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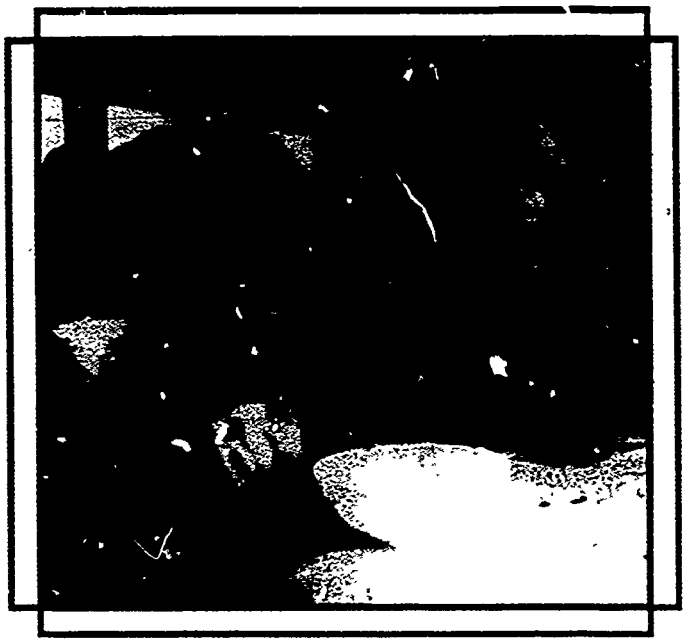
ABSTRACT

This document summarizes issues presented by 16 scholars, researchers, and practitioners from the United States and Canada at a conference on refugee children traumatized by war and violence and suggests a service delivery model for these children and their families. A large percentage of the legal and illegal immigrants who have entered the United States since the Refugee Act of 1980 are children who require assistance from community-based institutions. These children present the following problems to the human services delivery system: (1) lack of a common language; (2) culturally different concepts of illness and health; (3) educational deficiencies; and (4) fear of "foreign" treatment approaches. Current fiscal pressures have reduced the financial resources available to meet their needs. Policymakers and service providers must coordinate, communicate, and collaborate to make the best possible use of the remaining public and private resources. It is recommended that a central collection place for research and program information on refugees be created to help service providers overcome fragmentation, and that coalitions at the national, state, and local levels be developed to design, execute, and evaluate systems of care for refugees. Model service delivery programs foster a network of organizations and individuals concerned with refugee issues, redirect existing programs to meet immediate needs, and develop special culturally sensitive services for refugee children. Lists of the conference participants, the papers presented, and additional resources are included. (FMW)

REFUGEE CHILDREN TRAUMATIZED BY WAR AND VIOLENCE:

THE CHALLENGE OFFERED TO THE SERVICE DELIVERY SYSTEM



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PREFACE

This monograph summarizes issues presented by sixteen scholars, researchers, and practitioners from the United States and Canada at a Conference on Refugee Children Traumatized by War and Violence held between September 28-30, 1988 in Bethesda, Maryland.

The goals of this conference were to:

- Delineate the effects on refugee children of pre-migration, transmigration, and post-migration experiences through presentations using theory, research, and case studies.
- Focus attention on and increase understanding of child refugees--a group which has received limited attention in the literature.
- Explore issues of service delivery to refugee children and describe model strategies and programs.

The planning activities that led to this conference began in March, 1988 when Jean Garrison, Director of the High Risk Program, Child and Family Support Branch, National Institute of Mental Health (NIMH) and Michael E. Fishman, Assistant Director of the Division of Maternal, Child, and Infant Health, Bureau of Maternal and Child Health and Resources Development, identified and convened an eleven-member planning committee which was chaired by Fred Ahearn, Dean, School of Social Service, The Catholic University of America. This committee commissioned sixteen professionals knowledgeable about refugee experiences and about services provided to refugee families to develop scientific papers to present at the conference.

This monograph was subsequently developed by the Georgetown University Child Development Center in order to disseminate information from the conference in summary form to policymakers, program planners, and professionals in the major child service systems of health, mental

health, child welfare, juvenile justice, and education who have service delivery responsibility for refugee children and their families. It draws from the unpublished papers presented (see Bibliography) as well as from discussions held during the conference. It also draws some information on model programs from documents developed by the University of Minnesota's Refugee Assistance Program, Mental Health Technical Assistance Center.

The purpose of this monograph is to share information and knowledge about the experiences of refugee children who have been traumatized by war and violence and to suggest service delivery designs with the goal of improving services to these young people and their families.

The conference itself focused on the special physical, social, and mental health needs of refugee children and adolescents who have come from war-torn countries and/or have experienced violence. The three interrelated stages of the refugee experience investigated during the conference were:

- The Migration Process - Presenters described the different reasons for migration, identified common situations encountered during the process, and explored the effects this experience has on the lives of children and adolescents. Cultural, social, and developmental issues related to migration were identified.

- The Process of Adaptation - The variety of problems children and adolescents face once they arrive in the United States were identified and discussed. This includes (but is not limited to) problems encountered in everyday living, major changes that occur within many refugee families, and disorders exacerbated by the stress of the refugee experience.

- Model Programs and Services - Various types of programs designed to meet the special needs of refugee children were discussed and particular emphasis was put on identifying, developing, and using program strategies that are culturally-relevant, comprehensive, sound, and of high quality.

Some of the other issues discussed at the conference were: the need for accurate and consistent diagnosis of the physical and mental health problems of refugee children and adolescents; the need for a specific research agenda--systematic documentation of information on refugee

children and their families; and the shared perception that fragmentation of both services and policies often exists in public and private organizations that serve refugee families.

U.S. health and social service delivery systems have been responding to the unique needs of refugees for a long time. There is no indication that demands on these systems will diminish as drought, once again, devastates Africa, as ethnic unrest and geopolitical disputes plague the Middle East, and as civil strife continues in Southeast Asia and Central America. The influx of refugees is likely to continue and even expand.

In addition to refugee children needing support services now and in the future, there are hundreds of thousands of non-refugee children living in refugee-like situations both in this country and elsewhere in the world. Instead of being the victims of forced migrations, these other children are the victims of natural disasters, poverty, multi-problem family situations, and insufficient education. According to Norman V. Lourie, a presenter at the conference who has been involved for over fifty years in family service and child welfare issues, refugee children and children from other impoverished and underprivileged populations have had many experiences in common, such as:

- Recall of violent or negative experiences.
- Fear of the future.
- Depression over personal property losses.
- Grief over family separation.
- Discrimination because of color or language.
- Frustration because of failure to adapt to their economic or cultural environment.
- Intergenerational conflicts.
- A sense of non-acceptance by the majority society.

Programs developed and demonstrated to be effective for refugee children and families may also be effective for other populations who are disproportionately impacted by problems of racism and poverty.

As Carolyn L. Williams stated at the conference, it is critically important for researchers, scholars, policymakers, educators, and public- and private-sector service providers involved with refugees to be guided by past research and experience with refugees. By sharing their knowledge it is hoped they can more efficiently and effectively meet the needs of refugee children, adolescents, and their families. It is also hoped the lessons

learned may be useful in providing services not only to refugee children but also to other populations that have experienced prolonged crisis.

ACKNOWLEDGEMENTS

The Conference on Refugee Children Traumatized by War and Violence was made possible through the leadership and guidance of Jean Garrison, Ph.D., Child and Family Support Branch, National Institute of Mental Health (NIMH); Frederick Ahearn, D.S.W., School of Social Service, The Catholic University of America; Michael E. Fishman, M.D., Bureau of Maternal and Child Health and Resources Development, Health Resources and Services Administration (HRSA); and Richard B. Cravens, Ph.D. and Thomas H. Bornemann, Ed.D., Refugee Mental Health Program, NIMH.

In addition to the guidance and support provided by those listed above, a conference planning committee assumed major responsibility for designing the conference and for selecting presenters. (See Appendix for a listing of committee members).

