



Review of Child and Adolescent Refugee Mental Health

**White Paper from the
National Child Traumatic Stress Network
Refugee Trauma Task Force**

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White Paper Committee

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Introduction

According to the United Nations High Commissioner for Refugees (UNHCR), there are almost 22 million refugees located throughout the world (UNHCR, 2002a).

Article 1 of the 1951 U.N. Refugee Convention defines a refugee as "a person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution" (UNHCR, 2002b). While the Convention is limited in its capacity to provide legal definitions, it helps to distinguish refugees from other migrant groups who leave their homes voluntarily, e.g., economic migrants seeking financial opportunities in a different country. Refugees, on the other hand, leave their countries of origin involuntarily, in fear of persecution, while persistent dangers at home prevent their return. Legally, they are distinguished from asylum seekers by acquiring the appellation of "refugee" before arriving in the host country; asylum seekers, by contrast, must declare themselves as such after arrival (Doyle, 2002). Colloquially, however, those who flee from civil war or other armed conflict in their countries are often considered refugees (Howard and Hodes, 2000).

Approximately half of the world's 20 million refugees are

children (UNHCR, 2002a; Westermeyer, 1991). The ratio of child to adult refugees varies depending on region: for example, the majority of refugees in Central Africa are children (57%), while only one-fifth of Central and Eastern European refugees are under 18 (UNHCR, 2002a). The UNHCR provides services for an estimated 7.7 million refugee youth under the age of 18.

Between 1988 and 2001, over 1.3 million refugees were admitted to the United States of America (U.S. Committee for Refugees, 2001). U.S. healthcare providers are increasingly called upon to provide treatment and support to refugees at high risk for mental health problems. This paper reviews information that can inform the provision of culturally competent care and research relevant to improving welfare of refugees who come to the United States.

Previous reviews of child refugee mental health include those by Keyes (2000), Rousseau (1995), Jensen and Shaw (1993), and Hunt et al (2001). This white paper extends the work done in previous reviews by discussing the most recent empirical studies of pathology and services among refugees and by describing unique populations of child and adolescent refugees. These data, as well as treatments, are organized by phase of the refugee experience and contextualized in cultural and developmental frameworks. Adaptation and adjustment of refugees, with particular emphasis on coping and use of available resources, are also reviewed.



Development, Culture, and Theory

Since the U.S. refugee program began in 1975 with the fall of Saigon (Holtzman and Bornemann, 1990), mental health professionals have been calling attention to the needs of refugees who have been exposed to trauma (Marsella et al., 1994), particularly refugee children (Westermeyer and Wahmanholm, 1996). A large body of research has documented that refugee children exhibit symptoms of Post-Traumatic Stress Disorder (PTSD) at alarmingly high rates, as high as 75% in a community sample (Allwood et al., 2002). In addition to traumatic stress, refugee children experience acculturative stress (Berry, 1994; Birman et al., 2002) as well as stresses associated with migration and displacement. However, few of these children receive services for a number of reasons such as stigma associated with seeking mental health care and lack of understanding of the U.S. mental health system. Further, because of complexities involved in addressing issues of trauma, culture, and ongoing stress within a developmental context, existing models of the etiology and treatment of PTSD are often insufficient to meet the needs of these children.

A culturally relevant, developmental, theoretical foundation is essential to understanding the experience of refugee youth in the context of flight and resettlement. With respect to cultural issues, a large body of literature has emerged on culturally and linguistically appropriate services for ethnically

diverse clientele. In fact, in the U.S. context many of the earlier efforts to address mental health needs of refugees generated a number of innovative approaches, many of which focused on the needs of specific ethnic groups. For example, Kinzie and colleagues (1980), and Mollica (1988) have described service models for Southeast Asian refugees in the 1970's and 1980's. These ethnically based clinics have proven successful with relatively large, homogeneous refugee groups. However, today's migration patterns have shifted in ways that bring new challenges to the field of refugee mental health. New refugee arrivals are extremely diverse, with the largest place of origin today being Africa, a continent with overlapping national and tribal boundaries. As a result, multiple treatment approaches must be developed, building on prior work addressing the needs of diverse multicultural and multi-lingual populations.

A variety of theoretical frameworks on refugee children's mental health have been developed (Fox et al., 1994). However, it is not uncommon to identify the chronological stages of a refugees' experiences to organize research and clinical work (Berman, 2001; Papadopoulos, 2001). As a result, the phases of refugee experiences—namely, preflight, flight, and resettlement—will structure this review.

Erikson's developmental theory has been applied to understanding vulnerability among refugee children (Eisenbruch, 1988), whose war-time experiences of mistrust, self-doubt,



and inferiority exacerbate the psychosocial crises that occur during normal development. Psychological development mediates the impact of war and persecution, flight, and resettlement among both immigrant and refugee youth, who are dependent on adults' decisions (Coll and Magnuson, 1997). Because refugee parents have fewer choices than immigrants, they often have less ability to protect their children, potentially compromising children's basic trust in them.

However, assumptions about development, normality and psychopathology are culturally embedded (DiNicola, 1998; Kinzie, 2001). A critique of developmental theories is their cultural relativism and reliance upon western, middle class constructions of childhood and propriety, with questionable cross-cultural generalizability. Thus, assessments of war-affected youth typically measure loss and adversity (Summerfield, 1999). This pathologizing perspective (Summerfield, 1999; Summerfield, 2000; Watters, 2001), may increase access to needed services or benefits by bringing attention to the plight of refugees, but can detrimentally downplay child refugees' resilience and innate strengths (Papadopoulos, 2001; Rousseau, 1993-4; Watters, 2001). Assessment must avoid the narrow view of refugees as traumatized victims.

Several mental health models of trauma integrate culture and psychological development (Cooper and Denner, 1998; Elbedour et al., 1993; Garbarino, 1993). In particular, Ecological Systems Theories (Belsky,

1980; Bronfenbrenner, 1979), posits development occurring within the interactions between individuals and their environment. Four nested levels or systems affect individual functioning and interact with one another: the macrosystem (societal and cultural belief systems), exosystem (community and neighborhood factors), microsystem (family factors), and the ontogenic level (individual factors). Cicchetti and Lynch (1993) applied this Ecological/Trans-actional model to childhood and traumatic stress, considering the broader context of risk and protective factors operating across these social ecological systems.

Child refugees' native cultures also influences multiple aspects of their psychiatric treatment, (DiNicola, 1998; Kang et al., 1998; Kinzie, 2001; Kinzie and Leung, 1993; Morris and Silove, 1992), discussed further below. In addition, refugees' expectations of treatment may contrast with those of their providers. Cultural explanations for symptoms and etiology of illness may be very disparate from Western views. Finally, the use of different therapeutic techniques may be successful with one cultural group, but ineffective with another. Psychotherapy itself may be entirely unfamiliar to a refugee culture, and may be viewed unfavorably. Clinicians should be familiar with their patients' cultures, and an acquaintance with the meanings those cultures associate with stressful events relevant to the refugees' experiences (Morris and Silove, 1992). This knowledge base extrapolates to work with families,



whereby clinicians need to begin with cultural understandings, meanings, and symbols associated with the life cycle, development, the importance of the family, family systems and roles within the family (Tseng, 2001).

Phases of Refugee Experience

Four broad reactions have been described with reference to refugees' responses to the stressful experiences surrounding their flight: anticipation, devastating events, survival, and adjustment (Papadopoulos, 2001). These reactions fit within the three phases of the refugee experience, as described below. The three phases—preflight, flight, and resettlement—organize the findings in the literature in most sections of this paper.

Preflight

The preflight phase refers to the time prior to a refugee's escape from their country of origin, occurring at the onset of political violence and/or war. During the preflight phase, refugees are faced, at the societal and community levels, with social upheaval and increasing chaos in their region (Rumbaut, 1991). Limited access to schools disrupts education and social development. At the family and individual levels, refugees often face threats to their safety and that of family members. Prior to flight, refugees anticipate and then cope with devastating events (Gonsalves, 1992; Papadopoulos, 2001). Refugee youth may witness violence, or even engage in it.

Flight

During flight, a phase marked by great uncertainty about the future, refugees must survive displacement from their homes and transit or transitional placement (e.g., a refugee camp) (Papadopoulos, 2001). They are often at the mercy of external sources to meet their basic needs determine their options for asylum. At times, children are born into this phase, and endure psychological development during this transition period. Separation from parents and caregivers is common.

Resettlement

Once refugees resettle in a host country, new belief systems, values, and mores challenge their adjustment (Papadopoulos, 2001). Families may be disrupted once again by new family roles and patterns (Foner, 1997). Refugee children often straddle old and new cultures. Because of their educational experiences and more rapid attainment language acquisition than parents, they may act as cultural liaisons for other generations (Birman, 1998; Coll and Magnuson, 1997). During acculturation four broad phases may take place: contact, conflict, crisis, and eventually, adaptation (Williams and Berry, 1991).



