CHAPTER 44

Refugee, asylum-seeking and internally displaced children and adolescents

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Introduction

Children forced to flee from their homes because of organized violence, political or religious persecution, or rising ethnic tensions are often exposed to events that place great stress upon their psychological development. These children commonly witness and are subject to extreme violence, lose attachment figures because of family separations or bereavement and invariably leave familiar home and cultural surroundings with resultant disruption to their education and peer relationships. This can lead to different effects on children depending on the nature of their particular experiences, their environment and ongoing support as well as their personal characteristics. Some continue to develop on their pre-existing trajectory, showing remarkable resilience and capacity to survive or even thrive in the face of adversity (Tol *et al*., 2013). Others increasingly struggle with psychological difficulties under the weight of negative events and circumstances.

There is a misconception that potentially traumatic events are confined to displaced peoples' experiences in their homeland. However, these are often only the beginning of a chain of adverse events. Migration journeys and post-migration experiences are often sources of further distressing occurrences. Achieving settled status in a safe location may take years, or may never be achieved, depending on the legal frameworks and political stability of the resettlement location. During this period and beyond, displaced children and families must make new peer and neighborhood relationships, manage changes in familial roles and master a new language and cultural environment. In high-income countries, they must simultaneously negotiate the asylum processing systems and welfare agencies; in low-resource settings, flight may be followed by years of struggle to meet basic survival needs amid eruptions of organized violence and gender or ethnicity-based attacks. The serious consequences of cumulative adversity for children's mental health have long been established (Rutter, 1999).

Refugee, asylum seeking, and internally displaced children and adolescents are therefore a group of major concern. In addition, an understanding of the way in which their experiences influence them has the potential to contribute to our knowledge of psychological development. Studying the interplay of the many factors highlighted earlier can elucidate processes underlying resilience as well as psychopathology and help focus on potential areas of intervention (see Chapter 27). In this chapter, some background information on these populations is provided, followed by discussion of particular risk and protective factors for psychopathology, highlighting important studies. Finally, there will be a focus on interventions highlighting some that have been evaluated. It should be noted that interventions are important to consider at all levels—individual, family, school, community, and societal.

In 2011, approximately 16 million children, almost half of the total global population of refugees and people in refugee-like situations, were displaced from their homes (UNHCR, 2011). The variation between refugees' background circumstances, country-of-origin, country-of-resettlement, culture and experiences is so great that it should not be assumed that they are a homogeneous group. There are, however, key elements that are almost universally experienced by refugees: loss, uncertainty, fear, and discrimination. Many experience family and community disruption. It is common for the asylum process to last several years after arrival in the country of resettlement. Financial support for asylum-seekers is typically low even in high-income countries, and many report difficulties in accessing services to which they are legally entitled; those in low and middle-income countries (LMIC) are not uncommonly in situations of humanitarian crisis.

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For those internally displaced, or displaced to neighboring countries, local tensions and economic circumstances may necessitate a series of moves, which means that the children may experience repeated adversity and instability. Many have to live in refugee camps and the instability and greater experience of cumulative adverse events appear to place children in these situations at particularly high risk of psychological difficulty (Reed *et al*., 2012). Hereafter, the general term "forcibly displaced children" will be used to encompass this population, unless specifically referring to a subgroup.

Research with forcibly displaced children has largely focused on the minority who have resettled in high-income countries (Fazel *et al*., 2012). There are many challenges to conducting research with refugee populations, especially those living in LMICs including the need for cultural and linguistic adaptation of measures, and culturally differing models of conceptualizing adverse events (Bhui *et al*., 2003). Moreover, studies of interventions for displaced populations have been hampered by a number of methodological issues (Nickerson *et al*., 2011). These include small sample sizes, lack of post-treatment and long-term follow-up assessments, a lack of random assignment, the absence of appropriate control conditions or interventions and little treatment manualization. Therefore, only a small number of interventions have been adequately evaluated and those that have been evaluated have shown small to moderate effect sizes. While many of the interventions have had good face validity, these difficulties have limited the conclusions that can be drawn about the best way forward.

Definition of terms and the global refugee situation

People who have moved away from their home locality owing to persecution or organized violence are described as "forcibly displaced" and their situation is often exacerbated by the pressures of extreme poverty or environmental challenges. Those moving within their own national borders are described as "internally displaced." This term is also used for people who have moved owing to natural disasters or severe economic hardship, but in this chapter we use it with reference to those fleeing organized violence. Those who migrate to a different country to escape persecution are typically described by the broad term "refugees," although in many countries "refugee" has a more specific legal meaning denoting someone who has applied for and been granted political asylum. Hence refugees in these contexts have long-term or permanent rights of residence in the host country. An "asylum seeker" is someone who has applied for but not yet been granted refugee status by the host country. A "failed asylum seeker" is someone who has not been successful in their asylum application and, in many countries, has limited access to health or social care, employment or training, state-funded accommodation, financial support, or family reunification. Moreover, they may be at risk of forcible return to their country-of-origin. The 1951 UN Refugee Convention gave the original classification of a refugee (UNHCR, 1951) and although this definition is now potentially limited (Quinn, 2011), its principle of protection remains for those whose home countries offer limited protection or who are at risk of torture.

