

Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma

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Background: Increasingly clinicians are being asked to assess and treat young refugees, who have experienced traumatic events due to war and organised violence. However, evidence-based guidance remains scarce. **Method:** Published studies on the mental health difficulties of refugee children and adolescents, associated risk and protective factors, as well as effective interventions, particularly those designed to reduce war-related post-traumatic stress disorder (PTSD) symptoms, were identified and reviewed. The findings are summarised. **Results:** Young refugees are frequently subjected to multiple traumatic events and severe losses, as well as ongoing stressors within the host country. Although young refugees are often resilient, many experience mental health difficulties, including PTSD, depression, anxiety and grief. An awareness of relevant risk and protective factors is important. A phased model of intervention is often useful and the need for a holistic approach crucial. Promising treatments for alleviating symptoms of war-related PTSD include cognitive behavioural treatment (CBT), testimonial psychotherapy, narrative exposure therapy (NET) and eye movement desensitisation and reprocessing (EMDR). Knowledge of the particular needs of unaccompanied asylum-seeking children (UASC), working with interpreters, cross-cultural differences, medico-legal report writing and the importance of clinician self-care is also necessary. **Conclusion:** More research is required in order to expand our limited knowledge base. **Keywords:** Refugee, children, adolescents, assessment, treatment, post-traumatic stress disorder, trauma, war. **Abbreviations:** CBT: cognitive behavioural treatment; EMDR: eye movement desensitisation and reprocessing; NET: narrative exposure therapy; PTSD: post-traumatic stress disorder; UASC: unaccompanied asylum-seeking children.

Civilian populations have been increasingly targeted in recent wars, with 'ethnic cleansing' campaigns and deliberate massacres becoming a common reality. United Nations Children's Fund (UNICEF) has estimated that 80% of the victims in modern wars are women and children. In response to violence, many people are forced to flee their countries in search of safety. This has resulted in an estimated 19.2 million refugees and displaced people worldwide, almost half of whom are children (United Nations High Commissioner for Refugees, 2005).

According to the United Nations (1951 UN Convention) a refugee is defined as 'any person, who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail himself/herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence as a result of such events, is unable, or owing to such fear, is unwilling to return to it'.

Thus a refugee is an individual who has left his or her native country to go to another country due to war or violence that has threatened the safety of that individual, their family or community. Refugee sta-

tus protects a person from being returned to his or her country of origin. The term 'asylum seeker' describes an individual who has crossed an international border in search of safety and is in the process of trying to obtain refugee status in another country. The administrative procedures associated with obtaining asylum are arduous, stressful and often continue for many years.

Mental health difficulties in refugee children and adolescents

Young refugees¹ are often extremely resilient and resourceful despite the many adversities they face (Rutter, 2003). 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 (Rousseau, 1995). 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

¹ For the purposes of this article the term 'refugee' will be used to include asylum seekers (those applying for refugee status), those who have been granted temporary leave to remain and those with full refugee status, as the distinctions are primarily of a legal nature.

Conflict of interest statement: No conflicts declared.

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Published by Blackwell Publishing, 9600 Garsington Road, Oxford OX4 2DQ, UK and 350 Main Street, Malden, MA 02148, USA

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 (Hodes, 2000).

Post-traumatic stress disorder (PTSD). PTSD is characterised 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-Suwaid, 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 totalling 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 ($N = 61$) (Servan-Schreiber, Lin, & Birmaher, 1998) and 28% in Bosnian children ($N = 95$) (Papageorgiou et al., 2000) to 50% of Cambodian adolescents and young adults ($N = 40$) (Kinzie, Sack, Angell, Manson, & Rath, 1986). Such small sample sizes make generalising from these findings difficult. However, certain factors are known to increase levels of PTSD

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 ($N = 351$) (Felsman et al., 1990), 11.5% of Tibetan ($N = 61$) (Servan-Schreiber et al., 1998) and 47% of Bosnian ($N = 95$) (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 ($N = 351$) (Felsman et al., 1990) and 23% of Bosnian refugee children ($N = 95$) (Papageorgiou et al., 2000). Comorbidity with PTSD is common (Kinzie et al., 1986; Sack et al., 1994). For example, in a group of Cambodian refugee adolescents and young adults ($N = 59$) 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 generalised 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 ($N = 51$) 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, overdependence, 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 ($N = 40$), 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 ($N = 39$) 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 (Kinzie et al., 1989; Sack, Angell, Kinzie, & Rath, 1986).

