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The National Child
Traumatic Stress Network

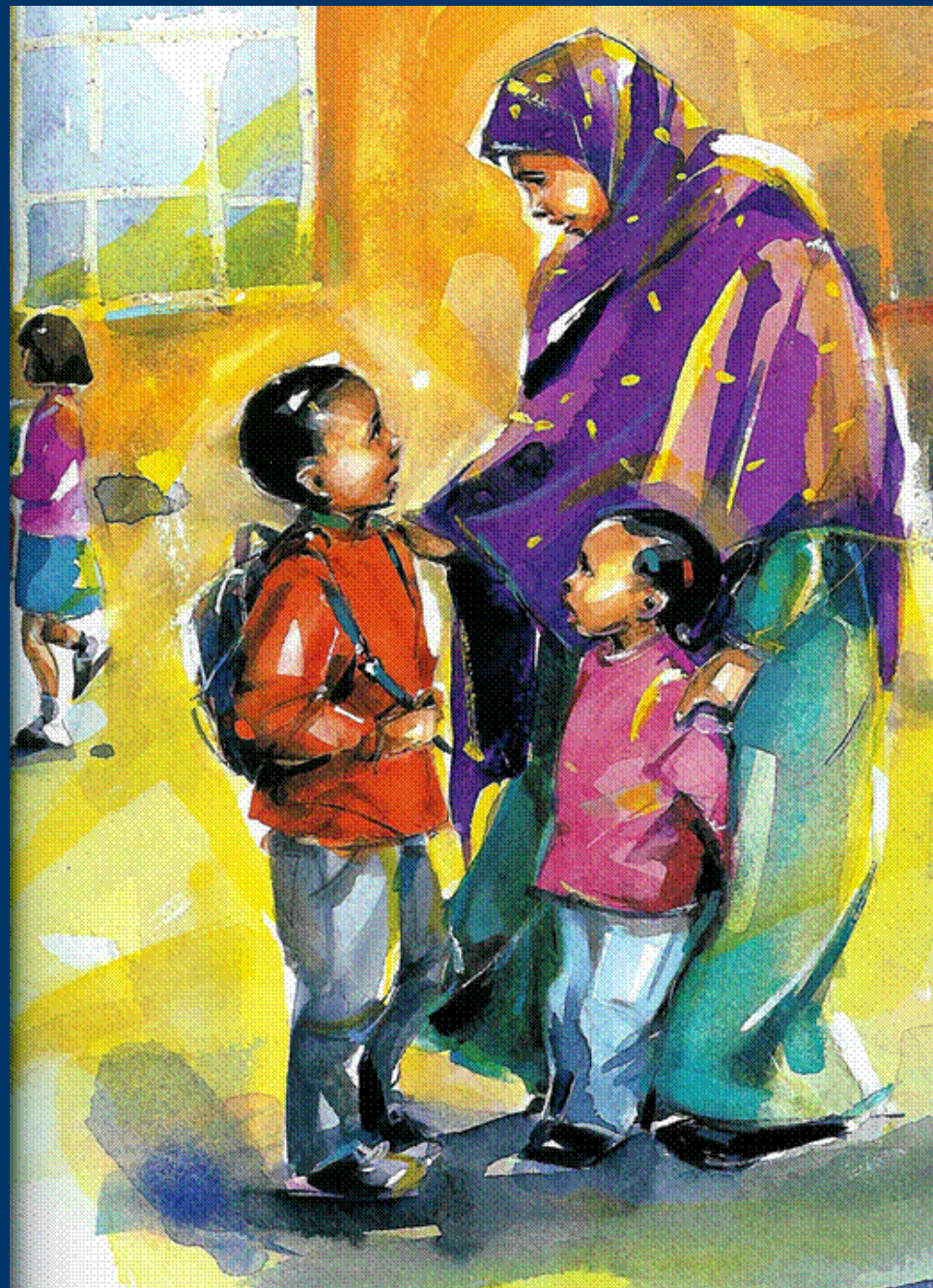
Trauma & Mental Health in Child and Adolescent Refugees

B. Heidi Ellis

Center for Behavioral Science

Harvard Medical School

Children's Hospital Boston



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



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

Summerfield, 2000. Childhood, war, refugeedom and ‘Trauma’: Three core questions for mental health professionals. Transcultural Psychiatry, 37, 417.