Stressors Affecting Refugee Youth

Preflight Stress

The impact of war on children has concerned psychiatric researchers for decades. Pioneers in the field noted comparatively greater impact of war-related separations between children and parents, than of exposure to war-time atrocities (Freud and Burlingham, 1943).

More recently, researchers have focused on the number and types of atrocities. In Mozambique, one study found that 77% of over 500 children surveyed had witnessed murders or mass killings (Boothby, 1994; Boothby et al., 1991). Elsewhere, among a sample of 40 adolescent Cambodian refugees who had survived four years in a Pol Pot “work camp,” 98% endured forced labor, 90% lived in age-segregated camps, and 83% went without enough food for long periods of time (Kinzie et al., 1986), common experience for refugee children either prior to or during flight is combat.

Combat Experience

An estimated 300,000 children under 18 years of age have fought in armed conflicts around the world, and many more are enrolled in armed forces in countries not currently involved in conflict (Child Soldiers, 2001). Child soldiers represent a special category of refugees because they both witness and participate in war violence. By their own accounts, front line combat puts child soldiers at risk for rape, torture, war injuries, substance abuse, depression, anxiety, and suicidal

ideation (de Silva et al., 2001; Peters and Richards, 1998; UNICEF, 2002). In addition to tangible losses such as home, possessions, friends, and family members, child soldiers may lose trust in authority figures who are unable to provide for their basic needs, or who themselves are perpetrating atrocities. Child soldiers can lose their moral perspective, as they come to believe that looting is not the same as stealing, or that killing for political reasons may, in fact, be justified (de Silva et al., 2001; Macksoud et al., 1993). Among child soldiers forced to participate in Mozambique’s rebel military organization, length of time in the organization was associated with difficulty refraining from learned, morally wrong behaviors (Boothby, 1994; Boothby et al., 1991).

Unanswered questions about child soldiers include long-term outcomes, demobilization efforts, reintegration, and appropriate psychosocial care (UNICEF, 2002). Some have cautioned that interventions focused solely on trauma and victimization overlook the complexities of child soldiers’ experiences (Peters and Richards, 1998; Summerfield, 2000). For example, some youth combatants described a sense of belonging and a support system within armed groups that served as surrogate family, particularly for children separated from biological families due to war conditions (UNICEF, 2002). Challenges to reintegration include histories of violence and perpetration, community ambivalence and issues around acceptance, disrupted education, and psychiatric symptoms such as



nightmares, persistent fears of death, and violent memories (UNICEF, 2002).

Flight Stress

The flight phase is particularly stressful because of its instability and unpredictability. Experiences which can be distressing and taxing on young refugees during this time include separation from caregivers, refugee camps, and detention centers.

Separation from Caregivers

Many of the world's young refugees do not have identified guardians, and may have traveled for quite some time with little or no adult supervision. An unaccompanied minor (UAM) is defined by the United Nations High Commissioner for Refugees (UNHCR) as someone "under 18 years who is separated from both parents and is not being cared for by an adult who, by law or by custom, is responsible for doing so" (1997). If both parents have died, children are also classified as orphans. Children identified as refugees may become separated from caregivers by accident or by the necessity of unsafe circumstances at home. Political violence or natural disasters can render entire villages suddenly devoid of adults.

Children's ability to self-regulate depends in large part upon the emotional state of their caretakers; those refugee youth without caretakers may be at even greater risk for psychiatric symptoms following traumatic stress. A study of 455 Vietnamese children compared unaccompanied refugees in camps

without their parents in Hong Kong and South East Asia (N=238) to a matched sample of children who had never left Vietnam (local children) on internalizing and externalizing behaviors and perceived self-efficacy (Loughry and Flouri, 2001). Compared to local children, unaccompanied minors had lower externalizing scores. In the same study, household wealth and perceived self-efficacy were negatively correlated with problem behaviors, and predicted positive functioning among unaccompanied minors. In a separate study of unaccompanied minors, younger children displayed more behavior problems and emotional distress than adolescents (Sourander, 1998).

Refugee Camps

While many new arrivals to the United States come as undocumented immigrants who may later seek asylum, others come through refugee camps where they may be accorded refugee status. Refugee camps have been described as "total institutions", places where, as in prisons or mental hospitals, everything is highly organized, where the inhabitants are depersonalized and where people become numbers without names" (Harrell-Bond, 2000). Interviews with young Sudanese in a Kenyan refugee camp revealed that severe deprivation, i.e. lack of adequate water, food and medical care, was common, while acute malnutrition among toddlers in nine Sudanese camps ranged from 20-70% (Harrell-Bond, 2000; Sommers, 2002). However, another researcher found the same camp's superior educational



programs attracted young people (Sommers, 2002). Traumatic events are common. Among Cuban refugees detained in a refugee camp prior to arrival in the U.S., during camp confinement, 80% witnessed acts of violence, 37% saw someone attempt or commit suicide, and 19% were separated from family members (19%) (Rothe et al., 2002).

Detention Centers

Children who come to the United States without a guardian face particularly stressful experiences; they must negotiate the legal system without an adult to advocate for their rights. Arrivals entering a country without proper documentation endure a lengthy asylum process. In 1990, the Immigration and Naturalization Service (INS) detained approximately 8,500 undocumented children, approximately 70% of whom were unaccompanied (Human Rights Watch Children's Rights Project, 1997). Currently, approximately 5,000 unaccompanied minors are detained by the INS in the U.S. each year (Women's Commission for Refugee Women and Children, 2002).

Children in detention in the U.S. provide one example of continued stress even after they reach a more stable country. While awaiting asylum hearings in the U.S., children are held for up to two years in either INS detention facilities, or even in juvenile jails in approximately one third of the cases, due to a purported lack of alternative space in INS facilities (Women's Commission for Refugee Women and Children, 2002). Juvenile jails continue to be used despite a

class action law suit (*Flores v. Reno*, 1985) settlement declaring that children in INS detention must be held in the least restrictive setting possible (Women's Commission for Refugee Women and Children, 2002).

Child refugees seeking asylum have few resources. Fewer than half have legal representation (Women's Commission for Refugee Women and Children, 2002), and some children who may have legitimate asylum claims never seek a hearing, because they are unaware of their legal rights (Women's Commission for Refugee Women and Children, 1998). Most detained refugee children do not receive adequate medical or psychological care (Nezer, 2000). Having neither legal representation nor guardians, few translation services, and facing a harsh and punitive environment, detained refugee children continue to endure psychosocial challenges to their development and health.

Resettlement Stress

During the resettlement phase many refugee children and families re-establish their lives and encounter Western mental health services for the first time (Rousseau, 1995).

Refugees escaping war and political persecution are at particularly high risk for mental health problems (Ahearn and Athey, 1991; Marsella et al., 1994; Williams and Berry, 1991). For them, a legacy of exposure to trauma is superimposed on already complex acculturation and adjustment processes, often resulting in a range of symptoms and difficulties. As Rousseau (1995)



notes, symptoms reported by refugee children in resettlement include anxiety, recurring nightmares, insomnia, secondary enuresis, introversion, anxiety and depressive symptoms, relationship problems, behavioral problems, academic difficulties, anorexia, and somatic problems (Allodi, 1980; Arroyo and Eth, 1985; Cohn et al., 1980; Gibson, 1989; Hjern et al., 1991a; Kinzie et al., 1986; Krener and Sabin, 1985; Williams and Westermeyer, 1983). Numerous studies have also documented a high prevalence of symptoms of PTSD and other mental disorders among refugee children and have linked these symptoms to exposure to trauma prior to migration (Almqvist and Brandell-Forsberg, 1997; Angel et al., 2001; Boothby, 1994; Felsman et al., 1990; Goldstein et al., 1997; Hjern et al., 1991b; Howard and Hodes, 2000; Kinzie et al., 1986; Macksoud and Aber, 1996; Masser, 1992; McCloskey and Southwick, 1996; McCloskey et al., 1995; Mollica et al., 1997; Muecke and Sassi, 1992; Paardekooper et al., 1999; Papageorgiou et al., 2000; Weine et al., 1997). Taken together, the literature suggests that immigrant refugee children in resettlement are impacted by stressors of varied severity due to (a) migration and loss of the familiar; (b) acculturation and the ensuing difficulties between generations, and (c) trauma.