Application of psychiatric diagnoses across cultures. The application of psychiatric diagnoses, such as PTSD, to refugees is a topic of much controversy. Opponents state that it is wrong to apply

Western and biomedical psychiatric classification to diverse cultures on the basis that it results in normal responses to abnormal situations being construed as abnormal states (Littlewood, 1992; Summerfield, 2000; Westermeyer & Janca, 1997). The use of psychiatric diagnoses is sometimes criticised as an inappropriate form of labelling that detracts from a more contextualised understanding of distress and fails to take into consideration the range of losses and adversities suffered.

However, refugee children who have suffered multiple and severe traumatic experiences such as the death of a parent, as well as the loss of their home and all that was familiar to them, will undoubtedly experience emotional reactions, as would any human being in response to such extreme adversity. Although in one sense these reactions are understandable given the circumstances, they still require that action be taken by those in positions of authority in order to alleviate the young person's distress. Among other things, diagnosis and labelling may be a means to mobilising the necessary resources so that appropriate help may be offered. PTSD can also be understood as a neurophysiological disorder characterised by an exaggerated readiness for flight or fight which is present across cultures, with the only differences being the culturally specific expression of symptoms and the indigenous ways in which survivors deal with them (Elbert & Schauer, 2002). It is also worth bearing in mind that the current classification of psychiatric disorders, ICD-10, is an internationally agreed system, not a solely Western one (WHO, 1992).

Risk and protective factors

Exposure to traumatic events. A dose-effect relationship between cumulative trauma and reported symptoms of emotional distress has been found in refugee children and adolescents exposed to war (Almqvist & Brandell-Forsberg, 1997; Heptinstall, Sethna, & Taylor, 2004; Mghir et al., 1995; Mollica et al., 1997). The type of traumatic exposure is also important: more severe types of trauma, such as the violent death of a family member or witnessing someone being injured, killed or tortured, are related to higher levels of psychological distress (Heptinstall et al., 2004; Kuterovac, Dyregrov, & Stuvland, 1994; Smith et al., 2002). An individual's perception of the degree of direct personal threat and their level of involvement during the traumatic event are also associated with increased psychological difficulties (Dyregrov et al., 2000; Garbarino & Kostelny, 1996; Nader et al., 1993; Smith et al., 2002). The disappearance of a family member is also a risk factor. As this type of loss involves uncertainty regarding death, individuals are unable to grieve fully and therefore experience high levels of distress (Quirk & Casco, 1994).

Individual characteristics. Pre-existing individual vulnerability, such as conduct problems or chronic physical illness, places refugee children at greater risk of developing mental health difficulties, whilst having a good temperament, positive self-esteem and the ability to respond to new situations is protective (Almqvist & Broberg, 1999; Garmezy & Rutter, 1985). Age and gender have also been investigated but findings remain inconclusive (Berman, 2001; Elbedour, Bensef, & Bastien, 1993).

Belief systems. Wider community factors and beliefs are also important, as having a strong ideological commitment to the aims of the combatants' own side appears to act as a protective factor. A study of Jewish Israeli adolescents found that stronger ideological commitment (which included glorification of war, patriotic involvement and defiant attitudes towards the enemy) was linked to less anxiety, insecurity, depression and feelings of failure when individuals were exposed to low levels of political violence (Punamäki, 1996). Tibetan refugee children have also reported that the sense of participating in their nation's struggle against an oppressor and their strong Buddhist beliefs protected against mental health difficulties and accelerated the healing process (Servan-Schreiber et al., 1998).

Role of the family. The family frequently acts as a buffer against stress (Garmezy & Rutter, 1985). Family cohesion before and after migration is a predictor of good mental health in refugee children (Almqvist & Broberg, 1999; Thabet & Vostanis, 2000). Adaptability and cohesion within families appears to protect the emotional well-being of very young children following traumatic exposure (Laor et al., 1996). Unfortunately, if mothers have trouble coping with the stress of displacement then refugee children often display greater stress reactions (Ajdukovic & Ajdukovic, 1993). Poor parental mental health (especially maternal mental distress) is associated with psychological distress in war-affected and refugee children (Almqvist & Broberg, 1999; Bryce, Walker, Ghorayeb, & Kanj, 1989; Mghir et al., 1995; Qouta, Punamäki, & Sarraj, 2005; Smith, Perrin, Yule, & Rabe-Hesketh, 2001). Political persecution and imprisonment of fathers has been linked to increased symptomatology in children (Almqvist & Brandell-Forsberg, 1997). If separated from family members, young refugees tend to be more distressed and at higher risk of mental health problems than their accompanied peers (Felsman et al., 1990; Kinzie et al., 1986).