More children and adolescents are internally displaced than are displaced across national borders. Of the latter, most remain in front-line states close to their country of origin. The vast majority of the world's forcibly displaced populations are, therefore, displaced from one LMIC to other nearby LMICs.

Unaccompanied and separated children are of particular concern as they are under 18 years, living outside their country of origin and separated from their parents or primary caregivers. Some may be totally alone while others may be living with extended family members. All such separated children are entitled to international protection under a broad range of international and regional legal instruments (Hancilova & Knauder, 2011). However, in practice, they can be subject to conflicting policy agendas: the protection of children and children's rights versus the enforcement of immigration control (Sigona & Hughes, 2012). Despite often experiencing potentially traumatic events in their countries of origin as well as poverty and disrupted education, many experience further harrowing events, abuse and hardship in their journeys to new countries and then have to settle and survive in a new country. Throughout, they lack the physical and psychological support of a trusted adult and this can render them particularly vulnerable. They can fall prey to victimization and trafficking for sexual or labour exploitation (Becker-Blease *et al*., 2010; Hancilova & Knauder, 2011).

Over the past decade, countries, especially those in the European Union, have been placing increasingly restrictive measures to prevent displaced populations from making asylum claims. Of particular concern is the use of immigration detention facilities that have so far been documented in 60 countries across the globe, both high-income and LMIC (Global Detention Project, 2013, Fazel *et al*., 2014). Children and adolescents can be detained in many countries for variable lengths of time. In addition, in some countries, children can be separated from their parents when parents are placed in immigration detention.

Prevalence of psychiatric disorder

The main studies that have explored psychiatric morbidity in forcibly displaced populations have focused on the disorders of PTSD, depression and anxiety disorders. Studies have typically (Tousignant *et al*., 1999; Fazel *et al*., 2005; Bronstein *et al*., 2013), although not universally (Rousseau *et al*., 2000) shown, that forcibly displaced children have substantially higher rates of psychiatric disorder than host populations. This higher prevalence has been demonstrated in systematic reviews for PTSD (Fazel *et al*., 2005), depression (Bronstein *et al*., 2013) and anxiety (Bronstein *et al*., 2013). The range of prevalence estimates for any of these disorders is variable between studies. Part of this variation reflects genuine differences in the balance

of risk and protective factors between the populations being studied, as well as methodological differences between studies.

The prevalence estimates for PTSD in forcibly displaced children show wide variation. A systematic review of PTSD in refugee children (Fazel *et al*., 2005), which excluded self-report questionnaire-based studies, showed a relatively narrow range of 7–17% across the eligible studies. Estimates of 10–25% are common in studies of children displaced to relatively safe high-income settings, those for internally displaced children in LMICs tend to be higher; for example, a study in a camp for internally displaced persons (IDP) in Darfur showed a PTSD prevalence of 75% in adolescents (Hasanović *et al*., 2006; Morgos *et al*., 2007). PTSD in forcibly displaced children is also potentially different to that more typically observed in other populations. This is primarily because they might have been subjected to multiple traumatic events that could be different in nature and in the context they were experienced. For example, a child might witness the death of a parent in their home country, followed by exposure to long and frightening migration journeys, possibly unaccompanied. These children might live without the support of their primary caregiver or with caregivers suffering from their own psychological disorders. All are living in a new country and culture where access to services, if these services exist, might be difficult. Moreover, these factors will have a potential impact on the presentation and treatment of other psychological disorders, such as depression and anxiety.

Estimates of depression typically fall in the range of 5–30% (Servan-Schreiber *et al*., 1998; Tousignant *et al*., 1999; Hasanović *et al*., 2006), again tending toward higher proportions in refugee camp situations (Morgos *et al*., 2007). Estimates for anxiety range from 10–30% (Tousignant *et al*., 1999; Bronstein *et al*., 2013). For depression and anxiety, as for PTSD, there is a relative dearth of high quality evidence. There are fewer studies reporting on other psychiatric symptoms, but a study of psychotic adolescents in in-patient units across London reported an over-representation of black African refugees (Tolmac & Hodes, 2004).