Migration and Loss

Resettlement means loss of homeland, family, friends, and

material possessions, and the challenges of a new language and culture upon arrival. Refugees often have conflicting loyalties to new versus old worlds. Loss of friends and family, including parents and other caregivers, may initially be offset by hopes for a safer and perhaps more prosperous life in the destination country. However, the challenge of helping the child cope with loss is particularly difficult for refugee families in resettlement because of the extreme nature of the move from one culture to another, often in the context of war and other political conflict. For refugee families it is much harder to comfort the child with familiar objects and reassurances from loved ones left behind. Loss of family members and neighbors is accompanied by few opportunities to stay in touch with them across geographic and political boundaries. It is also difficult for a family to reestablish routines and a sense of “normalcy” in a new community that may also be comforting to a child. Further, refugee parents have little time to devote to such tasks in resettlement as they struggle to survive economically. Thus, if and when children begin to show signs of distress they may be misunderstood or overlooked.

From a mental health perspective, “cultural bereavement” connotes refugees’ responses to losing touch with attributes of their homelands (Eisenbruch, 1991b). Elements of cultural bereavement include survivor guilt, anger, and ambivalence.



Acculturation and Acculturative Stress

The current influx of immigrants and refugees into the United States has resulted in an increasingly sophisticated literature on the adaptation process that accompanies such grand transitions (Vinokurov et al., 2002). The transition from one country to another often encompasses changes in almost every aspect of daily life, from the language one speaks to the ways in which individuals and groups interact. It includes major life events, such as the loss of social networks and changes in work status, as well as ongoing daily hassles, for instance communicating in a new language, and encountering discrimination. This process of cultural transition has been defined as acculturation and the stresses associated with it acculturative stress (Berry et al., 1987; Mena et al., 1987; Williams and Berry, 1991). Specifically, acculturative stress refers to stressors experienced by individuals undergoing cultural transition that are caused by contact with the new culture (Berry and Annis, 1974). The transition poses the challenge of new cultural systems, including food, mores, religious traditions, and language, leading to their subsequent rejection or integration into refugees' own value systems (Berry, 1991). Refugee children are often torn between the culture of their homeland in their (or their parents') memories, the culture of the new country, as well as the culture of refugee resettlement in general (Tobin and Friedman, 1984).

Research on acculturation and adjustment has long sought to

understand the relationship between styles of acculturation adopted by immigrants and refugees and their adjustment psychologically, socially, and economically. While early models proposed that acculturation to the U.S. American culture was the most important dimension, later models have suggested that it is also important to examine the extent to which refugees retain their own culture. In fact, some have posited that as acculturation to the host and original culture may involve two independent processes, the combination of these cultural affiliations may result in assimilation, traditionalism, marginalization, or bicultural adaptations (Berry, 1991). Research has also examined issues such as the extent to which community of resettlement (dispersed or ethnic density), level of discrimination and racism, age of arrival, gender, and many other factors impact acculturation and adjustment.

These factors can be even more intensified for unaccompanied minors. For example, some research has investigated the impact of placing refugee children with foster families of the same or different ethnicities. In one study, Cambodian refugees fostered in Cambodian group care in Australia was compared to a similar group placed with non-Cambodian foster families in the United States, and cultural bereavement was greater among the latter group (Eisenbruch, 1991a). Contributing factors may have included greater isolation from other Cambodians in the US group, and more tolerance and encouragement of indigenous



practices in Australia, as well as access to familiar religious figures and traditional healers. Similarly, unaccompanied Indochinese refugee adolescents resettled in the U.S. with ethnic foster families were significantly less depressed and had higher grade point averages than those in foster care with Caucasian families or in group homes (Porte and Torney-Purta, 1987).

For families that remain intact, perhaps the most important aspect of acculturative stress that affects children involves potential problems created by differential rates of acculturation between parents and children, difficulties negotiating dual cultural identities, and lack of guidance and supervision from parents who themselves are struggling to adapt to life in a new culture (Aronowitz, 1984; Gonzales et al., in press; Szapocznik et al., 1980). Without such supervision, and because immigrant parents do not fully understand the context of their children's lives, adolescents in particular become overly susceptible to negative peer influences and may engage in substance abuse and gang violence (Szapocznik et al., 1990). Children and adolescents struggling with identity formation may experience psychological difficulties in the context of dual cultural membership (Phinney, 1990), particularly if they are discriminated against and receive negative messages from the larger society about their race and culture (Portes and Zhou, 1993). In addition, immigrants and refugees confront many challenges associated with migration, such as establishing new

social relationships, locating services, and learning about new norms and customs, all in a foreign language. Because children tend to acquire the new language at a faster rate than their parents (Birman and Trickett, 2001), older children often serve in the role of "culture broker" (Buriel et al., 1998; Fulingi et al., 2002; McQuillan and Tse, 1995; Tse, 1995; Weisskirch and Alva, 2002) for their parents, translating the language and the culture in situations such as parent-teacher conferences, appointments with physicians and social service providers, or when filling out employment, medical, or tax forms. While no empirical studies appear in the literature to document the psychological effects of such "role reversal," some anecdotal evidence suggests that children are harmed by being placed in this position, as they both acquire more power, yet lose more parental guidance, than their native-born peers.

A particularly important setting for refugee children and adolescents where many of these acculturative struggles unfold are the schools. For example, a recent study not only documented the presence of high rates of PTSD, anxiety, and depression symptoms in school children who had experienced war, but also described specific behaviors reported by teachers that were linked to prior traumatic events (Allwood et al., 2002). Teachers have also described other in-school behaviors indicative of adjustment issues, such as delinquent behaviors, attention problems, aggressive behavior, and withdrawal. Thus refugee students may bring into the school setting experiences that



hinder their adaptation. Moreover, the school itself can create stress for refugee and immigrant students through its cultural misunderstanding of refugee or immigrant student behavior.

Stigma

Refugee adolescents are at risk for stigmatization as a result of their race and ethnicity, religion, and/or symptoms associated with mental illness. Link and Phelan (1995; 2000; 2001; 2002) propose a model “stigma as a fundamental cause of disease” that, when applied to refugee adolescents suggests two mechanisms by which stigma could powerfully influence mental health outcomes: (1) increased exposure to environmental stressors, and (2) decreased access to protective factors. Further exploration of these variables could illuminate key contributing factors to PTSD and other mental health problems in refugee youth, thus laying the foundation for effective intervention development.

Mghir and Raskin compared two different ethnic groups of adolescent refugees from Afghanistan who were resettled in the U.S. and found significantly different levels of PTSD (Mghir and Raskin, 1999). The Tajik refugees showed lower levels of PTSD than the Pashtun. Tajiks were also less likely to participate in Muslim activities, suggesting that this group may have experienced less stigma related to religious beliefs. In addition, Tajiks reported less direct exposure to traumatic events and were of higher SES (both in Afghanistan and the U.S.) compared

to the Pashtuns. The study raises the question as to whether the lower rate of PTSD in the Tajik adolescents is related to that group being both less stigmatized, and having more resources to protect them from exposure to trauma and stressors (possibly as a result of being less stigmatized).

Coping and Protection from Stress

Despite enduring horrific atrocities, some refugee children experience minimal symptoms. Compared to studies of psychopathology, investigations of coping and resilience among refugee youth have been relatively neglected (Athey and Ahearn, 1991). Further empirical work needs to identify and confirm factors that minimize psychological distress among refugee children. Certain strategies may be effective during flight but not in camp settings nor after resettlement (Farwell, 2001).

Preflight: Coping with War and Political Violence

Although much more research needs to be done, coping strategies employed by children exposed to war, political violence, and armed conflicts have been preliminarily investigated by a number of researchers. For example, Berk (1998) observed the following features among Bosnian war-exposed children: esprit de corps, ability to appeal to adults for caretaking, ability to discern danger and avoid precarious situations, ability to manage anxiety and calm oneself, devotion to a cause (e.g., caring for wounded victims of war), family



stability, sense of humor, and making meaning of their turbulent situation.

Among children in Lebanon exposed to war violence, prosocial behavior increased in relation to separations from parents, and/or the witnessing of violent acts, such as seeing people killed or intimidated by militia (Macksoud and Aber, 1996). Displacement from one's home or community was negatively correlated with planful behavior; thus, children whose living situation offered more stability were more deliberate in conduct. In addition, planful behavior was higher among children who had lost someone close to them during the war, attributed to a desire to gain control over the helplessness and pain associated with trauma.

A study examining intentional, cognitive, and emotional coping modes among Palestinian children found that the participants were more likely to endorse more active-intentional and courageous-emotional coping methods as their exposure to political hardship increased and their mothers experienced higher levels of psychological symptoms (Punamaki and Suleiman, 1990). Additionally, children with refugee status used more active and courageous coping modes than nonrefugee children. However, high exposure to political hardship was also related to increased psychological symptoms. Although the children expressed courage and active attempts to cope with adversity, the coping methods did not protect them from experiencing mental health symptoms. Thus, the effectiveness of coping strategies may depend on context; war violence and the specific social, cultural, and political setting

may influence risk of, and protection from, traumatic stress and the emergence of psychological symptoms.