Social support. Social support is widely viewed as a protective factor against the development of psychopathology following any traumatic or stressful event (Brewin, Andrews, & Valentine, 2000). The availability of social support facilitates successful adaptation of refugee children (Fox, Cowell, &

Montgomery, 1994; Kovacev & Shute, 2004). In contrast, low levels of social support are associated with psychiatric disorders (Beiser, Turner, & Ganesan, 1989; Gorst-Unsworth & Goldenberg, 1998; Hauff & Vaglum, 1995). A reduction in social networks has been found to predict adolescent depression better than exposure to war-related events (Farhood et al., 1993).

Post-migration stresses. The mental health difficulties of individuals already traumatised by pre-migration experiences may be exacerbated by post-migration stresses, including the asylum-seeking process itself (Silove, McIntosh, & Becker, 1993; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Sinnerbrink, Silove, Field, Steel, & Manicavasagar, 1997; Sourander, 1998). Post-migration factors which place individuals at risk of continued and increased psychological distress include delays in processing asylum applications, uncertainty about asylum status, negotiations with immigration authorities, obstacles to employment, inadequate housing, frequent moves, financial hardship, language problems, racial discrimination and social isolation. Unfavourable living conditions, such as communal shelters, have been found to place war-exposed children at greater risk of developing psychological difficulties (Ajdukovic & Ajdukovic, 1993). Unresolved asylum status is also associated with higher PTSD and depressive symptoms in refugee children (Heptinstall et al., 2004). An additional risk factor is the stress of adapting to a new culture (acculturation stress) (Rousseau, 1995).

In conclusion, different risks factors seem to operate for different types of psychological problems, e.g., with exposure to war-related trauma the most important factor for PTSD and current stressors/social support most important for depression. Unfortunately, many young refugees are exposed to multiple risk factors. See Table 1 for a summary of risk and protective factors.

Assessment

Clinical interviews

This Assessment section is based upon our clinical experience assessing young refugees in the UK rather than on previous research, as there is a poor evidence base from which to draw. As with the assessment of any child or adolescent's mental health, semi-structured clinical interviewing is the main technique used to establish rapport, engage the refugee child and/or family and collect information. Structured clinical interviews will sometimes need to be conducted in order to determine whether a child meets diagnostic criteria for a specific disorder and is particularly recommended when completing medico-legal reports.

Table 1 Summary of risk and protective factors

	Risk factors	Protective factors
<i>Related to trauma</i>	<ul style="list-style-type: none"> • Exposure to war-related traumatic events <ul style="list-style-type: none"> – multiple traumatic events – severity of the trauma, e.g., violent death of a family member or witnessing someone being injured, tortured or killed – perception of the degree of personal threat – level of personal involvement • Unknown fate of missing family members 	
<i>Characteristics of the individual</i>	<ul style="list-style-type: none"> • Pre-existing vulnerability <ul style="list-style-type: none"> – previous conduct problems – previous chronic physical illness 	<ul style="list-style-type: none"> • Disposition <ul style="list-style-type: none"> – good temperament – positive self-esteem – ability to respond to new situations • Belief systems <ul style="list-style-type: none"> – ideological commitment to aims of combatants' own side – strong Buddhist beliefs
<i>Family</i>	<ul style="list-style-type: none"> • Poor parental mental health <ul style="list-style-type: none"> – especially maternal distress – political persecution & imprisonment of father • Unaccompanied by family members 	<ul style="list-style-type: none"> • Role of the family <ul style="list-style-type: none"> – cohesion – adaptability
<i>Post-migration environment</i>	<ul style="list-style-type: none"> • Low levels of social support • Post-migration stresses <ul style="list-style-type: none"> – process of asylum seeking itself – negotiations with immigration authorities – unresolved asylum status – financial hardship – unemployment – inadequate or communal housing – frequent moves – language problems – social isolation – racial discrimination – stress of adapting to a new culture 	<ul style="list-style-type: none"> • High levels of social support