These disorders are also likely to be prevalent in any accompanying parents or caregivers (Hollifield *et al*., 2002; De Jong *et al*., 2003; Steel *et al*., 2009). Parental disorders might impact on their children's development (see Chapter 28). A systematic review of 181 studies of adults who had experienced conflict and displacement indicated a weighted prevalence of over 30% for both depression and for PTSD (Steel *et al*., 2009). Given the dual challenges of socioeconomic adversity and parental psychological difficulties, it is unsurprising that the children of forcibly displaced parents born after arrival in the country of settlement may also be at elevated risk of a range of conditions, including PTSD, depression and psychosis (Sigal and Weinfeld, 2001; Rutter, 2013).

In summary (Table 44.1), although studies commonly find forcibly displaced children and adolescents to be at increased risk of PTSD, depression, and anxiety, there is little evidence to suggest a significantly increased risk of other conditions, such as conduct problems or substance misuse (Sack *et al*., 1994; Tousignant *et al*., 1999). In fact, some studies suggest fewer behavioral problems in forcibly displaced families, citing a range of explanatory factors including being involved in a meaningful struggle, respect for one's cultural background and sensitivity to parents' difficulties (Sack *et al*., 1986; Rousseau and Drapeau, 2003).

Risk and resilience in young refugees

Although forcibly displaced children and families commonly experience a large number of distressing events, it is important not to make assumptions as to the impact of such events on the individual, based on the apparently "objective" severity or number of events. There is huge heterogeneity in individuals' responses to different stressors and adversity (Rutter, 2013). Whether or not they lead to prolonged adverse psychological consequences for the individual depends on a range of factors and on cultural differences in understanding and responding to adversity (Barber, 2013). These include the pre- and post-event context, ascribed meaning and appraisals, prior mental health, prior and subsequent adversity and distressing events, genetic influences and parental and social support (Miller and Rasmussen, 2010; Reed *et al*., 2012; Tol *et al*., 2013).

Those working with these children and adolescents must remain alert to all the standard risk factors for psychopathology in children; the unusual events experienced by displaced families should not distract clinicians from other significant past and present risks to children's mental health. On-going serious risks that therefore need to be assessed include child maltreatment, parental conflict and domestic violence, community violence, racially based discrimination, poverty and bullying, as studies have shown a possible increase in incidence in many of these for forcibly displaced populations (Catani *et al*., 2010; Layne *et al*., 2010).

The societal context

Post-migration factors, many of which are modifiable, have been shown to alter the risk of developing psychological problems in forcibly displaced children and adolescents (Fazel *et al*., 2012; Reed *et al*., 2012). While exile and repatriation are no doubt stressful experiences for children, remaining in a conflict situation without displacement is equally, if not more, detrimental to psychological well-being. In addition, living in refugee camps (Thabet and Vostanis, 1998; Izutsu *et al*., 2005) or within immigration detention facilities can place psychological health at serious risk (Rothe *et al*., 2002; Lorek *et al*., 2009). Detention facilities may expose children to witnessing and experiencing additional potentially traumatic events, including fires, rioting, violence and self-harm attempts by others (Mares *et al*., 2002), and furthermore may have a serious impact upon parental mental health, impairing the capacity to sensitively parent children with increased needs.

Table 44.1 Some illustrative studies of the prevalence and risk factors for psychiatric disorder in forcibly displaced children and young people.

Study	Year	Sample	Findings
LMIC studies			
Morgos (2007)	2007	331 internally displaced children in camps in southern Darfur	75% met criteria for PTSD, 38% for depression
Mels (2010)	2010	819 adolescents of age 13–21 in the eastern Democratic Republic of Congo (217 internally displaced and 496 previously displaced returnees)	Internally displaced adolescents reported the highest scores for post traumatic symptoms
Paardekooper *et al*. (1999)	1999	316 Sudanese refugees in Uganda compared to 80 local Ugandan children	Sudanese refugee children reported significantly more depressive and post traumatic symptoms and behavioral difficulties than local children
High-income country studies			
Nielsen (2008)	2008	246 children in Danish detention centers	Children with at least 4 relocations had worse mental health
Sujoldzic (2006)	2006	499 adolescent Bosnian refugees in Croatia and Austria compared to 359 internally displaced Bosnians and 424 non-displaced Bosnians	Girls had worse functioning than boys and were more likely to suffer anxiety and depression; discrimination and poor school and neighborhood connectedness was associated with worse functioning, whereas religious commitment was associated with better functioning
Studies of unaccompanied asylum-seeking children (UASC)			
Bronstein *et al*. (2013)	2012	222 Afghan unaccompanied asylum seeking adolescents, age 13–17	35% scored above cut-offs for anxiety and 23% for depression
Bean *et al*. (2007a)	2007	582 unaccompanied refugee children from 48 countries	Psychological distress was higher with increasing age and girls had higher scores for post traumatic and internalizing symptoms: unaccompanied young people had experienced twice as many post traumatic events as accompanied young people