Special thanks go out to each of the conference presenters who prepared papers on different aspects of Refugee Children Traumatized by War and Violence and who reviewed this monograph. These professionals, representing a diversity of disciplines, were:

William Arroyo, M.D., Clinical Assistant Professor of Psychiatry, University of Southern California.

John Berry, Ph.D., Professor of Psychology, Department of Psychology, Queens University in Kingston, Ontario.

Margaret de Monchy, Coordinator, Refugee Assistance Program, Department of Mental Health and Human Services, Commonwealth of Massachusetts.

Conchita M. Espino, Ph.D., Director of Psychology Training, Child and Youth Services Administration, Commission on Mental Health, Washington, D.C.

Norman Garmezy, Ph.D., Professor, Department of Psychology, University of Minnesota.

Giao N. Hoang, M.D., Director, Department of Community Medicine, University of Connecticut.

Dennis J. Hunt, Ph.D., Regional Director, Connections (Refugee Unaccompanied Minors Program), Catholic Charities of Richmond, Falls Church, Virginia.

Norman V. Lourie, Senior Policy Advisor, National Immigration, Refugee, and Citizenship Forum.

Jeanne F. Nidorf, Ph.D., Assistant Clinical Professor of Psychology, Division of Family Medicine, School of Medicine, University of California at San Diego.

Timothy Ready, Ph.D., Research Associate, Department of Anthropology, The Catholic University of America.

Ruben G. Rumbaut, Ph.D., Professor of Sociology, San Diego State University.

Holbrook Teter, Coordinator, Coalition to Aid Refugee Survivors of Torture and War Trauma, International Institute of San Francisco.

Tran Minh Tung, M.D., Psychiatrist, Falls Church, Virginia.

Patricia Weiss-Fagen, Public Information Officer, United Nations High Commissioner for Refugees.

Joseph Westermeyer, M.D., Professor of Psychiatry, University of Minnesota.

Carolyn L. Williams, Ph.D., Assistant Professor, Division of Epidemiology, School of Public Health, University of Minnesota.

Also participating in the conference were representatives from organizations actively involved in programs and policies that affect refugee children and their families. These organizations included the Child Welfare League of America, the Office of the Assistant Secretary of Health, the National Center for Social Policy and Practice, the National Association of Social Workers, the U.S. Conference of Catholic Bishops and Catholic

Charities, the Arlington, Virginia Social Service Department, and the Michigan State Department of Mental Health.

This monograph would not have been possible without the support of the four co-sponsors of the conference:

- The Bureau of Maternal and Child Health and Resources Development, Health Resources and Services Administration.
- The Catholic University of America.
- The Georgetown University Child Development Center.
- The National Institute of Mental Health, Child and Family Support Branch and The Refugee Mental Health Program.

We would also like to thank Jean Garrison and Michael E. Fishman, as well as Judy Katz-Leavy, M.Ed., Assistant Director, Child and Family Support Branch, NIMH, for their critical review of the draft of this monograph. Finally, a special debt of gratitude is owed to Phyllis Magrab, Ph.D., Director, Georgetown University Child Development Center, who from the very beginning supported the creation of this monograph, and to Kathleen McGhee, consultant, who provided editorial assistance.

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CHAPTER 1

INTRODUCTION

Refugees are people who have fled or been expelled from their country or place of usual or preferred residence for reasons of race, religion, nationality, membership in a particular social group, or because of their political opinions and are immigrants to the new country or place of settlement. During this century alone it is estimated that more than one hundred million people have crossed borders and continents in search of haven and a better future for themselves and their families.

According to Patricia Weiss-Fagen of the United Nations High Commissioner for Refugees, there are approximately 12 million refugees in the world today. Africa contains a quarter of these people--victims of tribal hostilities, political persecution, and famine. In the Middle East, the ten-year war in Afghanistan has destroyed and depopulated large parts of that country, and, although the conflict between Iran and Iraq is now abating, the Kurds, a minority population, are still fleeing attacks. In the Far East, war and economic disruption have generated millions of refugees from Vietnam, Laos, and Cambodia, the majority of them since 1975. In the Western Hemisphere, civil strife in Central America over the past fifteen years has produced an on-going stream of refugees; and Cubans and Haitians continue to seek asylum outside the borders of their countries.

Half of the refugees in the world today are children; there are an estimated six million under the age of eighteen. Fifteen to twenty percent of these children are less than five years of age.

Children are the greatest victims of the situations that produce refugees because they are more vulnerable both physically and emotionally than the adults around them. The refugee experience confronts them with multiple traumas: the death of parents, grandparents, brothers and sisters; the witnessing of war first hand; the loss of their home, friends, and

community; hunger and violence; and a sense of powerlessness to hold onto those things that give them security and sustenance.

The future of these children and of their families is largely dependent on the willingness of certain nations to offer them sanctuary and the chance to build new lives. Since the beginning of American history, the United States has taken in people from other cultures and continents. This country is a nation of immigrants--people who have chosen to relocate their lives in order to find a better economic, religious, and social future for themselves and their families. Refugees, on the other hand, are involuntarily and relatively unprepared migrants, forced to relocate by circumstances beyond their control. The United States has taken in large numbers of both immigrants and refugees, the latter particularly since World War II.

Since the end of the war in Vietnam, Southeast Asian refugees numbering in the hundreds of thousands have come to the U.S. Simultaneously, large numbers of people fleeing political disruption and civil war in Central America have moved north. Many of them have entered this country legally, but it is estimated that over one million are here illegally.

The fact that many of these recent refugees experienced war-related traumas both before they left their countries of origin as well as during their time of migration has made their adjustment to their life in the United States difficult. Given the trauma-related scars many have brought with them, as well as the acculturation problems they face on arrival, a large number of refugee families have needed to turn to social service agencies, including health and mental health programs, for help during their period of adaptation.

Refugee families themselves, the communities in which they are starting new lives, and the nation as a whole benefit when successful resettlement is achieved and new arrivals become productive members of American society. Thus, it is valuable for the agencies that provide services to refugee children and their families during the assimilation process to learn from each other how best to help refugees develop life skills that will allow them to become self-sufficient and productive citizens.

Following the war in Vietnam, the U.S. government allocated funds to provide special services to refugees from Southeast Asia, as well as from other areas of the world. Now, over ten years later, this federal money is diminishing even though refugees continue to arrive. This reduction of resources makes it even more important for states and public and private

agencies dealing with refugees to share research and program information so as to maximize those resources that continue to be available.

Refugee children, because of the trauma many of them have experienced, are young people at risk. Many of them bring with them physical problems caused by inadequate nutrition, by inattention to chronic conditions, and by injuries suffered before or during flight. Many bring emotional problems caused by feelings of alienation from their country and community of origin, by anxiety resulting from their perception of their parents' powerlessness to protect them from the negative dimensions of the refugee experience, and by a sense of disorientation and loss of identity. The capacities of public schools and agencies offering resettlement services are challenged by the acute needs of these youngsters. Providing effective assistance is complicated by young refugees' language problems, their diverse social and cultural backgrounds--not always well understood by service providers--and by the physical and emotional "baggage" they bring with them.

This monograph attempts to capture the deliberations that took place at the Conference on Refugee Children Traumatized by War and Violence, and to suggest innovative approaches for delivering services to these refugee children.

CHAPTER 2

THE MIGRATION PROCESS

Although each refugee experience is unique, all refugees deal with multiple stressors before migrating, while in flight, and, in many cases, during a temporary resettlement period prior to arriving in the United States. In order for service delivery systems to deal in a positive way with refugee children and their families once they have arrived in their country of refuge, an understanding of the migration process itself is essential.

DIFFICULTIES ENCOUNTERED BEFORE MIGRATION

It takes an accumulation of problems to force a family to leave its native country. These problems often include:

Civil Strife

Many families flee after having been terrorized by war-related events: bombardments, skirmishes, abductions, torture, killings. Children witness this violence. Often they know that family members are in hiding. They are taught to keep secrets. They feel the anxiety and fear of the adults around them. Older children may be inducted into local militia and forced to carry out military activities even against their own communities and families (e.g., the age for mandatory military service in El Salvador is fourteen and in Guatemala, fifteen. William Arroyo). Family life is disrupted, family members are separated.

