31 Psychopathology in Refugee and Asylum Seeking Children

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War and organized violence bring death and misery to combatants and civilian populations, especially those who are most vulnerable, such as women and children. Direct attacks may have devastating physical effects, including death and injury, and fear of further violence may cause the flight of surviving communities, with resulting disruption to family and cultural life. It is self-evident that such adversities bring great psychological distress. The massive scale of these events makes this an important topic in understanding international child and adolescent mental health (UNHCR, 2000, 2006).

This chapter reviews some of the major trends in population movements and the backgrounds of asylum seekers and refugees, and then focuses on psychopathology that may occur in young refugees. Factors associated with increased risk and continuity of disorder, as well as those that enhance resilience, are considered. Finally, there is a brief overview of some key issues and implications for mental health service and psychiatric treatment provision.

Population Movements

Population movements to escape persecution, organized violence and economic hardship that may be severe enough to cause famine are long-standing phenomena in human history. However, the 20th century witnessed migrations of far greater numbers of people (Kushner & Knox, 1999). The number of international migrants (defined as those who live outside their country for at least a year) has increased from 75.9 million in 1960 to 174.9 million in 2000 (United Nations Department of Economic and Social Affairs, 2004). Most of the migration is within regions.

War and organized violence have been important causes of migration. It has been estimated that since 1945 there have been at least 160 wars and 24 million war-related deaths (Pedersen, 2002). During the 1970s and 1980s there were proxy wars of the Cold War conflict in South-East Asia, the Horn of Africa, Afghanistan and Central America (UNHCR, 2000). In the 14-year period after the Cold War ended, 1990–2003, there have been 59 major armed conflicts in 48 locations, although only four have involved war between countries (UNICEF, 2004). The collapse of Soviet communism was associated with a reduction of power of many states, and the 1990s saw the destruction of Yugoslavia, an increase in wars in Central Asian areas such as Afghanistan, Chechnya, Tajikistan and Georgia, as well as war and genocide in central Africa including Rwanda (UNHCR, 2000). Since 1991 there has been increased war in the Middle East, especially in Iraq, and continuation of conflict in Gaza and the West Bank involving Israelis and Palestinians.

The United Nations, created in the aftermath of World War II, has had an important global role in monitoring and supporting populations. It defines a refugee as a person who "Owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality and being outside that country of his/her former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it" (UNHCR, 2000). A displaced person may experience the same kinds of threat but remains within his or her national borders.

People of concern to the UNHCR include those who leave their own countries (refugees, whose legal rights are recognized, and asylum seekers who are applying for refugee status) as well as those who are displaced within their national borders, or are returning refugees. From 1995 to 2005, the overall number had been fluctuating at around 20 million. In 2006 32.9 million people were of concern, of whom 9.7 million were in Africa, 14.9 million in Asia, 3.4 million in Europe, and 3.5 million in Latin American and the Caribbean (UNHCR, 2007). From 2000 to 2004, the numbers of asylum applications submitted to the top five European countries were: UK 393,800; Germany 324,100; France 270,300; Austria 144,800; and Sweden 127,300. The main countries of origin of asylum applicants in the top 10 European receiving countries were Serbia and Montenegro, Iraq, Turkey, Afghanistan and the Russian Federation (UNHCR, 2006).

Over the 15 years until 1998 it was estimated that approximately 300,000 refugees and asylum seekers came to the UK (Bardsley & Storkey, 2000). In 2004, there were 33,960 asylum applications in the UK. Most of the applicants were from Iran, Somalia, China, Zimbabwe and Pakistan (Home Office, 2005). In the same year, 54,310 people, including

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dependants, were accepted for permanent settlement (reflecting the fact that some people sought asylum before 2004).

For a variety of reasons it is difficult to obtain accurate figures on the numbers of people who are asylum seekers and have obtained refugee status in any one country. A high proportion of asylum seekers may not obtain the right to remain in a resettlement country, and leave that country after a short period. Years may elapse until applications are processed, and there may be many legal steps to obtain the legal right to remain. Some asylum seekers may reside in a country illegally. Others will obtain the right to remain and may then move between countries.

A further issue is that there may be many motives for migrating in the aftermath of war or organized violence. Wars result in loss of life to combatants and civilians, and destruction of property, but also contribute to many other difficulties such as economic collapse, poor food supplies and famine (Southall & O'Hare, 2002). Displacement will disrupt the continuation of important community activities including provision of health care and education (UNICEF, 2004). Thus, people categorized as "immigrants," whose expressed reason for resettlement is to improve economic standing and life chances, may have experienced some of the same war events as asylum seekers or refugees, even if they were less frequent (Silove, Steel, McGorry *et al.*, 1998).

Methodological Considerations

Refugees are a heterogeneous group, and this has major implications for research. In addition to the usual demographic variables, age and sex, the refugee population may also be ethnically and linguistically diverse. This introduces considerable complexity for carrying out research as instruments need to be selected according to the age of the subjects and translated. There are standard procedures for translating instruments used in psychiatric research, and these are generally applicable to work with young people (Westermeyer & Janca, 1997). The legal status of the subjects may be an important issue, as this is associated with different rights and will influence economic status and housing provision (e.g., asylum seekers in the UK are unable to work, while those with the legal right to remain have this entitlement, and also have access to permanent housing). A further factor is the duration of settlement. Over time, asylum seekers, some of whom will acquire legal rights to settlement, will build up social networks and acquire greater linguistic ability in the language of the host country (Hauff & Vaglum, 1997).

