Child, Adolescent and Family Refugee Mental Health

A Global Perspective

Suzan J. Song
Peter Ventevogel
Editors

Springer

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Editors
Suzan J. Song
Department of Psychiatry
George Washington University
Washington, DC
USA

Peter Ventevogel
Public Health Section (Division
of Resilience and Solutions)
United Nations High Commissioner
for Refugees
Genève
Geneve
Switzerland

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Foreword

Meeting the mental health needs of child and adolescent refugees poses major problems for all communities. Most mental health workers are well trained in helping individual families and children, but few are experienced in meeting the very complex needs of refugees. For a start, the sheer numbers are currently overwhelming. With many low- and middle-income countries having few qualified mental health personnel, how can they be expected to meet the acute and chronic needs of forced migrants? Faced with such challenges, people usually fall back on adapting and applying their existing skills and knowledge which may not always be appropriate. This welcome text in turn challenges many assumptions and points the way to applying better understanding based on contemporary models of child and family development.

Historically, it has to be conceded that many mental health workers responded to the perceived needs of refugees focusing on mainly individual therapeutic interventions. However, it soon became clear that these were insufficient in themselves and may even have been harmful. Cultural differences in understanding of mental health and widely differing contexts of family life rightly posed challenges. Focusing on stress reactions was seen as ignoring strengths and resilience. Outsiders rushing in to help without understanding the background of survivors and without knowing the supports and barriers within communities were inevitably less effective than they might have been.

This book provides helpful lessons from a wide range of academic and applied perspectives. Considerations of culture and the need to see the child in the context of family and community provide suggestions for improving the assessment of needs. Good, sensitive interviewing techniques—both with parents and children—form the basis of most assessments. Healthy skepticism is aired about questionnaires but screening remains a necessity. Similarly, while warning against an exclusive individual therapeutic approach, the particular needs of children with developmental disabilities, substance abuse, depression, grief and, yes, even PTSD are discussed. Throughout there are clinical examples that bring the issues to life.

One overriding problem is the great lack of acceptable evidence for the approaches recommended. At the wider community level, psychosocial interventions that claim they are not “clinical” offer help at what seems to be an acceptable level. But where is the evidence that safe child spaces or even psychological first aid are really effective in helping refugee children adjust to their reactions to being

uprooted? Difficult as it is, there is a moral as well as scientific imperative to evaluate all efforts to help.

While the main approaches discussed rightly argue that children should be supported along with and within their families, a high percentage of child refugees arrive at a hopefully safe and welcoming country but alone. The additional issues that unaccompanied minors pose to authorities require even greater planning. This, and evaluation, will feature in the next edition of this book, provided the mental health community takes heed of the lessons given here.

London, United Kingdom William Yule

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Contributors

Abdirahman Abdi Shanbaro Community Association, Chelsea Collaborative, Chelsea, MA, USA

Julia Bala, PhD ARQ National Psychotrauma Centre, Diemen, The Netherlands

Cyril Bennouna, MPH Political Science, Brown University, Providence, RI, USA

Lidewyde H. Berckmoes, PhD African Studies Centre, Leiden University, Leiden, The Netherlands

Jenna M. Berent, MPH Research Program on Children and Adversity, Boston College School of Social Work, Chestnut Hill, MA, USA

Theresa S. Betancourt, ScD, MA Research Program on Children and Adversity, Boston College School of Social Work, Chestnut Hill, MA, USA

Vanessa Cavallera, MD, MPH Independent Consultant, Milan, Italy

Neerja Chowdhary, MD Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland

Matty R. Crone, PhD Department of Public Health & Primary Care, Leiden University Medical Center (LUMC), Leiden, The Netherlands

Anne-Sophie Dybdal, MSc Save The Children Denmark, Frederiksberg, Denmark

Rochelle L. Frounfelker, ScD, MPH, MSSW Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University, Montreal, QC, Canada

Melanie M. Gagnon, PhD CIUSSS West-Central Montreal, Montreal, QC, Canada

Bhuwan Gautam, MPA Bhutanese Society of Western Massachusetts, Inc., Springfield, MA, USA

M. Claire Greene, PhD, MPH Department of Psychiatry, Columbia University/ New York State Psychiatric Institute, New York, NY, USA

Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA

Zeinab Hijazi, MsC, PsyD Mental Health and Psychosocial Support Specialist, Child Protection in Emergencies, Programme Division, New York, NY, USA

Lynne Jones, OBE, FRC Psych., PhD FXB Center for Health and Human Rights, Harvard University, Cambridge, MA, USA

Joop T. V. M. de Jong, MD, PhD Cultural Psychiatry and Global Mental Health, Amsterdam UMC, Amsterdam, The Netherlands

