Anxiety and maladaptive disorders in refugee children and adolescents

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Mental health difficulties in refugee children and adolescents

At any one time there are about two dozen armed conflicts throughout the world. It has been estimated that during 1993 alone violent upheavals generated about 16 million refugees worldwide The United States has received a significant refugee population from war zones. The two largest groups of refugees entering the country since 1975 were from Southeast Asia (about 820 000) and Central America (between 800 000 and 1 900 000). Although exact statistics are unavailable, it appears that as many as half of the Central American immigrants were children.

Various studies have documented common physical health problems in refugee children entering North America. Inactive tuberculosis and hepatitis are prevalent health risks for Southeast Asian youth; intestinal parasites and respiratory tract infections (eg, otitis media) are widespread in both Southeast Asian and Latin American refugee children. Histories of malnutrition and incomplete immunizations are common.

In a study of 23 Central American children residing in the southwest27% were depressed, 22% aggressive, 32% hyperactive, and 13% delinquent or antisocial according to their mothers, all significantly higher than a comparison sample of Mexican immigrant children, Those refugee children whose fathers had died or disappeared (but not through divorce or voluntary separation) or whose mothers manifested elevated symptoms on a posttraumatic stress index, showed the worst psychological profiles. In another study on the effects of violent death in

the family, one third of 25 Israeli children whose fathers were killed in war had increased aggressive behavior, discipline problems, and restlessness 2 to 3 years after their fathers' deaths. These findings indicate that when parents are killed or adversely affected, children are especially at risk.

Young refugees are often extremely resilient and resourceful despite the many adversities they face . However, experiences of war, violence, killing or torture, as well as the subsequent losses suffered, increase the risk for psychological distress and the development of psychiatric disorders.

Not only do refugees suffer from past losses or traumatic experiences but they also face further difficulties upon arrival in a host country. For instance, UK asylum policies place young refugees and their families under additional strain owing to low levels of financial support, restrictions on employment and frequent accommodation changes, as well as lengthy delays in processing asylum applications and thus ongoing fear of detention or deportation.

As a result of these multiple stressors, young refugees are more vulnerable to developing mental health difficulties. It is estimated that up to 40% of young refugees may have psychiatric disorders, mainly post-traumatic stress disorder, depression and other anxiety-related difficulties . Post-traumatic stress disorder (PTSD).

PTSD is characterized by exposure to an extremely stressful or catastrophic event or situation followed by three symptom clusters. These

include repeated reliving of the trauma, e.g., through intrusive images or dreams of the event or monotonous re-enactment of the traumatic events through play in young children; hyperarousal, e.g., increased vigilance or disturbed sleep; as well as persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (American Psychiatric Association, 1994; World Health Organisation [WHO], 1992). Substantial evidence supports the cross-cultural validity of PTSD. PTSD symptoms have been found following exposure to war and organised violence in children and adolescents from many different parts of the world, including Cambodia (Sack, Seeley, & Clarke, 1997), Lebanon (Saigh, 1991), Rwanda (Dyregrov, Gupta, Gjestad, & Mukanoheli, 2000), Kuwait (Nader, Pynoos, Fairbanks, Al-Ajeel, & Al- Asfour, 1993), Palestine (Thabet & Vostanis, 1999), Afghanistan (Mghir, Freed, Raskin, & Katon, 1995) and Bosnia (Papageorgiou et al., 2000). Estimates of PTSD vary considerably depending on the type of event(s) experienced, the population studied and the samples and diagnostic methods used. In a rigorous systematic review, Fazel and colleagues (2005) identified five surveys totaling 260 refugee children, who were originally from Bosnia, Central America, Iran, Kurdistan and Rwanda but had resettled in Western countries. Overall, 11% were diagnosed with PTSD according to interview-based assessments, with a range of 7– 17%. These estimated prevalence rates are much lower than those frequently cited and may be due to the fact that stringent criteria were applied. However, even this conservative estimate of 11% is about double the rate found in non-refugee adolescents (Giaconia et al., 1995). Other studies have reported rates of PTSD in young refugees ranging from 11.5% in Tibetan children (N ¼ 61) (Servan- Schreiber, Lin, & Birmaher, 1998) and 28% in Bosnian children (N ¼ 95) (Papageorgiou et al., 2000) to 50% of Cambodian adolescents and young adults (N ¼ 40) (Kinzie, Sack, Angell,

Manson, & Rath, 1986). Such small sample sizes make generalizing from these findings difficult.

However, certain factors are known to increase levels of PTS symptoms, including greater exposure to more personally threatening events (Macksoud & Aber, 1996) and severity of the exposure (number of events and proximity) (Almqvist & Brandell-Forsberg, 1997; Mghir et al., 1995; Papageorgiou et al., 2000; Thabet & Vostanis, 1999). Such factors may explain the wide variation between studies in reported PTSD symptoms. Depression, anxiety and grief. Refugee children and adolescents who have experienced war also report high levels of depression and anxiety (Felsman, Leong, Johnson, & Felsman, 1990; Mghir et al., 1995; Servan-Schreiber et al., 1998).

However, estimates of psychiatric disorders vary considerably depending on the type of event(s) experienced, the population studied and diagnostic methods used. For example, 4–8% of Vietnamese (N ¼ 351) (Felsman et al., 1990), 11.5% of Tibetan (N ¼ 61)
(Servan-Schreiber et al., 1998) and 47% of Bosnian (N ¼ 95) (Papageorgiou, et al., 2000) young refugees reported symptoms of depression. Although less frequently investigated, high levels of anxiety have been reported in 11% of Vietnamese refugee adolescents (N ¼ 351) (Felsman et al., 1990) and 23% of Bosnian refugee children (N ¼ 95) (Papageorgiou et al., 2000). Comorbidity with PTSD is common .