A protective factor in the context of war with preliminary empirical support is ideological commitment. A study of Israeli Jewish young adolescents exposed to political violence investigated ideological commitment as operationalized by attitudes towards war, peace, patriotism, and the political enemy (Punamaki, 1996). Stronger ideological commitment was associated with less anxiety, insecurity, depression and failure among children faced with low levels of war exposure. At higher levels of war exposure, the protective function of ideological commitment diminished. The relationship between ideological commitment and mental health merits further investigation, particularly in diverse cultural and political contexts.

Flight: Coping in the Context of Refugee Camps

Studies of coping and protection in refugee camps are limited, due in part to the obvious difficulties of research at a time of transition and adversity for youth and their families. However, several studies have examined coping strategies and factors related to positive well-being among youth in camps.

When compared to a Ugandan comparison group (nonrefugees with similar cultural background), Sudanese refugee children living in camps used a greater number of coping strategies. The refugee



children were more likely to endorse using emotion-inhibiting strategies (e.g., “keeping quiet”), emotion-focused strategies (e.g., spending time with others), wishful thinking strategies (e.g., “wishing things never happened”), and prayer (Paardekooper et al., 1999). The authors attribute the reliance on these particular strategies to the context of the refugee camps where there are a number of constraints, and few opportunities to implement problem-focused strategies. The authors also point out that refugee children were most likely to rely on coping mechanisms, such as wishing things were different, that served as a distraction from their present difficulties. It is important for future research to investigate coping strategies among this population further, and elucidate which strategies are most adaptive under which conditions.

Social support and parental well-being have been identified as important protective factors. In one study, Mayan refugee children living in camps or poor neighborhoods in Mexico identified parents and relatives as their primary supports during difficult times, followed by friends or caregivers (Melville and Lykes, 1992). Parents’ physical and/or psychological distress can also have a strong affect on children’s well-being. Mayan girls living in Mexican refugee camps demonstrated higher depressive symptoms in relation to their mothers’ reports of somatic and psychological distress (Miller, 1996).

Coping and Protection from Stress in Resettlement

Acculturation as a Protective Factor

Acculturation can facilitate young refugees’ transition in a new country, and acculturation to the new and old culture have been shown to enhance refugee youths’ adaptation, depending on the specific context of their lives. Among Soviet Jewish refugee adolescents resettled in the U.S., both American identity and Russian language acculturation were predictive of high grade point average in high school (Birman et al., 2002). With respect to social support, Russian behavioral acculturation was associated with greater support from Russian peers, and American behavioral acculturation with support from American peers. Further, Russian and American behavioral acculturation were both associated with reduced loneliness, presumably because this combination of cultural styles allowed the adolescents access to both Russian and English-speaking social networks.

Connections to one’s culture of origin and ideological commitment have been found to act protectively in resettlement for other refugee groups. Tibetan refugee children resettled in India indicated that religious beliefs, active community involvement, and a sense of solidarity in Tibet’s struggle against oppression had helped them cope with stress-related symptoms (Servan-Schreiber et al., 1998).



Parental Well-Being as a Protective Factor

Parental well-being plays an important role among resettled refugees. One study found that displaced Croatian children's stress levels were inversely related to their mothers' abilities to cope with displacement (Ajdukovic and Ajdukovic, 1993).

Among Central American refugee children resettled in the U.S., mothers' reports of PTSD symptoms were correlated with children's internalizing and PTSD symptoms (Locke et al., 1996). On the other hand, among Iranian refugees resettled in Sweden, mothers' emotional well-being predicted their children's long-term emotional well-being (as assessed by interview and standardized measures of adaptation, self-worth, and social adjustment) (Almqvist and Broberg, 1999). In this sample, positive peer relationships also helped to support children's self-worth and social adjustment. Bullying and negative peer relationships, on the other hand, were related to low levels of self-worth and adjustment (Almqvist and Broberg, 1999). Importantly, the longer the Iranian refugees had been in Sweden, the better their social adjustment. Thus, increased time to adjust can improve function. Time in the U.S. was positively related to grade point average and the expression of positive goals among Southeast Asian refugee adolescents, whereas acculturation was not (Lese and Robbins, 1994).

Although risk factors among boys include parental separation and number of changes in family structure and place of residence (Tousignant et al., 1999), and among girls, community context (Garbarino and Kostelny, 1996) and maternal poor health (Miller, 1996), sex does not consistently emerge as either a risk or protective factor (Ajdukovic, 1998; Hjern et al., 1998; Muecke and Sassi, 1992). It is unlikely that such generalized patterns would emerge because the impact of gender varies greatly among diverse refugee cultures. For example, post-traumatic responses were more likely among female than male displaced Bosnian adolescents (Ajdukovic, 1998), but there was no gender difference in anxiety symptoms among Cambodian teens in a Thai Refugee Processing Center (Muecke and Sassi, 1992). Psycho-pathology among female Chilean and Middle Eastern refugee children was more common than among males, in the early stages of resettlement in Sweden; however, this finding did not hold up over time (Hjern et al., 1991b).

The impact of age is similarly complex. Age when traumatized is not a consistent predictor of subsequent stress (Berman, 2001; Elbedour et al., 1993), although two studies found younger children to be more symptomatic than older ones (Sourander, 1998). Age likely affects cognitive processing, with uncertain impact on functioning. In addition, the process of acculturation and the ways it interacts with traumatic stress may vary by age group.



Stress Reactions and Psychopathological Outcomes

This section addresses traumatic stress from a medical standpoint, focusing on psychiatric symptoms in particular. Medical literature frequently relies on a psychopathology perspective in identifying effects of trauma, and subsequent interventions. This lens provides a context for comparison to children who have experienced other types of trauma or stress, and draws on an established infrastructure for conducting research with traumatized individuals. However, conceptualizing refugee children's stress responses from a psychopathological perspective pathologizes the individual, potentially ignoring coping and resilience, in a culturally biased manner.

By definition, trauma experienced as a refugee is interrelated with contextual political and social factors. Individual symptoms as a result of wartime trauma indicate a disturbed society, but diagnosis locates the problem within the individual. The medical model describes stress responses, shifting attention away from problems in other socioecological spheres. Racism, poverty, and wartime violence are all contextual factors that affect the mental health of refugee children.

In addition, focusing on symptoms fails to acknowledge the diversity of responses seen in refugee children. Many refugee children who experience severe traumas show exceptional resilience, and do not develop mental health problems, and those who are symptomatic can

function at very high levels (Sack et al., 1999). Research methodology that relies on checklists or structured interviews that focus on specific posttraumatic symptoms may also fail to capture stressful experiences of grief, loss, or readjustment difficulties—all common problems associated with being a refugee (Berman, 2001). Thus symptom checklists, while useful at times, may obscure the variety of responses seen in refugee children.

Finally, the medical model relies on a diagnostic system that was developed and validated on Euro-American populations. Use of this culturally-biased diagnostic system may lead to misdiagnosing, over-pathologizing, or failing to identify mental health problems in people of other cultures (Dana, 2001; Kleinman, 1981). In addition, cultural differences in attitudes towards research and mental health may further invalidate findings. Thus research on refugee groups that uses a medical model has several limitations. Research reviewed in this section should be interpreted with these limitations in mind.

In addition, as with research on any group, individual differences play a role in symptom expression. Exposure to war and political violence (Almqvist and Broberg, 1999; Garbarino and Kostelny, 1996a; Sack et al., 1996; Steele et al., 1999), individual vulnerability before trauma exposure (Almqvist and Broberg, 1999), lower premigratory expectations (McKelvey et al., 1993), and resettlement stress (Sack et al., 1996) are associated with increased vulnerability to psychological symptoms to varying degrees. Some



gender differences have been detected; risk factors among boys are parental separation and number of changes in family structure and place of residence (Tousignant et al., 1999). Among girls, community context (Garbarino and Kostelny, 1996) and poor health status of mothers (Miller, 1996) are risk factors.

Preflight: Exposure to Violence

Investigations of ensuing psychopathology among war-affected refugee children demonstrate that, among various cultures, refugees commonly experience anxiety and depression, anger and violence, psychic numbing, paranoia, insomnia, and a heightened awareness of death (Garbarino and Kostelny, 1996b; Jablensky et al., 1994). Children and adolescents are particularly vulnerable to psychological distress (Boothby, 1994; Malakoff, 1994).