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%

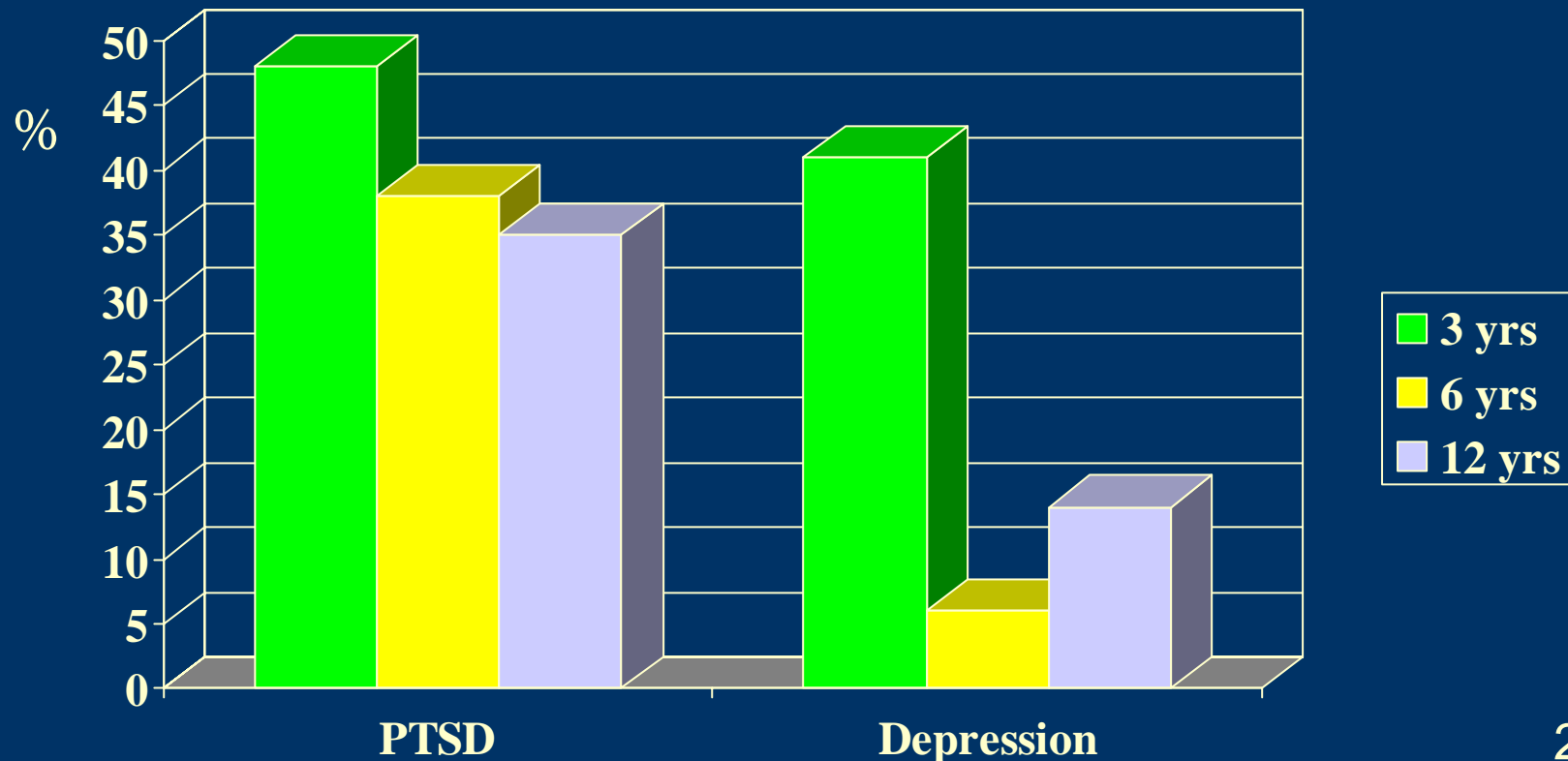
6-year : PTSD 38%

12-year: PTSD 35%

Depression 41%

Depression 6%

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?

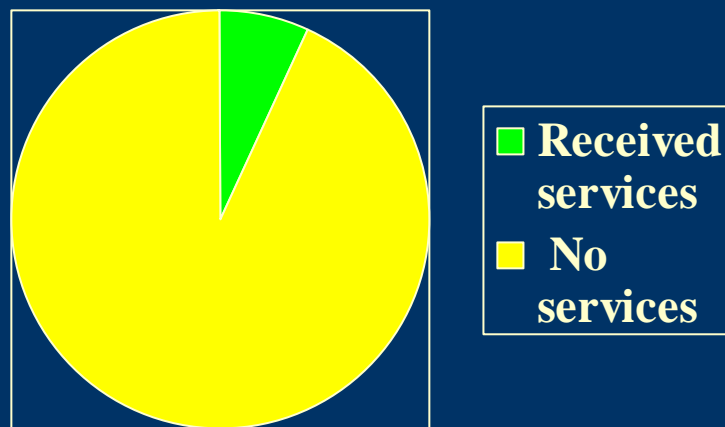
- Key risk factors:
 - Legal status/asylum seeking
 - Financial hardship/unemployment
 - Poor or inadequate housing
 - Discrimination
 - Acculturation stress

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)

Huang, Z, Yu, S., Ledsy, R. (2006). Health Status and Health Service Access and Use Among Children in U.S. Immigrant Families. By:, American Journal of Public Health, Vol. 96, Issue 4

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.

Geltman, P. L., M. Augustyn, et al. (2000). "War trauma experience and behavioral screening of Bosnian refugee children resettled in Massachusetts." Developmental and Behavioral Pediatrics 21(4): 255-261.

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

