Mental health issues among refugee children and adolescents

Joh HENLEY and Julie ROBINSON

School of Psychology, Flinders University, Adelaide, South Australia, Australia

Abstract

Each year, several thousand child refugees are resettled in Australia. These children have faced numerous stressors and are at increased risk for developing mental health problems including traumatic stress and a variety of emotional, behavioural, and educational difficulties. The diverse contexts in which refugee children may come into contact with mental health clinicians include school, child and adolescent mental health services, child protection services, and hospitals. This article summarises current knowledge regarding the mental health of refugee children and adolescents, distilling what is of particular relevance to Australian service providers. The stressors encountered by refugee children, psychological outcomes, appropriate interventions, and barriers to accessing services are discussed.

Overview of the Review and Aims

This review summarises the literature on the mental health of child refugees, with a particular focus on what is of relevance to Australian clinicians. Many child refugees resettled in Australia are likely to benefit from psychological services for a range of problems including traumatic stress, emotional and educational difficulties, physical injury, and disease (Lustig et al., 2004). Clinicians therefore need to be aware of the factors impacting on refugee children’s mental health, and interventions that may be helpful. While the Australian Psychological Society (APS) has already published a comprehensive review on refugee resettlement in Australia (Murray, Davidson, & Schweitzer, 2008), the current review focuses on children and adolescents and aims to provide practical information to guide clinical practice. The aim of this review is to raise awareness of mental health issues for refugee children, empowering clinicians to engage effectively with this client group. This review will therefore outline the stressors encountered by child refugees before examining existing knowledge on psychological outcomes. It will then explore implications for clinical assessment. Interventions that have been applied to refugee children will be critically reviewed and clinical issues relating to assessment, intervention, and service utilisation will be discussed.

Refugees and Asylum Seekers

An asylum seeker is someone who is seeking international protection but whose claim has not yet been evaluated by the country in which they have sought asylum (United Nations High Commissioner for Refugees (UNHCR), 2009). The United Nations 1951 Convention relating to the Status of Refugees is the foundation of international refugee protection (UNHCR, 2009) and has been ratified by Australia. To be awarded refugee status, asylum seekers must prove that they meet the definition of a refugee specified in the convention; that is, they are someone who “owing to a 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 nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country” (UNHCR, 2009, p. 4).

The majority of Australian humanitarian visas are awarded to offshore applicants. Half of these gain refugee visas, while the rest enter under the Special Humanitarian Program (SHP; Department of Immigration and Citizenship (DIAC), 2010a). Applicants for a SHP visa must demonstrate that they are subject to gross violation of human rights in their home country and that they are the immediate family of someone who has been granted permanent protection in Australia. SHP visa holders have Australian proposers who pay their travel costs and are responsible for their initial resettlement.

Around 15–30% of the total quota of humanitarian visas is awarded to those who apply for refugee visas after entering Australian territory (DIAC, 2010a). Of these, less than half arrive by unauthorised boats, with the majority arriving by air with a valid visa (e.g., student, tourist, business) before applying for asylum (Phillips, 2011). Current Australian government policy dictates mandatory detention for asylum seekers who arrive without valid travel documents (i.e., by boat) until their refugee status is determined (DIAC, 2010c), even though they are more likely to be recognised as refugees than those who arrived by air (Phillips, 2011).

Australia resettles 13,000–14,000 refugees annually (DIAC, 2010a), around 40% of whom are children who arrive with or without family members (DIAC, 2010d). While at the turn of the millennium, the majority of offshore humanitarian visas were granted to people of European origin, the composition has changed over the last decade such that most are now granted to people of African, Middle Eastern, and Asian origin (DIAC, 2010a). Specifically, in 2009–2010, most were granted to applicants from Burma, Iraq, Bhutan, and Afghanistan, with significant numbers also from various African countries (DIAC, 2010a). Thus, humanitarian entrants to Australia come from a variety of countries with very different cultural traditions, histories of past trauma, and migration experiences. Like other holders of permanent visas, humanitarian entrants can access the full range of Medicare services. In contrast, asylum seekers (i.e., those awaiting refugee status determination) do not hold permanent visas and many are ineligible for Medicare services (DIAC, 2010b).