Goldstein et al. (1997) surveyed internally-displaced Bosnian children ages 6-12 using the Sead Picture Survey Tool, a modified cartoon-based interview instrument (Martinez and Richters, 1993). Children's distress symptoms were associated with violence exposure. Over 93% of respondents met full criteria for PTSD.

A study of displaced children in Bosnia found that while boys had significantly higher initial symptoms, eight months later girls exhibited higher posttraumatic emotional numbing, hyperarousal and intrusive thoughts, anxiety, and depressive symptoms (Stein et al., 1999).

Flight: Refugee Camps

Screening assessments of mental health status among 168 unaccompanied Sudanese refugee children in a Kenyan refugee camp indicated that virtually all of them suffered from symptoms of PTSD, with almost 75% suffering moderately or severely (Duncan, 2000a). The pervasive belief that they may be attacked or killed at any time likely contributes to the universal experience of nightmares about previous attacks and flights. Among a sample of 33 girls ages 14-17 living in the refugee camp who were either unaccompanied or separated from adults, 48% had severe PTSD symptoms, 45% had moderate to severe anxiety symptoms, and 42% had moderate to severe symptoms of depression (Duncan, 2000b). The small sample size available for assessment reflects the fact that girls disappear into the fabric of refugee camp life, often through indentured servitude or forced marriage, absencing their experiences from the literature. However, available accounts suggest that unaccompanied girls appear to suffer from psychiatric symptoms as frequently as their male counterparts (Sourander, 1998).

Paardekooper et al. (1999) evaluated Sudanese refugee children ages 7-12 who arrived in Ugandan refugee camps following exposure to war and flight. With a culturally adapted and pilot-tested version of the Levonn Cartoon-based Interview



for Assessing Children's Distress Symptoms (Richters et al., 1990), individual PTSD symptoms were reported with frequencies ranging from 35% to over 60%.

Mollica et al. (1997) used culturally sensitive versions of the Child Behavior Checklist (CBCL) and the Youth Self-Report (YSR) to evaluate functional and mental health status among Cambodian adolescents ages 12-13 living in a refugee camp on the Thai-Cambodian border (Achenbach, 1991a; Achenbach, 1991b). Seventy-five percent reported symptoms in the clinical or borderline range on the CBCL, while 40% scored within the clinical range on the YSR.

Resettlement: Longitudinal Course of Symptoms

Within families, fathers' long-term unemployment (more than six months) in the first year of settlement (Tousignant et al., 1999), mother's emotional well-being (Almqvist and Broberg, 1999), and family negativity (Garbarino and Kostelny, 1996) are associated with increases in refugee children's symptomatology.

The hardships of a refugee camp may contribute to symptoms following discharge from the camp. Rothe et al. (2002) assessed 87 Cuban children and adolescents detained in a United States refugee camp, four to six months after release from the camp. Using a translated Posttraumatic Stress Disorder Reaction Index (PTSD-RI), the study found that 57% of the youth reported moderate to severe PTSD symptoms. Nevertheless, length of time in the camp did not predict presence of

PTSD (Rothe et al., 2002). Meanwhile, Cambodian adolescents in a Thai refugee camp endorsed fewer anxiety symptoms on the Hopkins Symptom Checklist-25 than their counterparts from the camp who had been resettled in Tacoma, Washington (Muecke and Sassi, 1992). The apparently protective effect of camp life was attributed to the hopeful attitudes of those in the former group who were actively preparing for imminent resettlement in the U.S.

There are few longitudinal studies of psychiatric symptoms among young refugees, the largest and longest being that of Kinzie and colleagues (1986). Their sample of forty Cambodian adolescent refugees revealed rates of PTSD of 50% two years after arriving in the United States, while 53% met criteria for diagnoses of depression. The comorbidity was significant; 17 of the 21 depression diagnoses were made among the 20 youth with PTSD. When PTSD was reassessed at 3-year, 6-year, and 12-year follow-up interviews with the Diagnostic Interview Schedule and the Diagnostic Interview for Children and Adolescents, rates were 48%, 38%, and 35% respectively (Kinzie et al., 1989; Sack et al., 1993; Sack et al., 1999). However, the depressive symptoms, assessed with the Schedule for Affective Disorders and Schizophrenia and the Kiddie Schedule for Affective Disorders and Schizophrenia respectively, dropped to 41% after 3 years, and to 6% after 6 years, but increased to 14% after 12 years (Kinzie et al., 1989; Sack et al., 1993; Sack et al., 1999). Some evidence suggests that depression and posttraumatic symptoms have



distinct associations; namely, depressive symptoms are more affected by recent stressful events and PTSD symptoms are associated more closely with prior trauma (Sack et al., 1996; Savin et al., 1996).

Becker et al. (1999) followed ten Bosnian adolescent refugees for one year. At baseline, three refugees met criteria for PTSD, but none met criteria for the disorder one year later. Similarly, in a study of 34 Iranian refugee children with traumatic exposure resettled in Sweden, Almqvist and Brandell-Forsberg (1997) found that overall psychological symptoms decreased over a two and a half year period. However, most (82%) continued to experience some symptoms; a diagnosis of PTSD persisted for six of eight children who had met criteria for PTSD initially, and the other two children continued to report at least three Posttraumatic symptoms.

A comparison of Central American and Southeast Asian refugee children resettled in Canada exemplifies the significance of cultural idioms of distress. The study found that learning difficulties were associated with hyperactivity and social isolation in the former group, in contrast to aggression and depression in the latter, while somatization was seen in both (Rousseau et al., 1996).

Violence and problem behaviors are other expressions of symptoms that may hold significant consequences for both individuals and society. The complex risk and protective factors associated with refugee youth behavior problems, as well as their prevalence, have been reviewed extensively by Hunt et al.

(2001). They conclude that while the same general protective and risk factors that impact problem behaviors in youth from the dominant culture are present for refugee and immigrant youth, the latter may also experience unique risk factors related to trauma, loss, and immigration.

Physical Health and Its Impact on Stress

Physical health problems may affect or reflect mental health status in refugees with high levels of social functioning (Mollica et al., 1997). The presence of physical signs and symptoms is largely dependent on experiences prior to and during refugee flight.

Preflight and Flight: Health Risks

In acute settings of refugee flight, civil strife, or warfare, disruptions of food supplies and unhygienic conditions cause high frequencies of diarrheal disease, malnutrition, and infections (Toole and Waldman, 1993). Close living quarters in refugee camps and urban centers lead to increased exposure to infectious diseases with simultaneous loss of herd immunity to common vaccine-preventable illnesses.

Physical trauma also causes problems among refugee youth who often endure physical and sexual assault. Fractures and other common musculoskeletal injuries often go untreated, as evidenced by the number of limb deformities reported in one study of refugee children resettled in Buffalo, NY (Meropol, 1995). Scars found on examination of



child refugees may also be the result of physical torture (Petersen and Wandall, 1995). Given high rates of reported head trauma (e.g., from gun shot wounds, shrapnel, or falls) and severe beatings in refugees (Mollica et al., 1993), neurological damage may be present.

Similarly, nutritional deficits and infections such as cerebral malaria, meningitis, and encephalitis all can cause permanent neurological and psychological sequelae. Over time, acute malnutrition with its immediate health consequences, such as marasmus and kwashiorkor (Dowell et al., 1995), often leads to chronic malnutrition (exemplified by stunting). Malnutrition, particularly protein insufficiency and iron deficiency, may also impair immune function and increase susceptibility to infections (Dallman, 1987). Iron deficiency anemia causes lethargy and depression, while iodine deficiency in young children can cause mental retardation.

Resettlement: Enduring Health Conditions and Cultural Considerations

By the time refugee youth have arrived in the United States or elsewhere, they may have resolved acute physical health problems and instead present with chronic problems: ear infections (often with chronic perforations of the tympanic membrane), fungal and parasitic infestations of the skin, latent tuberculosis, carriage of intestinal parasites, hepatitis B, anemia, lead poisoning, dental caries and other dental abnormalities, stunting, and

developmental delay (Dallman, 1987; Evans et al., 1985; Geltman et al., 2001a; Geltman et al., 2001b; Hjern et al., 1991b; Parenti et al., 1987; Waldman et al., 1979). The frequency of skin and ear problems may reflect health conditions of the refugee's region of origin (Bulto et al., 1993).

Some physical findings may result from generally benign cultural practices used in traditional healing, such as "cupping" or "coining" (in which cups or coins are applied topically to create pressure, draw blood to the surface and alleviate pain) (Ackerman, 1997). Furthermore, reflecting both cultural norms for emotional expression and manifestations of psychological distress, somatization can become a significant component of symptomatology (Locke et al., 1996). Vague chronic complaints such as headache, insomnia or hypersomnia, abdominal pain, anorexia, myalgias, and nausea should be evaluated thoroughly but also viewed as potential clues to underlying suffering psychological distress.