Civil strife also increases poverty and reduces access to medical, social, and educational services, reasons that increase many families' desire to seek a better life elsewhere.

Political Revolution

In both Southeast Asia and parts of Central America, major political changes have taken place since 1970. These changes often have been brought about by violent means and have resulted in the killing of political opponents, the branding of those who were politically suspect, and the re-education of the masses with children being particular targets of new-regime propaganda.

Many parents have decided to remove their families from their country of origin when they find themselves no longer politically welcome, when the new government has caused their position in society to be radically changed both socially and economically, and when they find their children being politically indoctrinated with principles with which they do not agree.

Poverty

Lack of money, food, and other resources are major problems in most Third World countries--areas from which the majority of the refugees in the world originate. This translates into poor housing, inadequate sanitation, malnutrition--circumstances that foster in children stunted growth, developmental disabilities, chronic and neglected health problems, and high susceptibility to illness and death. (The death rate of children under age five in El Salvador in recent years has been twenty-five percent. William Arroyo).

ISSUES FACED DURING FLIGHT

Often during the migration process families are separated: a parent will migrate before the rest of the family to prepare the way; older brothers will be sent ahead to prevent them from coercive induction on one side or another of a local conflict; immediate or extended family members will be lost in transit or end up in different countries or different parts of the same country.

Regardless of why families become separated or whether they lose connection before, during, or after migration, the result is that a critical element in children's lives is stressed and disrupted. During the actual escape period, children often are:

- Separated from their siblings, parents, extended family members, and friends.

- Witnesses to the death of people close to them due to natural elements (exposure to sun, storms, drought); by accidents en route; by militia or by pirates. (In the past several years, one out of three refugee boats in the Gulf of Siam have been attacked by pirates. Tran Minh Tung).

- Susceptible to physical injury due to war or the dangers of travel.

- Subjected to turmoil all around them which can be as disruptive as war and violence itself.

- Aware of parents' fear, anxiety, and lack of control over current circumstances.

- Vulnerable to illnesses due to poor sanitation and malnutrition.

- Faced with making decisions beyond their years.

During the crisis of flight, family ties can sometimes be enhanced. The flip side of having the migration exodus be a disaster is having it be, for children, an adventure of sorts. How it is perceived by young people, however, is largely dependent on how it is portrayed to them by their closest caretakers; and, in times of war or great disruption, these caretakers often are not able to offer children much buffering from the difficulties around them.

No matter how the period of flight is perceived, the changes that result from a migration experience are extensive, and children have to learn how both to assimilate the exodus experience and to cope with its consequences.

SITUATIONS ENCOUNTERED IN REFUGEE CAMPS

Refugees coming from Southeast Asia often spend from a few weeks to several years in refugee camps before resettlement in a third country. During their stay in these camps, the United Nations High Commissioner for Refugees (UNHCR) tries to intervene with governments on their behalf and to voice their interests, something that is very difficult for refugees in states of trauma and transition to do for themselves. In fact, in August of 1988, the UNHCR published Guidelines On Refugee Children to address the special issues and problems that specifically affect refugee children and to provide guidance for international and national personnel working with young refugees (Patricia Weiss-Fagen).

In spite of such efforts, life in many refugee camps continues to be unhealthy for both adults and children:

- Some camps are unsafe; attacks, brutality, and extortion can be regular occurrences.

- Adults in refugee camps are in a waiting mode. Usually they are not in charge of their next steps and are therefore anxious, disoriented, and unproductive: states of mind which are easily perceived by their children and which do not promote good parenting.

- Health, social, and educational services often are not available to children in camps, since most camps are located in impoverished Third World countries which often do not have the resources to offer such services even to their own citizens.

- Many young children find themselves free to get into trouble since their parents are disoriented by their transitional state and overburdened by their own losses and cannot attend to their children's needs, and since few recreational or educational programs exist.

- Adolescents can take particular advantage of the freedom from parental controls, educational responsibilities, and work expectations to pursue their own pleasures. Their acting out extends from sexual promiscuity to vandalism, petty theft, extortion, or violence.

- Older children are also affected by extended camp stays, particularly those without accompanying family members. Effects on adolescents range from depression, apathy, delinquent behavior or aggressive acts to situational mental disturbances, substance abuse, and suicide. In many cases, suicide is the result not only of individual distress but is also a reflection of the high level of anxiety and despair within the refugee community as a whole." (United Nations High Commissioner for Refugees, Guidelines on Refugee Children, August 1988, p. 18).

In summary, before and during the migration process, refugee children are forced to face multiple change situations that threaten their familial relationships, break their connections with their community of origin, challenge the behavioral expectations of their culture, and leave them uncertain about their future. The enormity of these changes needs to be understood as refugee children face the task of building a new life in their country of asylum.

CHAPTER 3

THE PROCESS OF ADAPTATION

If we can come to understand the imprint of the refugee experience on children's minds, spirits, and behaviors, we may be able to explain--and perhaps predict and prevent--many of the problems that are plaguing... refugee children in the United States. (Adapted from Tran Minh Tung).

When refugee families arrive in the United States, their physical odyssey may be mostly over, but the process of learning to live a constructive life in the new society is just beginning.

Most refugees, when they first arrive, experience a sense of elation. The journey is over, asylum has been found, the family can be rebuilt, and a new life begun. Usually this euphoria is short-lived, however, as refugee adults and children realize the number of obstacles they must overcome in order to establish a "successful" new life. These factors include: mastering a new language; learning to live in a new climate; obtaining the necessary skills to get a job and support one's family; and adjusting to a society which has different laws, political, economic, and educational systems, and values, customs, and unspoken expectations. These major challenges must be met by people who have already been highly stressed by the migration experience, who may have suffered major physical, economic, political, and emotional losses, and who feel rejected by their society of origin just as they feel alien to the one that is receiving them. This difficult combination of circumstances is made even more complex if, as in the case of many of those coming from Central America, refugees do not have legal status in this country and if they are perceived as having migrated for primarily economic reasons.

This post-euphoric period may be a time of depression and low sense of well being. It is characterized by confusion and a perception of helplessness, hopelessness, and powerlessness. Frequently, stresses

leading to and experienced during this period exceed both adults' and children's capacities to cope. It is at this time that American service delivery systems often are called upon to provide support.

If these systems can successfully offer assistance at this point, they can help refugee children and their families move to a positive state of adaptation--one of "psychological rebounding"--in which confidence can be reconstructed and true adaptation to the new society accomplished. For human service providers to play a significant healing role in the adaptation process, they need to be sensitive to the experiences refugee children and their families have been through. Recognizing the need for this sensitivity and taking concrete action in order to learn about the refugee experience is an important first step for service providers to take.

A great deal of information exists about the experiences of refugees. Data shared at the conference included information from a 1982-85 longitudinal study conducted by Ruben G. Rumbaut of over 500 Vietnamese, Cambodian, Chinese, and Hmong refugees in San Diego County to identify the major stressful life events which occurred during their migration to the United States. These situations included:

- Fear of being killed during escape 79.4%
- Death of family members 48.6%
- Stay of over two years in refugee camps 47.7%
- Use of bribes to exit country of origin 35.9%
- Loss of connection with family left behind (this statistic from 1983) 31.7%

With an understanding of experiences such as these and with sensitivity to the key elements of the culture of origin, service delivery systems can facilitate refugees' transition to their adoptive country. Without such sensitivity, service providers, even with the best of intentions, can inadvertently revictimize refugee families and perpetuate destructive patterns established during the migration process (Margaret de Monchy).

DIFFICULTIES COMMONLY FACED BY REFUGEE CHILDREN

Norman Garmezy pointed out that stress comes from experiencing specific stressful occurrences. With refugee children, however, there is an accumulation over time of many interactive stressors. Significant difficulties commonly faced by the refugee child during the acculturation period include:

Reconfiguration of Families

Many children begin life in the U.S. within a family unit different from the one they had in their country of origin. A parent or sibling may have been killed or lost during the migration process. Grandparents and extended family members may still be in their native country. A marriage may have broken up due to stresses put on it by the migration experience. A mother or father may have acquired a different mate during migration and that person may have brought additional children into the family unit. (Out of 136 refugee families studied in Los Angeles since 1980, 97 did not include both original parents. William Arroyo).