The Refugee Journey

The refugee journey consists of three phases: pre-migration, migration, and resettlement, each presenting unique challenges (Lustig et al., 2004). In the prepregnancy phase, children may be exposed to violent conflict, in some cases through combat involvement (Lustig et al., 2004). Many children also experience persecution of family members, disappearances, deaths, and deprivation (Berman, 2001). Indeed, by definition, refugee families have been able to demonstrate grounds for fear of pre-migration persecution or threat.

The migration phase is characterised by forced and usually sudden evacuation and may involve dangers posed by geography (e.g., crossing deserts, mountains, rivers), encountering wild animals, further conflict, and a lack of basic resources (Geltman et al., 2005). This phase may also involve lengthy stays in refugee camps or urban centres in countries of first asylum, where discrimination and inadequate access to food, water, security, and education are commonplace (Grabska, 2006; Crowley, 2009). Those who flee by sea face the perils of dehydration, starvation, extreme weather, and may witness the deaths of fellow passengers (Hekmat, 2010).

These pre-migration and migration experiences may lead to a diverse range of adverse outcomes. For example, children of refugee background may be afraid of authority figures and seek isolation as a result of experiences with secret police and informers. Children may sustain physical injuries as a result of conflict or flight. Malnutrition in infancy and early childhood can lead to permanent intellectual disability, and disrupted education has significant implications for success in the Australian school system.

Less than 1% of the world’s refugees are offered the opportunity for resettlement in a country such as Australia (Phillips, 2011). These lucky few confront additional challenges. Australian and international research reveals that the post-migration environment can have at least as much impact on mental health as pre-migration and migration factors (Silove, Steel, McGorry, & Mohan, 1998; Porter & Haslam, 2005). During resettlement, refugee children must navigate a new society and culture, adjusting to school systems and peer groups in a foreign language (Bates et al., 2005). Australian communities into which refugee children are settling are sometimes hostile and discriminatory towards asylum seekers and refugees (Westoby & Ingamells, 2010). It has been suggested that the strict regulatory framework applied by the Australian government (Christie & Sidhu, 2006), representations in the Australian media (O’Doherty & Lecouteur, 2007) and the prevalence of misinformation in Australian society (Pedersen, Watt, & Hansen, 2006) have provided fuel for prejudicial attitudes about refugees and asylum seekers. Indeed, there is growing evidence that many Australians hold explicitly negative attitudes towards asylum seekers (Hartley & Pedersen, 2007) and refugee youth in Australia have reported experiencing discrimination (Brough, Gorman, Ramirez,
Family Relationships

Although refugee family functioning has not been a focus of quantitative research (Weine et al., 2005), the stressors and coping methods of refugee families have been explored in several qualitative studies. Many families face devastating separations (Rousseau et al., 2004), while some also suffer impaired parenting and attachment relationships as a result of parents’ distress and subsequent emotional unavailability (Frye & D’Avanzo, 1994; Howard & Hodes, 2000). In addition, several processes may lead to intergenerational conflict. Parents’ attempts to preserve culture and parental behaviour affected by trauma may cause their children to view them as punitive and controlling (Merali, 2004; Peltonen & Punamaki, 2010). Second, children’s faster acculturation can lead to incompatible values and preferences (Merali, 2004) and can disrupt family roles because children need to take on responsibilities that are usually filled by their parents (Howard & Hodes, 2000). Finally, underemployment and loss of community roles are very common among adult male refugees. This can challenge patriarchal family patterns, causing friction.

It is important to remember, however, that many families renegotiate roles and work through these challenges together (Weine et al., 2004). Moreover, adversity can also draw families together (Rousseau et al., 2004; Peltonen & Punamaki, 2010) and some changes can bring benefits. For example, redefined family roles may allow children to develop closer relationships with their parents (Rousseau et al., 2004). These supportive family relationships provide protection against poor mental health (Peltonen & Punamaki, 2010). Similarly, refugee children also protect the mental health of their parents. Many refugee parents see their children as a source of hope for the future and draw encouragement from them (Weine et al., 2004).