Asylum seekers and refugees generally have a high level of mobility, although there are exceptions (e.g., people who are displaced but forcibly settled). This means that care is needed over sampling for studies. While random sampling may be the ideal for epidemiological studies (Mollica, Poole, Son *et al.*, 1997), the sample may need to be derived from municipality (local government) lists or areas (Thabet, Abed, & Vostanis, 2002). Research with children and adolescents is facilitated as children who are asylum seekers, as well as refugees, have entitlement to many welfare services including education. Many studies have used school registers as a way of defining the sample (Fazel & Stein, 2003; Leavey, Hollins, King *et al.*, 2004; Smith, Perrin, Yule *et al.*, 2002; Tousignant, Habimana, Biron *et al.*, 1999). Other studies have selected children on the basis of agency support, such as social services that have responsibilities for unaccompanied asylum seeking children (Wade, Mitchell, & Baylis, 2005). Other techniques may be needed to access refugees, such as targeted sampling (e.g., recruiting from ethnic or religious centers), convenience sampling and snowball sampling. Interestingly, in one of the few studies that has looked at these methods, the sample characteristics were only slightly different according to method of recruitment, probably because of the care with which the study was carried out, including adequate sample size (Spring, Westermeyer, Halcon *et al.*, 2003).

Refugees will be heterogeneous with respect to the kinds of war events and other adversities they have experienced (see chapter 25), and so consideration needs to be given to the way these are assessed. A number of instruments have been developed for the assessment of exposure to war and torture, initially developed for use with adults but since widely used for the investigation of adolescents (Hollifield, Warner, Lian *et al.*, 2002). Some instruments such as the Harvard Trauma Scale (Mollica, Caspi-Yavin, Bollini *et al.*, 1992) have been widely used, their brevity makes them accessible, and they show statistically significant associations with health status (Hollifield *et al.*, 2002; Willis & Gonzalez, 1998). Interview methods of assessments of past traumatic events and adversities may be preferable (Rutter & Sandberg, 1992; Sandberg, Rutter, Giles *et al.*, 1993), but their benefit with this population which has often experienced very high levels of trauma has not yet been established. One particular issue is that memories of past events may be unstable (Herlihy, Scragg, & Turner, 2002; Spinhoven, Bean & Eurelings-Bontekoe, 2006).

There are a number of ethical considerations for research with refugees, who are a vulnerable population (Leaning, 2001). Asylum seekers in particular may have fears regarding disclosure of information, in view of their insecure legal position, and so assurances of confidentiality are important. Specific care is needed in research with unaccompanied children seeking asylum, especially with regard to consent (Thomas & Byford, 2003). Nevertheless, refugees may regard participation in research as a positive experience (Dyregrov, Dyregrov, & Raundalen, 2000). Furthermore, it has been argued that research may be used to challenge the oppression and inequalities experienced by refugees (Kirmayer, Rousseau, & Crepeau, 2004).

Conceptual Issues in Refugee Mental Health

A number of controversies, mostly focused on post-traumatic stress disorder (PTSD), in view of its association with exposure

to violent events, have arisen in the refugee mental health field (see chapter 42). These partly relate to issues in psychiatric research with culturally diverse populations. It has been argued that PTSD is a culturally constructed psychiatric disorder that does not have validity in non-western cultures (Bracken, Giller, & Summerfield, 1995; Eisenbruch, 1991; Summerfield, 2000, 2001). Rather, it is suggested that suffering and psychiatric symptoms should be described on the basis of local meanings, to produce a more culturally "embedded" understanding (Eisenbruch, 1991; Kleinman, Das, & Lock, 1997). The social use, and indeed abuse of the concept of PTSD has been blamed as a contributory factor for the poor organization and inappropriate development of psychological trauma services in the aftermath of disasters (Summerfield, 1999, 2000).

There are numerous reasons for rejecting this critique (Hodes, 2002a). PTSD has been found in all cultures in which people have been exposed to violent events, and there have been no reports of a "culture-specific illness associated with mass violence and torture experienced by refugees" (Mollica, 2000). Numerous studies attest to the validity of the disorder (e.g., the recognition of symptoms across cultures and feasibility of translating instruments; de Jong, Komproe, van Ommeren *et al.*, 2001; Elsass, 2001; Sack, Seeley, & Clarke, 1997), the association of PTSD with the degree of exposure to past war events (rather than all adversities; Heptinstall, Sethna, & Taylor, 2004; Sack, Clarke, & Seeley, 1996), the stability of the disorder and a trajectory different to that of other comorbid disorders such as depression (Sack, Him, & Dickason, 1999). It is important to bear in mind that an approach that includes psychopathology, such as recognition of PTSD, does not determine the kind of mental health service provision, which should be influenced by many social factors such as the level of infrastructure development and human resources, and cultural influences regarding treatment appropriateness (see p. 481; de Jong, 2002; van Ommeren, Saxena, & Saracena, 2005).