Interventions for Refugee Children and Families

Preflight and during flight, refugees typically endure the disrupted social environment of a country at war or at its brink, displacement from their communities, separation from family members, and uncertainty about the future. Prior to resettlement, most interventions are focused on basic survival, such as food, water, and shelter.

During resettlement, refugee youth and families contend with



various agencies and organizations, schools, courts, medical facilities, and departments of social service. A clear hierarchy of needs may determine their agendas. For example, refugee families often need to address immediate issues of safety and survival (e.g., financial benefits or accommodations) before focusing on psychotherapy (Geltman et al., 2000). They may first (and sometimes exclusively) seek services such as welfare benefits, education, and occupational training. Most interventions evaluated empirically occur in the resettlement phase, and are described here. From an Ecological/Transactional perspective, protective factors specific to the child or the environment may be used in treatment to improve outcome. Similarly, an important goal of treatment is to alleviate environmental risk factors that may contribute to poor outcomes, suggesting the need for interventions that operate at multiple levels.

However, traditional Western mental health approaches have often not been effective with immigrants and refugees, who tend to under-utilize mental health services (Geltman et al., 2000; Munroe-Blum et al., 1989). A number of barriers to service utilization for refugee children have been identified, including stigma associated with mental illness and treatment in countries of origin, a dearth of clinicians who speak refugee languages, low priority given to mental health because of other, overwhelming needs of newly immigrated families, and lack of resources to pay for services (Westermeyer and Williams, 1986).

Existing mental health service may not be adequately meeting the needs of all children in the country, with epidemiological studies indicating that fewer than 20% of children who need mental health care actually receive services (Lahey et al., 1996). In addition, of those children who do receive services, fewer than 50% receive the appropriate service relative to their need (Kazdin, 1996). These realities are even starker for refugee children, as studies with various refugee populations have shown that many exhibit symptoms of trauma, yet very few receive care (Rousseau, 1995).

The literature on interventions developed to address the needs of refugee and immigrant children is sparse. Some clinical vignettes and guidelines (Bevin, 1991; Elbedour et al., 1993; Foster, 2001; Westermeyer and Wahmanholm, 1996) have been described, and a number of authors have recommended nontraditional interventions with refugee children such as prevention (Williams, 1991), consultation, and outreach services (Gong-Guy et al., 1991). Trauma clinics have also provided interventions to refugees (Kinzie et al., 1980; Westermeyer, 1991), though the effectiveness of these interventions relative to control groups has not been assessed. In addition, interventions aimed at mothers (Dybdahl, 2001), teachers (Miller, 1994; O'Shea et al., 2000) and other caregivers have been reported. For example, Dybdahl (2001) reports on a controlled intervention study that shows positive effects of a psychosocial program with mothers on Bosnian refugee children's



psychosocial functioning and mental health.

This meager literature suggests the importance of pursuing research and evaluations of existing programs that address mental health problems of refugee children to inform practice and further develop ways to address the diversity of needs. In particular, the literature raises the following issues:

Settings of Intervention

The setting where interventions take place have been noted as important factors that can support and enhance mental health services. Locating interventions in clinics, community settings, or schools, etc. can facilitate or impede access to services for refugee children. Clinics and medical settings have been noted to have some advantages for some populations, as medical care is more readily accepted and not associated with stigma among many groups. On the other hand, among some groups stigma associated with seeking psychiatric or medical care for mental health problems prevents people from accessing services. Schools provide an important opportunity to intervene with refugee children as a setting of utmost importance where they spend a great deal of time and encounter acculturative struggles. Placing interventions in school can help reduce stigma, and also provide an opportunity to intervene with the school setting itself, having an impact on its ecology. For example, affecting a school's norms, policies, and attitudes with respect to immigrant and refugee children can help support

individualized interventions for refugee children. Thus providing care in a variety of settings, including medical settings, community mental health clinics, schools, and other community institutions can help address the multitude of needs in these varied refugee communities.

Involvement of Parents

The importance of involving parents and other members of the child's social network in interventions is suggested by research reviewed above that identified parents' well being as a protective factor in refugee children's mental health and coping with trauma. The importance of engaging parents and supporting their parenting efforts in the context of differential acculturation rates within families has been noted earlier. Furthermore, parental involvement in school for immigrant and refugee children has also been noted as an important factor that affects children's school and social adjustment (Delgad-Gaitan, 1991). However, engaging refugee parents in family-based interventions in the U.S. context has been shown to be extremely difficult in general (Szapocznik et al., 1990). Exploring alternative settings for intervention may address some of the barriers to involving parents.

Qualifications of Service Providers

Concerns about providing competent mental health care to refugee children focus on issues of competence with respect to treatment of trauma in children, as well as competence with respect to cultural and linguistic



issues involved with working with refugee children and families. Providers have employed a range of approaches to address these issues. On one end of the continuum, some programs employ mental health professionals with U.S. training exclusively to provide services, regardless of their level of cultural competence, while on the other end some programs engage in exclusively preventive efforts employing culturally indigenous paraprofessionals. However most programs represent a hybrid of such approaches, providing a combination of professional and paraprofessional services, and employing interpreters when needed to assist mental health providers in treatment sessions. Further, diverse models of working with interpreters have been articulated, including the interpreter as an impartial and “invisible” presence, and the triadic model that involves interpreters as partners in the interaction between clinicians and patients.

Modalities of Intervention

A variety of modalities of interventions have been proposed including individual psychotherapy, family, group, medication treatment, preventive interventions (Williams and Berry, 1991), and school-based services (Layne et al., 2001; O'Shea et al., 2000). Given the range of issues and diversity of refugee populations, and how little has been documented with respect to effectiveness of interventions with refugee children, the literature speaks to the importance of employing a diversity of modalities of interventions, such as

individual, family, or group therapy, preventive interventions, and supportive counseling in order to address the range of refugee mental health needs.

Interventions Focusing on the Individual

Prior research on the treatment of childhood psychopathology outside the field of refugee mental health has evaluated the efficacy of individual treatment on functional outcome. Several well-designed studies have evaluated forms of cognitive behavioral therapy for PTSD in children and adolescents (Cohen, 1998; Deblinger et al., 1990; Goenjian et al., 1997; March et al., 1998; Saigh, 1986; Saigh, 1987a; Saigh, 1987b; Saigh, 1989), but not specifically among refugees.

Crisis intervention studies have produced varied outcomes. For adults, it is unclear whether early interventions following trauma are useful, neutral or potentially even harmful (Rose and Bisson, 1998). Research with child survivors of disaster has been more promising, suggesting that early debriefing can reduce long-term distress reduction, but further research is necessary to determine the utility and timing of this approach with war-exposed youth, and to better define appropriate candidates for the debriefing method (Yule, 2000).

Testimonial psychotherapy may be a promising technique for older adolescents that borrows from previously tested treatments for traumatic stress, such as exposure and desensitization, relaxation



training, and cognitive restructuring. Testimonials have the dual purpose of healing through both story-telling and transcending one's persecution by using one's testimonial for political purposes, enabling the survivor to become an educator or advocate. Importantly, a refugee giving testimony does not need to take on the culturally determined role of a psychiatric patient to participate (Agger and Jensen, 1990; Lustig et al., ; Mollica, 2001; van der Veer, 1998; Weine and Laub, 1995; Weine et al., 1998).

While individual psychotherapy has unique advantages in the treatment of psychiatric problems, its focus on the individual fails to consider fully the impact of community and family circumstances. Traditional, narrowly focused treatments often do not adequately address the extent to which altering an individual's real or perceived interactions with the social world can positively affect one's general wellbeing. While individual psychological treatment is the primary empirically tested treatment for PTSD among young people, in large part, this individual focus has stemmed from the downward extension and application of adult treatments to children, without appreciating the extent to which context shapes and influences children's functioning.

Medication can be very helpful in treating psychiatric symptoms among refugees, as demonstrated by a study of clonidine among Cambodian adults with PTSD (Kinzie and Leung, 1989). Psychopharmacological interventions have not been empirically evaluated among

refugee children, although are potentially helpful for PTSD in non-refugee populations (Donnelly et al., 1999; Seedat et al., 2002).