It is usually best to begin by interviewing family members together, with the assistance of a professional interpreter. A child should never be required to act as an interpreter. For unaccompanied asylum-seeking children it is often very useful to involve their social worker or foster carer in the initial assessment. When working with people from different cultures it is also important to spend time explaining what a mental health professional is, how the service works, what type of help is available and how confidentiality applies. Interviewing the child or children separately from the adult(s) gives individual family members the opportunity to express their difficulties and emotional reactions more freely, as family members may try to protect one another by not sharing distressing information. Specific information to be gathered includes the child's first language, country of origin, ethnic background, past traumatic experiences (in as much detail as they can comfortably provide), whether they have been separated from family members, and current legal status. Therapists should bear in mind that the structure

and nature of assessment interviews may remind individuals of past interrogations if they are conducted in too formal a manner. Following the experience of human rights violations it is often extremely difficult to trust others. Therefore, more time will usually need to be spent in engaging young refugees and establishing trust.

Self-report measures

Questionnaires play a useful role as screening instruments and can be used in diverse settings. Standardised measures can determine both the levels of exposure to war trauma and the subjective reactions experienced by affected children. They are helpful in tracking treatment progress and evaluating the effectiveness of various interventions. A standard set of self-report measures used regularly in our clinics consists of an adapted version of the War Trauma Questionnaire (WTQ; Macksoud, 1992); the revised 13-item version of the Impact of Event Scale for Children (R-IES; Smith, Perrin, Dyregrov, &

Yule, 2003) for PTSD symptoms; the Birlleson Depression Self-rating Scale (DSRS; Birlleson, 1981); the revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978); and the brief Grief Questionnaire (Nader et al., 1993). The R-IES-13 is free and available in several languages (<http://www.childrenandwar.org>). This battery appears to have good validity across cultures (Yule, 2002). In addition, a useful behavioural screening measure to ask parents or teachers to complete is the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1994), which has been translated into over fifty languages.

However, there are limitations to using such measures. Firstly, scores should be interpreted with caution as some measures have been standardised mainly on British and American children. Differences due to language and culture need to be taken into account when interpreting the results. The development of new measures designed specifically for young refugees or at the very least studies that investigate the reliability and validity of using existing measures with this population are urgently required (Hollifield et al., 2002).

Interventions (general)

In general, a holistic approach is necessary when working with young refugees (Papadopoulos, 1999). Frequently refugees need to discuss practical or present difficulties rather than past experiences owing to the high levels of social and material adversity under which they are often living. Many refugees have escaped horrific circumstances and may not wish to reflect on the past but instead choose to focus on the future. Such a focus should not necessarily be discouraged, as holding a more future-oriented view is associated with less depression in refugees (Beiser & Hyman, 1997).

A phased model approach to intervention

Clinical work with refugees can be conceptualised in terms of a phased model approach to intervention (Gorman, 2001; National Institute for Clinical Excellence, 2005). See Figure 1. Phased interventions have been well described by Herman (1997) and are considered an appropriate way of working therapeutically with traumatised individuals living in situations of ongoing threat. Movement back and

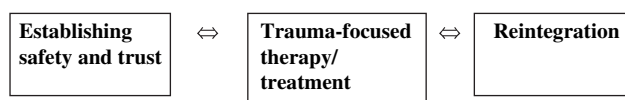


Figure 1 Diagram of a phased model approach to intervention

forth between phases is common. It is to be expected particularly when working with people seeking asylum because emotional states are so heavily influenced by asylum status and the impact that this has upon life circumstances. As there is no research evidence to support this model, it reflects a purely pragmatic approach.

Establishing safety and trust. During the early stages of therapy the aims are to help the young person or family develop a sense of stability, safety and trust, as well as to regain a sense of control over their lives. Frequently a primary need is to achieve safety from further persecution, which may be difficult until legal status, which allows them to remain in the host country, has been obtained. Therefore, clinicians working with refugees must have an awareness of immigration law, the sociopolitical situation in other countries and welfare rights. In this first phase, much time may have to be set aside for liaising with agencies to ensure that basic needs are being addressed and support networks created. Initial sessions may need to focus on solving housing and financial problems, as well as facilitating access to reputable solicitors, family tracing services, educational, health, religious, cultural and leisure facilities. Appropriate therapeutic interventions during this stage may include psychoeducation regarding symptoms and treatment models, normalising reactions to trauma, as well as the provision of symptom management and coping strategies. It is usually too difficult for an individual to share their most personal and upsetting memories with a therapist at this early stage. It can be particularly difficult when a young person does not feel safe and faces a realistic prospect of being returned to experience more trauma in their country of origin. Only after individuals feel that they have some sense of safety and predictability, more control over their symptoms, as well as some level of trust, are they ready to begin the next phase of treatment.