Prolonged insecure asylum status and residential instability are disorientating and distressing for parents and children alike (Bean *et al*., 2007b; Nielsen *et al*., 2008), and often give rise to secondary adversities such as parental unemployment, financial strain, social isolation and limited engagement with education or community life. Government policies differ greatly between countries with regards to the detention of child and adult asylum seekers, and the time-frame for the resolution of asylum claims. Attempts to minimize the duration of uncertainty and residential disruption of asylum-seeking families, to avoid the detention of children, their parents and pregnant women, and to abolish the separation of parents and children for the purposes of detaining adults in a family, are important safeguards to prevent deterioration in children's mental health (Fazel *et al*., 2012).

Consideration must also be given to the impact of the relative privacy and security of accommodation on mental health (Ajduković and Ajduković, 1993; Geltman *et al*., 2005). For unaccompanied young people, accommodation in centers is associated with poorer functioning than independent accommodation or foster care (Derluyn and Broekaert, 2007). More supported living arrangements are associated with better psychological outcomes (Bean *et al*., 2007a; Derluyn and Broekaert, 2007; Hodes *et al*., 2008). Foster care raises additional challenges but same-ethnicity placements appear to confer a protective effect (Porte & Torney-Purta, 1987; Geltman *et al*., 2005).

The community context

Higher levels of perceived acceptance and connectedness within a community and low levels of racial discrimination have been associated with lower levels of psychological problems (Sujoldžić *et al*., 2006; Montgomery and Foldspang, 2008). The issue of acculturation has received considerable attention; the construct is difficult to measure, and usually reduced to linguistic competency and time since migration. Overall, the ability to integrate into the host society and acquire the local language while maintaining a sense of one's cultural identity emerges as somewhat protective (Fazel *et al*., 2012). The importance of the formation and maintenance of social networks within the same ethnic group and some form of religious belief, as well as a sense of connectedness to the neighborhood and school, are linked to positive mental health outcomes (Sujoldžić *et al*., 2006; Kia-Keating and Ellis, 2007).

Children and young people with friendships have fewer psychological difficulties (Almqvist and Brandell-Forsberg, 1997; Berthold, 2000) and parental support networks also have an indirect positive impact on children (Ekblad, 1993). In some cultural contexts, a large same-ethnicity network may

have an adverse rather than protective effect, possibly related to increased social obligations and expectations (Rousseau *et al*., 1998).

The family context

There is increasing evidence for the importance of good parental functioning in protecting the mental health of young people who have experienced forced displacement (Catani *et al*., 2010; Walker *et al*., 2011; Tol *et al*., 2013) and a large body of work outside refugee studies also attests to the importance of remaining with family or steadfast caregivers. When we consider young people who arrive with their families, the family may appear to be one "constant" in a maelstrom of change and can cushion against external adversities. However, the dramatic changes and shifts that may occur in forced displacement can cause disruptions to family structure and function that can compromise the adequacy of parental caregiving (Walker *et al*., 2011). At the very time when children are most in need of sensitive parental care to buffer them against the adverse events around them, parents themselves are distressed, preoccupied and over-burdened with the struggle for basic survival needs.

It is, however, well-demonstrated that the presence of parents is nonetheless protective and improves outcome; unaccompanied young people are known to be at increased risk not only of a higher toll of potentially traumatic events during their migration journey, but also of a higher likelihood of significant psychological difficulty after arrival (Hodes *et al*., 2008; Thabet *et al*., 2008).

The individual context

The cumulative number of pre-migration adverse events is the strongest predictor of psychological disturbance (Fazel *et al*., 2012; Reed *et al*., 2012). These risks are higher with events of greater personal threat (Angel *et al*., 2001; Geltman *et al*., 2005). Different patterns of exposure by gender are observed in different contexts, for example, the use of rape as a weapon against girls in refugee camps (Crisp, 2000), or the targeted recruitment of boys as child soldiers (Betancourt *et al*., 2010b), and stigma and discrimination resulting from these particular types of exposure are major barriers to recovery and social reintegration (Betancourt *et al*., 2010a). Exposure to post-migration violence is also associated with increased risk (Berthold, 1999). Children who have experienced conflict also experience a wide range of non-conflict related potentially traumatic events, which they may identify as equally or more traumatic, including experiences of domestic and community violence (Panter-Brick *et al*., 2009).

