In the past decade, the number of refugee families has risen precipitously (van der Veer, 1998), and there are more than twenty-six million refugees worldwide (United Nations, 1995). In the wake of the sudden and unpredictable socio-economic and personal changes wrought by war, how do refugee families adapt? This study examines how the resources and coping strategies of Greek Cypriot families affect their adaptation to catastrophic events such as the loss of their homes and disappearance and death of family members in the 1974 war. The psychological well being of Greek Cypriots across the categories of refugee status, sex, and generation is examined twenty-eight years after the war.

Review of the Literature

Most studies on the effects of war (e.g., Fairbank and Nicholson, 1995; Hogancamp and Figley, 1983; van der Kolk, 1985; Solomon and Flum, 1988) have

focused on combat veterans and have not examined social and family relationships (Figley, 1995). Hill (1949) conducted the first major study of the role social relationships play in individuals' adjustment to war trauma. In a study of World War II veterans and their families, Hill found that the crises of war and post-war reunion have considerable impact on the family system. While research has indicated that families can work to alleviate the deleterious sequelae of traumatic events (Figley, 1983, 1989), family systems can also be sources of stress and trauma themselves (Matsakis, 1988), as in cases of family physical and sexual abuse. Studying family characteristics of Israeli soldiers who had suffered combat stress reaction Solomon, Mikulincer, Freid, and Wosner (1987) found that one-year after the war married soldiers had higher rates of post-traumatic stress disorder (PTSD) than unmarried soldiers. In a study of Vietnam veterans and their families recruited via a national random survey, Kulka et al. (1990) found significantly more problems (e.g., marital distress, family violence, child behavioural problems) in families with a PTSD-inflicted parent than veteran families without a PTSD-inflicted parent. Such findings challenge conventional wisdom that intimate partners or family members necessarily mitigate the impact of trauma.

The Diagnostic and Statistical Manual IV (American Psychological Association, 1994) asserts that individuals can develop PTSD in response to three kinds of events: (1) incidents that are, or are perceived as, threatening to one's life or physical safety; (2) witnessing acts of violence against others; or (3) hearing about violence to or the unexpected or violent death of persons one knows well. Common symptoms of PTSD include anxiety, startle responses, sleep disturbance, nightmares, intrusive thoughts, difficulty concentrating, and problems dealing with feelings of anger (Keane, Wolfe, and Taylor, 1987). As a group, refugees may endure many traumatic events, including armed conflict, witnessing the beating, killing, and mutilation of people, sudden flight, and involuntary migration (Chambon, 1989; Stein, 1986). Sack et al. (1994) asserted that war-related traumas increase the risk of developing PTSD, and Lipton (1994) posited that any traumatic experience in which people perceive that death is imminent or people perceive themselves as totally helpless increases the risk of developing PTSD. Acute emotional reactions to war trauma include numbing, panic, and bereavement (van der Veer, 1998), and PTSD symptoms can appear months or even years after exposure to war trauma.

Figley (1979) identified four elements of war which define it as a traumatic stressor. First, armed conflict is imminently *life-threatening,* with refugees fearing for their lives and the lives of others (van der Veer, 1998). Second, refugee families experience a *sense of loss.* Refugees lose their communities, homes, and personal belongings, which may never be recovered following their destruction and/or a forced exodus due to military occupation of territory. Refugees may also lose

relatives or close friends due to death and/or disappearances that may never be fully resolved (L'Hoste, 1986; van der Veer, 1998). Third, war produces a *sense of helplessness,* in which refugees cannot stop the killing and devastation, and may be powerless for extended periods of time to protect themselves or those close to them. Last, refugees are witnesses to destruction and *disruption.* In the terror and confusion associated with armed conflict, family members can become separated from one another, and later endure hardships in the strange surroundings of refugee camps (van der Veer, 1998). In the case of Greek Cypriot refugees, disruption means a "a loss of continuity with the past-the home as the physical and symbolic representation of what has been irreplaceably lost in exile" (Zetter, 1999, p. 9).

Only a handful of studies have examined the direct impact of war on family relations or how families cope and transform their lives from war trauma. For example, Zetter (1992, 1999) conducted a longitudinal, ethnographic study of Greek Cypriot refugees' processes for adjusting to the meaning of protracted exile and their perceptions of a "return home." But no study in Cyprus has examined the mental health consequences of war or the impact of war trauma on families. Research in other countries has demonstrated that the stressors of war are associated with somatic disorders, depression, anxiety, and poor interpersonal relations (Ben-David and Lavee, 1992; Boscarino, 1995; Farhood, 1986; Farhood, Chaya, and Madi-Skaff, 1997; Finley-Jones and Brown, 1981; Kaplan, Roberts, Camacho, and Coyne, 1987; McCubbin, Joy, Cauble, Patterson, and Needle, 1980). For example, a random, population-based survey in war-time Lebanon found that the loss of one's home and property was related to psychological distress (Hourani, Aremenian, Zuryak, and Afifi, 1986). War and non-war stressful life events were associated with depressive symptoms in Lebanese women, with income and education acting as buffers to symptomatology (Bryce, Walker, and Peterson, 1989; Bryce, Walker, Ghorayeb, and Kanj, 1989). Studying families who had endured the sixteen-year Lebanese war, Farhood et al., (1993) found that war stress reduces mental health, with social support working as a mediating factor. Farhood (1999) found that family resources, such as social support and education, had a positive impact on family adaptation.