Particularly when there has been prolonged separation during the refugee experience, relationships suffer and normal developmental issues can become unmanageable.

Change in Traditional Male-Female Roles

In many Third World countries, the everyday roles of men and women have stayed somewhat clearly delineated. Especially in rural areas, women might keep gardens, repair clothes, care for children, and prepare food, whereas men might deal with farm equipment, tend large animals, handle commercial transactions, and, in more urban areas, be the primary breadwinners for their families.

In the United States, such division of roles is threatened. Refugee women frequently are able to find employment more easily than men. Even if the jobs they find require few skills and are low in pay (often they work as maids, housekeepers, office cleaners), refugee women end up not only moving away from their traditional support roles within the family but also becoming the initial breadwinners. This can cause resentment on the part of their spouses, that the economic provider role has been usurped and the husband's position of authority diminished. Divisiveness between husband and wife also is caused as many women acculturate more quickly

because of their daily contact with American society. The result of all this for refugee children is stress, as the relationship between their parents is pressured.

Parent-Child Role Reversals

Most refugee children adapt more rapidly to the receiving society than do their parents. This causes role reversals where children become culture brokers by acting as translators and then gradually become family decision-makers by doing such things as screening phone calls, managing the household budget, and influencing or making major social and economic decisions. Not only does this wreak havoc with traditional roles expected of parents and children, but it can deprive children of an ordinary childhood (Joseph Westermeyer).

Intergenerational Conflicts

The rapid acculturation of refugee children has also caused strife between generations, as children adopt different behaviors, etiquettes, values, and expectations from those of their parents. Refugee children are particularly susceptible to peer pressure because they so strongly want to be accepted, yet following the lead of American friends often forces them to abandon traditional values. No small amount of stress stems from refugee children trying to become Americanized while their parents are trying to socialize them according to the old culture. Conflict is particularly evident in adolescents who are working to establish their own identities. This conflict can cause tragedies.

Parental Acculturation Failure

Parents who can't master English, who fail to adjust to the American culture, and who have difficulty finding and keeping jobs find it difficult, if not impossible, to help prepare their children effectively for life in the United States. They also find it difficult to retain their children's attention and respect.

Child Neglect and Abuse

With a large number of refugee parents either unemployed or underemployed and feeling stressed, depressed, somewhat powerless, and sometimes overwhelmed, it is not surprising that many refugee children are neglected or abused. Furthermore, urban poverty settings in which refugee families often live can exacerbate conflicts within families.

In addition, many refugee children spend a period of time living with relatives, surrogate parents, or in foster care situations in which they may be occasionally used as servants, be neglected, or be sexually abused.

Human service providers should be careful not to mistake certain folk practices of some Southeast Asian families for child abuse. Coining, for example, is used by Vietnamese and sometimes by Cambodians to exude "bad wind" or noxious, harmful presences from the body. It is indicated for headaches, pain, colds, and vomiting. Menthol oil or ointment is applied to the painful area and the edge of a coin is rubbed over the area in downward strokes, producing either a deep purple skin color or redness. Done in moderation, this practice may cause some bruising, but it does not constitute child abuse.

Inadequate Educational Preparation

Although there are many educational success stories, particularly of Southeast Asian youth who have become model students in American schools, more stories tell of refugee children who have problems fitting into the U.S. school system. The children of many recent refugees have received little education in their country of origin and no education during their time in flight and in camp. When they arrive in the United States, most speak no English, some can't read or write in their native language, and many have had little exposure to formal education.

It should be noted that the impact of refugee children on the U.S. school system is not minimal. In 1987, 25,296 of the children enrolled in the state of California's public schools were refugees (Refugee Resettlement Program, 1988 Report to Congress, Appendix B-13).

For some children, particularly those from Southeast Asia where academic success has historically been a key to social mobility, the pressure to succeed in the American school system can take on an enormous--and unhealthy--importance. For other children, for instance some from Central America, success in school may be looked upon as being less important than providing child care or performing household duties. This can make it hard for these children to succeed in school and therefore to broaden their opportunities in life.

Seventy-three percent of Central American refugee children tested (in Spanish) in a recent study were two or more years behind in reading and math skills. These delays, which cause an academic "catch up" problem,

also contribute to self-esteem problems for the children who are performing poorly. Problems of adaptation and low self-esteem can make these youngsters candidates for delinquency (Conchita Espino).

Language

Learning English is a key to operating productively in American society. The Office of Refugee Resettlement report to Congress for 1987 states that proficiency in English has a major effect on employability. Among those refugees who spoke no English, the employment rate was seven percent. Among those who spoke English well, the employment rate was fifty-one percent.

Teenage refugees are particularly susceptible to frustration that stems from the need to express their feelings and their inability to do so in a foreign language; negative behavior often results.

Employment Problems

Many refugees come from rural areas, but the majority of them have ended up in urban settings where their skills have little value. Many of these men and women can only find low-skill, low-paying jobs. Even refugees who were educated and had white collar jobs in their country of origin often are unable to translate their professional experience into that of the receiving culture. For example, physicians who had been practicing medicine in their own country now work as outreach workers or may well have jobs in low-skill, non-medical fields.

For children, the employment problems of parents translate into stressful family relationships and a diminished sense of individual and family capability.

Residence in Low-Income, High-Crime Areas

Many refugee families begin their life in the U.S. as part of America's urban poor. They can only afford housing in low-income neighborhoods and have to deal with the poverty, drugs, and violence found there. As a result of this setting and because of the multiple problems faced by those who live in urban slums, many refugee survival communities exhibit corruption, exploitation, and mistrust both of community members and of society at large. This setting and these attitudes become another major barrier for refugee children and their families to overcome. Moreover, the

violence and gang-dominated activities occurring in these communities may serve as painful reminders of refugees' recent past.

Racial Discrimination

The majority of the refugees entering the United States in the 20th century from war-torn areas are part of minority racial groups. In addition to having to deal with the discrimination which has historically greeted any new immigrants, they have to face additional problems because of their non-Anglo racial makeup. Furthermore, recently arrived refugees frequently compete with other inner city poor for limited numbers of low-skill jobs, housing, and upward mobility opportunities. Again, the effect on children is stress for their families, a perception of competition, and even conflict with the community around them, and a sense that in many instances they have to fight to survive.

Post-Traumatic Stress Disorder (PTSD)

PTSD is a stress-induced syndrome found in refugee children, adolescents, and adults who have been directly victimized by war-related violence. This disorder shows up as children re-experience traumas undergone previously by having recurring dreams about them, by being suddenly reminded of them by a current event, or by feeling that the trauma is about to recur. Resulting behavior can include an inability to relate to the outside world, an exaggerated startle response, trouble concentrating, and avoidance of activities that conjure up negative memories (Conchita Espino). When PTSD combines with depression, it can be a major problem for children and for adults.

REFUGEE CHILDREN WITH ADDITIONAL DIFFICULTIES

Most refugee children face at least some--and often many--of the above-mentioned problems during their time of adjustment to their new lives in the United States. At least two categories of refugee children, however, face additional difficulties:

Unaccompanied Children

Many refugee children enter the U.S. unaccompanied by parents or family members. Since 1979, 8,069 of these unaccompanied minors have entered the country under the auspices of the Office of Refugee Resettlement. For the most part, these children are placed in American foster homes through

two national voluntary agencies: U.S. Catholic Charities and the Lutheran Immigration and Refugee Service.

Children are unaccompanied on arrival in the U.S. for many reasons, not always obvious. Their parents may be dead or they may be children with problems who have been rejected by their own society. Regardless of why these children are on their own, the fact that they face adjustment issues alone adds to the nature and degree of the difficulties they experience. Many of them feel anger at their parents, homeland, and culture for having abandoned them. Most mourn the loss of family and community. According to Joseph Westermeyer, a large number of them have trouble adjusting to their foster homes and evince sleep disturbances, depression, withdrawal, excessive fears, and refusal to learn new skills, including English. For service providers to help them and their foster families through the time of adjustment, an understanding is needed of the sense these children have of the enormity of their loss and of their solitariness in facing acculturation issues.