With regard to gender, girls generally have a higher risk of poor mental health outcomes, especially after puberty (Sujoldžić *et al*., 2006; Derluyn and Broekaert, 2007; Fazel *et al*., 2012), in keeping with childhood patterns of anxiety, depressive, and post traumatic symptoms in the general population (Ford *et al*., 2003). No clear age effects have emerged from the available studies (Reed *et al*., 2012; Fazel *et al*., 2012), although studies from countries where a final asylum decision is made at a specific age (typically around 18 years) commonly show a deterioration in later adolescence, reflecting the approach of this decision point (Bean *et al*., 2007a, b).

Assessment

Clinicians may be part of a targeted service or only examine such children infrequently. The assessment of such children needs to be carried out with particular sensitivity. In areas with high forcibly displaced populations, there is scope for a group of professionals to work together and develop expertise in advocacy and in addressing other educational and community needs. A careful explanation as to the purposes of the assessment and wish to help the child is important and an initial focus on the here-and-now and less distressing issues can be helpful. As a result of their experiences, such children may be wary of anybody who appears to be in authority, especially if they are asking questions about their past. Furthermore, many may have difficulty talking about past traumatic experiences especially if, for example, it has involved witnessing the killing of loved ones and the experience of torture. The assessment will need to proceed cautiously and at a pace that the child can manage. The assessment needs to include the range of past and current experiences. Figure 44.1 illustrates some of the specific questions that may need to be considered and their relationship to the child's migration experience.

Children and adolescents who have undergone forced displacement will have experienced life in at least two countries. The assessment needs to include positive strengths and qualities, temperament, coping skills and adaptability, language, ethnic and religious identity, and, for accompanied children, key family relationships. Assessment can, therefore, be particularly complex. For simplicity, this is often considered in pre-migration, peri-migration (journey from the country of origin to the new country, including residence in camps) and post-migration phases. Many children can have more complex experiences, including multiple displacements and returns within their own or other countries, being born in camps or in a country of transit, or being held in immigration detention facilities.

Clinicians should expect to obtain information slowly and patchily. In addition, careful attention must be given to risk assessment and child protection issues, particularly for unaccompanied minors. Time should also be allowed for liaison with other statutory and non-statutory agencies supporting the families and young person, in particular those dealing with accommodation, care needs and legal issues around asylum claims.

Other complexities of assessment include:

1 Language and cultural differences. As with any cross-cultural assessment, it is important to gain an understanding of the cultural influence on concepts of: physical and psychological health and illness; the meaning of the distressing events experienced; any stigma attached to the events experienced, resultant symptoms or attitudes to accessing services; the acceptability of treatments and the use of alternative healing practitioners or preparations. Moreover, it should be borne in mind

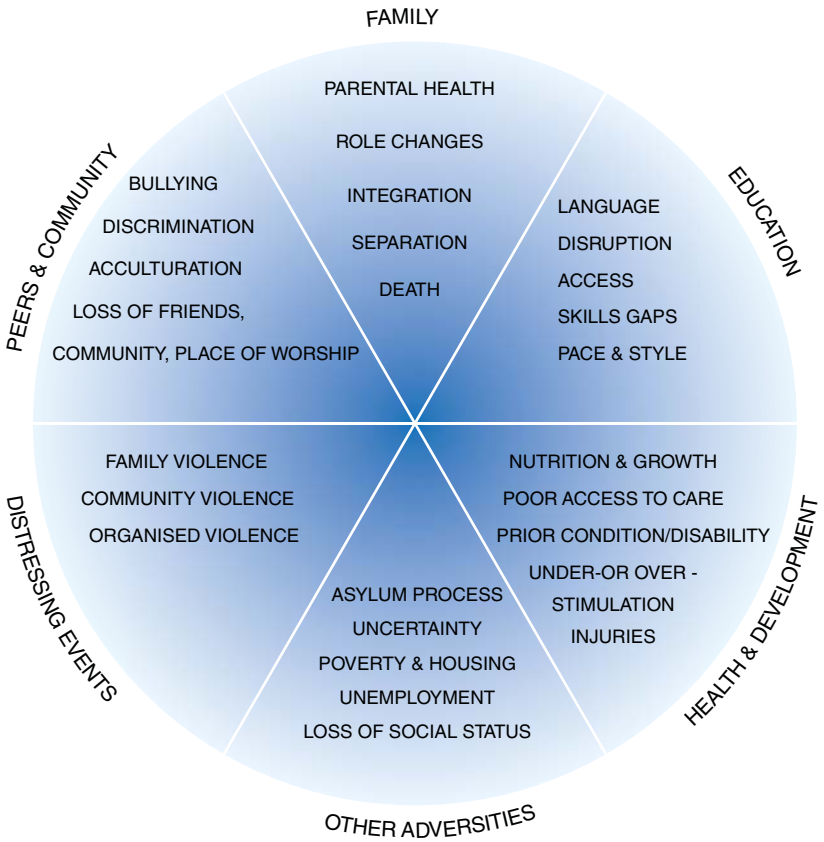

Figure 44.1 Assessment considerations for forcibly displaced children. Some of the factors described apply only at one phase of the migration process, but it is important to remember that most adverse exposures, such as violence and multiple relocation, can be experienced at any stage of migration.

that family members and young people may be at very different stages of linguistic and cultural adaptation to the host society and may view their cultural identity differently.