Theoretical Rationale

The authors grounded the present study in family stress theory and the Resiliency Model of Family Stress, Adjustment, and Adaptation (Mccubbin and Mccubbin, 1996). This model attempts to account for the personal, family, and community processes and properties that interact and influence families' healthy functioning over time. Post-crisis processes that contribute to the quality of family's adaptation to traumatic life events include vulnerabilities (subsequent stressors,

strains, and transitions that challenge a family's ability to adapt), family resources (family and social resources called upon in order to adapt), and coping and problem solving (cognitive and behavioural strategies for coping). For healthy adaptation to occur, families must institute changes in patterns of functioning and in their relationship within a larger social context. This study considers three primary factors: (a) Family Life Events, specifically, war and non-war traumas, and more recent family strains and transitions, (b) Family Resources, including social support adaptability in the face of crises, education, and income, and (c) Family Health including family members' physical, emotional, and social well-being and post-traumatic stress symptoms.

The following series of hypotheses about relationships between the variables are examined in the present study. The greater the frequency and severity of war and non-war traumas experienced by the family, the more likely the family will have a more difficult time creating strategies for transforming trauma. Problematic adaptation is manifested in lower physical, emotional, and social well-being and in post-traumatic stress symptoms. Furthermore, it is hypothesised that the frequency and severity of traumas will contribute to a greater number of recent family stressors, which will decrease family adaptation. In addition to family resources, coping strategies will work to mediate the impact of stressful life events.

Differentials in power and the cultural context of the research subjects are taken into account in the interpretation of the study's findings. Analysis of the data was guided by feminist and ecosystemic theoretical frameworks (Agathangelou, 2000; Falicov, 1995; Keeney, 1982) that emphasise the importance of the historical and social contexts in which family relationships and presenting problems are embedded. Any person's access to resources, power, and privilege relative to others is constituted through multiple locations within the ecosystems of gender culture, social class, race, ability, religion, education, and age, to name a few, and effects further access to resources and institutions.

Method

Subjects

Thirty Greek Cypriot refugee families were selected from a government database on displaced and missing people by drawing a random sample. A comparison group of non-refugee families was drawn from the urban and rural areas in which the refugee families resided. The total sample comprised twelve families who did not lose their homes and possessions in the war, eighteen refugee families who lost their homes and possessions, and twelve refugee families who lost their homes, possessions, and a family member in the war. Two to four family

members responded from each family, at least one respondent from each of two generations (total N=118, 54 men and 64 women). Parents were at least fifty years old and had one or more adult children who were six years or older at the time of the war.

Procedure

The measures consisted of previously devised instruments that had been translated and then validated on the Greek Cypriot population. The participants completed a brief demographic questionnaire and ten self-report instruments. A trauma inventory tapped subjects' experience of severe stressors such as combat, major fire, natural disaster, serious car accident, violent crime, displacement, witnessing someone being mutilated, injured, or violently killed, sexual coercion, death of a family member by accident or homicide, any other traumatic event, and a traumatic event that they could not speak about or describe. Subjects were asked to report the frequency and severity of each trauma at the time of the event. Subjects were also administered the Penn Inventory for PTSD (Hammarberg, 1992), which measures twenty-six post-traumatic stress symptoms and has an internal consistency of .94 and an overall predictive power of 93% for correctly diagnosing cases of PTSD.

Eight additional instruments measured the major components of the Resiliency Model: a twenty-item measure of family transitions and strains in the past year (McCubbin and Patterson, 1981; Mccubbin and Patterson, 1982); the seventeen-item Social Support Index (SSI) (McCubbin, Patterson, and Glynn, 1982); a twenty- four-item measure of family coping behaviours called the Family Coping Index (FAMCI) (McCubbin, Thompson, and Elver, 1995); a ten-item measure of family coping strategies called Problem-Solving Communication (PSC) (Mccubbin, Thompson, and Elver, 1995); the twenty-item Family Hardiness Index (FHI) (McCubbin, McCubbin, and Thompson, 1986), featuring three subscales measuring cohesion, adaptability, and locus of control (higher scores on this subscale reflect a generalised belief that personal events and occurrences are more the result of one's own efforts and behaviour [internal control] instead of luck, chance, or other contingencies [external control]); Family Solidarity, a nine-item measure of families' sense of strength and cooperation in the face of problems and challenges, derived from items from the FAMCI and FHI; finally, an eleven-item measure of Family Member Well-being derived from the original FMWB (McCubbin and Patterson, 1982) and augmented with three items from a measure of Family Distress (McCubbin and Patterson, 1981). These measures possess internal reliability coefficients ranging from .74 to .89. Informed consent was obtained, confidentiality and anonymity were assured, and participation in the study was voluntary, involving minimal personal risk. The forms were completed in the participants' homes and

they were free to withdraw from the study at any time. Data were analysed, T-tests and multiple regression procedures.