Psychological Distress

Facing these challenges over a protracted length of time takes its toll on many refugee children as even those who are resilient are likely to have their resources overwhelmed. Prevalence rates of mental health problems vary widely across studies, which differ in sample characteristics (e.g., type and extent of exposure to stressors, post-migration resources, and length of time since resettlement). Studies also vary in their methodology and screening techniques. Despite these variations, there is a wide consensus that the prevalence of post-traumatic stress disorder (PTSD) and other mental health problems are higher in refugee children than host populations (Hodes, 2000; Thomas & Lau, 2002; Yule, 2002). This elevation of mental health problems is unique to the refugee experience, over and above risks associated with confounding factors such as socio-economic and ethnic minority status (Fazel & Stein, 2003).

The most researched diagnoses are PTSD and other anxiety disorders, and depression. Comorbidity is common (Thomas & Lau, 2002; Ehntholt & Yule, 2006) and refugee children may present with several symptoms, which may not constitute a single disorder (Fazel & Stein, 2002). As there are few Australian studies investigating the prevalence of mental health outcomes in refugee youth, it is necessary to draw upon research carried out in other Western countries. Before reviewing the literature concerning psychological distress, we will explore two controversies influencing the understanding of refugee children’s psychosocial adaptation.

The first controversy relates to anthropological versus biomedical perspectives of distress (Hodes, 2002). Writers from the anthropological perspective argue that psychiatric diagnoses may not be applied to refugees (Summerfield, 1999). While a full discussion of this issue is beyond the scope of this article, at its core, the anthropological approach has the concern that psychiatric diagnosis may replace appropriate community, social, or political action (de Anstiss, Ziaian, Procter, & Warland, 2009). Some Australian writers have also argued that a focus on psychiatric diagnosis prioritises practical needs as secondary in the eyes of refugee clients, who may take on a “victim” role as it allows access to more resources, and service providers (Colic-Peisker & Tilbury, 2003; Westoby & Ingamells, 2010). Hodes (2000, 2002) helpfully argues that diagnostic and political perspectives are not mutually exclusive. One can maintain a focus on social and political advocacy while utilising diagnostic categories to identify and treat
those experiencing distress. de Anstiss et al. (2009) point to the example of psychologists using evidence of the negative effects of immigration detention on children’s mental health to advocate for changes in Australian policy (discussed later in this article).

The second controversy relates to applying Western-derived diagnoses to culturally diverse populations. It has been argued that such diagnoses, with PTSD being the focus, are not universally valid (Bracken, Giller, & Summerfield, 1995; Montgomery & Foldspang, 2006). Factor analyses of PTSD symptoms with child refugee samples have yielded conflicting results, highlighting the need for more research in this area (Sack, Seeley, & Clarke, 1997; Montgomery & Foldspang, 2006). Several studies have provided support for the validity of PTSD symptoms through associations found between the severity of traumatic exposure and the level of symptoms among youth in a variety of cultures (Hodes, 2000). While it appears that the majority of the literature supports the cross-cultural applicability of PTSD symptoms, the way in which these symptoms cluster, and the salience of particular symptoms may vary across cultures.

Prevalence of Problems

Post-traumatic stress disorder

Assuming that the PTSD diagnosis is appropriate, findings relating to its prevalence are described here. Regardless of the country of origin or resettlement, research has shown an elevated prevalence of PTSD among refugee children. Fazel, Wheeler, and Danesh (2005) conducted a systematic review identifying five surveys of 260 refugee children. They determined an overall prevalence rate for PTSD of 11% (99% CI 7–17%), which is almost double the rate found in non-refugee adolescents (Ehntholt & Yule, 2006).

In addition to having elevated prevalence, PTSD is also enduring. Longitudinal studies in Sweden and America have documented persistently high rates of PTSD up to 12 years following resettlement (Almqvist & Brandell-Forsberg, 1997; Sack, Him, & Dickason, 1999). An American and an Australian study have documented dramatic declines in PTSD diagnoses following resettlement; however, they both have significant methodological limitations (Krupinski & Burrows, 1986; Becker, Weine, Vojvoda, & McGlashan, 1999).

Functional impairment

Several studies show that refugee children can maintain academic and social adjustment despite experiencing psychopathology (e.g., Mollica, Poole, Son, Murray, & Tor, 1997; Sack et al., 1999; Tousignant et al., 1999; Rousseau & Drapeau, 2003; Geltman et al., 2005). Rousseau and Drapeau (2003) suggest that the discrepancy between symptoms and function is evidence of the resilience of refugee children and that clinicians should not ignore either refugee children’s resilience or their distress.