Amerasian Children

Another category of refugee children with special problems is Amerasians. By 1990, approximately 30,000 Amerasian children (offspring of American fathers and primarily Vietnamese mothers) and accompanying family members will have arrived in the United States. Many of these children face multiple levels of rejection: rejection by American fathers who refuse to acknowledge their parentage; rejection by their mother's family which feels shamed by their daughter's unwed status; and rejection by the races of both parents as being a full member of neither one. High percentages of these children are raised by their mothers alone--women who often have few job skills.

In addition to the already-cited problems faced by refugee children on their arrival in the U.S., Amerasian children have the added burden of needing to come to some terms with their split national and racial identities. For the Amerasian child, particularly those who appear black, identity confusion is a major issue.

SYMPTOMS, BEHAVIORS, AND DISORDERS

Given the many stresses faced by refugee children and adolescents during the acculturation process, it is not surprising that a large number of these young people exhibit, at least for a time during periods of maximum stress,

certain symptoms, behaviors, and disorders. At the conference, Dennis J. Hunt described some of these as:

Distrustfulness

So many ties have been severed and patterns disrupted that refugee children have difficulty trusting new situations, developing solid relationships with people in the receiving society, and putting confidence in its processes and institutions.

Depression

Studies show that major depression is the most prevalent psychiatric disorder in adult refugees. Fewer studies have been done on refugee children, but one such study shows that thirty-five percent of the Vietnamese teenagers in foster care in the Washington, D.C. area met the DSM III criteria for clinical depression during the first eighteen months they were in the United States (Dennis Hunt). Their depression seemed to stem from their loss of loved ones, their sense of being uprooted, a certain "survivor's guilt," and feelings of helplessness, powerlessness, and insecurity.

Anxiety Disorder

Anxiety is another common characteristic of refugee children who have lived lives filled with non-contingent life changes and traumas. It is closely tied in with the sense of distrust and vulnerability. Refugee children deal with their anxiety by withdrawing socially or by overcontrolling, as in obsessive-compulsive behavior. Others display irrational fears that impair functioning.

Anger

Pent-up anger at constantly facing circumstances beyond their control is sometimes released through negative behavior: vandalism, thievery, extortion, substance abuse, and violence.

Relationship Difficulties

For those refugee children who have experienced multiple losses, new relationships are sometimes avoided out of a fear that they will only have to deal with a new separation and loss experience in the future. Some refugee children are capable of developing many new friendships but will

not allow the relationships to become deep or longlasting. This tendency protects the child from experiencing additional losses in his life but also prevents him from developing the interpersonal bonds every human being needs to maintain an emotionally stable life.

Distorted Value Systems

To survive the migration process, stealing, lying, and deception may have been necessary, yet children who continue to exhibit these behaviors in the new country are at odds with their new society.

Sexual Acting Out

Throughout the refugee experience, adolescents have been placed in situations fostering a precocious maturity that can ultimately result in age-inappropriate social behavior. In refugee camps, adolescents often were free to make sexual choices uninhibited by adults or by previous cultural restrictions. Living in a new country with different sexual mores has confused many adolescents' understanding of what is expected of them socially. In addition, many teenage girls and boys, both during the time of migration and on their arrival in the United States, were given adult responsibilities and, therefore, feel they should be given commensurate social freedom. Finally, many refugee adolescents need to feel valued and loved, and look to sexual relationships to fill emotional voids.

Psychiatric Problems

The prolonged stress experienced during the period of migration and during early stages of acculturation results in a high incidence of psychiatric problems among some refugee children and adults. Common mental health problems in refugees, beyond PTSD and major depression, include paranoid syndromes, mania, schizophrenia, and "refugee neurosis," which is characterized by a mix of insomnia, nightmares, somatic complaints, problems with personal relationships, mistrust, and social isolation.

In summary, participants in the Conference on Refugee Children Traumatized by War and Violence agreed that health and human service providers play a critical role in helping refugee children and their families adapt to their new lives in the United States. To offer effective support, however, these service providers need to:

- Identify the nature of the stresses faced by refugee children during the adaptation period;

- Be aware of the special categories of refugee children who are at particularly high risk; and

- Recognize negative behavior often exhibited by refugee children as being natural reactions to the very real stresses they have had to face.

Although the above-mentioned difficulties faced by refugee children may sometimes seem insurmountable both to refugee families and to the receiving society, these obstacles for the most part are overcome, adaptation does occur, and refugee children do become positive and contributing members of their adoptive society. The following chapter of this monograph describes some of the basic service delivery approaches that have been successful in helping refugee children and their families with this adaptation process.

CHAPTER 4

BARRIERS TO SERVICE DELIVERY, MODEL PROGRAMS AND SERVICES, AND SUCCESSFUL SERVICE DELIVERY APPROACHES

Refugee children who have survived war and violence live in a different world from other children. They have had experiences outside the realm of what we know as normal human experience. They have lived in countries where terrorism and death are the norm...They know the world is not a safe place (Margaret de Monchy).

The policymakers, researchers, program administrators, and clinicians at the conference drew on their diverse experiences to describe various traumatic situations undergone by refugee children. They also detailed the effect these experiences had on the personalities, development, and life view of the young refugees involved. In spite of the difficult situations cited, there was agreement among presenters that, in most cases, refugee children's unique traumas do not yield lifelong disability. While children are the most vulnerable refugees, they also are the most resilient--frequently more so than their adult caretakers. Out of their trauma, more often than not, comes survival (physical and emotional), a rebuilding of themselves and their families, and, ultimately, productive new lives.

"Individuals <u>can</u> move successfully between cultures...and the process of acculturation can be <u>managed</u> (by individuals and agencies) to increase the probability of successful adaptation" (John Berry). This message conveys the perception, discussed at some length at the conference and reiterated in the presentation of Timothy Ready, that adaptation is a dynamic process --one that takes place over stretches of time and involves multiple interactive factors. The degree of success in adaptation is largely contingent upon meaningful participation in the social and economic institutions of the host society and the re-emergence (or emergence) of a coherent pattern of conventional understandings, values, and norms

relating to the understanding of self in the new social context(s). The above message also conveys the "winning" side of the refugee experience and is, therefore one that needs to be expressed both to refugee children and their families going through the adaptation process and to the service providers who offer them assistance.

To provide effective support, a health clinic, social service agency, or mental health facility must adjust its programs to take into account the distinct features of the culture of origin, the uniqueness of the refugee experience itself, and the specific acculturation problems faced by individual refugee families. Successful providers are aware that they may be unfamiliar with cross-cultural assessment and treatment; they evidence a willingness to learn new ways to present services in order to make them understandable by and acceptable to refugee clients.

A discussion of potential barriers to service, specific features of effective programs, and successful program approaches now follows.

BARRIERS TO SERVICE

Often U.S. health and social service facilities are not the first providers of care to refugees. Southeast Asian refugees, more often than not, have spent time in refugee camps. At most of these sites, basic medical care as well as some supportive social services are available. Refugees from Central America and the Caribbean, on the other hand, frequently enter the U.S. (legally or illegally) without having received social or health services of any kind. Depending on the specific features of the refugee crisis, identified issues may have been adequately addressed in refugee camps. However, this should not be assumed in all cases.

Regardless of what support refugees may or may not have received en route to the U.S., the starting point for treatment of refugee children and their families is a baseline medical examination with screening for diseases endemic to their country of origin and to those countries transited during the flight process. Except in circumstances of extraordinary psychological distress, it is only after basic physical health issues (e.g., malnutrition, parasites, blood disorders, injuries) have been taken care of that emotional/psychological problems are addressed.