2 Use of interpreters. Ensuring the acceptability of a particular interpreter and trying to keep the same interpreter from session to session is ideal. It is important to discuss confidentiality issues with the interpreter before a session, as interpreters might not have health training. It is also essential to have time with the interpreter alone at the end of potentially distressing sessions to discuss confidentiality and ensure that the session has not raised any difficult issues or memories for the interpreter, who might themselves have come from a conflict-affected area. Interpreters from smaller communities or language groups might present difficulties as they can often interpret for the children in multiple contexts. Sharing a language might be indicative of that person coming from the same region but potentially from the "other" side, placing a child at perceived or real risk if the interpreter remains in the session and privy to personal information.

3 Limited availability of information regarding the child's development and current risks, either because of absence of primary caregivers or due to communication difficulties.

4 Misinformation about immigration processes. The children and their families might have been told, by people traffickers and others who helped them enter the country, not to share certain aspects of their background and history with immigration and care organizations. The reasons such people give are often incorrect, potentially exposing them to more difficulties with post-migration authorities.

5 Lack of understanding about the role of the different health and social care agencies involved by children and their families.

6 Use by families of other potential mental health providers including traditional healers and religious leaders.

Interventions

Forcibly displaced children encounter many barriers in accessing health care. The development of interventions to address the needs of forcibly displaced children and adolescents needs to be twofold. General multimodal interventions that concurrently address a number of issues in the environment and social networks need to take place alongside targeted interventions for those with more specific trauma-related needs (Miller and Rasmussen, 2010; Nickerson *et al.*, 2011). This dual strategy approach is supported by a number of reviews exploring interventions for refugee children (Tyrer and Fazel,

2014), war-affected children (Betancourt and Williams, 2008; Jordans *et al*., 2009) and adults (Nickerson *et al*., 2011). The available evidence on interventions for forcibly displaced children and adolescents is, however, limited, so general principles and interventions of note are explored in the following sections (see Chapters 36 and 59). There is a scarcity of rigorous studies and the interventions that have been evaluated thus far are different from each other, both in terms of their settings and their specific findings (Jordans, 2009). In the following section, we summarize the key components of these interventions and highlight the areas that are most important.

In LMICs, the resource constraints are considerable and mental health services usually fall far below need, especially when compared to other health care provisions (Patel *et al*., 2007a). Interventions might need to be delivered in refugee camps and the stigma of having a mental health problem can often impede help-seeking behaviors. Multimodal interventions integrated into other systems of care, such as women's health or primary care, might be more acceptable in these settings, where mental health resources are scarce. Moreover, considerable barriers exist within high-income settings. These include resources, linguistic and cultural barriers, concerns about stigma and confidentiality, and beliefs that having a psychological problem might negatively impact on asylum applications.

Trauma-focused interventions

The best evidence available to date is for trauma-focused interventions. These have mainly been studied when delivered on an individual basis although some interventions have used groups. The settings have ranged from specialized mental health services to schools and refugee camps. These findings are in line with the overall evidence for treatment of PTSD where exposure to the "event" or events is a key feature in effective psychological treatments (see Chapter 59). The majority of studies have been conducted in high-income countries where the best evidence for efficacy lies with cognitive behavioral therapy (CBT), in particular Trauma-Focused CBT (Cohen *et al*., 2000; Taylor and Chemtob, 2004; Fremont, 2004; Silverman *et al*., 2008; Tol *et al*., 2008). In this treatment modality, the fear conditioning is treated as a key etiological agent alongside disturbances in memory processing and cognitive appraisal (Nickerson *et al*., 2011). CBT facilitates the extinction of this learning by processing the traumatic memories and altering maladaptive appraisals of threat and overcoming avoidance behaviors. For children and adolescents useful techniques include cognitive restructuring, relaxation training, anger management training, teaching coping skills, and grief management (Fremont, 2004).