Epidemiological Findings

Community Studies

The studies in this section are described according to the sequence of refugee experiences: before flight from the home community, in-flight and on arrival in resettlement countries (Hodes, 2000; Lustig, Kia-Keating, Knight *et al.*, 2004). There have been an increasing number of community-based studies regarding the pre-flight and in-flight phases (e.g., those in refugee camps) with young people in recent years, especially those from Vietnam (Felsman, Leong, Johnson *et al.*, 1990) and Cambodia (Mollica *et al.*, 1997; Savin, Sack, Clarke *et al.*, 1996), the former Yugoslavia, mainly Croatia (Zivcic, 1993; Kuterovac-Jagodie, 2003) and Bosnia-Herzegovina (Jones & Kafetsios, 2005; Smith, Perrin, Yule *et al.*, 2001; Smith *et al.*, 2002), and also the Middle East, focusing on Palestinians (Garbarino & Kostelny, 1996; Punamaki, 1996; Quota, Punamaki, & El Sarraj, 2003, 2005; Thabet, Abed, & Vostanis, 2002, 2004; Thabet, Karin, & Vostanis, 2006) and people from Iraq (Ahmad, Sofi, Sundelin-Wahlsten *et al.*, 2000), and other countries such as Afghanistan (Mghir, Freed, Raskin *et al.*, 1995) and regions in Africa (Paardekooper, de Jong, & Hermanns, 1999). They have assessed psychopathology mainly using questionnaires, with report by parents and sometimes self-report by older children (but there are rare interview-based studies, e.g., Ahmad *et al.*, 2000). The studies described here are selected on the basis of methodological quality.

There are a number of considerations in interpreting epidemiological studies of young refugees. Many have been designed to investigate post-traumatic stress, anxiety and depressive symptoms following exposure to traumatic events and most have confirmed high levels of these symptoms. These studies do not reflect the psychiatric heterogeneity that occurs amongst this population. For example, high levels of disruptive behavior have been found amongst populations exposed to ongoing war events and hardship (Quota, Punamaki, & El Sarraj, 2005). Other symptoms such as nocturnal enuresis which might arise from stress are often not assessed. Severe disorders such as psychoses that may occur at higher prevalence amongst some refugee populations such as those from Africa have not been systematically investigated (Fearon, Kirkbride, Morgan *et al.*, 2006). Many studies have relied on questionnaire measures that identify symptom levels rather than psychiatric disorder. While high levels of symptoms indicate high risk of disorder, the questionnaires are rarely calibrated against interview-based measures in the populations under investigation, so that estimates of prevalence are somewhat inaccurate. Another consideration relates to the frequent absence of measures of psychosocial impairment, which may elevate estimated rates of disorder. The studies are varied with respect to duration of exposure to war events and also time delay until participation in the studies (Table 31.1). Thus, the study of Bosnian children (Smith *et al.*, 2002) did not find elevated rates of depressive symptoms, perhaps because the study was carried out years after the cessation of hostilities. By contrast, investigation of Palestinian children living in a situation of ongoing conflict showed a strong association between post-traumatic and depressive symptoms (Thabet, Abed, & Vostanis, 2004).

The high-quality interview-based studies carried out in western resettlement countries add to the findings regarding pre-flight and displaced populations, and reveal high rates of psychiatric disorder and comorbidity. A systematic review of interview-based studies carried out in resettlement countries identified five surveys of 260 children and adolescents younger than 18 years (Fazel, Wheeler, & Danesh, 2005). The prevalence rate for PTSD was 11%, approximately 10 times the rate in non-refugee peers.

Numerous surveys have been carried out in resettlement countries using questionnaire methods of assessment, investigating ethnically diverse refugee populations (Espino, 1991; Leavey *et al.*, 2004; Montgomery, 1998; Rousseau, Drapeau, & Corin, 1996). Some surveys of ethnically mixed refugees

Table 31.1 Selected community studies of prevalence of psychopathology amongst young refugees.