Social and psychological factors, however, ultimately are the critical determinants of successful adaptation to American life. It is, therefore, best to link social and mental health services to those health clinics which are the first to treat refugees' physical needs. This allows refugees to

become aware that additional services exist and may encourage them to take advantage of these resources either immediately or as they are needed in the longer run.

Even when refugees are aware of the array of services available to them, and when U.S. service providers are ready and willing to help, the connection between refugee and service facility is not always made. Barriers exist both for refugees and for providers of services. Identifying these obstacles can help both parties overcome them.

Barriers perceived by service providers include:

- Not being familiar with the cultural norms, behaviors, and physical and mental health expectations of refugees.
- Not knowing the language of their clients and, therefore, having to adjust to using an interpreter.
- Lacking basic medical histories as well as social/developmental information for these clients.
- Dealing with clients who don't trust the service provider and may not carry through on prescribed treatment.
- Having to address multiple needs (physical, social, psychological) at the same time.

Some refugee children and their families, for their part, resist approaching service providers for related reasons, such as:

- Fear of not being able to communicate physical or emotional problems due to a lack of English proficiency.
- Reluctance to work through translators, who may intrude on privacy, project their own refugee traumas onto a case, or manipulate or misinterpret a need.
- Unwillingness to trust "foreign" medicine, doctors, or service providers.
- Reluctance to seek help except in times of emergency.
- Disinterest in giving up long-used folk remedies.

- Desire, based on cultural norms, to conceal suffering and emotions.

- Unwillingness to credit the severity of emotional--as opposed to physical--distress and to seek assistance for psychological problems.

- Lack of money to pay for treatment.

- Fear that asking for services will surface an illegal status in the country. (Out of 141 refugee young people involved in a study in Los Angeles since 1980, only two had visas. William Arroyo).

MODEL PROGRAMS

Having recognized the barriers that inhibit treatment, successful service providers must come up with ways or programs to surmount them. Information describing one such program is drawn from a paper, "Program Models for Mental Health Treatment of Refugees" by Pauline Bamford and James Jaranson of the University of Minnesota's Refugee Assistance Program. This model is of a Community Mental Health Center program in Clark County, Washington which has been and continues to be responsible for providing services to all eligible persons in the county. However, it was not until a culturally-sensitive program was developed that barriers to service delivery for Southeast Asian refugees were removed. The program utilizes an outreach case management approach as its primary service modality. Clients are assisted in accessing and using community resources and systems, in building social and functional skills, and in planning for their own treatment.

In establishing the theoretical model for the Clark County program, staff at the Center began with the assumption that Western psychoanalytic, cognitive, and behavioristic therapies were only partially applicable to Southeast Asian refugee clients. Although it was necessary to accept American service delivery approaches to mental health and the framework of DSM III criteria for diagnosis (the most widely-used mental health diagnostic manual in the U.S.), it was recognized that such models could not be transposed in their entirety to meet Southeast Asian client needs.

Traditional American/Western approaches have provided limited means of explaining illnesses, emotional disorders, and difficulties in living to Southeast Asian refugee clients. Western approaches have likewise offered few comprehensible reasons for recovery because--to the Southeast Asian client--illness, emotional and mental difficulties, and problems in everyday living have both natural and supernatural causes. Western conceptualizations, elaborated outside the world of these beliefs, are foreign and strange and, most important, meaningless. It was therefore imperative to develop a theoretical model in keeping with the psychological reality and cultural background of the Southeast Asian refugee clients and to interweave this model with Western approaches.

A few of the adaptations made in delivering services to Southeast Asian refugees in the Clark County, Washington program were:

- Use of community classes to provide information about mental health, given Southeast Asians' tendency towards non-expression of emotional problems and needs outside the family.

- Use of a culturally-specific mental status examination to diagnose mental health problems.

- Use of culturally-indigenous staff.

- Use of contacts with local leaders respected by the Southeast Asian refugee population (shamans, monks, eldest of extended family) both as a way of imparting an attitude of "common cause" in addressing treatment issues and of using these resources to supplement treatment programs.

- Encouragement of the use of certain folk medicines for psychiatric disorders in conjunction with Western treatment methods.

- Willingness to combine traditional U.S. healing methods with healing approaches favored by Southeast Asians, such as having Center staff accompany a client and family members on healing visits to Buddhist monks. These non-traditional healing activities are based on such Southeast Asian cultural tenets as the unity of body and soul and the importance of the involvement of family in a healing process.

- Involvement of the Center's staff in public well-wishing ceremonies (joyous occasions involving dancing, food, and networking) as a way of showing the Center's support of Southeast Asian community celebrations.

- Creation of a culturally-familiar treatment setting within the mainstream mental health facility--a lounge decorated with oriental furnishings and artifacts, a large wooden map of Cambodia, a screen with bamboo frame, rattan chairs, and an oriental tea service.

Central to the success of this program, obviously, are the links the Clark County staff developed with the refugee community. The three Southeast Asian groups in the client population--Vietnamese, Laotian, and Cambodian--are all represented on the professional and paraprofessional staff. In addition, members of the local Southeast Asian community organizations helped the Center establish connections with several other Southeast Asian community organizations that serve the Southeast Asian population by providing social support, legal assistance, and shelter to these refugees while also attending to their spiritual needs and promoting cohesiveness within the various groups. Many of these community organizations are chapters in national organizations run and maintained by culturally-indigenous volunteers. Leaders of the local community organizations view Clark County's culturally-enhanced program for community mental health as being very supportive of refugee families and note that more and more persons in the Southeast Asian refugee community have expressed curiosity about the program and view it as a source of help.

It should be noted that the program described above is only a component of a larger community mental health effort. Southeast Asians represent a small percentage of the total population served by the Center, but it was not until the Center's services were made culturally appropriate that refugee families began to make use of the available resources. The tailoring of services to make them culturally acceptable to refugee clients was made possible in part through special funding provided by the Washington State Mental Health Division.

The Bamford-Jaranson paper goes on to describe other model programs serving refugees within psychiatric clinics, within primary health care clinics and within multi-service agencies.

In addition to carrying out the above study of model programs, the University of Minnesota has developed other materials useful to service delivery systems involved with refugees. These include a 650-item, annotated bibliography on refugee mental health as well as a number of pertinent papers concerned with refugee mental health (Williams, 1987b).

SERVICE DELIVERY SYSTEM APPROACHES/COMPONENTS

Deliberations at the conference focused less on describing specific operating programs, which might be used as models of service delivery, than on identifying some of the basic approaches/components that exist in systems offering useful support to refugee children and their families.

Some of the service approaches/components used by effective programs were described as attitudinal ones, others as specific features of a model delivery system, and still others as procedures for handling child refugee clients. The following attitudes/principles and particular features of a model service delivery system are adapted from the paper presented by Margaret de Monchy.

Basic Attitudes/Principles in a Competent System of Care for Refugee Families

While the principles outlined below are basic and, in fact, are routine considerations in any quality program, they are repeated here in order to stress their importance in the overall approach used to assist the refugee child and his family in rebuilding their lives in this country. These principles are:

- Physical health and safety are priorities. Not until children are healthy and secure do they begin to heal emotionally.
- Children shouldn't be separated from their families during treatment unless absolutely necessary.
- Trauma experiences need to be acknowledged so that they can be put into the larger perspective of a child's life experience.
- Positive bicultural identities need to be developed and cross-cultural living skills need to be learned.

- Recognition needs to be given of refugees' success as survivors.

- Values and behavioral norms which were acceptable in time of war need to be replaced by values and behavior acceptable in a peaceful society.

- Cultural traditions and expectations from the country of origin need to be understood and taken into account by service providers offering treatment.

- Representatives of the refugee community need to be involved in planning the services that are delivered and the ways in which they are presented.

- A full range of service components (physical health, mental health, and social services including job counseling and training, dental care, nutrition education, hygiene, family planning and genetic counseling) should be available in order to address refugees' needs.

- Empowerment (recovery of control over one's life) needs to be encouraged.

Components and Features of a Model Service Delivery System

Service delivery systems that have dealt successfully with refugee children and their families include many of the following model components and features:

- Knowledge of refugee trauma experiences which help service delivery staff to:

    - Understand what refugee children have experienced.