For example, in a group of Cambodian refugee adolescents and young adults (N ¼ 59) who had been exposed to war trauma as children, 24% had PTSD of whom 57% had an additional affective or anxiety disorder, with major depression and generalized anxiety disorder being the most

common (Hubbard, Realmuto, Northwood, & Masten, 1995). Although many children are bereaved during war, grief reactions have rarely been investigated. Nader et al.
(1993) assessed grief reactions in Kuwaiti children and young adults (8–21 years) following the Gulf war and found that 98% of the sample (N ¼ 51) reported at least one symptom of grief. Similar grief levels were reported by war-exposed Bosnian children (Smith, Perrin, Yule, Hacam, & Stuvland, 2002).

It is interesting to note that the presence of PTSD appears to be related to earlier war trauma and resettlement strain, while depression is linked to recent life difficulties or stressors, such as poorer spoken English (Sack, Clarke, & Seeley, 1996) and maternal mental health difficulties (Smith, Perrin, Yule, & Rabe-Hesketh, 2001). Heptinstall and colleagues (2004) found that the number of traumatic events experienced in the country of origin and the nature of the event(s) (namely the death of family members) were associated with higher PTSD symptoms, while the number of current life stressors was linked to children's levels of depression. In particular, severe financial difficulties and insecure asylum status were related to greater depressive symptoms in refugee children.

Additional psychological difficulties. Other commonly reported problems in young refugees and children exposed to war include somatic complaints, sleep problems, conduct disorder, social withdrawal, attention problems, generalised fear, overdependency, restlessness and irritability, as well as difficulties in peer relationships (Almqvist & Brandell-Forsberg, 1997; Mollica, Poole, Son, Murray, & Tor, 1997; Tousignant et al., 1999). There can be a loss of previously acquired skills, such as bladder control, with secondary enuresis and separation anxiety

being common in young children (Chimienti, Nasr, & Khalifeh, 1989). Adolescent refugees may be at increased risk of psychosis (Tolmac & Hodes, 2004). Young refugees also present with disorders that would have developed even if they had not been exposed to war-related experiences, such as learning disabilities and developmental disorders (Williams & Westermeyer, 1983).

Enduring nature of mental health difficulties. Psychiatric symptoms and disorders in refugee children have been found to persist over many years. One pioneering but small follow-up study of Cambodian adolescent refugees (N ¼ 40), who had been traumatised by massive war trauma as children, revealed that four years after leaving Cambodia, 50% met criteria for PTSD and 53% for depression (Kinzie et al., 1986). Although there was a sizeable attrition rate at the 3-year, 6-year and 12-year follow-up interviews, PTSD rates were 48%, 38% and 35% respectively (Kinzie, Sack, Angell, Clarke, & Ben, 1989; Sack et al., 1993; Sack, Him, & Dickason, 1999). Depressive symptoms decreased to 41% after 3 years and to 6% after 6 years but increased to 14% after 12 years (Kinzie et al., 1989; Sack et al., 1993; Sack et al., 1999). It is important to note that these studies describe children who suffered the most severe levels of war trauma and privation, therefore it is expected that rates of psychological recovery would be higher in other samples. Another study with Iranian refugee preschool children (N ¼ 39) found that although overall psychological symptoms decreased slightly over a two and a half year period, most children (82%) continued to experience symptoms, 21% of whom still met criteria for PTSD (Almqvist & Brandell-Forsberg, 1997).

These studies suggest that regardless of the passage of time, many young refugees continue to suffer from distressing symptoms, with PTSD symptoms being most persistent. Despite the presence of mental health difficulties, young refugees tend to function relatively well overall, both socially and academically.

Clinical Characteristics for depressed refugees children:

The diagnostic criteria and key defining features of major depressive disorder in children and adolescents are the same as they are for adults. However, recognition and diagnosis of the disorder may be more difficult in youth for several reasons. The way symptoms are expressed varies with the developmental stage of the youngster. In addition, children and young adolescents with depression may have difficulty in properly identifying and describing their internal emotional or mood states. For example, instead of communicating how bad they feel, they may act out and be irritable toward others, which may be interpreted simply as misbehavior or disobedience. Research has found that parents are even less likely to identify major depression in their adolescents than are the adolescents themselves.

Symptoms of Major Depressive Disorder Common to Adults, Children, and Adolescents:

- Persistent sad or irritable mood
- Loss of interest in activities once enjoyed
- Significant change in appetite or body weight
- Difficulty sleeping or oversleeping

- Psychomotor agitation or retardation
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating
- Recurrent thoughts of death or suicide

Five or more of these symptoms must persist for 2 or more weeks before a diagnosis of major depression is indicated.

Signs That May Be Associated with Depression in Children and Adolescents

- Frequent vague, non-specific physical complaints such as headaches, muscle aches, stomachaches or tiredness
- Frequent absences from school or poor performance in school
- Talk of or efforts to run away from home
- Outbursts of shouting, complaining, unexplained irritability, or crying
- Being bored
- Lack of interest in playing with friends
- Alcohol or substance abuse
- Social isolation, poor communication
- Fear of death
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Reckless behavior
- Difficulty with relationships

While the recovery rate from a single episode of major depression in children and adolescents is quite high, episodes are likely to recur. In addition, youth with dysthymic disorder are at risk for

developing major depression. Prompt identification and treatment of depression can reduce its duration and severity and associated functional impairment.

Other risk factors include:

- Stress
- Cigarette smoking
- A loss of a parent or loved one
- Break-up of a romantic relationship
- Attentional, conduct or learning disorders
- Chronic illnesses, such as diabetes
- Abuse or neglect