Stage of refugee experiences	Ethnicity/culture of subjects	Sample characteristics	Instruments	Main findings	References
Pre-flight	Bosnian 98% Muslim	$n = 2976$. Mean age 12.1 years (range 9–14). Exposed to bombing over 2 years. Data collected 2 years later	RIES; DSRS; RCMAS	On RIES 52% high-risk PTSD; DSRS low, but higher than UK normative data; RCMAS not elevated. War exposure explained most of variance	Smith *et al.* (2002)
	* Palestinian, in Gaza	$n = 309$ aged 3–6 years. Exposed to regular bombardment, displacement, economic deprivation	Strengths & Difficulties Questionnaire; BCL	War exposure predicted symptoms; BCL symptoms (e.g., faddy eating, settling at night) overactivity much higher than UK comparison	Thabet *et al.* (2006)
	* Palestinian, in Gaza	$n = 91$ exposed to bombardment & home demolition; $n = 89$ not exposed Age 9–18 years	Child post-traumatic stress reaction index; RCMAS; Children fears checklist	Severe PTSD reaction in 59% exposed, 25% non-exposed ($P = 0.0009$); high-risk anxiety disorders less amongst those not exposed. Bombardment predicted PTSD symptoms and fears	Thabet *et al.* (2002)
In-flight	Kurdish in Iraq	$n = 45$. Mean age 12.4 years (range 7–17). Exposed to "Anfal," many killed, moved to displacement camps	Post-traumatic stress symptoms in children	87% children had PTSD. Duration of captivity and war exposure predictors of symptoms	Ahmad *et al.* (2000)
	Cambodia	$n = 182$, in refugee camp. Aged 12–13, parents included as informants	CBCL Youth self-report	CBCL: 54% had total problem scores in clinical range, 26% by self-report. Most common symptoms somatic, withdrawal, social problems. Less than 10% significant functional impairment. Cumulative trauma associated with increased functional impairment	Mollica *et al.*, (1997)
In resettlement countries	Cambodia	$n = 46$; 40 exposed to Pol Pot regime aged 8–12 years; Mean age 17 years (range 14–20) when assessed in USA	SADS using Research diagnostic criteria CGAS	20 had PTSD and 21 had some type of depression (5 major depression). CGAS 43–75 for those exposed to Pol Pot regime, CGAS 84 for those not exposed. Impairment visible in school settings	Kinzie *et al.* (1986) Sack *et al.* (1986)
	Cambodia	$n = 209$ living in USA. Age 13–25 years. As children, many witnessed atrocities including killing of family	SADS GAF	18% had PTSD (GAF 72); 11% depression (GAF 68). GAF 82 in those without PTSD or depression	Sack *et al.* (1994, 1995b)
	Iranian	$n = 50$ living in Sweden. Experienced attacks in war, family separation. Mean age 5 years 10 months	Semistructured interview parents and child	19 (38%) preoccupied with violence; only 13 (26%) good emotional well-being	Almquist & Brandell-Forsberg (1995)
	From 35 nations (29% South-East Asia; 27% Central America)	$n = 203$ Age 13–19 years 70% migrated to Canada before age 6 years; most not war exposed	DISC – 2.25	Rate psychiatric disorder 21% refugee group vs. 11% non-refugee peers. Over-anxious disorder in 13% in refugee group. Psychiatric diagnosis associated with family status (single/reconstituted family) and parental unemployment for 6 months after arrival in Canada	Tousignant *et al.* (1999)

BCL, Behavior Checklist; CBCL, children's behavior checklist; CGAS, children's global assessment scale; DISC, Diagnostic interview schedule for children; DSRS, depression self-rating scale; GAF, global assessment of functioning; SADS, Schedule for Affective Disorder and Schizophrenia; RCMAS, revised childrens' manifest anxiety scale; RIES, revised impact of events scale.

* These studies included some children living in refugee camps so overlap with the "in-flight" section of table.

have been carried out in the UK. A survey of primary school children found that the refugee children were more distressed than their peer group (Fazel & Stein, 2003). Another study of refugee children, mean age 11 years, mainly non-referred, used self-report measures of post-traumatic stress and depressive symptoms (Heptinstall, Sethna, & Taylor, 2004). A high level of post-traumatic and depressive symptoms was found, with more than half of the children being at risk of PTSD and depression.

A different picture emerges of multiethnic refugee adolescents who were living in Montreal, most of whom had not been exposed to war (Table 31.1; Tousignant *et al.*, 1999). The greatest differences occurred amongst females, who had elevated rates of over-anxious disorder and phobias compared with non-refugee peers. Psychosocial impairment was greatest amongst those with conduct disorder.

Clinic- and Service-Based Studies

It is well known that only a small proportion of children and adolescents in the community with psychiatric disorders are attending mental health services (Ford, Sayal, Meltzer *et al.*, 2005; Verhulst & van der Ende, 1997). A number of factors influence who gets help, including the severity of the disorder and level of social impairment. Only a small number of studies of young refugees who have accessed mental health services have been published.

Young refugees often present with disorders that reflect exposure to past violence and disruptions of relationships such as PTSD, adjustment disorders and depression (Arroyo & Eth, 1985; Howard & Hodes, 2000). Interestingly, a report from Kosovo of child mental health service users soon after the war (1998–99) found that in addition to stress-related disorders such as PTSD and adjustment disorder, enuresis was a frequent problem (Jones, Rrustemi, Shahini *et al.*, 2003). Psychosocial impairment of the refugee children may be similar to that of other children in the same service, and certainly much greater than would be expected in a community comparison group (Howard & Hodes, 2000).

Young refugees using services may have disorders that have multifactorial causation, but may be precipitated by experience of adversities and cultural change. Eating disorders, anorexia nervosa (Kope & Sack, 1987) or bulimia nervosa (Stein, Chalhoub, & Hodes, 1998) have been reported, as well as rarer severe problems such as somatoform disorders associated with depression, in which children become withdrawn and lose the ability to eat and talk (Bodegard, 2005). High levels of stressful events including intrafamilial abuse may also precipitate violent deliberate self-harm (Patel & Hodes, 2006). Young refugees were highly represented in a survey of adolescent psychiatric in-patients in London, largely because of psychosis (Tolmac & Hodes, 2004). This group were predominantly African adolescents who had experienced a high level of war exposure, including witnessing the killing of family members, and had low social support, reflected in the fact that they were less likely to be living with a parent than other in-patients (Hodes & Tolmac, 2005).

It should be remembered that young refugees could have psychiatric and developmental difficulties (e.g., learning difficulties, pervasive developmental disorders, obsessive compulsive disorder and hyperkinetic disorder), which can occur independently of adverse experiences and displacement (Howard & Hodes, 2000; Williams & Westermeyer, 1983).

