Trauma & Mental Health in Child and Adolescent Refugees

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Overview

• Child refugees: definitions, prevalence, and mental health
• PTSD among refugee children: Controversy and implications of the diagnosis
• Risk factors for mental illness among refugee children
• Interventions for refugee children, and key barriers to accessing care
Technical definition: Refugee

• A person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution. -- Article 1 of the 1951 U.N. Refugee Convention
Colloquial definition

- Refugee
- Asylum seekers/asylees
- Undocumented immigrants
- Unaccompanied minors (UAM)
Prevalence

• Approximately 9.9 million refugees worldwide (UNHCR)
• About half of these are children <18yrs
Pre-migration

- Exposed to war, experienced or witnessed atrocities to themselves or family members
- Kidnapping, killing, rape and torture
- Disruption of basic needs (education, health care, food sources)
- Separation from family members/caregivers
Migration

- May reside in refugee camps for years: conditions are often crowded, dangerous
- Limited in resources such as food and health care
- May be perceived as ‘safe’ relative to other experiences
Resettlement

- Resettlement in a host community (e.g. U.S.)
- Some assistance immediately post arrival (e.g. up to 8 months of welfare, 90 days resettlement agency assistance)
- Stigmatization (due to race, religion, immigrant status)
- Traumatic events sometimes continue (community violence etc.)
TRAUMA → PTSD
TRAUMA → ? → PTSD
PTSD?

• ‘Medicalization’ of distress
  – Medicine and psychotherapy vs. Religion
  – Distress as a personal/emotional experience vs. disruptions to social/moral order
  – Expressions of distress universal?
  – Symptoms of distress may manifest in other ways, e.g. somatic symptoms

PTSD?

• Overemphasis on trauma and pathology
  – See victim rather than resilient survivor
  – Obscures other suffering of import (e.g. loss of culture, poverty)
  – Locates the problem in the individual, rather than society
PTSD?

• Biological/universal model of how trauma affects emotions
  – Identification of similar symptoms across different cultural groups
  – Greater severity of symptoms associated with more trauma

_Hodes, 2002. Three key issues for young refugees’ mental health. Transcultural Psychiatry, 39(2), 196-213._
PTSD?

- Diverse needs/suffering (e.g. poverty, cultural bereavement) are important and should be considered as essential contextual factors in treatment of PTSD
TRAUMA → PTSD
Loss
Disruption of basic experiences
Trauma
Cultural bereavement
Resettlement experiences and interventions
Depression
PTSD
Human suffering
Resilience
Mental Health in adolescent refugees

PTSD

• Prevalence estimates range from 11-75% (Allwood et al. 2002; Kinzie et al. 1999; Saigh, 1989; Fazel et al., 2005; Ellis et al, 2007).
  – Differences in exposure to trauma, time since resettlement, and experiences in resettlement may account for some difference
  – Many studies have found approximately 1/3 of the youth experience significant PTSD symptoms
Mental Health in adolescent refugees

Depression

- Prevalence estimates range from 4-47% (Felsman et al, 1990; Servan-Schreiber et al., 1998; Papageorgiou et al., 2000; Ellis et al, 2007).
  - High comorbidity with PTSD
  - Associated with recent life stressors and maternal depression (vs. trauma and resettlement stressors).
Mental Health in adolescent refugees

Relative risk

- In UK sample, >25% of refugee youth showed significant psychological disturbance (Fazel & Stein, 2003).
  - More than 3 times the national average
  - Significantly higher than matched controls in same schools
PTSD and Depression in Cambodian adolescent refugees over course of 12 years

3-year: PTSD 48% Depression 41%
6-year: PTSD 38% Depression 6%
12-year: PTSD 35% Depression 14%
Central questions

• Why do some youth develop PTSD and others don’t?
• Why doesn’t PTSD diminish significantly after resettlement?
  – Ongoing risk factors? Postresettlement experiences?
• What about intervention?
Why do some youth develop PTSD and others don’t?

- Social support (Almqvist & Broberg, 1999)
  - Family cohesion (Almqvist & Broberg, 1999)
- Powerlessness (Rumbaut, 1991; Sundquist et al., 2000)
- Not knowing fate of one’s parents (Quirk & Casco, 1994)
- Beliefs and political involvement (Punamaki, 1996; Servan-Schreiber et al., 1998)
- Severity of trauma exposure
Why doesn’t PTSD diminish significantly after resettlement?

- Key risk factors:
  - Legal status/asylum seeking
  - Financial hardship/unemployment
  - Poor or inadequate housing
  - Discrimination
  - Acculturation stress
What about intervention?

- Are our interventions working?
- But first, are youth receiving interventions?
Service utilization: Unmet need

- Kataoka et al. (2002) found that of children aged 6-17 who needed services nearly 80% did not receive them
  - 93% of children of non-US born parents
Immigrant youth Service utilization

- Foreign-born non-citizen children 4 times less likely to have visited a mental health specialist in the preceding year (compared to children from native families)

Refugee youth service utilization

- 31 Bosnian youth assessed for violence exposure and behavioral problems during refugee health assessment
  - 81% of these youth were directly exposed to armed combat
  - 77% had significant behavioral problems
  - only one family expressed interest in receiving a mental health referral.

Barriers to care

- Families don’t want the services offered
  - Stigma of mental illness
  - Different explanatory model/different solution
  - Services aren’t seen as helpful
    - Culturally or linguistically inappropriate/inaccessible
    - Mental illness is not primary concern
      - Especially for new arrivals
Qualitative interviews: Help seeking

“One of my best friends. . . He started feeling depressed and all. He wasn’t enjoying his life and all that stuff. We were afraid that he was going to hurt himself so now we’re buying him a ticket to go back to Somalia. They. . . read the Koran over him. . . If you need help basically go to the mosque and pray for God. We don’t believe another person can help you with your life. --Somali Adolescent
Where this brings us. . .

- Refugees youth are an increasing presence in our communities
- Many of these youth have significant needs, mental health and otherwise, related to past trauma and loss
- Evidence that PTSD, in particular, does not significantly diminish over time
- Almost none of the refugee youth ‘in need’ of services are receiving them
Bridging the gap?

• Services need to be integrated into the system of care
  – Decrease stigma associated with mental health services
  – Build on preexisting structures that engage families
  – Integrate care so that services are coordinated and better able to meet the multiple needs of families
Bridging the gap?

• Services need to be culturally and linguistically appropriate
  – Consider models of capacity building to increase trained mental health specialists within different communities
  – Partner with community providers/agencies so that cultural expertise is integral
Bridging the gap?

• Services need to be trauma-informed
  – Critical to understand how trauma-related symptoms may affect adjustment

• and also comprehensive
  – Case management often essential tool for engaging families and also reducing risk factors/resettlement stressors that directly relate to PTSD
Models of interventions

- **TF-CBT**
  - Well-validated trauma treatment, not specifically evaluated with refugees, may need to be combined with other approaches to address other non-trauma factors
  - School adaptations (CBITS) effective with immigrants

- **Testimonial psychotherapy**
  - Adapted for youth, pilot shows feasibility but not data on effectiveness

- **Trauma Systems Therapy (Saxe, Ellis and Kaplow, 2006)**
  - Focuses on intersection of traumatic stress symptoms and the social environment, integrated into the system of care, adapted for refugees
Future directions

• Towards evidence-based, effective care that is culturally and linguistically competent:
  – Continued integration of knowledge from research, practice, and members of the communities to be served