Depression and anxiety

Depression and anxiety have received less attention than PTSD in the literature. As with PTSD, rates of depression and anxiety vary across studies. This is likely to be due, in part, to differences in samples and differences in time in the country of resettlement (Sack et al., 1994; Mghir, Freed, Raskin, & Katon, 1995; Tousignant et al., 1999). The relevance of time in resettlement is demonstrated by Sack et al. (1999), who observed that depression rates decreased more dramatically than PTSD over time, but by 14 years post-settlement were still relatively high. The prevalence of anxiety disorders over time is not clear, but it appears to be of less concern than depression or PTSD. In fact, in some studies, the prevalence of anxiety disorders is no greater in refugee samples (Sack et al., 1994; Mghir et al., 1995) than host-nation samples (Sawyer et al., 2001).

Other mental health problems

Other commonly reported problems displayed by child refugees include symptoms possibly associated with sub-threshold depression or PTSD (e.g., somatic complaints, irritability, withdrawal, sadness, suicidal ideation, self-harm, as well as problems with peers, attention, sleeping, and eating; Almqvist & Brandell-Forsberg, 1997; Mollica et al., 1997; Adjukovic & Adjukovic, 1998; Tousignant et al., 1999; Montgomery & Foldspang, 2005). The prevalence of grief reactions and psychosis may also be higher in child refugees than the general population (Williams & Westermeyer, 1983; Ehntholt & Yule, 2006). Behavioural problems that have been reported in studies with child refugees include conduct disorder, aggression, hyperactivity, and enuresis regression (Adjukovic & Adjukovic, 1998; Tousignant et al., 1999; Leavey et al., 2004).

Learning difficulties and intellectual disability

An elevated prevalence of learning difficulties and intellectual disability among child refugees has also been reported (e.g., Kinzie, Cheng, Tsai, & Riley, 2006). While some of these reflect genetic anomalies, many aspects of the refugee experience increase the incidence of childhood neurological damage: exposure to infection and illness (e.g., cerebral malaria, encephalitis,
and meningitis) without adequate medical treatment (Williams & Westermeyer, 1983; Lustig et al., 2004), malnutrition, head injuries, and iodine deficiency (Williams & Westermeyer, 1983; Adjukovic & Adjukovic, 1998; Lustig et al., 2004). The lack of appropriate tests for use with children who have had little access to education or English language make the assessment and diagnosis of intellectual disabilities in child refugees extremely difficult.

**Variety of responses**

Despite findings of increased psychopathology, several writers have emphasised the importance of not pathologising refugees (Hyman, Beiser, & Vu, 1996; Summerfield, 1999; Rousseau & Drapeau, 2003; Lustig et al., 2004). It is important to remember that although child refugees are at increased risk of developing a variety of problems, the majority show good adjustment (Hodes, 2000; Yule, 2002). It is also important to remember that, as with any population, differences remain between sub-groups and individuals in exposure to adversity and in outcomes. Some studies of child refugees resettled for several years have found levels of adjustment that are similar to host populations (McKelvey et al., 2002; Rousseau & Drapeau, 2003).

**Implications for Clinical Assessment**

There are several ways in which clinicians can modify their assessment procedures when working with refugee clients. Particular considerations for history taking, whether to assess families or individuals, and the selection of measures are discussed as examples of these. Where necessary, assessments of trauma history should be conducted carefully, once trust has been established. Assessment procedures may remind refugee clients of previous interrogations (Hodes, 2000) or of situations where “history taking” may have been highly stressful and met with mistrust and hostility from immigration officials (Murray et al., 2008). Therefore, clinicians need to carefully explain their role and the purpose of the assessment, understanding that the establishment of trust and rapport may take longer than usual (Ehntholt & Yule, 2006). This is especially the case when refugees come from cultures in which mental health problems and disability are highly stigmatised. The effects of exposure to trauma on the brain and memory processes and different cultural traditions of storytelling can also make it difficult for refugees to tell their story in a chronological and detailed way (Murray et al., 2008; Peltonen & Punamaki, 2010).

It is usually best to interview families together (Ehntholt & Yule, 2006) as refugee parents have spent years protecting their children from threat and many are afraid of presenting their children to mental health services (Kinzie et al., 2006). However, separate interviews are useful once parents feel more comfortable, because refugee children often hide difficulties from their parents to protect them (Ehntholt & Yule, 2006).