Risk and Resilience for Psychopathology

Some theoretical considerations are important in considering the variation in children's psychological response to organized violence and associated adversities. First, in relation to risk events, as can be seen from the account already given, isolated events in "refugee" experiences are relatively unusual, and adversities typically cluster, occurring in close temporal proximity and perhaps also as a protracted process. Available evidence suggests that greater psychological harm comes from an accumulation of risk factors. This refers both to the type of event and duration of exposure, with increasing risk associated with increasing personal threat (Espino, 1991; Garbarino & Kostelny, 1996; Kinzie, Sack, Angell *et al.*, 1986; Mollica *et al.*, 1997; Sack, Clarke, & Seeley, 1996; Sack, Seely, & Clarke, 1997). Second, with regard to resilience, it has been cogently explained that "Resilience does not constitute an individual trait or characteristic. . . . Resilience involves a range of processes that bring together quite diverse mechanisms operating before, during or after the encounter with the stress experience or adversity that is being considered . . ." (Rutter, 1999). The succinct account that follows, which cannot bring out all the subtleties of the findings, might appear to be organized as if risk and resilience are characteristics of events or individuals, but a tendency to interpret the data this way should be resisted (see chapter 25). Some of the main influences on mental health that have been investigated in young refugees are shown in Table 31.2.

Many of the risk factors described here are also considered in chapter 42 with regards to PTSD. Individual attributes such as age and gender may influence psychological adjustment in complex ways. Age and developmental level influence cognitive function, including appraisal of events, as well as biological processes such as responses to stress. Gender may be associated with differing war exposure (Ahmad *et al.*, 2000; Derluyn, Broekaert, Schuyten *et al.*, 2004; Montgomery, 1998; Somasundaram, 2002). Research investigating associations between war events and psychological distress has often controlled for number of events, rather than looking at the links between types of events and gender (Smith *et al.*, 2002; Vizek-Vidovic, Kuterovac-Jagodic, & Aarambasic, 2000). Some reports have found greater levels of post-traumatic and anxiety symptoms among girls than boys (Jones & Kafetsios, 2005; Smith *et al.*, 2001; Vizek-Vidovic, Kuterovac-Jagodic, & Aarambasic, 2000), but other studies did not find this (Thabet, Abed, & Vostanis, 2002).

Table 31.2 Risk and protective factors for psychopathology.

	Risk factors	Protective factors
Individual experience of war events	Proximity to events: range from witnessing at distance, to direct involvement in violent events Repetition of events Degree of personal threat, including witnessing maltreatment of family Appraisal of events that involve hopelessness and despair	Low-level exposure to distant war events might increase resilience Appraisal of events that reflects ideological commitment in conflict Cultural and religious influences on appraisal of events
Individual factors	Gender: **1** Gender differences in exposure to war events: females more likely to be victims of sexual assault; males more likely to become combatants **2** Females probably more vulnerable to internalizing symptoms; males more vulnerable to externalizing symptoms Temperament: anxious or vulnerable temperament increases risk Past psychopathology	
Family factors	Separation from family Parental psychological distress (mostly investigated for mothers) Family conflict	Greater family cohesion Appropriate family expectations of resettlement country Parental fluency in language of host country
Social factors	Uncertainty regarding asylum application and legal status Detention and restrictive living arrangements Financial hardship Parental unemployment High mobility and poor housing Social isolation Hostility and discrimination in host country	Greater social support including links with same ethnic/language group

The individual's understanding of events is also important. This will be shaped by beliefs and ideologies that may be shared with the social or cultural group, including specific attitudes to preparedness for war events (Jones & Kafetsios, 2005; Punamaki, 1996). Realistic expectations are associated with better adjustment (McKelvey & Webb, 1996).

Positive effects of the family were observed during World War II, when it was noted that the presence of parents protected against psychological distress during bombing (Freud & Burlingham, 1943). Investigation of unaccompanied asylum seeking children suggest that they may be more distressed than those who are accompanied (see p. 480; McKelvey & Webb, 1995). Large surveys have shown that children's distress is related to parental distress, although the studies have largely focused on mothers rather than fathers (Smith *et al.*, 2001). There may be an interaction between a child's gender and the effect of maternal distress. A study of Palestinian children in Gaza found that boys were at special risk for post-traumatic and emotional symptoms when the mothers and the boys themselves were exposed to a high level of war, whereas for girls these symptoms were more associated with mothers' exposure (Quota, Punamaki, & El Sarraj, 2005). The quality of family relationships is also important, as children in cohesive well-functioning families experience less distress from external war events (Garbarino & Kostleny, 1996; Laor, Wolmer, Mayes *et al.*, 1996).