Results

A step-wise multiple regression procedure found that 62% of the variance in the dependent variable PTSD symptoms was accounted for ($F < .0001$) by the independent variables of trauma history ($B = .34$, $p < .001$), family member well being (FMWB) ($B = -.33$, $p < .001$), social support ($B = -.31$, $p = .005$), educational level ($B = -.24$, $p = .01$), and focus of control ($B = -.15$, $p = .048$) (Beta coefficients are all standardised). Support from friends, family and the community, education, a more internal focus of control, and a strong sense of emotional and physical health in oneself and one's family was reciprocally related to the reporting of PTSD symptoms. Logically, the frequency and severity of traumas were positively associated with the reporting of PTSD symptoms. In addition to the direct reciprocal relationship between the family resource of education and PTSD symptoms, the resources of family adaptability and income had an indirect, reciprocal relationship to PTSD symptoms by accounting for 47% of the variance in the independent variable of locus of control.

A step-wise multiple regression procedure found that 49% of the variance FMWB was accounted for ($F < .0001$) by three independent variables: fam stressors in the past year ($B = -.36$, $p = .0002$), PTSD symptoms ($B = -.33$, $p .0006$), and family coping behaviours ($B = .22$, $p = .0135$). Thus, symptoms PTSD and recent family stresses and strains appear to diminish subjects' FMV\ while family coping behaviours buoy FMWB in refugee families.

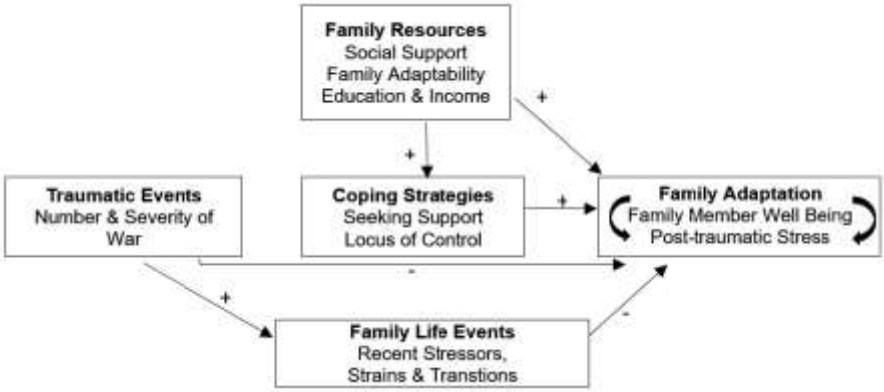
Regarding the T-tests, the mean for the non-refugee families on FMWB was significantly higher than for the refugee families ($p = .004$), but the means for social support did not differ between refugees and non-refugees. Men scored significantly higher on FMWB than women ($p = .004$), but the means for locus of control did not significantly differ between men and women, or between generation one and two. However, refugees reported a more external locus of control than non-refuge, ($p < .001$) and significantly higher levels of experienced trauma ($p < .001$) ar PTSD symptoms ($p < .001$) than non-refugees. Women reported more PTS symptoms than men did ($p < .001$), less education ($p = .032$), less social support ($p = .004$), and less seeking of support from friends and relatives ($p = .05$). The was also an interaction between gender and social class on the dependent variable of FMWB. Finally, FMWB, social support, and family stressors did not differ between the generations, although parents did report significantly more traumas ($p = .005$) and significantly more PTSD symptoms ($p = .002$) than their adult offspring.

Discussion

Support for the Refugee Family Adaptation Model

The results supported the hypothesised relationships in the model. Figure 1 shows a trimmed model of the statistically supported paths among the variables. Non-normative traumatic events and normative family stresses predicted family adaptation. Specifically, war and non-war traumas predicted post-traumatic stress symptoms while more recent family stressors and transitions predicted family member well-being. This finding lends legitimacy to the model because, logically, traumatic events, not normative family stresses, would contribute to post-traumatic symptoms. In addition, it makes sense that normative family stressors in the past year would have an impact on FMWB in the past month but would not contribute to PTSD symptoms. Number and severity of traumas also accounted for 10% of the variance in family stressors in the past year.

Figure 1:
Statistically Supported, Trimmed Model of Refugee Family Adaptation



The perception of family and community social support positively predicted FMWB, and utilisation of these supports in their coping strategies reduced PTSD symptoms. While family solidarity did predict a significant proportion (27%) of the variance in problem solving communication (PSC), PSC failed to reach significance ($p = .15$) in its prediction of either measure of family adaptation in this sample. This is a curious finding in light of past research, clinical anecdotes, and conventional

wisdom which have held that affirming, non-incendiary communication styles are positively related to well-being in post-crisis families (Figley, 1995; Mccubbin and Thompson, 1992; McCubbin, Thompson, Thompson, Elver, and McCubbin, 19 McCubbin, McCubbin, Thompson, and Thompson, 1995). Because family is centrally important in Greek culture (Tsemberis and Orfanos, 1996), it is possible that some subjects provided socially desirable responses to this inventory so that their families would appear healthier and happier regardless of the act communication patterns. Another possibility is that PSC is not an appropriate measure for Greek Cypriot refugee families due to cultural differences. For instance, yelling and shouting during arguments or debates are not necessarily viewed as inappropriate in the Greek Cypriot cultural context. Further research could explore the extent to which measures of problem solving are reliable and valid across cultures.