Interventions Focusing on the Family

Several authors have described family therapy approaches with refugee families (Arrendondo et al., 1989; Bemak, 1989; Mehraby, 2000; Mock, 1998; Silove et al., 1997; Sveaass and Reichelt, 2001). While these cases provide rich examples, the discrete circumstances of individual family cases limit their generalizability. Broadly, however, they offer clinical insights. For example, Arrendondo et al. (1989) present the case of an El Salvadoran family referred by its immigration attorney. The authors suggest that therapists should be attuned to asylum seekers with legal difficulties who may feel particularly vulnerable and suspicious of therapists' attempts to gather information. Sveaass and Reichelt (2001) examine the position of the therapist in relation to the family, and underscore the importance of minimizing power differentials when appropriate, observing cultural norms, and using therapeutic techniques that are consistent with family preferences. Bemak (1989) suggests a three-phase model to employ in family therapy with Southeast Asian refugees including: (1) establishing security and safety in their new environment, (2) integration of self and family into the new cultural context, and (3) redefining one's identity, including acculturation and mastery of new skills.



Interventions Focusing on the Impact of Multiple Systems

Finally, a number of experts recommend holistic assessments and interventions with refugees (Aroche and Coello, 1994; Papadopoulos, 2001). Thus, several professionals can work simultaneously to target different domains that impact refugees. This multi-systemic approach (Chichetti and Lynch, 1993) appears to allow flexibility to meet young refugees' diverse needs. Further research must evaluate effectiveness.

School-Based Interventions

Interventions outside of clinical settings have been proposed to reduce power disparities. Further, paraprofessionals working in such settings can help diffuse these issues, though they themselves may be in relatively powerless roles in their agency. School based interventions are an important modality to explore in services for refugee children as they offer a number of ways to both overcome barriers to accessing services as well as ways of effectively intervening with refugee children. First, because school is a setting that all children attend, integrating mental health services with other school programs can avoid the cultural barriers that may interfere with access to services, such as stigma associated with contacting a mental health agency (Adelman, 1996; Adelman and Taylor, 1998; Adelman and Taylor, 1999; Atkins et al., 1998). Second, public schools represent the setting where many of the acculturative

struggles of refugee children unfold. Public schools have traditionally served as a vehicle of socialization and "assimilation" of immigrants and refugees in the U.S. (Dewey, 1934). Schools are where children experience cultural conflict and acculturative stress, which is hypothesized to be linked to maladaptive behaviors (Delgado-Gaitan, 1991; Gonzales et al., in press). School is where they struggle with identity conflicts and relate to their peers. Third, school interventions provide an opportunity to intervene not only with the children but also with the environment that shapes their experience. From an ecological perspective, interventions designed to address acculturative conflicts can be most effective when they address not only the acculturation of the child, but also the "acculturative press" of the school environment that may contribute to stress or facilitate adjustment. Fourth, schools provide a potential avenue to engage the youths' parents in interventions and create a bridge between the worlds of family and school. Though parent involvement in immigrant schooling is challenging, it is particularly important for parents who themselves often know little about the ways that schools work. By engaging parents, school-based interventions can provide an orientation and education about the larger culture and the lives of their children, facilitate parental involvement in school, and reduce the acculturative gap that often develops between parents and children (Delgado-Gaitan, 1991; Szapocznik et al., 1978).



Despite a relatively large literature on school-based interventions for children in general (Adelman, 1996), most have focused on providing the same services, such as individual counseling, or group therapy within the school setting. With respect to refugees, Layne et al. (2001) have published a preliminary effectiveness evaluation of a trauma and grief-focused group psychotherapy conducted in Bosnian schools with war-exposed adolescents. Their manualized treatment, intended for war-traumatized adolescents, combines psychoeducation, therapeutic exposure, cognitive restructuring, stress management-relaxation skills, and practical problem-solving skills. Based on an evaluation of 55 high school students who participated in the treatment, the authors found that the students experienced significant reductions in posttraumatic stress, depression, and grief symptoms.

Outside the refugee context, some have implemented preventive interventions, such as teaching social competence skills, yet these approaches have also focused on enhancing the skills or capacities of individual children. While such approaches are promising, as they often solve the issue of barriers to accessing services, they fail to take full advantage of the school context to provide a more comprehensive range of services that can both address children's individual needs as well as impact the school and classroom environment itself; and address a range of problems from severe mental illness to preventive services, depending on the needs of the child,

teacher, classroom, and school. Such a flexible approach is being developed by (Atkins et al., 2003) in Chicago public schools with predominantly low income African American populations. Such interventions have great potential to be transported into schools that serve refugee children, as their flexibility allows for diverse children to be served. With respect to outcome data, while prevention researchers suggest that such interventions have been shown to be effective, none have been conducted or studied with refugee children in particular. And the (Atkins et al., 2003; Atkins et al., 1998) project has shown excellent outcomes with respect to engagement of children in services as contrasted with referrals to clinic, with over 94% of intervention children remaining in services after 18 months as contrasted with 4% of the control. However, no outcomes with respect to whether children improved as a result of services have yet been reported, and the intervention has not been applied to refugee children.

Interventions Focusing on Culturally Relevant Healing

For child and adolescent refugees, culturally relevant healing practices may prove useful. In one case study, a therapy team working with a Cambodian family attended to culturally meaningful aspects of "magic string" that one individual obtained from a shaman and used as a central part of a family intervention (Bemak, 1989; Woodcock, 1995). Similarly, integrating rituals into family therapy may be important. A case report described rituals involving



the creation of a family genogram and honoring memorabilia with one Kurdish family, and the celebration of traditional New Year festivities as part of the process of family healing for several Iranian families (Woodcock, 1995). Although worthy of note and culturally appropriate, these interventions require further study of efficacy and possible integration, when appropriate, with psychotherapies considered standard in this country.

Multicultural Competency: Ethics and Disparities of Power

The vulnerability of refugee youth and the urgent need for clinical services and research both challenge and mandate the maintenance of ethical practices. Refugees are vulnerable in various ways during different phases of their experiences, and critical periods of development take place during forced separations from caregivers and other family members, or during periods of environmental deprivation and violence (Berman, 2001; Boothby, 1994). Refugees may not be aware of their rights, and may lack access to effective advocates.

The Clinical Encounter

Sveaass and Reichelt (2001) note tension between refugees and service providers due to power differentials between the two groups. Similarly, Summerfield (1999) points out that service providers often epitomize that which the refugee has lost, particularly when the providers have “a fixed place in society, a voice, status, money.” These disparities can

create a major chasm between provider and patient, straining rapport and trust. Awareness of one’s own cultural heritage, and of other cultures’ history, sociopolitical influences, normative values, family/community structures, and diagnostic categories and assessment procedures, are critical to providing culturally sensitive assessment and treatment (Hansen et al., 2000; Pernice, 1994). Other ethical issues in treatment are the concepts of therapeutic neutrality, which may be interpreted by refugees as sympathy or collusion with the perpetrators of violence (Apfel and Simon, 1996), and of self-disclosure (Straker, 1996) which, when appropriately done, may help decrease the power differential between refugee and therapist.

Research

Research with young refugees also raises ethical concerns, although being a research subject has been reported as a positive experience in one study of child and parent refugees (Dyregrov et al., 2000). One of the principal dilemmas of research in refugee populations is the struggle between developing empirically-supported mental health interventions and protecting a vulnerable group from harm (Leaning, 2001). Obtaining adequate informed consent is critical. Potential impediments to gaining voluntary, informed consent include disparities in language, cultural and social norms, power, education, and familiarity with research paradigms (Leaning, 2001). These issues can be even more complicated with young refugees. In Dyregrov et al’s (2000)



study of Bosnian refugee families' experience of research participation the process of informed consent was noted to be limited in the case of children because of cultural factors. In particular, parents often neglected to consult with or inform their children regarding participation in the study. Thus, the researchers had to revise their assumption that parents would independently obtain their children's assent to participate. Despite their acquiescent and cooperative statements regarding participation, a majority of the children agreed that they would have preferred their own separate invitation to participate in the study. These issues warrant further study.

In brief, there is a clear need for high standards for informed consent. One way to protect prospective participants from harm is to clarify potential adverse effects and possible risks of participation. Risks and benefits specific to traumatized refugees include sociopolitical consequences (Dyregrov et al., 2000; Hansen et al., 2000), and painful re-visiting of traumatic events and further emotional suffering (Rousseau, 1993-4), as well as the presumed benefits of verbalizing traumatic experiences (Leaning, 2001; Pennebaker, 1993).

More generally, studies are limited by the use of western diagnostic symptoms and instruments (Draguns, 1977; Pernice, 1994), and the complications inherent in the westernized medicalization of what elsewhere may be viewed as religious or social issues (Kleinman, 1995). Research and treatment must account for different cultural

understandings of what North Americans deem mental illness (Mghir and Raskin, 1999).