Boston University School of Medicine, Boston, MA, USA

Jeremy C. Kane, PhD, MPH Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA

Department of Epidemiology, Columbia University, New York, NY, USA

Nancy H. Liu, PhD Department of Psychology, University of California, Berkeley, Berkeley, CA, USA

Tej Mishra, MPH Research Program on Children and Adversity, Boston College School of Social Work, Chestnut Hill, MA, USA

Trudy Mooren, PhD ARQ Centrum'45, Diemen, The Netherlands

Kerim Munir, MD, MPH, DSc Boston Children's Hospital, Harvard Medical School, Boston, MA, USA

Ramzi Nasir, MD, MPH Consultant in Developmental Behavioral Pediatrics, London, UK

Julia Oakley, LCSW Northern Virginia Family Services, Program for Survivors of Severe Torture and Trauma, Arlington, VA, USA

Yoke Rabaia, PhD Institute of Community and Public Health, Birzeit University, Birzeit, Palestine

Ria Reis, PhD Department of Public Health & Primary Care, Leiden University Medical Center (LUMC), Leiden, The Netherlands

Department of Anthropology, University of Amsterdam, Amsterdam, The Netherlands

Amsterdam Institute for Global Health and Development (AIGHD), Amsterdam, The Netherlands

The Children's Institute, School of Child and Adolescent Health, University of Cape Town, Cape Town, South Africa

Cécile Rousseau, MD Division of Social and Cultural Psychiatry, McGill University, Montreal, QC, Canada

Leslie Snider, MD, MPH The MHPSS Collaborative, Save the Children, Copenhagen, Denmark

Suzan J. Song, MD, MPH, PhD Department of Psychiatry, George Washington University, Washington, DC, USA

Lindsay Stark, DrPH Brown School, Washington University in St. Louis, St. Louis, MO, USA

Peter Ventevogel, MD, PhD Public Health Section (Division of Resilience and Solutions), United Nations High Commissioner for Refugees, Geneva, Switzerland

An Verelst, PhD Department of Social Work and Social Pedalogy, Ghent University, Gent, Belgium

Sofie Vindevogel, PhD Department of Social Educational Carework, University of Applied Sciences and Arts Ghent, Gent, Belgium

Michael G. Wessells, PhD Program on Forced Migration and Health, Columbia University, New York, NY, USA

About the Authors

Abdirahman Abdi is a Somali Bantu community leader and partner with the "Refugee Behavioral Health Program" at the Research Program on Children and Adversity at Boston College School of Social Work, Chestnut Hill, Massachusetts, USA.

Julia Bala, PhD is a clinical psychologist, psychotherapist, and independent consultant, a former staff member of ARQ Centrum45 in the Netherlands. Her main fields of interest include the intergenerational consequences of trauma, preventive multi-family interventions, and strengthening family resilience.

Cyril Bennouna, MPH is a Fellow at the Center for Human Rights and Humanitarian Studies and a PhD student in comparative politics and international relations at Brown University. His research focuses on the politics of forced migration and efforts to reduce violence against civilians during armed conflict.

Lidewyde H. Berckmoes, PhD is assistant professor at the African Studies Centre at Leiden University in the Netherlands. Having a background in anthropology, her research focus is on the long-term effects of conflict and violence on children and youth in war-affected and refugee contexts. She has extensive research experience in the Great Lakes region, particularly Burundi.

Jenna M. Berent, MPH is a program manager for the "Refugee Behavioral Health Program" at the Research Program on Children and Adversity at Boston College School of Social Work, Chestnut Hill, Massachusetts, USA.

Theresa S. Betancourt, ScD, MA is the inaugural Salem Professor in Global Practice at the Boston College School of Social Work and Director of the Research Program on Children and Adversity, Chestnut Hill, Massachusetts, USA.

Vanessa Cavallera, MD, MPH is child neurologist and psychiatrist with a Master's Degree in Public Health. She has been working for the World Health Organization and other UN agencies and NGOs focusing on early childhood development and child and adolescent mental health in developing and humanitarian contexts.

Neerja Chowdhary, MD Technical Officer in the Department of Mental Health and Substance Use, World Health Organization, Geneva.

A psychiatrist by training, she works as part of WHO's brain health team, supporting implementation of the global action plan on the public health response to dementia 2017–2025. Her other areas of work include provision of technical assistance for WHO's mental health Gap Action Programme (mhGAP) including development of training and guidance documents and providing technical support to country implementation. She is one of the co-authors of the WHO guidelines for the management of physical health conditions in people with severe mental disorders.