Other family resources that played a significant role in family adaptation were education, income, and family adaptability. Family income and adaptability were linked to locus of control, with a more internal locus of control predicting fewer PTSD symptoms, while higher levels of education were directly linked to fewer PTSD symptoms. One interpretation of this finding is that having more knowledge about topics such as physical and mental health affords subjects an awareness self, alternative frameworks for understanding events, experiences, and symptoms and alternative methods of responding to them. For example, having gone to college, a family member is likely to be aware of the psychological concepts of stress, anxiety, and panic, and this information would be available to help explain the occurrence of symptoms such as palpitations, cold sweats, and unusual breathing patterns. Additionally, these family members may be aware of the institutional resources available (e.g., access to "good" doctors, access to the state's resources and knowledge) and the methods necessary to tap into them when needed. A subject possessing two years of college education might view these symptoms as indicators of a psychological state of anxiety or a panic attack: and examine what is going on internally and externally to contextualise the experience. In contrast, a subject possessing two years of primary school, education might view these symptoms as an indication of a serious health problem (e.g., a heart attack) or as a sign that they are "going crazy." Because education plays such an important role in how persons (1) make sense of their of experience, and (2) access resources and support, helping professionals should include it as a standard part of their assessment protocol when working with survivors of traumatic events.

An unanticipated finding was the strong reciprocal relationship between the family adaptation variables of FMWB and PTSD symptoms. As noted earlier, studies of families with a PTSD-inflicted member have demonstrated that the

presence of a person suffering from PTSD symptoms is frequently associated with stressful experiences for all family members (Matsakis, 1988). Flashbacks, nightmares and sleep disturbance, outbursts of anger, substance abuse, and violence can work to traumatise those intimately connected to a person with PTSD, and the consequent deleterious effects to family systems can be extensive and enduring (Boudewyns, Hyer, Klein, Nichols, and Sperr, 1995). In this study, the presence of a member manifesting significant PTSD symptoms diminished members' sense of FMWB, suggesting that some family systems were themselves sources of stress, and the presence of a PTSD-inflicted member elevated other members' concerns about their own health and that of others. The authors explored this phenomenon further by comparing scores on FMWB between families who did and did not have a member who had a probable diagnosis of PTSD. The criterion was whether a family member had scored at or above the clinical cut-off score of thirty-five on the Penn Inventory (Hammarberg, 1992). Families who had a PTSD-inflicted member scored significantly lower on FMWB ($p = .004$) than families who had members who scored less than thirty-five on the Penn Inventory. Families who had a PTSD-inflicted member also sought more support from relatives and friends than those who did not have a PTSD-inflicted member ($p = .025$).

Conversely, families who possess a strong sense of emotional and physical health may draw upon this as a resource to buffer the impact of traumas. For example, families who did not experience emotional and physical violence or substance abuse before, during, or following traumatic events probably view themselves as stronger and more emotionally and physically healthy; a positive history of family health as well as access to alternative therapies (such as homeopathy, chiropractic care) may help members view a trauma as something that they can handle and survive together. Additional findings are discussed below under the categories of refugee status, gender, and generation.

Refugee Status

As expected, refugees reported significantly more traumatic experiences and post-traumatic stress symptoms than persons who had not lost their homes and possessions. Thirteen out of sixty refugees (22%), and no non-refugees, scored at or above the clinical cut-off score on the Penn Inventory suggesting the presence of significant post-traumatic stress symptoms. This finding is consistent with others (Bramsen, 1995; Mooren and Kleber, 1996) which stipulate that 15-25% of those who suffer multiple traumas as a result of war can exhibit signs of serious mental disorder up to fifty years afterward, but that most people do not develop serious disorders such as post-traumatic stress (Yehuda and McFarlane, 1995). Twenty-seven years after the war, 22% of the Greek Cypriot refugee sample were suffering from PTSD. The prevalence of PTSD in this refugee family sample stands in stark

contrast to the 1% prevalence found in the general population in the U.S. (Davidson, Hughes, Blazer, and George, 1991; Sack et al., 1994), but parallels the estimates of prevalence of 16% (Gong-Guy, 1987) and 22% (Clarke et al., 1993 found in Cambodian refugees twelve to fifteen years after their displacement. Similarly, in their national sample of Vietnam veterans, Kulka et al. (1990) found PTSD prevalence rate of over 15% ten to twenty years after their service Vietnam. Refugees also reported a more external locus of control than non-refugees, meaning that they tend to view life events as being determined by circumstances and luck and not by their own agency. This finding is likely to be connected to the experience of a catastrophic stressor (e.g., displacement) that is sudden, unpredictable, and completely out of one's control, both then and now (no refugee has returned home to the Turkish-occupied north of Cyprus). Interestingly levels of social support did not differ across refugee status. Despite their diaspora within Cyprus and the disruption of their original communities in the north, refugee may have maintained a sense of connectedness and continuity by developing bonds in their new communities and by attending the weddings and funerals of former co-villagers (Zetter, 1999).