Trauma-focused therapy/treatment. Although this model was originally developed for individuals who require trauma-focused treatment, not all refugees will be experiencing PTSD-related difficulties. Depending on the young person's current complaints, alternative interventions may be offered at this stage for a range of difficulties, including depression, anxiety, sleep problems, somatic complaints and behavioural difficulties. For those who are suffering from PTSD symptoms, this phase can involve working through traumatic events to create a coherent and detailed narrative of past experiences. In this way, painful memories can be processed and more fully integrated into an individual's life story. Discussing and remembering traumatic past events is often extremely difficult and must be carefully paced according to how much the young person can comfortably tolerate. A substantial amount of time

should also be spent exploring feelings of guilt and shame, which often arise after witnessing the brutal killing of close family members or the experience of rape. Such feelings may be reframed by taking into account the political and contextual realities. The therapist plays an important role as someone who bears witness to the horrors and atrocities that the young person has experienced. Issues of loss and bereavement often need to be confronted during this phase. Frequently a crisis occurs and it will be necessary to return to the stabilisation work of phase one. However, at the end of this middle phase, an individual should be able to recall their traumatic experiences with less emotional intensity and there should be a reduction in PTSD or other symptoms.

Reintegration. This phase focuses on creating a future and beginning to integrate into a new community. Many young refugees will have already spontaneously begun this process on their own or with help from schools, refugee organisations and other community members. The young person or family is encouraged to rebuild their present life and relationships. It is also an opportunity to develop a sense of future goals and aspirations. The therapist may wish to discuss educational plans or future employment with young refugees and their parents so that a clear route to their goals can be established. Young refugees and their families may also choose to become more involved in their religious communities or in extracurricular and social activities during this final phase.

Promising treatments for reducing war-related PTSD symptoms

This article does not have the scope to systematically review the various types of treatment which can be offered to young refugees experiencing a broad range of mental health difficulties. However, evidence-based interventions which have been developed for the general population of children and adolescents should be routinely offered. Placing a mental health worker within the school setting is also an effective way of improving access to interventions for distressed refugee children (O'Shea, Hodes, Down, & Bramley, 2000).

The following section summarises effective treatments for reducing PTSD symptoms in young refugees. Randomised controlled trials remain scarce. However, several promising treatments do emerge from the existing literature, including CBT, testimonial psychotherapy, NET and EMDR.

Cognitive-behavioural treatment

Cognitive-behavioural interventions for PTSD are based on learning and information-processing theories (Smith, Perrin, & Yule, 1999). According to

learning theory, changes in behaviour may be brought about by influencing antecedents and consequences. Information-processing theory holds that cognitions drive behaviour and therefore altering cognitions can lead to changes in behaviour, as well as in affect. Cognitive-behavioural work with children generally draws on both theories by relying on the application of behavioural techniques, as well as considering the cognitive interpretations and attributions about events made by children. Interventions range from problem-solving strategies to behaviourally based exposure methods or cognitive techniques aimed at modifying distorted thinking.

CBT has been effective at reducing PTSD symptoms in adult refugees (Paunovic & Öst, 2001; Snodgrass et al., 1993) and victims of torture (Başoğlu, Ekblad, Bäärnhielm, & Livanou, 2004). A combination of CBT and pharmacotherapy has been shown to be beneficial for adult refugees (Otto et al., 2003). The Ehlers and Clark (2000) cognitive model of PTSD has also been successfully applied to refugee children and described in two case vignettes (Vickers, 2005).

A controlled study ($N = 26$) demonstrated that group CBT was effective at reducing PTSD symptoms, as well as behavioural difficulties and emotional symptoms, in young refugees from a range of countries, who had experienced war-related trauma (Ehnholt, Smith, & Yule, 2005). Based on a manual (Smith et al., 2000), this six-session weekly school-based intervention focused on psychoeducation, normalising reactions to trauma and developing coping strategies, e.g., visual imagery, relaxation exercises, activity scheduling and coping self-statements. Within the sessions children also engaged in trauma-focused exposure therapy using dual attention techniques, as well as through drawing, writing and talking about their traumatic past experiences. Unfortunately, post-treatment improvements were not maintained at two-month follow-up, possibly due to small sample size ($n = 8$), the treatment being too brief or 'dilute' when delivered in a group format or the renewal of hostilities in the children's region of origin.