Mathilde R. Crone, PhD is a health scientist and has extensive research experience in the field of public health, in particular child health. She has particular expertise in exploring the determinants of (un)healthy behavior and chronic physical and mental health conditions of children/adults, evaluation studies of (preventive) care programs, and implementation studies. https://www.researchgate.net/profile/Matty_Crone/publications

Anne-Sophie Dybdal, MSc is a Licensed Clinical Child Psychologist from University of Copenhagen. She has 28 years of experience working with children and families with a focus on child development, resilience and well-being. Anne-Sophie Dybdal has worked in the humanitarian sector since 2000 and from 2006 as senior child protection and MHPSS advisor for Save The Children Denmark. For the last 5 years she has been involved in implementation of the Save The Children Youth Resilience Programme, currently running in 10 countries globally, including in refugee camps and extremely vulnerable communities.

Rochelle L. Frounfelker, ScD, MPH, MSSW is a social epidemiologist and postdoctoral fellow in the Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University, Montreal, Canada.

Melanie M. Gagnon, PhD is a clinical psychologist. She is also responsible for coordinating the Center of Expertise for the Wellbeing and Physical Health of Refugees and Asylum Seekers at the Centre-Ouest-de-l'Île-de-Montréal CIUSSS. She is involved in the field of research and is a researcher-practitioner at the Sherpa Research Center, University Institute for Ethnocultural Communities.

Bhuwan Gautam, MPA is a Bhutanese community leader and co-investigator in the "Refugee Behavioral Health Program" at the Research Program on Children and Adversity at Boston College School of Social Work, Chestnut Hill, Massachusetts, USA.

M. Claire Greene, PhD, MPH is a psychiatric epidemiologist in the Department of Psychiatry at Columbia University. Her research focuses on the implementation and evaluation of interventions to address alcohol and other drug use, mental health, and psychosocial problems in humanitarian settings.

Zeinab Hijazi, MsC, PsyD is a Global Mental Health and Psychosocial Support Specialist, UNICEF, New York Headquarters.

Zeinab has 14 years of experience supporting MHPSS programs globally, and was in an advisory role with International Medical Corps providing guidance and oversight in the development, monitoring, evaluation, and running of culturally appropriate MHPSS activities in Lebanon, Jordan, Syria, Turkey, Palestine, Iraq, Tunisia, Libya, and Yemen.

At present, Zeinab is the MHPSS specialist and technical lead at UNICEF, and provides program guidance and technical support to enhance UNICEF's approach to the provision of mental health and psychosocial support for children and families in humanitarian settings. This includes supporting UNICEF country teams in designing and implementing locally relevant, comprehensive, and sustainable MHPSS strategies that (1) promote safe, nurturing environments for the recovery, psychosocial well-being, and protection of children; and (2) engage children, caregivers and families, community systems, and service providers at all levels of the social-ecological framework.

Lynne Jones, OBE, FRC Psych., PhD is a child psychiatrist, relief worker, and writer. She has spent much of the last 25 years establishing and running mental health programs in areas of conflict or natural disaster including the Balkans, East and West Africa, South East Asia, the Middle East, Haiti, and Central America. Most recently she has worked in the migrant crisis in Europe and Central America. She is a course director for the annual course on Mental Health in Complex Emergencies, run by the Institute of International Humanitarian Affairs at Fordham University, in collaboration with UNHCR. Her most recent book is *Outside the Asylum: A Memoir of War, Disaster and Humanitarian Psychiatry* (Orion 2017). Jones has an MA in human sciences from the University of Oxford. She qualified in medicine before specializing in psychiatry and has a PhD in social psychology and political science. In 2001, she was made an Officer of the British Empire for her work in child psychiatry in conflict-affected areas of Central Europe. She regularly consults for UNICEF and WHO. She is an honorary consultant at the Maudsley Hospital, London, and with Cornwall Partnership NHS Foundation Trust. She is a visiting scientist at the François-Xavier Bagnoud Centre for Health and Human Rights, Harvard University.

Joop T. V. M. de Jong, MD, PhD is Emeritus Professor of Cultural Psychiatry and Global Mental Health at UMC Amsterdam, Adjunct Professor of Psychiatry at Boston University School of Medicine, and Emeritus Visiting Professor of Psychology at Rhodes University, South Africa. He founded the Transcultural Psychosocial Organization (TPO), a relief organization in mental health and psychosocial care of (post)conflict and post-disaster populations in over 20 countries in Africa, Asia, and Europe. He worked part time as a psychotherapist and psychiatrist with immigrants and refugees in the Netherlands. His research interests focus on cultural psychiatry, public and global mental health, epidemiology, psychotraumatology, and medical anthropology.