Societal response to those who have experienced organized violence and displacement can influence psychological adjustment. In societies where there have been abductions and suspected but not confirmed killings, grieving is not possible, and this heightens distress for children (Quirk & Casco, 1994). Those who have fled their own communities and live in refugee camps may experience very difficult conditions with regard to the physical environment, such as overcrowding and inadequate facilities for children. For asylum seekers in resettlement countries, detention policies (Fazel & Silove, 2006; Reijneveld, De Boer, Bean *et al.*, 2005) and long delays and uncertainties regarding their application for refugee status may increase psychiatric disorders such as anxiety, depression and somatoform disorders (Laban, Gernaat, Komproe *et al.*, 2004). Ongoing daily hassles, or resettlement stressors have been shown to increase depressive symptoms in children (Heptinstall, Sethna, & Taylor, 2004; Sack, Clarke, & Seeley, 1996). Greater resilience for parents and well-being of children is seen amongst those who have stronger social networks, usually associated with greater ethnic density, more opportunities for work and greater residential stability (Ahearn, 2000).

Course and Intergenerational Effects

The persistence of psychopathology has been identified from studies with children with diverse cultural backgrounds. A cohort of 46 children from Cambodia, 40 of whom had experienced the Pol Pot regime in primary school years, were followed up while living in the USA (Sack, Clarke, Him *et al.*, 1993; Sack, Him, & Dickason, 1999). Six years after the initial assessment, 48% had PTSD and the figure was 35% at 12 years. Regarding depression, the figures at the same time points were 7% and 14%, respectively. Other studies have found the persistence of PTSD but lower levels of depression with resettlement (Hubbard, Realmuto, Northwood *et al.*, 1995). The persistence was also found in a report of Kurdish children who had PTSD years after experiencing a military campaign against their communities and experiencing displacement at a later time (Ahmad, Sofi, Sundelin-Wahlsten *et al.*, 2000). Many of the young people in the studies had quite good social function with respect to school attendance and attainment despite the presence of psychopathology.

Very long-term psychiatric outcomes have been described in survivors of the Holocaust, experienced in adolescence or early adulthood. Emotional distress, including anxiety symptoms, lower mood and psychiatric service use were much higher in middle-aged Holocaust survivors than immigrant controls (Carmil & Carel, 1986). In old age, the Holocaust survivors continued to have more distress with regard to post-traumatic symptoms and general psychopathology (Joffe, Brodaty, Luscombe *et al.*, 2003). The Holocaust survivors were also more likely to experience further post-traumatic symptoms when retraumatized by bombing (Robinson, Hemmendinger, Netanel *et al.*, 1994).

The catastrophic losses and abuse experienced by survivors of the Holocaust will often have long-term effects on feelings of safety or insecurity, self-esteem and development and maintenance of relationships. For this reason, attention has been given to the children of Holocaust survivors, as many reports suggested that they were at increased risk of psychopathology (Felsen, 1998). However, a meta-analysis has found that children of Holocaust survivors are no less well-adjusted than their peers, and had not experienced secondary traumatization (van IJzendoorn, Bakermans-Kraneberg, & Sagi-Schwartz, 2003).

Aggregation of disorders in families has been investigated with regard to the association between child and adult psychopathology, especially PTSD and war trauma (see above). A report regarding PTSD across two generations of Cambodian refugees living in the USA found a significant relationship between parent–child PTSD, but not depression (Sack, Clarke, & Seeley, 1995a). Clustering of disorders in families may occur because of genetic factors, but these have not been investigated amongst refugee populations.

The changes associated with migration, adaptation to new cultures and communities will affect generations in different ways. Adult asylum seekers may have limited rights, be unable to work, their acquisition of the language of the resettlement country may be slow and they may be socially isolated. By contrast, their children will attend school, will rapidly have a peer group and opportunity to learn the new language. Thus, the children will assimilate and adapt much more quickly than their parents. They may take on tasks to support the family, and in some case they may become carers of parents who are unwell (e.g., because of torture or psychiatric impairment). These changes can also create tensions, in part because of the burden for the children, but also because the usual family organization and parental authority may diminish (Tobin & Friedman, 1984). This may result in poor boundaries and containment for younger children, and reduced surveillance and advice for adolescent offspring (Westermeyer, 1991). These factors might in part explain the higher level of psychiatric disorders including conduct disorder amongst the refugee adolescents in Canada who had largely not been exposed to war experiences (Table 31.1; Tousignant *et al.*, 1999).

Unaccompanied Asylum Seeking Children

During the course of war and organized violence, family members may become separated and children orphaned. Some children are sent away from imminent danger, and may experience harrowing journeys, with further risk of abuse or illness. In some regions of the world, such as Sri Lanka and North Uganda, abduction of children has been common, and many of them are then forced to become soldiers (Derluyn *et al.*, 2004; Somasundaram, 2002). It has been estimated that there are 300,000 child soldiers worldwide (Human Rights Watch, 2006). It is unclear how many unaccompanied asylum seeking children there are globally. Estimates of the numbers in the UK suggest the number has increased since 1990, and over the first part of the decade, 2000–2005, has been around 5500.

Unaccompanied asylum seeking children can be regarded as at special risk. They have experienced high levels of war events and separations (McKelvey & Webb, 1995; Thomas, Thomas, Nafees *et al.*, 2004). Journeys may have been harrowing, and their arrival in resettlement countries may be associated with great uncertainties. It is expected that child asylum seekers will be offered special protection (UNHCR, 1994). In the UK they are entitled to care under the Children Act 1989, and so are supported by local authorities (Wade, Mitchell, & Baylis, 2005). However, the initial assessment and level of support, including accommodation, may be poor (Wade, Mitchell, & Baylis, 2005).