Gender

Women scored significantly higher on PTSD symptoms than men, and reported less social support, less seeking of support, less education, and less FMWB than men. The interaction between gender and social class on FMWB also indicates that being female and working class predicts significantly lower scores on this dimension of overall emotional and psychological health. Twenty-five per cent the women and only 2% of the men received a diagnosis of PTSD, and sixteen out of seventeen of the persons receiving a PTSD diagnosis were women (χ^2 = .001).·Since the adaptation model suggests that education is a major resource and seeking support is a major coping strategy in reducing PTSD symptoms, Greek Cypriot women logically are at a higher risk than men for developing PTSD. This finding is consistent with others (e.g., Kinzie et al., 1990) that being female has, been correlated with a higher prevalence of PTSD in refugee groups. However since women reported fewer traumas (p = .07) and somewhat less distress associated with these traumas (p = .094) than men, questions arise about their adaptation processes and the *qualitative nature* of their traumas.

In 1980, the United Nations High Commissioner designated refugee women, a high-risk group for developing severe psychological problems due to pre- migration war experiences of rape and sexual violence (Refugee Women Development, 1990). In this study, for the hugely underreported trauma of sexual coercion and violence, five women reported experiences, whereas no men reported such an experience. Eleven women also reported experiencing a trauma that they

could not talk about, and six men reported having had such an experience. The total frequency of sexual violence and traumas participants could not talk about was sixteen for women and six for men, indicating a gender gap in the incidence of traumatic events which the participants experienced difficulty disclosing.

Some feminists argue that modern medicine and psychiatry developed in a process parallel to colonial expansion (Myntti, 1985, p. 169; Giacaman, 1989), and their practice serves the interests of capitalist-patriarchy. Women's health, and lack thereof (Kirk and Okazawa-Rey, 1998; Thompson, 1994), is intimately connected to women's access to resources, knowledge production, and power both inside and outside the family . Across the globe, women face barriers to their use of medical care such as not being able to take time out of work or losing pay for doing so, childcare, limited economic resources, and fewer facilities in rural communities. "Who gets health care and what kind of care" are political questions, and the health care strategies of any society have a significant class, gender, a racial, national, and ethnic dimension (Stork, 1989, p. 4). Similarly, in Cyprus, the refugee women's experience of the state's support and caring in 1974 is no exception. The Greek Cypriot state approached women's violated bodies in the conflict ridden context as propaganda tools. In 1991 it seized upon international events, such as the ethnic cleansing in former Yugoslavia, and fomented anxieties about the sexually violent practices of the enemy in 1974. However, this same state did not invest any resources to create agencies to support and care for the women sexually violated during the war (personal interviews with women sexually violated in 1974). Such lack of support through state policies reflect an attempt to recapture and recuperate the past while simultaneously neglecting the needs of women traumatised in 1974 (Agathangelou, 2000, p. 14).

It is possible that the tendency for families and communities to shun or "blame the victim" in cases of abuse, molestation, and sexual assault and the intense feelings of shame associated with such experiences may contribute to silence around their experiences. In addition, women are sometimes seen as "damaged goods" or property in patriarchal social relations, and women may perceive that a discussion of sexual violence might erode spouses' sense of being in control and in power. Furthermore, in wartime, discussing the traumas of being physically beaten or witnessing a mutilation or killing may carry less severe social consequences in one's social network than talking about the trauma of sexual violence. The mental health of particular persons (e.g., a woman who lost her husband and son in 1974) and groups (e.g., those living in refugee housing) is linked to the institutionalisation of trauma, which in turn, is linked to a focus on the still unresolved national question. The institutionalisation of trauma locks many persons into the category of "victim" blocking other strategies and "possibilities of intervention ....short of the removal of the military occupation" (Giacaman, 1989, p. 19).[1] In the hermeneutic world, the self

is a constantly changing affair, not a fixed social property. "Understanding and meaning are cultural, public, and intersubjective" (Goolishian and Anderson, 1992 p. 11). Mental space is a public space, public through labour and dialogue, and the self is always evolving out of this public space. Thus, not talking about traumatic experiences can delay or impede the healing process (Koss et al., 1988), and this phenomenon, combined with a lack of social support and community resources, may contribute to more PTSD symptoms and a lower sense of well-being in women.

Generation

The number and severity of traumas and PTSD symptoms were significantly higher for generation one than two. This makes sense because research participants who were parents in 1974 had already experienced traumas prior to this war. They were witnesses to or participants in the war against the British in the 1950s, and the ethnic conflicts of 1963, 1964, and/or 1967, and were more likely to have experienced a broad range of stressful situations during the 1974 war (e.g being beaten and/or imprisoned, or actually killing people). This finding supports the notion of "stacking," which suggests that a greater number of traumatic events clustered together carries a greater risk factor for developing PTSD. However, the variables of family member well-being, social support, and family stressors in the past year did not differ between the generations. Further analyses, beyond the scope of this article, may shed light on these findings.