Other therapeutic treatments for which there is increasing evidence of effectiveness include Narrative Exposure Therapy (NET) (Robjant and Fazel, 2010) and a range of creative-expressive techniques. There is evidence for Eye-Movement Desensitization and Reprocessing in non-refugee children with PTSD (Cloitre, 2009). Studies exploring the use of pharmacotherapy in this population are lacking but given the high prevalence of depression and anxiety, medication may be an adjunct or alternative treatment to psychological therapies and other interventions, depending on treatment availability including supervision, patient preference, comorbidity, and symptom severity.

Multimodal interventions

Multimodal interventions aim to concurrently address issues of psychological functioning, social and cultural adaptation, physical health and ongoing psychosocial difficulties (Nickerson *et al*., 2011). Although the evidence supporting their use is limited, it is relevant that such programmes offer a range of interventions because forcibly displaced populations can be exposed to diverse stressors and challenges leading to a complex array of psychological reactions.

At the societal level, these interventions aim to influence the wider environment through advocating for more services and stable housing, promoting language proficiency, improving immigration applications, and employment opportunities. The restoration of an enabling/supportive environment for the young person and their family and friends is likely to be key to stabilizing their psychological health (Betancourt and Williams, 2008; Jordans *et al*., 2009). As Miller points out, a focus on healing the effects of previously experienced war trauma may appear valueless to a child who is currently being beaten or sexually abused at home or in the community (Miller and Rasmussen, 2010) or whose basic survival needs are a day-to-day struggle (Mels *et al*., 2010).

Multimodal interventions have also tried to address community and school-based needs. Achieving in school, with regard to both education and peer relationships is a key determinant of success and future mental health (Viner *et al*., 2012). Refugee children can experience specific problems fitting into school because of language and cultural differences as well as bullying and discrimination (Kia-Keating and Ellis, 2007). A systematic review of community and school interventions for forcibly displaced children and adolescents (Tyrer and Fazel, 2014) identified 20 studies in total, of which seven were conducted in refugee camp settings and the rest were mainly school-based interventions in high-income countries. The interventions were a combination of individual, family and group, or classroom interventions and the multimodal interventions used an array of creative art techniques, often in combination with trauma-focused interventions.

Interventions should aim to help strengthen families (Walker *et al*., 2011). This is because a consistent finding across studies is the importance of parental support for children's mental health (Tol *et al*., 2013). The studies to elucidate how best this can be performed are limited, but some studies have offered support to parents and siblings and others have focused on the parent–child interaction in therapy. Restoration of social support networks for children and their families is another important aspect of multimodal interventions more generally (Jordans *et al*., 2010). Although some studies have tried to

address these in post-conflict settings, the studies on forcibly displaced children and adolescents are still limited. Moreover, the importance of harnessing cultural resources and extended kin networks are likely to be important (Tingvold *et al*., 2012).

In summary, the individual psychological needs of these children require addressing using the most effective available interventions (Table 44.2). Moreover, the overall needs of this population need to be considered. If housing or educational needs are not being addressed, for example, if they are living in an unhappy foster home or if they have additional learning difficulties, then a clinical service might need to work to assist all these areas. For the young person, having these different services brought under the umbrella or oversight of one service might be very helpful and so ensuring flexibility in response is likely to be of greatest overall benefit. In addition, many young people find their therapists getting involved in their asylum application supportive and important.

Course and long-term outcomes for young refugees

A 9-year follow-up study of 131 refugees in Denmark (mean age 15.3 years) showed that the long-term effects of pre-migration trauma are mediated by risk and protective factors at the individual, family, and community level (Montgomery and Foldspang, 2008; Montgomery, 2010). Aspects of social life in Denmark and the stresses experienced in exile were more strongly predictive of psychological problems 8–9 years after arrival than traumatic experiences before arrival, highlighting the importance of the post-migration environment. Sack and colleagues' 12-year follow-up study of Cambodian adolescents indicated that post-migration stressors were particularly associated with depression, whereas post-traumatic stress was more closely related to pre-migration events (Sack *et al*., 1993; Sack *et al*., 1994). Bean and colleagues noted strong continuity and ongoing high levels of psychopathology at 1-year follow-up in a cohort of 582 unaccompanied minors (Bean *et al*., 2007b).

There are a number of studies of note from adult populations that can also inform our understanding of the long-term outcomes in children and adolescents exposed to forced displacement or war experiences. A study of adults in four post-conflict settings (Ethiopia, Algeria, Cambodia, and Gaza) highlighted the range of PTSD prevalence rates across contexts with a diversity of risk factors (De Jong *et al*., 2001; De Jong *et al*., 2003). In addition, the study demonstrated that conflict events after age 12 were particularly likely to have an adverse effect, and this could be because of developmental, cognitive, or environmental influences. Another study of Cambodian refugees interviewed two decades after resettlement in the United States of America showed how prolonged the psychological effects of forced displacement can be as 62% fulfilled diagnostic criteria for PTSD and 51% for depression (Marshall *et al*., 2005). Those who had been displaced in adolescence had better psychological health but these results highlight how both children and their parents can be affected by their experiences for considerable periods of time.