Screening instruments that have been widely used cross-culturally should be selected and results interpreted cautiously as reliability and validity studies are yet to be conducted with refugee samples. Some such instruments are freely available from http://www.childrenandwar.org/measures/. In addition, the Strengths and Difficulties Questionnaire is a multidimensional screening instrument that has been used with refugee samples (e.g., O’Shea, Hodes, Down, & Bramley, 2000; Leavey et al., 2004; Rousseau et al., 2007) and is freely available in several languages (http://www.sdqinfo.org). Detailed information about conducting clinical assessments with refugee clients can be found elsewhere (e.g., Saylor & Deroma, 2002; Davidson et al., 2004; Ehntholt & Yule, 2006; Murray et al., 2008).

**Intervention**

**Government policy**

Of the many government policies relating to refugees and asylum seekers, immigration detention is prioritised here because of the high risk it presents to the mental health of child refugees (Allan, Davidson, Tyson, Schweitzer, & Starr, 2002; Silove, Austin, & Steel, 2007). Australian detention centres expose children to high rates of violence (Fazel & Silove, 2006; Silove et al., 2007), undermine parental roles, and limit children’s play and educational opportunities (Fazel & Silove, 2006; Silove et al., 2007). A child psychiatrist who had worked in Woomera Detention Centre said, “It is hard to conceive of an environment more potentially toxic to child development” (Human Rights and Equal Opportunity Commission, 2004, p. 397).

However, this policy is amenable to change through the intervention of professionals. In response to the Australian government’s introduction of indefinite mandatory detention in 2002, the APS and several independent professionals made submissions to the National Inquiry into Children in Immigration Detention condemning the detention of children (Allan et al., 2002; Silove et al., 2007). In June 2006, the policy was amended and families were released from detention centres to community facilities (Fazel & Silove, 2006). However, in February 2011, there were again 1,027 children in immigration
detention (DIAC, 2011). Thus, there is still a role for mental health professionals to inform debates on policies concerning asylum seekers. This form of intervention can have far-reaching consequences on the mental health of child refugees.

Considerations for individual and group interventions

The range of psychological reactions and comorbid diagnoses in refugee clients should be carefully considered when choosing interventions. As with other client groups, treatment goals should be negotiated with the client and should target symptoms that are causing the most distress and functional impairment (Nickerson, Bryant, Silove, & Steel, 2011). Psychological interventions can target disorders and risk modifiers such as social competence, affect regulation, problem-solving and coping skills, future orientation, positive relationships with a supportive adult, parent’s mental health, and family cohesion (Berman, 2001; Lustig et al., 2004; Ehnholt & Yule, 2006; de Anstiss et al., 2009).

During assessment, it may become clear that a child’s lack of fluency in English, limited education, or cognitive impairments will impact on the choice of therapeutic intervention. For example, Kinzie et al. (2006) suggest that these factors be taken into consideration before applying cognitive techniques. Murray et al. (2008) suggest that expressive therapies (e.g., Narrative Exposure Therapy, music, or art therapies) may be more appropriate with clients who are not literate in English. Evidence for the use of these therapies will be discussed later.

Due to problems with accessing services (discussed later), school may be an important environment for intervention delivery. On arrival in Australia, children with limited English are placed in specialist language learning centres, which may provide a unique opportunity for the delivery of psychosocial services at a crucial time. However, individual interventions may be more appropriate for children who are more vulnerable, highly symptomatic, have cognitive impairments, or demonstrate continuing problems following group interventions (Yule, 2002; Barenbaum, Ruchkin, & Schwab-Stone, 2004; Kinzie et al., 2006).

Review of Interventions

Interventions for PTSD, depression, and anxiety

There is emerging evidence for the efficacy of group cognitive-behavioural interventions (Layne et al., 2001; Ehnholt, Smith, & Yule, 2005; Möhlen, Parzer, Resch, & Brunner, 2005; Berger, Pat-Horenczyk, & Gelkopf, 2007; Tol et al., 2008; Peltonen & Punamaki, 2010), and to a lesser extent, Narrative Exposure Therapy (Onyut et al., 2005), testimonial psychotherapy (Lustig, Weine, Saxe, & Beardslee, 2004), and eye movement desensitization and reprocessing (Oras, De Ezepeleta, & Ahmad, 2004), in reducing PTSD in children from refugee backgrounds. The common thread between these various approaches is the incorporation of exposure techniques. Gradual exposure to traumatic memories is effective in alleviating intrusive thoughts and behavioural avoidance among those with PTSD, but should only be done once trust and safety have been established (Yule, 2002; Ehnholt & Yule, 2006).