The Significance of Social Support

Studies have found community social support to be significantly related to successful family adaptation in adjusting to stressful circumstances (Lavee, McCubbin, and Patterson, 1985; McCubbin and Thompson, 1988; McCubbin and Thompson, 1992; Thompson, Mccubbin, Thompson, and Elver, 1995). In this study, perception of social support strongly predicted lower PTSD symptoms, suggesting a finding of other researchers (Brownwell and Shumaker, 1984; Figley 1983, 1988; Pilisuk and Parks, 1986) that social support networks play a vital role in the healing process of traumatised families. Women's significantly lower scores on social support indicate that they perceived that this resource was not available to them to the extent that men viewed it to be available for themselves. The reasons why men report higher levels of social support than women will be explored further elsewhere, but preliminary findings from descriptive data suggest that men typically frequent the *kafeneia,* or coffee houses, in their local communities on a daily, and sometimes nightly, basis in Cyprus, and this provides a very regular opportunity for both routine and sociopolitical conversation. Having a place to go and talk about daily and historical events may serve as a buffer to long-term maladaptation to trauma and may enhance a person's sense of well-being.

However, patriarchy privileges men's power and control but does not bestow the same prerogatives to women. Men's social support at the *kafeneia* represents access to a public space whereas there is no parallel privilege, activity, or social outlet for women in the Greek Cypriot context.

Implications for Public Policy and Intervention

In the case of Greek Cypriot refugees, families were relocated on the southern side of the UN Green Line within their own country, sometimes only minutes away from their original homes. They did not experience the culture shock that most refugees undergo in having to adjust to a new language and totally unfamiliar beliefs, customs, and traditions. Nevertheless, refugee families have experienced significant forms of disruption and discontinuity. Greek Cypriot refugees are distinguished from their non-refugee hosts, in that they "cannot repossess their original houses either as symbols or physical artefacts" (Zetter, 1999, p. 9). Zetter (1999) describes the metaphorical meanings of home and how these are integral to "the myth of return":

> The metaphor of roots permeates the construction of the myth... not just of return to their village.. .but an imperative to reclaim the very foundations of the house they were forced to leave in 1974. Continuity is expressed, preserved and reinforced by the culturally specific symbol of the house, built and inherited from preceding generations.. ..Exile from access to the ancestral graves intensifies, for the refugees, the significance of this lost rite....The acquisition, ownership and disposal of land symbolised social status and material wealth and, especially through the dowry system, the continuity of line (p. 11-12).

But public policies such as the housing programme have not taken into account these important symbolic meanings and need to re-establish continuity. Specifically, as Zetter (1999) asserts:

> ...small terraced housing for nuclear families, incapable of extension or adaptation, on large, mass-produced 'refugee' estates, contrasts in every way with the traditional housing type of the past. Paradoxically, despite the remarkable physical achievement, this has created a powerful symbol of refugeehood, reinforced their status as insiders and outsiders, and has limited transition in some cases (p. 20).

Regarding the provision of other services, the prevailing view in the Western tradition of the helping professions is that talking about traumatic experiences is the single most therapeutic behaviour in which survivors of trauma can engage (Bolton, 2001; Davis and Friedman, 1985). However, the value of a "talking cure" has not been established in many cultures, and psychotherapy has not gained universal acceptance. In some European countries (e.g., Greece), counselling and therapy

are taboo, and families do not discuss personal problems with strangers (McGoldrick, Giordano, and Pearce, 1996). In Greek Cypriot society, therapy is still not viewed as a legitimate option by many distressed families, even those who have suffered the loss of family members, their homes, and their possessions as a result of war. Therefore, the following questions remain: To whom do refugees talk, and how can helping professionals approach the provision of services to refugee families in an effective, politically aware manner?

At the level of groups and communities, public health officials and mental health professionals should not underestimate the value of group organisations and group healing for persons who have experienced displacement and/or combat. Officials, professionals, and other civil society organisations can help families connect with other families who have gone through similar difficult experiences to share their own hardships and strategies of survival. Group treatment approaches help survivors, to realise that life will go on for them and empower them to reconnect with a wider community by devising strategies that centralise them as agents and designers of their own communities and lives. Examples include veterans gathering at Vet Centres, utilisation of indigenous healing practices by Native Americans veterans and treatment of Southeast Asian refugees in socialisation group settings (Boehnlein and Kinzie, 1997). When relocated families perceive a positive and supportive community, members can be encouraged to tap into available resources of advice, favours, companionship, and a sense of belonging (i.e., being part of something bigger than themselves). In addition, women lacking formal or informal social support networks can be supported through state resources and women's organisations to meet together to discuss their experiences, the structural context within which these social relations of violence and violation emerge and the conditions under which they become possible. Moreover, the state and women's organisations need to work with women of all classes to recognise that healing requires more than just understanding one's feelings regarding sexual violence and violation and their refugee position in the society. It calls for the recognition that health requires clean water, air, food, adequate housing, safety and security healthy working conditions, and emotional and material resources. Thus seemingly unconnected issues like poverty, racism, and sexism are also healtr issues and need to be linked to the conditions that create them. However, war rips the social fabric of refugees' lives, disrupting physical, psychological, and emotiona structures that may have been in place for generations and leaving persons botr without a home and without a sense of belonging. Empowering communit cohesion in villages and towns in Cyprus enters the realm of grass roots organising, activism, and public policy, and thus working with refugee families erodes the Western dichotomy between public and private; the two are inextricably linked.