Although not specifically cognitive-behavioural in orientation, the following two manual-based group interventions appear to share a similar focus but cover a wider range of topics, over a greater number of sessions and in more depth. In common with a CBT approach, these interventions are goal oriented, time limited, skills based and include a trauma-focused exposure component. Layne et al. (2001) evaluated a school-based intervention lasting approximately twenty sessions for war-exposed Bosnian adolescents ($N = 55$) in schools. The intervention consisted of a trauma and grief-focused group therapy. Sessions focused on traumatic experiences, reminders of trauma and loss, post-war adversities, bereavement and the interplay between trauma and grief, as well as the developmental im-

pact. Significant reductions in post-traumatic stress, depressive and grief symptoms were reported post-treatment. Reductions in distress symptoms were associated with higher levels of psychosocial adaptation. Möhlen and colleagues (2005) evaluated another treatment programme designed to lower emotional distress and improve psychosocial functioning in adolescent Kosovan refugees ($N = 10$) suffering from war-related trauma. The intervention was conducted over a twelve-week period. It included individual, family and group sessions. Sessions focused on psychoeducation, trauma and grief-focused activities, as well as relaxation techniques. Following the intervention, post-traumatic stress, anxiety and depressive symptoms were decreased, while psychosocial functioning was increased.

Testimonial psychotherapy

Testimonial psychotherapy was developed specifically for adult survivors of torture and severe human rights abuses, who had suffered multiple traumatic events over an extended period of time. This method involves recording an individual's verbal account of what they have experienced, often with the assistance of a tape recorder. Their account is then revised jointly by the therapist and the individual during subsequent sessions until it forms a written document which may be used for documentary or political purposes. The integrative nature of this method enables an individual to assimilate fragmented traumatic memories with their accompanying affective and cognitive states while also placing them within a sociopolitical context. Testimonial psychotherapy fits culturally with the oral tradition of story telling. The signing of the completed document signals a formal end to the process and the completed document can then be presented to human rights organisations or others as evidence of an individual's experience of abuse. What distinguishes this approach is its social aspect, as one of its explicit aims is to reframe the individual survivor's story within the social and historical context in which the state-sponsored violence took place.

This therapeutic technique was originally devised by Lira and Weinstein (published under the pseudonyms Cienfuegos & Monelli, 1983) for former prisoners of the Chilean military government. Based on clinical observation, this approach was found to be effective at reducing symptoms of distress in survivors of political persecution, torture and imprisonment, as well as in adult political refugees (Agger & Jensen, 1990). It was effective in a case series study with adult Bosnian refugees ($N = 20$) who showed an improvement in PTSD and depressive symptoms, as well as in overall functioning at post-treatment, two- and six-month follow-up (Weine, Kulenovic, Pavkovic, & Gibbons, 1998). Testimonial psychotherapy has also been described as being effective with adolescent Sudanese refugees, as illustrated by

three case studies (Lustig, Weine, Saxe, & Beardslee, 2004).

Narrative exposure therapy

NET is an innovative approach, which combines elements of testimonial psychotherapy with cognitive behavioural techniques and theory. It was developed as a short-term treatment based on the principles of cognitive behavioural exposure therapy but using an adapted narrative approach to exposure. This was thought to better suit victims of organised violence, who have experienced multiple traumatic events and usually find it difficult to identify just one worst event. Thus instead of identifying a single event as the target in therapy, the individual constructs a narrative about his or her whole life from birth up to the present time, while also giving a detailed report of all traumatic events. One of the goals of this approach is to reduce PTSD symptoms by confronting the individual with memories of the traumatic event. However, habituation of emotional responses appears to be only one mechanism which results in an improvement of symptoms. Recent theories of PTSD and emotional processing suggest that autobiographic memories about traumatic events are distorted and fragmented (Ehlers & Clark, 2000). The reconstruction of autobiographic memory through the development of a consistent narrative is thus necessary and should be used in conjunction with exposure therapy. NET uses both strategies: the habituation of emotional responses to reminders of the traumatic event as well as the creation of a detailed narrative of the event and its consequences to bring about improvement. NET is well described in a published treatment manual (Schauer, Neuner, & Elbert, 2005).