    - Offer a framework within which both healing and adaptation can take place.

- Use of trained bilingual/bicultural staff to:

  - Act as translators of the language.

  - Serve as cultural brokers to explain cultural norms, values, and expectations.

  - Provide links to the ethnic community.

  - Offer positive ethnic role models to refugee children, adolescents, and their families.

- Development of cross-cultural teams to:

  - Offer flexible treatment approaches in order to meet a child's particular needs.

  - Help support bicultural staff, many of whom also are refugees coping with the healing process.

  - Increase the cross-disciplinary skills and professional exposure of refugee staff members who tend to get overburdened and overwhelmed and need ways to grow professionally.

  - Be a model of collaboration to children struggling with the problem of integrating two cultures.

- Communication with the refugee community which:

  - Provides opportunities for mutual education.

  - Encourages refugees to use available services.

  - Supports the refugee community's efforts to re-establish natural support systems for its members.

  - Uses the resources of the refugee community to assist in treatment and to help in the adaptation process.

- Willingness to understand the value of some folk remedies and healing approaches in order to:

  - Reassure refugee children and their families that certain familiar healing practices (such as acupuncture and some herbal medicines) have value.

  - Involve respected members of the refugee community in the healing process ("accepted" healers often include family members, elders, community leaders, folk practitioners, and spiritual leaders).

  - Give the refugee family a sense of partial control which is especially important for people who have experienced powerlessness during the migration process.

- Provision of services geographically within refugee communities which:

  - Offers easy access to needed services.

  - Encourages use of services by people who may be unaware of their eligibility or fearful of the unknown.

  - Offers clinicians a better opportunity to obtain information about and develop insights into a client's needs.

- Integration of refugees into the mainstream of human service systems which:

  - Provides refugees with access to the array of support services available to them (including resources such as job placement counseling and adult education), thus ensuring that the diverse needs of the refugee population are met.

  - Avoids providing isolated services that may be ineffective or duplicative.

- Reduces isolation of refugee children and families.

- Supports continuity of care.

- Helps the larger community of service providers become sensitive to refugee needs. (This is especially important as federal funds supporting specialized services to refugees diminish).

- Takes advantage of the full-array of resources available within the U.S. educational system, a critical, but often underutilized resource for refugee children.

Often refugee families need help in understanding the variety of resources (remedial education, English as a Second Language, school breakfast, and lunch programs, etc.) available through local schools. They also need to be educated about the various ways in which they can support their children in school such as through Parent Teacher Associations, involvement in extra-curricula programs, and conferring with teaching staff and program administrators about the particular needs of their child.

In turn, the school systems often need help in understanding the special nature of the refugee experience, differences in cultural expectations, and the symptoms of traumatic stress. Schools also need to be made aware of those services specific children already are receiving and to operate collaboratively with both refugee parents and other service providers.

A study cited by Conchita M. Espino at the conference indicated that the parents of Central American refugee children in Miami, Florida, Alexandria, Virginia, and the District of Columbia--all areas with a high population of Central American refugees--participated little in school activities and were inattentive both to their children's homework assignments and to discipline problems. One of the reasons it is difficult for parents to participate in school activities is because of their long working hours. Moreover, unlike some American parents, many refugee parents give the school the "power and responsibility" for school-related activities, although this may be perceived by some as a lack of interest. The parents of these children need to be helped to work jointly with the basic American system and use it as a resource for their children and themselves

Procedures for Dealing with Refugee Children Clients

Although the underlying principles and specific features of service delivery systems for refugees are important, the critical issue is precisely how the individual child is dealt with when he or she enters a service facility. In many ways, a refugee child is handled like an ordinary American child or adolescent. In other ways, however, treatment has to be shaped to fit the circumstances of that particular child's refugee history and the current stage he or she is at in the acculturation process.

Once again, the steps outlined below are self-evident, but worth reiterating as a way of reminding service providers of the importance of taking the uniqueness of the refugee experience into account at every step of the service delivery process.

Generally speaking, clinicians faced with treating refugee children go through the following sequence:

- Assess the nature and severity of the presenting problem

  Whether the issue that brings the child to the service facility is physical (injury, illness, basic state of poor health) or mental/emotional (depression, anti-social behavior, nightmares, school failure, etc.), the clinician obtains as much information as possible about that specific condition and determines how best to treat it.

- Obtain as complete a medical and social history of the child as possible, including:

  - Information about the child's medical past and developmental data.

  - A description of the child's specific migration experience including pre-flight stressors, reasons for flight, dangers and losses en route, conditions at refugee camps, status of family before, during, and after flight, age of child during flight and relocation, issues faced on arrival, and traditions and values of the specific family and culture.

- Conduct a physical examination of the child

  A baseline physical exam would involve screening for diseases endemic to the country of origin as well as diseases encountered in countries traveled through during the exodus.

- Review commonly observed behavior associated with adaptational difficulties, such as those identified by Jeanne Nidorf, which are outlined below:

  Preschool children:

  - Poor appetite.
  - Generalized anxiety and depression.
  - Limited vocabulary.
  - Age-inappropriate separation anxiety.
  - Excessive fearfulness and shyness.
  - Regressive behavior.
  - Developmental disabilities and behavioral disturbances resulting from organic impairment.

  Latency age:

  - Hyperalertness and/or hyperaggressivity in the absence of organic ideology.
  - Learning disabilities associated with undetected neurologic impairment.
  - School phobia.
  - Malingering.
  - Chronic "sadness" and anxiety.
  - Symptoms of Post-Traumatic Stress Disorder during childhood.
  - Hoarding and stealing food.
  - Nocturnal eneuresis.
  - Suicidal ideation.
  - Vegetative signs of depression.
  - Hysterical conversion symptoms.
  - Marked difficulty with English language acquisition.
  - Lying and fabricating stories about the past and present to gain sympathy from outsiders.

Adolescents:

- Survivor guilt.
- Post-Traumatic Stress Disorder symptoms.
- The posing of existential dilemmas like "Why me?" and "Why are people bad?"
- Moral nihilism.
- Identity confusion.
- Intergenerational conflicts and alienation from parents and family.
- Sexual promiscuity.
- Suicidal ideation.
- Substance abuse.
- Gang affiliation leading to criminal conduct.
- School truancy and poor school performance.
- Premature marriage by young women to escape a dysfunctional household or sexual molestation by a relative.
- Overwhelming feelings of helplessness resulting from pressure to support and care for younger siblings and/or to send money to relatives in the homeland.

Assess the child's mental health status by determining:

- The child's perception of his or her current level of functioning (in home, in school, in social situations).

- The family's perceptions of the child's as well as the family's most severe pressures and critical needs. A program is strengthened when it accepts the fact that people from very different backgrounds will have different life views, concepts of spirituality, and definitions of health and family. Identifying these different views is critical if services are to be successfully delivered to people of diverse backgrounds.

  It should be noted that both assessment and treatment of the mental health problems of refugees is complicated when certain refugee groups do not acknowledge emotional problems and choose not to

deal with them outside the family. Further complications are caused by on-going communication problems that exist between refugees and service providers given their different languages, cultural backgrounds, and understanding of illness and wellness.

- Determine treatment or support needed

Obviously, clinicians providing treatment to refugee children must take the child's background into account as treatment is prescribed in order to avoid problems and bring about positive change in the physical and mental health of the patient.

For example, when providing treatment for emotional problems of Southeast Asian children, certain cultural attitudes must be understood (Jeanne Nidorf). These include:

- Feelings of collective pride (as distinct from individual achievement).
- A sense of duty and obligation to family as well as an interest in behaving in ways that will not shame one's relatives.
- Favoring of indirect communication over direct expression of feelings or thoughts. Avoidance of confrontation.
- Placing of positive value on mute suffering.
- A clear definition of familial roles (for example, elder sister functioning as surrogate mother and elder brother as chief disciplinarian).
- Use of somatization as an acceptable form of dealing with psychological stressors.