Jeremy C. Kane, PhD, MPH is a psychiatric epidemiologist whose research is focused on measuring patterns of alcohol use, substance use, and related mental health problems among populations affected by HIV and violence in low- and middle-income countries and adapting, testing, and implementing evidence-based interventions for these problems.

Nancy H. Liu, PhD Assistant Clinical Professor, Department of Psychology, University of California, Berkeley.

Nancy is a clinical psychologist. Her expertise is in the clinical training and implementation of evidence-based psychological interventions for trauma, depression, and severe mental disorders. She teaches coursework in global mental health and clinical diagnosis, assessment, and interventions. She was a former Consultant with the WHO focusing on guidelines for reducing excess mortality in individuals with severe mental disorders.

Tej Mishra, MPH is an epidemiologist and researcher with the "Refugee Behavioral Health Program" at the Research Program on Children and Adversity at Boston College School of Social Work, Chestnut Hill, Massachusetts, USA.

Trudy Mooren, PhD is a clinical psychologist and senior researcher at ARQ Centrum'45 and Endowed Professor 'Family Functioning after Psychotrauma' at the Department of Clinical Psychology, Faculty of Social Sciences, Utrecht University. She studies the consequences of psychotrauma and forced migration for family functioning and is interested in assessment and interventions to support family resilience.

Kerim Munir, MD, MPH, DSc is Director of Psychiatry, University Center in Developmental Disabilities, Division of Developmental Medicine, Boston Children's Hospital, and Holmes Society Fellow in Global Health and Associate Professor of Psychiatry and Pediatrics, Harvard Medical School, Boston, USA.

Ramzi Nasir, MD, MPH is a Consultant Paediatrician in Developmental-Behavioral Paediatrics at the Royal Free London NHS Foundation Trust and the Portland Hospital, London, UK. He is involved in a variety of initiatives to promote the well-being of children with developmental disabilities in the humanitarian context.

Julia Oakley, LCSW is a mental health therapist and coordinator of the Program for Survivors of Torture and Severe Trauma at Northern Virginia Family Service's Multicultural Center in Falls Church, Virginia, USA. As part of a multilingual team offering mental health and immigration legal services, she works predominantly with asylum seekers, asylees, and refugees who are survivors of trauma. She earned a Master of Science in Social Work and a Master of International Affairs from Columbia University.

Yoke Rabaia, PhD conducts research related to mental and psychosocial health at the Community and Public Health Institute at Birzeit University, Palestine.

Ria Reis, PhD is a cultural anthropologist, specialized in religious and medical anthropology. Her research focus is on young people's health perceptions and strategies, the intergenerational transmission of vulnerabilities in contexts of inequality, and children's cultural idioms of distress. She is an expert in, and passionate about, the articulation of anthropological research within multidisciplinary (mental) health research and interventions.

Cécile Rousseau, MD is professor of the Division of Social and Cultural Psychiatry at McGill University. She has worked extensively with immigrant and refugee communities, developing specific school-based interventions and leading policy-oriented research. Presently her research focuses on intervention and prevention programs to address violent radicalization.

Leslie Snider, MD, MPH is a psychiatrist with over 20 years' experience in mental health and psychosocial support programs and research in diverse global settings. She serves as Director of the Global MHPSS Collaborative for Children and Families in Adversity, hosted by Save the Children Denmark. She began as a public mental health clinician while directing International Mental Health Studies for 10 years at Tulane Public Health School. Internationally, she collaborates with various UN agencies, governments, and NGOs in developing programs and quality care standards for children and families affected by disasters, conflict, HIV/AIDS, poverty and exploitation, and served as technical advisor to the US government, UNICEF, and others. She has over 40 publications, developed several widely used international resources for MHPSS in emergencies, and authored a children's book for children and caregivers affected by the Ebola crisis.

Suzan J. Song, MD, MPH, PhD is a double-board certified child/adolescent and adult psychiatrist and humanitarian mental health and psychosocial (MHPSS) consultant. Currently, she is Director of the Division of Child/Adolescent & Family Psychiatry and Associate Professor at George Washington University, spokesperson on Refugee Mental Health for the American Psychiatric Association, and subject matter expert to the US Department of Health and Human Services on refugee mental health and to the US State Department's Office to Monitor and Combat Trafficking in Persons. She has provided multiple testimonies to Congress on the mental health of unaccompanied minors and child trafficking. Her work as a humanitarian MHPSS consultant with UNHCR, UNICEF, the International Medical Corps, and the International Rescue Committee is informed by her clinical care of forcibly displaced children, adults, and families (survivors of torture, refugees, asylum seekers, unaccompanied minors, survivors of trafficking, and returned hostages) for over 10 years as medical director of two community clinics and in her current clinic. Dr. Song completed training from the University of Chicago, Harvard, Stanford, and the University of Amsterdam. Her two decades of global mental work span Sierra Leone, Liberia, Ethiopia, KwaZulu/Natal, Haiti, Burundi, Syria/Jordan, the D.R. Congo, and the USA as technical adviser to multiple refugee and survivor of torture programs.