Neuner et al. (2004) conducted a randomised controlled study which found that NET was an effective treatment for adult refugees with PTSD. Forty-three adult refugees who were diagnosed with PTSD and living within a refugee settlement participated, receiving either four sessions of NET, four sessions of supportive counselling (SC) or one session of psychoeducation (PE). One year after treatment, only 29% of those who had received NET still fulfilled PTSD criteria compared to 79% of the SC group and 80% of the PE group.

NET has now been adapted for use with children older than eight (KIDNET). In contrast to the adult version, KIDNET uses more illustrative material, for example a rope or string is used to represent a lifeline: flowers and stones are placed on the lifeline to signify both positive and negative life events respectively. Children are also encouraged to extend their narrative beyond the present so that it describes their hopes and aspirations for the future. In a small case series study ($N = 6$), Somali refugee children with PTSD, aged 12–17 and living in a

Ugandan refugee settlement, received four to six individual sessions of KIDNET. All children showed important reductions in PTSD and depressive symptoms, which were maintained at the nine-month follow-up (Onyut et al., 2005). The use of KIDNET is described in detail in a case study of a Somali refugee boy (Schauer et al., 2004).

Eye movement desensitisation and reprocessing

EMDR is a treatment that uses bilateral stimulation when processing traumatic memories in individuals with PTSD (Shapiro, 1995). With this method, the young person is often asked to conjure up an image of their traumatic event while the therapist simultaneously moves his or her finger in front of the young person's eyes in a rhythmic, lateral motion. The treatment involves a combination of both exposure and distraction or 'dual attention' as it is most frequently referred to. A case series study ($N = 13$) reports significant improvements following the use of EMDR with refugee children experiencing PTSD symptoms (Oras, Cancela de Ezpeleta, & Ahmad, 2004). However, these findings must be interpreted with caution owing to the lack of a control group, small sample size and the mixture of psychotherapeutic methods with EMDR. Therefore, improvements may have been due to natural recovery over time, the granting of permanent residence to the majority of the sample or treatment components other than EMDR. Although promising, further research is required.

Pharmacological treatments

There is no evidence to suggest that pharmacological treatments are beneficial to young refugees with PTSD. Such treatments are usually only used as an adjunct to psychosocial treatments for children with PTSD and are not recommended in the UK (NICE, 2005). They may only be relied upon as a last resort if psychological therapies do not result in an improvement and the child or adolescent is in severe distress. Clinical experience suggests that the benefits of conventional drug treatments in PTSD for children and adolescents are modest (Cohen, Berliner, & March, 2000).

Interventions for war-affected children under the age of eight

Research into interventions designed to help war-affected children under the age of eight is scarce. As the family plays a particularly important role in the well-being of young children, interventions which offer additional support to the child's parent or caregiver would appear to be most appropriate. A randomised controlled trial evaluated the effects on five-year-olds in war-affected Bosnia and Herzegov-

ina of a psychosocial intervention programme consisting of weekly support group meetings for mothers over a five-month period (Dybdahl, 2001). Internally displaced mothers received either psychosocial support and basic medical care ($n = 42$) or medical care only ($n = 45$). The primary aim of the psychosocial intervention was to promote the development and well-being of young children through parental involvement, support and education. The importance of the mother-child interaction was emphasised. Psychoeducation was provided regarding trauma and common post-traumatic stress reactions. Sessions focused on strengthening the mothers' coping strategies, as well as on eliciting positive interactions and sensitive communication between mothers and their children. The psychosocial intervention improved both the mothers' and children's mental health. Notably it had a positive effect on the children's weight gain.

Interventions for traumatic grief

Many young refugees will be grieving the loss of family members and friends. It may be appropriate to involve spiritual leaders in the planning of memorial services for deceased or missing family members. Rituals and traditional healers may also have an important role to play (illustrated by two case examples, Jaffa, 1996; Schreiber, 1995). Monroe and Kraus (2005) provide an overview of brief interventions for bereaved children.