Implications and Future Directions

As a general trend, more research has been conducted with Southeast Asian and Eastern European refugee populations than with refugees from Africa, the Middle East, and several Latin American countries. It is worth exploring and addressing the reasons why these gaps exist. For example, it may be that refugees are not seeking services because they are not necessary, or it may be that significant barriers to appropriate service exist. Alternately, it could be that public hospitals and community clinics are seeing significant numbers of refugees, but take no systematic account of the needs they present with and how to treat them. In any event, additional research is needed with refugee groups, such as Africans, for which there is little information.

Despite the challenges of acculturation and often, exposure to traumatic war experiences, child and adolescent refugees make up a resilient population. Clinicians trained to treat traumatized children must be sensitive to cultural variations in experiences of symptomatology as well as culturally sanctioned approaches to treatment. While there are a number of established research instruments assessing psychological symptoms and general functioning, many of these instruments have not been validated with refugee populations or in different languages. Developing a consensus on a battery of research instruments to be used



with refugee populations and having them available in multiple languages is a critical step in promoting further research with refugees. Researchers must strive to integrate into empirically-based treatment factors such as young refugees' social construction of world events and their considerable experience with the world beyond our North American borders. Finally, policy makers must think broadly about financial, social, and legal decisions that affect both refugees' wellbeing and their ability to use services that clinicians provide.

Recommendations

Based on the limitations of empirical work done thus far on refugee populations and the lack of an established expert consensus, it is premature to put forward firm mandates. At the same time, it is important to begin the process of formulating tentative recommendations for clinicians, researchers, and policy-makers, in order to begin the processes of improving and expanding refugee services. These recommendations are based in part upon the expert consensus of members of the NCTSN Refugee Trauma Task Force, and are derived from research findings, or lack thereof, as available. Thus, we present our recommendations below, with the acknowledgement that they are preliminary and in progress.

Recommendations for Clinicians Working with Refugee Populations

1. Address social needs early, as these may motivate initial contact with health and services agencies. These may be financial, occupational, educational, legal, residential, or spiritual.
2. Learn about culturally familiar people and supports available within the community, and facilitate their availability to refugee patients.
3. To facilitate communication, use counselors, trained in basic therapeutic techniques, from within the culture. They serve as cultural brokers, enticing patients to come, and representing the agency or clinic to the community. Otherwise, use interpreters trained to work in mental health settings.
4. Account for developmental vulnerabilities when determining the nature and pace of psychotherapeutic interventions for refugees of any age, especially children and adolescents.
5. Capitalize upon the positive regard generally afforded to physicians, and be aware of the stigma associated with seeking mental health services.
6. When appropriate, refer refugees to other medical practitioners for assessment of medical problems that may augment psychiatric symptoms.
7. Take into account the role of somatization as a common presentation of underlying psychopathology.
8. Explore with refugees which coping strategies and sources of personal strength they have used in the past in overcoming tremendous adversity, and identify those that are healthy and adaptive for the future.



9. Encourage alternative means of expression besides “talk therapy,” such as testimonials, drama, dance, music, and art.
10. Remember that talking about painful events may not be experienced as valuable or therapeutic by refugees from societies in which psychological models are not hegemonic; explore how they would experience a therapeutic encounter.
11. Take into account the role of ongoing traumatic triggers, current examples of which include the U.S.’s war with Iraq and the attack on the World Trade Center. Assess for parents’ reactions as contributors to children’s responses.

Recommendations for Researchers Studying Refugee Populations

1. Conduct studies of mental health interventions for refugees in order to identify approaches and models that can be effective with diverse populations. Develop new and test existing child trauma intervention models to determine whether these can be helpful to refugee children. Learn from refugee communities, families, and patients about what is helpful to them, and how existing mental health models can be adapted, revised, or developed to address their needs.
2. Conduct research in collaboration between universities, refugee communities and community-based agencies. Only such approaches can help bridge the worlds of cultures, research and practice, and differential ecologies of refugee children and mental health providers.
3. Address ethical issues in working with diverse refugee populations. Include very clear means of protecting subjects from unwanted interventions that might be difficult to refuse. Ensure that consent is truly informed, and take additional steps to explain the study to participants.
4. Account for cultural differences in the acceptability of proposed data gathering or interventions. Engage local refugee communities in developing data gathering and intervention approaches that are culturally congruent.
5. Further clarify mediators and moderators of resilience
6. Where possible, implement cohort studies of migrating refugee groups that prospectively assess developmental milestones and psychological wellbeing both before departure from the country of origin and after settlement in the host country.
7. Make a commitment to sharing research findings with refugee populations and organizations working with them through creating reports on study findings in refugee languages and using lay phrasing, and finding other ways to disseminate the information such as refugee community newspapers, ethnic radio and TV stations, etc.
8. Develop long-term studies on the effect of early trauma on cognitive and social development, and relevant mediating variables.



**Recommendations for Policy Makers
Acting on Behalf of
Refugee Populations**

1. Consult with all stakeholders prior to forming policy for young refugees: parents, young refugees themselves, psychiatrists, psychologists, social workers, pediatricians, teachers, and representatives from all sectors of service provision, namely medical, legal, financial, residential, occupational, vocational, and spiritual.
2. Carefully consider the possible deleterious effects of legislative actions and legal rulings concerning immigration, detention, and naturalization on the day-to-day lives of refugees who have arrived in this country.
3. Provide medical, social, and residential services early to newly arriving young refugees and their caretakers, as early prevention is less expensive than subsequent treatment.
4. Young refugees and the caretakers with whom they arrive should be kept together, assuming that the family provides a safe social environment, as the toll exerted by further separations can be psychologically devastating.
5. When evaluating policy decisions based on refugees' renditions of horrific events, remember that the experience of trauma, particularly among the young, can distort memories; such discrepancies in personal histories should not be viewed as necessarily detracting from the truthfulness of the narratives.



Refugee Agencies and Services

A number of international agencies (e.g., UNHCR, UNICEF, and the Red Cross), provide emergency relief services to refugee youth and their families. U.S. government organizations, such as the Centers for Disease Control and Prevention (CDC) and the Office of Refugee Resettlement (ORR), the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services, and private resettlement agencies (e.g., International Rescue Committee (IRC), and Lutheran Immigration and Refugee Services (LIRS). Other voluntary agencies that provide refugee services include: Catholic Charities, World Relief, Church World Service, Hebrew Immigrant Aid Society, and Immigrant and Refugee Services of America. Finally, numerous U.S. and international voluntary agencies and human rights and educational organizations (e.g., Amnesty International, Refugees International, the United States Committee for Refugees (USCR) provide assistance to and information about refugees abroad.

Collaborating with these agencies can expand the resources and information available to providers who typically focus solely on mental health issues. In fact, many of these agencies have developed mental health programs that work collaboratively with their resettlement programs to assist newly arriving refugees. An important aspect of offering culturally appropriate services is coordinating with

established community supports (U.S. Department of Health and Human Services, 1999). Menon et al. (2002) suggest community outreach strategies, such as life skills groups, nutrition classes, stress management classes, gender specific support groups, and English as a Second Language classes, in addition to mental health treatment

NCTSN Refugee Services

Sixteen National Child Traumatic Stress Network (NCTSN) sites, across nine states, offer mental health services for refugees. These include:

In California:

- The Chadwick Center for Children and Families Trauma Counseling Program at Children's Hospital and Health Center in San Diego
- Children's Institute International at Central LA Child Trauma Treatment Center in Los Angeles
- LAUSD Community Practice Center at the Los Angeles Unified School District in Van Nuys
- The Miller Children's Abuse and Violence Intervention Center in Long Beach

In Florida:

- Healing the Hurt at Directions for Mental Health, Inc. in Clearwater

In Illinois:

- Family, Adolescent, & Child Enhancement Services (FACES) at Chicago Health Outreach, Inc. in Chicago



In Massachusetts:

- **The Trauma Center, Massachusetts Mental Health Institute in Allston**
- **The Center for Medical and Refugee Trauma at Boston Medical Center in Boston**

In New York

- **The Jewish Board of Family and Children's Services (JBFCS) Center for Trauma Program Innovation (CTPI) in New York City**
- **Mount Sinai Adolescent Health Center in New York City**
- **North Shore University Hospital at the Adolescent Trauma Treatment Development Center in Manhasset**
- **Safe Horizon-Saint Vincent's Child Trauma Care Continuum in New York City**

In Oregon:

- **Intercultural Child Traumatic Stress Center of Oregon at the Department of Psychiatry in Portland**

In Pennsylvania:

- **Children's Crisis Treatment Center West African Refugee Project in Philadelphia**

In Virginia

- **International C.H.I.L.D. at the Center for Multicultural Human Services (CMHS) in Falls Church**

In Washington, D.C.:

- **Identification and Treatment of Traumatic Stress in Children and Adolescents in Latino and Other Immigrant Populations at La Clinica del Pueblo, Inc.**

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