Available evidence suggests that unaccompanied asylum seeking children and young adults have high levels of psychological distress even after controlling for traumatic events (Bean, Eurelings-Bontekoe, Mooijaart *et al.*, 2006; McKelvey & Webb, 1995). A study from Finland of 46 adolescents mainly from Somali background, found that on the basis of the Child

Behavior Checklist, nearly half were in the clinical or borderline range (Sourander, 1998). Younger children were significantly more distressed than the older ones. Studies of child soldiers from Uganda and Sri Lanka who had experienced very high levels of war events, including killing someone themselves, found high levels of post-traumatic stress, anxiety and somatization (Derluyn *et al.*, 2004; Somasundaram, 2002).

Agencies that provide care for these children have considered the importance of foster care or group homes that might mitigate the effects of losses and increase resilience, by increasing social links with an ethnically and linguistically similar peer group and community (Geltman, Grant-Knight, Mehta *et al.*, 2005; Porte & Tomey-Purta, 1987; Wade, Mitchell, & Baylis, 2005). Same ethnic group foster families, or perhaps group homes, are much preferred to fostering with culturally different families (Geltman *et al.*, 2005; Wade, Mitchell, & Baylis, 2005). The preferred arrangement has been found to be associated with significantly less risk of depression, in the case of South-East Asian youngsters (Porte & Tomey-Purta, 1987), and PTSD, in the case of Sudanese adolescents (Geltman *et al.*, 2005).

Implications for Services and Interventions

There has been debate regarding the best means of intervening and promoting the welfare of displaced people. Primary prevention of conflict sadly seems to be unattainable, but concerted international efforts have been made over years to regulate the treatment of prisoners and detained people (UNHCR, 2006). Children's special needs and rights have been identified (UNHCR, 1994). Recruiting children into armies has been condemned by the United Nations, but that organization has been criticized for not being adequately effective (Editorial, *Lancet*, 2004).

When it is feasible after cessation of hostilities, there is a need for general welfare provision which should include schools and other services (Inter-agency Standing Committee 2007; van Ommeren, Saxena, & Saraceno, 2005). In this tiered approach to the provision of services, community support will benefit large populations. Services that might specifically help children include family reunification programs, adequate protection and care – including medical care – for orphans or unaccompanied asylum seeking children. In the more affluent countries such as the UK, general services that target excluded communities with children may include refugees within their remit (Hodes, 2002b). Strengthening families is likely to promote the mental health of parents and children. Initiatives in Kosovo that promote family strengths, using psychoeducation and multifamily groups (Griffiths, Agani, Weine *et al.*, 2005), have been reported. Other useful approaches may focus on maintaining continuities in family life, and coping with change including reunification with separated family members (Rousseau, Rufagari, Bagilishya *et al.*, 2004; Weine, Dheeraj, Merita *et al.*, 2003). A well-designed study from Bosnia offered weekly group meetings with mothers over 5 months, with the provision of psychoeducation regarding their children's needs and helping the children to describe traumatic experiences, in addition to medical care, which was the only intervention for the control group (Dybdahl, 2001). Those who received the psychosocial intervention made greater progress: mothers had better mental health, children gained more weight and had better psychosocial functioning.

Controversies have arisen regarding the extent to which mental health services in disaster zones, including areas where there are refugees, should be established to focus on post-traumatic psychopathology. Trauma services have been criticized for focusing on psychological distress outside of a context that considers the whole infrastructure and resource provision, and may neglect cultural factors and other disorders (Eisenbruch, de Jong, & van de Prut, 2004; Summerfield, 1999; van Ommeren, Saxena, & Saraceno, 2005). The criticism is especially cogent in view of the absence of evidence of effectiveness in support of primary prevention of post-traumatic stress symptoms for those exposed to traumatic events, and failure to show benefit for non-refugee populations suggest this would be an inappropriate use of resources.

A preferred option is to integrate trauma-based care into general mental health care (Eisenbruch, de Jong, & van de Prut, 2004; Inter-agency Standing Committee 2007; Summerfield, 1999; van Ommeren, Saxena, & Saraceno, 2005). The benefit of this is apparent from the report from Kosovo described previously, in which by the second year after the war ended, frequent reasons for attending were learning difficulties (intellectual disability) and enuresis (Jones *et al.*, 2003). However, even in affluent countries, mainstream services including primary care may have organizational difficulties meeting the mental health needs of refugees. Access should be facilitated by using interpreters, and consider the fact that asylum seekers may live in homeless accommodation and experience high mobility (Lamb & Cunningham, 2003).

More targeted services can be established for special populations such as unaccompanied asylum seeking children. This group will have health screening and ideally this should include screening assessment of mental health difficulties (Geltman *et al.*, 2005; Wade, Mitchell, & Baylis, 2005). Preschool children may be prioritized by health visitors and others working with this age group.

