

# Research into the psychological well-being of young refugees

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Interest in the psychological well-being of refugees and asylum seekers has steadily grown in recent years. Latest estimates indicate there are 32.9 million people of concern to the United Nations High Commissioner for Refugees (2006). A refugee is defined as being in that position because of a well-founded fear of persecution due to race, religion, nationality, social group or political opinion, and who is consequently outside and unable to return to his or her country. The status of 'refugee' is contrasted with that of a person seeking asylum, whose experiences may be similar but who is not formally determined in the same way.

The literature reporting mental health research concerning young refugees and asylum seekers is less comprehensive than that concerning adults. This is remarkable, given that almost half the world's refugees are children and adolescents (United Nations High Commissioner for Refugees, 2006). This paper summarises key research findings about the psychological well-being of child and adolescent refugees and asylum seekers. A full review has been presented by the Australian Human Rights and Equal Opportunity Commission (2002). For brevity, the term 'refugee' will be used hereafter to encompass those also seeking asylum.

## Symptoms of post-traumatic stress

Many young refugees migrate with histories of exposure to trauma. Such trauma may include the violent death of a parent, injury to or torture of a family member, separation from parents, witness of murder or even massacre, exposure to bombardments, shelling or terrorist attack, forcible eviction from home, detention, physical injury and disability inflicted by violence, sexual assault, disappearance of loved ones, enduring political oppression, deprivation of human rights and education, and subjection to child-soldier activities. Children and adolescents are especially vulnerable to these effects because of their incomplete biopsychosocial and cognitive development, dependence, and underdeveloped coping skills. This vulnerability is increased owing to potential under-reporting of symptoms by parents (Almqvist & Broberg, 1999).

In the main, investigations have considered the impact of traumatic events upon psychological well-being, predominantly in terms of post-traumatic stress disorder (PTSD) or related symptoms. Included within this broader set of symptoms may be presentations of physical discomfort,

trauma-themed repetitive play, personality changes, regressive or violent behaviour, high anxiety, social withdrawal, conduct problems or survivor guilt.

Despite controversy surrounding the application of the term PTSD to populations affected by war (arguably, this diagnostic approach 'pathologises' normal reactions to abnormal situations), many studies have shown that trauma symptoms are common among young refugees. The studies by Kinzie *et al* (1986) and Sack *et al* (1999) are frequently cited to attest to the persistence of post-traumatic stress and poor adaptation in young refugees exposed to trauma as children. Others have successfully used interviews with children to identify a large, otherwise hidden, proportion who were not known by their parents to have symptoms, yet who had a diagnosis of PTSD (Almqvist & Brandell Forsberg, 1997).

While the nature of traumatic exposure varies, from direct to indirect and from single to repeated events, post-traumatic stress is well established in young refugees from many different regions, including, for example, Bosnia (Papageorgiou *et al*, 2000), Central America (Rousseau *et al*, 1997), Iran (Almqvist & Broberg, 1999) and Somalia (Ellis *et al*, 2008). Although prevalence rates of PTSD are highly variable (from 2% up to 50%; Howard & Hodes, 2000), there is general support for the validity of the diagnosis as a useful construct in children, cross-culturally.

Studies have also examined the impact of trauma before immigration, in relation to its type, amount and duration. Review of such studies indicates that the greater the severity, number and extent of exposures, the poorer the psychological outcome in terms of onset and severity of PTSD symptoms (Papageorgiou *et al*, 2000). For example, children directly exposed to violence (e.g. an assault on parents) or multiple trauma (e.g. shelling, combat) have a greater risk of developing chronic or severe PTSD (Almqvist & Brandell Forsberg, 1997).

Although it is not yet established whether the legacy of exposure to traumatic stress is carried into adulthood, longitudinal studies do show that while the severity of these symptoms may lessen, they nevertheless persist over time in up to a third of young refugees, causing continued distress (Sack *et al*, 1999). Another consistent finding is that disorders cluster in families, with the risk of PTSD increasing when a parent or other family member exhibits PTSD (Sack *et al*, 1996). Young refugees are also susceptible to vicarious trauma; in such cases a parent's own traumatic experience can influence the symptoms experienced by the children (Hodes, 2000).

Although consistent outcomes are reported in the literature for young refugees regardless of the type of traumatic experiences and cultures, the specific impact of trauma within a cultural context has rarely been examined. There is, though, increasing evidence that trauma symptoms are influenced by culture (Rousseau *et al*, 1997).

## Comorbidity and other psychological outcomes

Adverse psychological outcomes are exacerbated by problems of malnutrition, disease, physical injuries, brain damage and sexual abuse. These should not be overlooked when making psychological enquiries of young refugees.

Disorders that are commonly associated with PTSD include high rates of anxiety and depression, with the latter being more closely associated with ongoing adversity during resettlement (Sack *et al*, 1996). Somatic complaints include sweating, headaches, respiratory and gastric problems. Cognitive problems include negative beliefs, expectations and suicidal thoughts. In displaced children, eating and sleep disorders are reported to accompany uncertainty regarding current status and fears about the future (Kocijan-Hercigonja *et al*, 1998). Among adolescents, a small number experience psychoses (Hodes & Tolmac, 2005). In terms of psychosocial outcomes, young refugees experience learning difficulties, isolation and social disadvantage (Howard & Hodes, 2000).