Evaluations of interventions designed to address other outcomes are scarce. No interventions targeting depression have been evaluated with child refugees resettled in Western countries. However, a randomised controlled trial of group interpersonal psychotherapy (IPT-G) with internally displaced adolescents in Uganda found that unlike creative play and the waitlist control conditions, IPT-G effectively reduced girls’, but not boys’, depression symptoms (Bolton et al., 2007). In an Australian study, Barrett, Moore and Sonderegger (2000) trialled the FRIENDS cognitive-behavioural anxiety-reduction programme with 20 adolescent former-Yugoslavian refugees. Participants showed a reduction in anxiety and overall internalising symptoms, whereas internalising symptoms increased in the control group. Participants also reported finding the programme both enjoyable and helpful.

Interventions for emotional and behavioural problems

Two intervention studies have demonstrated significant improvements in general internalising and externalising systems. One incorporated storytelling and artistic expression (Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005), while the other was a non-specific school-based mental health service (O’Shea et al., 2000). A classroom-based drama therapy programme was less successful, with no improvements in emotional and behavioural problems (Rousseau et al., 2007). Baker and Jones (2006) evaluated a school-based music therapy programme in an Australian intensive “English as a second language” high school, which they claim had a positive effect on students’ externalising behaviours. However, it is unclear from the research design and analyses used whether or not the intervention was effective.

Interventions reducing discrimination

School-based programmes are more effective in reducing prejudice if they adopt an explicit anti-racism curriculum.
Interventions enhancing family relationships

Considering the strain that the refugee experience places on families, this is a surprisingly understudied area. However, some potentially effective interventions have been described. Weine et al. (2008, 2003) have evaluated multiple-family support and education groups with refugee families. These groups are based on a family strength and resiliency approaches and emphasise the role of family processes in facilitating adjustment (Weine et al., 2008). Families who have engaged in these groups have demonstrated increased social support, family hardiness, problem-solving communication, and family communication around mental health issues, which has led to increased access to mental health services (Weine et al., 2003, 2008).

Qualitative studies of two novel Australian interventions for families support their effectiveness. Refugee parents reported being more connected with their children, feeling less socially isolated and that their children’s mood and behaviour improved following involvement in supported playgroups (Jackson, 2006). The Kite of Life (Denborough, 2010) programme aims to reduce intergenerational conflict and increase intergenerational alliance using a narrative therapy approach. In a Canadian trial with immigrant families, both young and elderly participants reported that the programme opened up avenues of intergenerational communication and respect. This programme has been applied with refugee populations in Australia, but not yet systematically evaluated. The Incredible Years parenting programme has also been implemented with refugee families through Australian government social services, but is yet to be evaluated with these populations (Lewig, Arney, & Salveron, 2009).

Interventions summary

Considering the vast numbers of refugee children internationally, there are few rigorous evaluations of interventions enhancing their well-being (Peltonen & Punamaki, 2010). Randomised controlled trials are scarce, but greatly needed, although they are difficult to conduct with refugee populations. A recent Australian review of interventions for adult refugees with PTSD highlights the need for multistage evaluations leading to the development of interventions that have demonstrated capacity to reduce psychopathology under both controlled and real-life settings while being culturally acceptable to the recipient communities (Nickerson et al., 2011). Such an evaluation strategy is urgently needed for interventions addressing the array of psychological outcomes in child refugees. Until this is available, interventions should be modelled on the emerging evidence, which demonstrates that, when adapted sensitively, a range of established evidence-based therapies for specific target problems may be effective for child refugees. Treatments with the strongest evidence for improving specific outcomes are recommended (i.e., cognitive behaviour therapy (CBT) for PTSD and anxiety; IPT for depression).