In view of the difficulties that might arise for young refugees in gaining access to clinic-based child and adolescent services, outreach programs in schools have been described, with some encouraging data available from evaluations (Ehntholt, Smith, & Yule, 2005; Hodes, 2002b; O'Shea, Hodes, Down *et al.*, 2000; Stein, Jaycox, Kataoka *et al.*, 2003). Such services have been provided in communities such as Bosnia following the war, with the involvement of teachers as therapists, in view of the dearth of child mental health professionals there (Udwin, 1995). One advantage of school-based work is that all refugee children, regardless of legal status, are expected to attend. Teachers can identify those who are psychologically distressed and make referral to the school-based mental health

service, so bypassing reliance on primary care which may be difficult for refugees to access. Families may also experience school-based services as less stigmatizing than clinic-based services. A further advantage is that child mental health practitioners working in the schools will establish good liaison with teachers, and can also provide a consultation model to reach more children. Given resource limitations, it may only be feasible to provide child mental health outreach to schools that have significant numbers of refugee pupils, and adequate infrastructure including effective school referral systems and support from interpreters.

The psychiatric heterogeneity of young impaired refugees, including some with high levels of distress and poor social function, means that some will need referral to specialist child and adolescents mental health services. Despite the difficulties the young refugees and families may have had in accessing services, and the very frequent need for interpreters, they may not have a higher dropout that non-refugees in the same service (Howard & Hodes, 2000). Impressions are that newly arrived asylum seekers are more likely to be seen because of post-traumatic stress, anxiety and mood disorders but, as the communities become more settled, children will be increasingly referred because of disruptive behaviors. The clinical assessment may be complex as it is necessary to consider development in environments that may have been very abnormal (e.g., absence of schooling, prison, multiple moves between countries, homes and carers). The high level of background stressors may have contributed to behavioral, conduct and attentional problems, making the differential diagnosis among hyperkinetic, conduct disorders and adjustment disorders difficult. For some children a symptomatic treatment approach and regular reassessments may identify stable specific symptom clusters, and clarify diagnostic difficulties. In these situations, psychometric testing for intellectual ability and physical examination to assess in particular coordination disorder, which is commonly comorbid with hyperkinetic disorder (Gillberg & Kadesjo, 2003), may point towards a neurodevelopmental basis for the attentional and conduct problems.

Some children will require psychiatric admission for further assessment and treatment. This group may have experienced high levels of past war traumatic events and current low family support. This combination may in part explain the high rate of involuntary admission for adolescents with severe psychopathology including psychosis (Tolmac & Hodes, 2004).

Clinical work may require an expanded role for child and adolescent mental health professionals. Requests may be made for reports to access housing and school, and legal reports to support asylum applications (Tufnell, 2003). Attention needs to be given to parental mental health difficulties (Ahearn & Athey, 1991; Howard & Hodes, 2000). Intervention often needs to be multiagency, and draw on the range of services from social services as well as other heath services such as child health (Geltman *et al.*, 2005; Wade, Mitchell, & Baylis, 2005; Westermeyer, 1991).

There are specific skills in working with interpreters, and key points are given here (Farooq & Fear, 2003; Raval, 2005). First, it is generally not appropriate to involve a child as an interpreter, in part because of the responsibility this gives to the child, and also because of the effect on family relationships, as parents become dependent on their child's skills and integrity for accurate interpreting. If an interpreter is needed, it is necessary to consider their gender and ethnicity, and their suitability for the particular family. Discussion with the family, perhaps involving the interpreter (e.g., over the telephone), might be useful. There are techniques for interviewing with the interpreter. During the session, eye contact and questions should be directed to the person who is being addressed, not the interpreter. Speech should be at an appropriate speed, and technical words and terms that elicit feelings or particular psychological experiences may require discussion with the interpreter. Following the session it is often useful to speak to the interpreter to identify any difficulties that might have arisen.

Asylum seeking families in particular may have fears regarding the "assessment" process, which may be reminiscent of interrogations. Furthermore, there may be unease, perhaps not voiced, regarding the degree of confidentiality in the clinic setting. A further feature of work with refugees is that many things may be "unknown" for the clinician. Families may find it hard, or unthinkable, to disclose background adversities (e.g., the rape of females in the family).

Regarding treatments, given the heterogeneity of psychiatric disorders and problems, it is not possible to provide an adequate account here, but summary accounts are available elsewhere for specific disorders such as PTSD (see chapter 42; Hodes & Diaz-Caneja, 2006). A number of general points can be made (Hodes, 2000). Culturally shaped attitudes may influence the way parents explain their children's adjustment and responses to the changes they have encountered, and this may affect attitudes to specific treatments. One aspect of this is the wish to look forward, rather than back. This may be manifest as a preference to deal with current difficulties (e.g., school problems) rather than look back and address past traumatic events, which would be required for cognitive-behavioral work. Another related feature is the extent to which evidence-based treatments can be provided for this culturally heterogeneous population. Evidence available for PTSD is that existing treatments are effective (see chapter 41; Neuner, Schauer, Klaschik *et al.*, 2004; NCCMH, 2005; Onyut, Neurer, Schauer *et al.*, 2005; Paunovic & Ost, 2001; Stein, Jaycox, Kataoka *et al.*, 2003). However, treatment needs to be adapted to be culturally congruent with families' understanding and beliefs.

Conclusions

The scale of war and organized violence globally has had a major impact on child and adolescent mental health. In recent years, increasing attention has been paid to this area but

there are still significant gaps in knowledge. From a research perspective, there is a need to investigate further young peoples' risk and resilience for psychopathology, as well as the effectiveness of available interventions. It continues to be important to plan services for this vulnerable population.

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