For mental health professionals working on an individual basis, a good

beginning would be to assess the severity of post-traumatic stress symptoms and the presence of those resources that predict positive adaptation in refugee families. Investigating providers' knowledge, attitudes, and service provision patterns for Bosnian refugees suffering from post-traumatic stress, Weine et al. (2001) found that "less than half of all providers systematically assess for PTSD, and standardised instruments for PTSD are rarely used" (p. 261). In addition, only half of the providers reported providing education to refugees and their families about the possible mental health consequences of trauma. Weine et al. (2001) conclude that assessment, intervention and educational activities of providers are inconsistent with literature documenting the high prevalence of PTSD in refugee populations. Such research highlights the importance of education and training in assessing and treating PTSD for those helping professionals providing services to refugee populations. Use of an instrument such as the Penn Inventory (Hammarberg, 1992) that has a proven specificity or "hit" ratio for diagnosing PTSD is highly recommended. In addition, it would be helpful to know what specific traumas were experienced in addition to displacement (e.g., combat, sexual coercion, refugee camp experience, etc.) and family members' appraisals of how distressing these events were to them. Since some traumas are too painful, terrifying, or shaming to discuss verbally, it is wise to include as part of an interview or assessment form an item asking refugees if there was an event that they cannot describe or talk about.

Severe symptoms of PTSD, or a diagnosis of complicated or "chronic" PTSD, necessitate a treatment regimen that will provide sufferers the safety, predictability, and control they need to tolerate later clinical interventions (Boudewyns et al., 1997). Persons suffering from severe PTSD are so vulnerable and fragile that questions, directives, and challenges by therapists and other authority figures are frequently construed as threats. Even impeccably timed and sound technique can be misperceived and become counterproductive:

> Therapy in which technique is good, but knowledge of the dynamics of the disorder is lacking, can be just as dangerous...The therapist must be knowledgeable about PTSD and clear about what he or she is trying to accomplish with an intervention, so that unexpected responses or deviations can be shaped to accomplish the original therapeutic goal (Boudewyns et al., 1997, p. 372).

A critical component in clients' healing is the carefully guided recollection of forgotten aspects of the traumatic events. But equally important to the healing process is the therapeutic *management* of the remembering. The rushing flood of memories can be very distressing and precipitates a dissociative reaction in many clients (American Association for Marriage and Family Therapy, 2000). Thus, it is important for helping professionals to assess clients' ability to self-sooth and

effectively cope with their memories of traumatic events and to refrain from treatment if such skills have yet to be developed. To minimise the risk of retraumatisation, decompensation, or even suicide in traumatised clients, helping professionals can evaluate their resilience and stability by finding answers to the following two questions: (a) Have the clients experienced a single traumatic event (b) if they have been repeatedly traumatised, do the clients possess stable backgrounds and the resources and resilience to sort out and distinguish the personal traumatic events? An affirmative answer to either question means that the client can talk about a personal trauma, and address personal traumas, one at a time (Rothschild, 2000). Usually these clients have the resources necessary to begin to work directly on the traumatic incidents that precipitated their need for services. In contrast, a negative answer to the second question points to the need for resource rebuilding through the therapeutic relationship before the traumas can be addressed.

As this study demonstrated that social support is crucial in recovery from war trauma, this resource should also be assessed in families that have relocated. In addition to perceiving the presence of a supportive family and community, another factor associated with higher levels of well-being was the coping strategy of actively seeking support from friends, relatives, and neighbours. Professionals should also evaluate family members' levels of education as part of their assessment protocol, since education was shown to be another major predictor of family adaptation. Because a positive family environment is a resource for families who have a member suffering from PTSD, assessment of members' perceptions of their own emotional, social, and physical well-being would also be useful, including a measure of depression to screen for the risk of suicide (e.g., Scale for Suicide Ideation (SSI), Beck, Steer, and Ranieri, 1988). Therapists also should assess family members' adaptability, problem-solving communication, and indications of substance abuse or family violence.