Key issues to consider when working with young refugees

Unaccompanied asylum-seeking children

An unaccompanied asylum-seeking child (UASC) is defined by the United Nations High Commissioner for Refugees (UNHCR) (1994) as an individual under the age of 18, who is separated from both parents and is not being cared for by an adult who, by law or custom, is responsible for doing so. Thomas and colleagues (2004) interviewed 100 UASC in the UK and discovered that the majority of these young people had been forced to flee from their country of origin owing to various forms of violence, which included the death or persecution of family members, persecution of the young person, and war, as well as forced recruitment as child soldiers or domestic/sex slaves. Approximately a third (32%) of the UASC, some of whom were male, reported that they had been raped. UASC display more symptoms of psychological distress than their accompanied peers (Felsman et al., 1990; Fox et al., 1994; McKelvey & Webb, 1995). For UASC issues of loss are often exacerbated and intensified by social isolation within the host country. Group psychosocial interventions that help UASC develop resili-

ency through shared problem solving and the creation of a friendship network appear beneficial (Heaphy, Ehntholt, & Sclare, in press). One of the greatest challenges practitioners face when working with UASC in the UK involves immigration uncertainty, as the majority of UASC are given only temporary leave to remain in Britain until the age of 18.

Working with interpreters

Much can be gained by using a collaborative approach and working with interpreters as bilingual co-workers. Raval (2005) uses the term bilingual worker to describe someone who brings experience and skill as well as cross-cultural understanding and who facilitates communication through a variety of roles, which can include translation and cultural consultancy. Consideration must be taken when booking an interpreter so that someone of the appropriate ethnicity, political party, dialect and gender is requested. Additional time will need to be allocated for these sessions. Seating should be arranged so that everyone in the room is able to maintain eye contact. The clinician will need to practise keeping questions and comments succinct. It is also important to ensure continuity by having the same interpreter at every appointment. An essential part of this work involves meeting with the interpreter for planning before and debriefing after the sessions. Tribe and Raval (2003) provide good practice guidelines for working with interpreters in mental health settings.

Cross-cultural knowledge

Cultural differences need to be acknowledged and respected. It can be very helpful for the clinician to find out more about a young person's country of origin and culture before the initial assessment. Jill Rutter's book (Rutter, 2003) contains information on the general cultural backgrounds and sociopolitical context of thirty-five of the major refugee groups in Britain. Websites belonging to Amnesty International, UNHCR and UNICEF also contain regularly updated information about ongoing international conflicts, as well as maps.

Medico-legal report writing

Reputable solicitors will often instruct mental health professionals to complete medico-legal reports on the mental health of young refugee clients which are submitted along with the asylum application or appeal. Tufnell (2003) outlines questions commonly posed by solicitors, as well as guidance on conducting assessments and constructing medico-legal reports. Advice on how to structure, format and write expert witness court reports for children and adolescents has been provided elsewhere (Tufnell, Cottrell, & Georgiades, 1996).

Clinician self-care

Lastly, but not to be underestimated, is the high emotional impact that this type of work has on the clinician. Listening to detailed accounts of horrific events, torture and other human rights violations, as well as the frustrations of supporting people who often face ongoing practical problems and great adversity, is understandably exhausting. Therefore, it is essential that clinicians have adequate supervision and an established means of personal support.

Conclusion

This article is meant not only for mental health professionals but for all those, including social workers, GPs, paediatricians, teachers and other school or health care staff, who come into contact with young refugees, as holistic care and increased cooperation between different agencies is essential in this area of work. Young refugees and their families are frequently subjected to multiple traumatic events and severe losses. Ongoing stressors within the host country often exacerbate an already difficult situation. Although many young refugees are resilient, some will develop mental health difficulties. Clinicians must be mindful that even though PTSD is frequently diagnosed, other mental health difficulties, such as depression, anxiety and grief, commonly coexist and must not be overlooked. Surprisingly few randomised controlled trials, large-scale or systematic studies have been conducted in this area. Further research is thus required in order to increase our currently limited knowledge base. Small-scale studies have, however, highlighted several promising treatments for war-related PTSD in young refugees, including CBT, testimonial psychotherapy, NET and EMDR. Fundamental to this work is a willingness to engage with interpreters as potential co-therapists and a respectful, welcoming attitude towards young people from other cultures.

Acknowledgements

We would like to thank our colleagues Grace Heaphy, Patrick Smith and David Trickey, as well as the reviewers, for their very helpful comments on the initial draft of this manuscript. We are also grateful to Health Action Zone for funding the Young Refugee Mental Health Project and Irene Sclare, Project Co-ordinator.

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Manuscript accepted 7 March 2006

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