There is limited knowledge regarding the intergenerational repercussions of traumatic events, although second generation refugee children had worse psychological outcomes in a study in rural South Africa (Cortina *et al*., 2013) and there is evidence from a registry-based study that second-generation refugees have an increased risk of hospital admission for psychotic illness, whereas there was no elevated risk for second generation labor migrants (Rutter, 2013).

Conclusions

The psychological adjustment of a child or adolescent who has been forcibly displaced because of organized violence is likely to be influenced by a number of different factors that may be inter-related or independent. These include the severity of exposure to any potentially traumatic experiences, previous and current family support, the degree and duration of disruption to their life and the amount of social disorganization that ensued and still exists in their environment (Pine *et al*., 2005). Therefore, when trying to meet the mental health needs of these children, interventions to address distressing memories and family dynamics must take place alongside attempts to address the wider local and regional social, economic, and educational systems disrupted by war. This can seem like an impossible task for the LMIC countries, in which the majority of forcibly displaced children live, given their overall lack of mental health services, especially for young people (Patel *et al*., 2007b; Chapter 16).

Table 44.2 Examples of randomized controlled trials.

Intervention domain	Study	Year	Sample	Intervention	Findings
Individual therapy	Ertl (2011)	2011	85 Ugandan former child soldiers	Narrative Exposure Therapy-8 sessions conducted in camps	Improvements in PTSD symptoms
School-based	Rousseau (2005)	2005	138 immigrant children in Canada	Creative expression classroom programme over 12 weeks	Beneficial effects on self-esteem
Community-based	Bolton (2007)	2007	Ugandan internally displaced children living in refugee camps	Group Interpersonal Therapy (IPT-G)-16 sessions conducted in camps	IPT-G helped reduce levels of depression, especially in girls and older children

Moreover, while education and employment are likely to be key factors for their long-term mental health (Viner *et al*., 2012), access to these is a further challenge in LMIC settings.

The main focus of research now lies in the development of appropriate and sustainable interventions (Tol *et al*., 2009). For LMICs, interventions developed in high-income settings are unlikely to be generalizable to these environments (De Jong *et al*., 2001). A major development involves understanding how to adapt interventions delivered by clinical health specialists so that they may be carried out by lay or generic workers with limited training (Tol *et al*., 2012; see Chapter 48). This has been achieved in some studies for adult refugee populations and for children in conflict settings (Robjant & Fazel, 2010). Further research should identify the core skills that are necessary, how training should be conducted and the groups most likely to benefit from such interventions. There is some emerging evidence of differential gender effects, with girls possibly benefiting more from certain interventions (Bolton *et al*., 2007); research should also seek to identify how to modify interventions to optimize outcomes across all groups. It is also vital that interventions do not undermine natural recovery processes in individuals, families, or communities (Tol *et al*., 2012). It may be necessary to adapt interventions to make them more culturally sensitive in areas with relatively homogeneous displaced populations, which might be more likely in LMICs. However, in high-income settings, where refugee communities can be highly heterogeneous, they might instead be targeted to the local context rather than a specific cultural group, for example, improving school integration and addressing bullying in a locality where the refugee community suffers discrimination and stigmatization.

Regardless of the setting, learning how best to harness cultural, community, and family resources is essential. Certain policies and practices are overtly detrimental to mental health (Viner *et al*., 2012) and need to be prevented, such as immigration detention. There are also likely to be benefits of integrating mental health services with other youth health and welfare expertise (Patel *et al*., 2007b) and delivering a multi-layered care package (Jordans *et al*., 2010).

While developing emotionally, socially, intellectually, and physically, forcibly displaced children and adolescents face disruption to their family structure, accommodation, cultural and linguistic environment, friendships, and education. Many also suffer bereavements or disappearance of family or friends and struggle with intrusive memories of violence. Despite this, many children nonetheless thrive and develop well, and there is much to be learnt from the processes and factors that promote positive outcomes after extreme adversity. Although there has been encouraging progress in research into refugee mental health, many potentially modifiable factors continue to impact adversely upon children and families' health even after arrival in safe, stable, and well-resourced resettlement countries. There is a clear role for mental health professionals to address barriers to accessing health care, improve the cultural sensitivity and acceptability of services, challenge stigma and prejudice, develop effective interventions and modes of service delivery and advocate for refugees' mental health when local or national policy and practice endangers the fragile balance between risk and resilience.

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