Once clients feel a sense of familiarity and safety with the therapist, promising avenues of intervention include trauma therapy, psycho-education, relationship enhancement, and community activism. When clients are in touch with their resources and can cope with traumatic memories, family sessions can become an important part of therapy. Professionals can assess the degree to which family members are supportive to one another, coach them when interpersonal and communication skills are lacking, and encourage them to utilise social supportiveness from their own members and communities. Educating families about normative emotional and psychological acute and long-term reactions to extreme stressors may provide the basic knowledge survivors need to develop alternative understandings of what has happened and how they can choose to respond to the trauma and its sequelae in the future. Eschewing clinical terminology

and pathologising concepts, therapists can describe PTSD symptoms in terms of relational dynamics frequently observed in PTSD sufferers such as social withdrawal. Over time, these strategies for avoiding painful intrusive thoughts and feelings connected with traumas dramatically diminish intimacy, self-disclosure, and skills for conflict resolution in couples and families. Thus, systems in crisis can benefit from learning and implementing a variety of interpersonal skills. Therapists can coach families to engage in behaviours that lead to effective information exchange, problem solving, and resolving conflicts (Guerney, 1977).

Figley (1995) discussed how families who are still in crisis years after the original traumas can be assisted in learning and using helpful, therapeutic skills. Healthy families help each other by encouraging recapitulation of the trauma and facilitating resolution of their memories and conflicts. Supporters can facilitate a review of the circumstances of traumatic events and the meanings associated with them. Important questions include "what happened and why," "why did I react the way I did," and "if something like this occurs again, will I be able to cope more effectively?" (Figley, 1995). By listening to the recounting of traumatic events in a non-judgmental and caring manner, and offering constructive interpretations of the meaning of such events, families help reframe traumas and facilitate a movement towards a *healing theory* (Figley, 1979) in which survivors can finally answer the preceding questions to their satisfaction. Nearly always, families possess the capacity for coping with nearly all of their traumatic stressors (Figley and McCubbin, 1983; Figley, 1989). By talking about their experiences, they may feel more confident and competent about future challenges.

Future Directions for Research

Future studies could focus on comparative studies of refugee families that have relocated to different contexts, such as Greece, the US, or Great Britain. While this study did account for a majority of the variance in the adaptation variable of PTSD symptoms, the inclusion of additional variables might increase the proportion of variance accounted for in this variable and that of FMWB. Possibilities include subjects' level of self-disclosure following traumatic events (Bolton, 2001) and the degree to which they experience supportive or unsupportive social interactions from others and the larger society in the wake of trauma. Such variables may prove important because the period immediately after a trauma significantly shapes clients' overall experience of how severe and enduring the effects of that particular trauma will be in their lives. In addition, since current knowledge about adaptation and resilience in a family context is limited, more qualitative studies are needed to complement quantitative studies (McCubbin, Thompson, and McCubbin, 1996). The meanings that subjects make of their traumas and what would constitute help in their aftermath are of vital importance to health and family researchers and

therapists. Additional investigations are needed regarding the ethnic, class, and gender factors that account for women's higher rates and severity of post-traumatic stress. Finally the political economy of choosing to provide particular health care strategies should be further examined.

Conclusion

This study found that particular family resources-social support, education income, and adaptability – are crucial to families' long-term adaptation to war trauma. Living in a community that is safe and secure increases the likelihood that family members will feel supported. Education permits family members new paradigms for understanding symptoms and behaviours in themselves and others. Income allows access to material resources such as quality health care and safe housing, thereby permitting a greater sense of agency and a more internal locus of control following trauma. Family adaptability translates into the ability to collectively reframe painful events and demonstrate resilience in the face of the hardships of losing one's home, all one's possessions, and even family members.

As the incidence of armed conflicts and natural disasters persists at high levels, and as European Union member states continue to absorb high numbers of refugees and asylum seekers, it is crucial that public health officials and mental health professionals become aware of the unique experiences of refugee families and learn effective assessment and delivery of resources to these families so that they can be assisted in (re) integrating to their new environments. Since most family systems do not self-destruct or deteriorate to the point of requiring therapy, but recover from adversity, larger system interventions intended to augment family well-being should ideally work in tandem with families' own resources and resiliencies (McCubbin and Mccubbin, 1996; Walsh, 1998). For this reason, public policies should be guided by research and theory that acknowledge and build upon families' own material resources, ways of understanding and making meaning, and strategies of survival. Refugee family crises also must be assessed and understood within the context of larger social systems and structures which may not be conducive to healing (e.g., a host context in which Greek Cypriot refugees are both insiders and outsiders). Mental health "is not a neutral set of institutions, knowledge and practice. In conjunction with other sectors and relationships, it reproduces power." (Navarro, 1989). Movement from the status quo in mental health requires "new mechanisms of accountability" among social institutions: the state, the social networks, communities, helping professionals, and the citizens themselves (Navarro, 1989). Transforming trauma at the levels of citizens, families, and nation will require material and social resources to create new mental health services and enhance their accessibility. Equally crucial is the need for consciousness raising about mental health, as a transformation in popular understandings of mental health can open space for the development of new narratives of what is a healthy society.

* The authors are listed in alphabetical order and were equal participants in this research study. We wish to thank all the research participants who generously shared their stories and struggles over the course of this project. We also acknowledge the helpful comments of the two anonymous reviewers.

Note

1. For example, the primacy of the discourse surrounding the national political contradiction pushes new strategies for mental health to the margins of the political agenda, even for feminists and members of the political left.

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