Considerations for Clinical Work with Refugee Children and Adolescents

The following clinical issues will now be highlighted: factors which impede referrals being made and clients attending appointments; the cultural competence of individual clinicians and organisations; cooperation between service providers; and effective practice with interpreters. The mental health needs of refugee children often go unmet due to various access and cultural issues (Barenbaum et al., 2004; Weine et al., 2008). In a study of service utilisation among refugee children, Kinzie et al. (2006) reported that most were referred to mental health services as a last resort after displaying severely disruptive behaviour. As the prevalence of mental health problems is thought to be higher in refugee than non-refugee children (Kinzie et al., 2006), creative approaches are required to overcome barriers and provide services to this population.

As children rarely seek services for themselves, it is crucial for adults to identify problems and pursue assistance on their behalf (Cauce et al., 2002; de Anstiss et al., 2009). However, parents and teachers are poor at recognising children’s internal distress (Achenbach, McConaughy, & Howell, 1987; Cauce et al., 2002). Even if distress is recognised, refugee parents may be reticent to present children to services because of stigma associated with mental health problems (Lustig, et al., 2004; Kinzie...
et al., 2006). Refugees may also be unaware of the range and nature of mental health services available or believe that services are only available in times of crisis (Crowley, 2009). Further practical barriers, including time and financial constraints, may prevent refugee clients from physically attending treatment (Lustig, Kia-Keating et al., 2004). However, Howard and Hodes (2000) demonstrated that when child mental health services are culturally sensitive and involve collaboration with teachers, they are acceptable to refugee families. Their study found that despite challenges in accessing services, refugee children were no more likely to drop out of treatment than immigrant or “White” British controls. In addition to working with teachers, clinicians can facilitate access to services by delaying treatment until after the busy initial resettlement period, assisting clients’ understanding of public transport routes, childcare facilities for attending treatment, and bulk-billing, and working with case workers, interpreters, or volunteers to ensure that clients’ appointments do not conflict.

Mainstream service providers can enhance the cultural competence of their work, making their services more appropriate and acceptable to refugee clients (de Anstiss et al., 2009). Key characteristics of individual cultural competency include openness and flexibility, self-awareness, intercultural communication skills, scientific mindedness (gathering evidence to support hypotheses rather than making assumptions), dynamic sizing (knowing when to generalise or be exclusive), and culture-specific expertise or proficiency (Stanley, 1998; Sue, 2001; Graf, 2004; Bean, 2006). Organisational cultural competency can involve diversity among staff, systems which facilitate and reward professional development in cultural competence and the provision of services that meet the needs of diverse clients, including access to interpreters (Sue, 2001; Betancourt, Green, Carrillo, & Park, 2005; de Anstiss et al., 2009). A variety of government, private, and not-for-profit services provide effective training in cultural competence at both individual and organisational levels across Australia (Bean, 2006).

The needs of refugee children and their families may be best addressed through coordinated programmes in which child mental health services work closely with those who can “help shape a culturally sensitive position,” incorporating the social, cultural, and political environments of refugee clients (Davies & Webb, 2000, p. 551). Such a coordinated effort is more likely to meet the diverse needs of refugee families, which usually include pressing economic and general survival issues (Birman et al., 2005).

Language barriers can impede work with refugee clients. Few clinicians speak the same languages as refugee clients (Lustig et al., 2004), so interpreters are often required. Many clinicians are unfamiliar with working with interpreters, and it can impede the therapeutic relationship. However, interpreters can also bring experience, skill, and their cultural consultancy to the clinical encounter, as bilingual co-workers (Ehntholt & Yule, 2006). Several guidelines are available for working with interpreters in mental health settings (e.g., Atkin, 2008; Centre for Multicultural Youth Issues, 2003; Miletic et al., 2006; Tribe & Raval, 2003).

Conclusion and Future Directions

There is an elevated need for psychological services among child refugees. However, many are not receiving these services. Equipped with increased knowledge of the possible stressors encountered, prevalent psychosocial outcomes, appropriate assessment, evidence guiding treatment choice, and creative solutions to overcome access barriers, we hope that clinicians will feel confident to engage further with this client group. Hopefully, this will lead to an increase in practice-based evidence refining our knowledge of psychological outcomes and effective and appropriate interventions for this client group. Also, publication of evaluations of interventions with this group can be seen to be high priority given the dearth of literature in this area, especially within Australia.

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