Dr. Joseph Westermeyer recommended, when offering treatment to refugee children, that clinicians take into account the following possibilities:

When prescribing medications, care should be taken in two areas. First, data from recent studies indicates that certain recently arrived groups react differently to particular drugs than do other groups who have resided in this country for longer periods of time. Given this possibility, prescribing clinicians might want to begin with lower than standard doses of a drug and then increase the dosage until results are achieved.

Second, refugee families may need to be educated about the safe and effective use of prescription drugs. Specific guidelines to parents could include: not giving medications to siblings, relatives, or friends; using no more than the prescribed amount of any drug; continuing medications over a period of time even if little effect is perceived because some medications--particularly psychotropic ones--take several weeks to show results; and making the clinician aware of all other medications being taken--including folk remedies and illicit drugs--because these medications may significantly affect the treatment being prescribed.

When prescribing psychiatric care, Dr. Westermeyer recommends that the clinician determine what are the patient's basic concepts of health illness, well being,. and disease, and what his and her family's expectations are concerning mental health and psychiatric issues. He further recommends that, if at all possible, a qualified mental health professional with the same ethnic background as the refugee child provide the treatment, or at least someone with good cross-cultural skills.

CHAPTER 5

PREVENTION PROGRAMS

I plead...that we add massive preventive efforts to our rescue efforts...Only that will solve the migration dilemma. Only then will children be safe (No. ·an Lourie).

Conference presenters agreed that the prevention of some of the distresses faced by refugee children can be achieved by establishing programs that anticipate these distresses and help children avoid them, prepare for them, or find ways to mitigate them. This chapter looks at primary, secondary, and tertiary prevention programs aimed at preventing or allaying some of the common problems faced by refugee children and adolescents.

Primary prevention programs are those that attempt to stop specific problems before they happen and/or promote general health as a way of decreasing the severity of any problems that do occur. Exemplary primary prevention programs for refugee children aim to:

- Include mental health professionals and child development specialists in the groups that plan and administer programs in refugee camps so that long range plans can be developed for the mental and emotional adjustment of refugee children.

- Provide recreational and educational activities in refugee camps as a way of keeping children active in constructive ways, and thereby preventing attitudinal problems and behavioral acting out.

- Educate refugee children and their parents about what they are going to face in the receiving society. An example of such a program--called "Preparing for American Secondary Education"--exists at a Khmer refugee camp at Phanat Nikhom, Thailand. This course, offered to families about to resettle in

the United States, informs teenagers about the basic features of the American secondary school system and tries to help parents understand the role they will need to play in their children's education in American schools (Carolyn Williams).

- Reduce the amount of time children stay in the problematic environment of refugee camps.

- Maintain the integrity of large families when they resettle.

- Promote efforts to help refugee children develop and maintain positive bicultural identities. Many refugee children demonstrate a negative attitude towards their culture of origin stemming from a sense of rejection by their homeland and a lack of in-depth knowledge about their original language, country, and culture. Yet data shows that children who develop bicultural strategies--those who adapt to the new culture but retain some of the features of the old--seem to do best in the new society. Programs that help children to build bicultural skills include:

  - Weekend schools to teach the language, arts, culture, history, and ethnic skills of the original country.

  - Ethnic summer camps staffed by both American and refugee personnel who provide positive role models for both societies and constructive examples of collaboration.

  - Ethnic teams, performance groups, cultural societies, or expatriate community associations with common political, social, or recreational interests such as Lao dance troupes or Salvadorian soccer teams.

- Provide education and training programs for refugee parents to give them information specific to the unknown culture and to help them develop different parenting skills. Possible subjects could be: nutrition in the new society (including the dangers of junk food); how to assess and access health services; the dangers of unattended chronic conditions; the pluses and minuses of folk therapies; stresses stemming

from role changes brought about by living in the new society; and how to anticipate and cope with culture shock.

Secondary and tertiary program prevention models are those aimed at helping children regain a normal level of functioning and prevent progression of a problem or illness after its occurrence. Early diagnosis of a problem and intervention can shorten the period of crisis and increase the chance of achieving a positive outcome. This is particularly important for children and adolescents because the optimal age for certain levels of emotional and behavioral development can pass if remediation is delayed.

Exemplary secondary and tertiary prevention programs for refugee children include:

- Crisis intervention efforts while in refugee camps or during early resettlement.

- Efforts to help family, schools, social workers, sponsors, and health care staff recognize the signs of acculturation failure, of PTSD, and of other psychiatric disorders.

- Protocols that call for psychiatric evaluations when somatic complaints have repeatedly been presented and treatment has been ineffective.

Presenters at the conference shared their research as well as their program and clinical experiences as a way of documenting the current status of refugee children in the U.S. It was agreed that service delivery systems that offer effective services to refugee children who have been traumatized by war and violence are those which:

- Recognize the natural barriers that exist between themselves and these clients;

- Credit the unique difficulties of each refugee child's migration experience;

- Take into account the cultural practices and expectations of the child's society of origin;

- Make use of certain attitudes, features, and approaches that have proven successful in various programs serving refugee

children and adolescents and their families around the country.

CHAPTER 6

CONCLUSION

The influx of refugees into the United States shows no signs of abating. Since the Refugee Act of 1980, approximately 65,000 refugees a year--a ceiling set annually by the President in consultation with Congress--have legally entered this country; uncounted tens of thousands enter each year illegally. A large percentage of these newcomers are children.

As refugee children and adults alike work to create new lives in new surroundings, they require assistance from community-based institutions: schools, health clinics, welfare systems, mental health facilities. This presents a special challenge to service delivery systems because of the natural barriers that exist to providing effective services to refugees: lack of a common language, culturally-different concepts of illness and health, deficiencies in education, and fear of "foreign" treatment approaches. These barriers are compounded by the physical and emotional toll of the refugee experience.

An additional barrier to providing ample and effective services to refugee families is the fact that financial and program resources have been diminishing over the past few years. Immediately following the end of the war in Vietnam, programs were created to respond to the special needs of people escaping that conflict, and these programs have served both Southeast Asian and other refugee populations since then. Given current fiscal pressures, however, fewer resources have been available to support these program efforts. It is therefore imperative for policymakers and service providers to work to make the best possible use of whatever public and private resources that continue to exist. Coordination, communication, and collaboration among all those involved with refugees were repeatedly called for at the Conference on Refugee Children Traumatized by War and Violence.

Norman V. Lourie recommended the creation of a central collection place for research and program information on refugees in order to help service providers offer less fragmented services He also advocated the development of coalitions at national, state, and local levels to design, execute, and evaluate systems of care for refugees.

An example of collaboration at the local level was presented by Holbrook Teter of the Coalition to Aid Refugee Survivors of Torture and War Trauma. This voluntary coalition of health and service agencies was formed in 1985 to address the mental health needs of the approximately 100,000 Central American refugees in the San Francisco area. It has worked to develop mental health promoters in the refugee community, foster a network of organizations and individuals concerned with refugee issues, redirect existing programs to address the immediate needs of these refugees, and develop special services for refugee children within the San Francisco school system.

Another collaborative effort was this Conference on Refugee Children Traumatized by War and Violence. Its uniqueness was twofold. First, it brought together people who had a common interest in refugee children but who came from multiple disciplines and program areas: international, federal, state, and county organizations; public and private interest groups; child advocacy programs; and researchers, educators, program managers, service providers, and policymakers. Second, this conference focused exclusively on refugee children who have been traumatized and the special challenge they pose to U.S. service providers.

The information that was shared at the conference has been summarized in this monograph in order to increase the dialogue among the professionals in the many disciplines involved with refugee families, as well as to improve the ability of service providers to offer the kinds of support children need to become comfortable in their new country and to become contributing members of its society.

An additional benefit to sharing this information is its potential application to children in parallel situations. The problems faced by many refugee families when they first arrive in the U.S.--urban poverty, overcrowding, neighborhood violence, discrimination, unemployment, drug abuse--are basic inner city problems. When such problems are faced and addressed, an ongoing issue in American society is also dealt with: that of empowering poor and minority populations and accepting them as full participants in American society.

APPENDIX

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