It should be noted that there is inconsistency in reports, with some studies documenting equivocal findings concerning the prevalence of mental health disorder among refugee children. Rather than suggesting an absence of distress, this may indicate that symptoms can be transient. Alternatively, psychopathological outcomes may form only part of the short- and long-term trauma response, which includes not only PTSD, anxiety and depression, but also other negative outcomes, such as loss and grief (Howard & Hodes, 2000).

Moreover, there is good evidence that, despite multiple traumas and elevated prevalence rates in young refugees, adaptation does occur (Punamaki *et al*, 2001). That there is resilience and recovery, after multiple loss and hardship, is reassuring. None the less, when compared with non-refugees, there is significantly greater psychological disturbance in young refugees. For example, psychological disturbance is three times greater among refugee children in Britain than among children in the general population (Fazel & Stein, 2003).

## Risk and protective factors

This discussion has highlighted the fact that specific pre-migration risk factors, including trauma exposure and forced migration, are the most detrimental. Previous research also identifies dispositional and environmental factors as predictors of mental health. An ability to respond to new situations, positive self-esteem, good temperament and positive support through strong peer relationships are protective factors (Almqvist & Broberg, 1999).

The risk and protective factors during the post-migration period are equally important. This is because ongoing resettlement stressors can significantly undermine well-being. As is the case before migration, existing mental health

problems, family dysfunction, parental incapacity and unavailability (especially maternal in origin) are critical post-migration risk factors (Almqvist & Broberg, 1999). Furthermore, stressors that occur during resettlement can exacerbate or reactivate memories and emotions of past trauma.

It has been consistently shown that young refugees who are unaccompanied or who have been separated from their families have a greater risk of mental health problems than those who are accompanied or who later re-establish contact with their family (Sourander, 1998). Because of their heightened vulnerability to being forced to undertake child-soldier activity as well as their greater potential to support a family financially at resettlement, boys are highly represented in this unaccompanied group (Rousseau *et al*, 1997). The risk to unaccompanied minors is exacerbated following a history of multiple separations (Rousseau *et al*, 1997) and when caregivers other than the natural parents are substituted at resettlement (Kinzie & Sack, 1991).

Displacement and the processes associated with seeking asylum pose risks to young refugees for many reasons. These include the compounding stressors of camp life, enforced supervision and communal living outside the family and/or cultural group. The risk of mental health problems is also increased by delays in processing immigration status, dealing with officials, racism and discrimination, uncertainty about asylum status, loneliness and boredom (Silove *et al*, 1997). In Australia, mandatory detention has now been abandoned as a government policy: while in operation it increased the risks of hopelessness, despair and self-harm among those seeking asylum (Fazel & Silove, 2006). Negative outcomes associated with displacement and detention may also be attributable to the loss of traditional parent roles, perceived control and learned helplessness.

Acculturative stressors, including low socio-economic status, problems in language and school adjustment also predict poor adaptation. By contrast, good academic achievement, as influenced by language acquisition and good peer relations, is predictive of adaptation (Rousseau *et al*, 1997). Importantly, discrimination and financial hardship have been shown to predict depression in the resettlement period (Ellis *et al*, 2008), supporting the strong association between depression and acculturative stress (Sack *et al*, 1996). Conflict in adolescent identity formation is related to poor psychological adjustment. The process of adapting to a new culture can further increase vulnerability through high parental expectations and intergenerational conflict (Rousseau *et al*, 1997).

There are contradictory findings regarding the influence of age and gender on risk of mental health problems among immigrant children. While some suggest cognitive immaturity in younger children is protective (Papageorgiou *et al*, 2000), others have suggested that an inability to articulate and express distress on the part of younger children may increase risk (Berman, 2001). Girls and boys are more vulnerable at different ages and in rather different conditions (Papageorgiou *et al*, 2000). Of course, differences in gender may reflect cultural expectations for the display of emotions.

The availability of social support and positive peer relationships can facilitate successful adaptation in the resettlement period despite a history of extreme trauma (Almqvist & Broberg, 1999). The maintenance of close ethnic community ties is also protective, alongside cultural and religious traditions, which assist in restoring a sense of continuity

(Rousseau *et al*, 1997). Despite low rates of help-seeking, early intervention and appropriate psychosocial assistance have been reported as crucial protective factors (Howard & Hodes, 2000; Punamaki *et al*, 2001).

## Conclusions

Unfortunately, the major risk factor is traumatic war exposure, and that cannot be eliminated. Let us remember, though, that with knowledge of the factors that are significant, especially those that enhance resilience, we can help to minimise the burdensome effects of trauma and give strength to this vulnerable and growing population.

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## Estonia

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**E**stonia is a small country (45 000 km<sup>2</sup>) with a population of 1.3 million people. It has undergone rapid change since it gained independence from the Soviet Union in 1991. It has achieved some economic success, although there is a suggestion that this has been at the expense of the mental health and general emotional well-being of the people. In the Estonian Health Interview Survey, depressive symptoms were observed in 11.1% of respondents and their presence was strongly correlated with socio-economic status (Aluoja *et al*, 2004).

### Health system

The Estonian health system is funded via a national social insurance scheme. The Health Insurance Fund is provided from taxes on incomes of the working population, but it also covers those who have no income from employment. It is a universal scheme, under which medical institutions are reimbursed for treatments provided to all patients.

The first point of contact for the patient is the family doctor. Where necessary, the family doctor can refer the