Lindsay Stark, DrPH is an Associate Professor at Washington University in St. Louis' Brown School and an internationally recognized expert on the protection and well-being of women and children in situations of extreme adversity. Dr. Stark's particular area of expertise is measuring sensitive social phenomenon and evaluating related interventions that seek to reduce violence, abuse, and exploitation of women and children.

Peter Ventevogel, MD, PhD is a psychiatrist and a medical anthropologist. Since 2013, he has worked with UNHCR, the refugee agency of the United Nations, as their Senior Mental Health Officer based in Geneva. In this role he is responsible for providing guidance and technical support to the country operations of UNHCR worldwide. From 2008 to 2013 he was editor-in-chief of *Intervention, Journal for Mental Health and Psychosocial Support in Conflict Affected Areas*. He worked with the NGO HealthNet TPO in mental health projects in Afghanistan (2002–2005) and Burundi (2005–2008) and as their Technical Advisor Mental Health in the head office in Amsterdam (2008–2011). In 2011 and 2012 he also worked as psychiatrist with Arq Foundation, the national trauma expert center in the Netherlands. Peter regularly did consultancies for the World Health Organization and the UNHCR in Egypt, Jordan, Libya, Pakistan, Sudan, and Syria. He is involved in several academic short courses such the annual course Mental Health in Complex Emergencies (Fordham University, New York) and the Summer Institute Global Mental Health (Teachers College, Columbia University).

An Verelst, PhD is a clinical psychologist with a doctoral degree in Educational Sciences. Currently, An is project coordinator for Ghent University on a Horizon 2020 project called RefgueesWellSchool that evaluates the impact of six psychosocial interventions for young refugees and migrants in schools. Previously, she managed a psychosocial support center for children and communities affected by war in Eastern Congo where she also carried out her doctoral research on the psychosocial consequences of sexual violence during and after the armed conflict.

Sofie Vindevogel, PhD in educational sciences, has been working with populations affected by war and political violence for over ten years. Her research is situated at the intersection of strength-oriented, community-based, and transcultural approaches. It addresses stressors and resources in the context of stressful events and focuses primarily on how children, adolescents, families, and communities deal individually and collectively with various forms of adversity and what contributes to resilience and quality of life.

Michael Wessells, PhD is Professor at Columbia University in the Program on Forced Migration and Health. A long time psychosocial and child protection practitioner and researcher on the holistic impacts of war and political violence on children, he currently leads inter-agency, multi-country research on community-led child protection.

Part I

Theoretical Approaches to Comprehensive Understanding of Child, Adolescent, and Family Refugee Mental Health

1 Bridging the Humanitarian, Academic, and Clinical Fields Toward the Mental Health of Child and Adolescent Refugees

Peter Ventevogel and Suzan J. Song

Conceptual Debates in the Field of Child Refugee Mental Health

Many early publications on the effects of collective violence focused on posttraumatic stress disorder (PTSD), a diagnostic category that was only in 1980 enshrined in the third edition of the *Diagnostic and Statistical Manual* (DSM-III), the formal psychiatric classification system (DSM-III). While the concept was not completely new [26], the adoption by the DSM prompted major research efforts around PTSD. Increasingly, symptoms of PTSD were identified among children [90] including among resettled refugee children [3, 5, 36, 86]. However, from the beginning, there was a vocal group of critics who questioned the applicability of the concept among refugees. They argued that framing phenomena like recurrent memories, high vigilance, and loss of hope in refugees as symptoms of PTSD requiring medical treatment were an imposition of Western diagnostic categories. Doing so would ignore the social context that produces "symptoms" and as such only makes things worse by "pathologizing" reactions that could be better perceived as socially and culturally patterned adaptive reactions to adversity and loss [10, 21, 61].

Overall, the debate among mental health professionals around the presence of PTSD among refugees seems to have withered down over time, at least among mental health professionals working with refugees in high-income countries. In recent major publications around mental health of refugees and disaster-affected populations, the PSTD concept is not contested or seen as controversial anymore [28, 46, 82, 92].

P. Ventevogel
Public Health Section (Division of Resilience and Solutions), United Nations High Commissioner for Refugees, Geneva, Switzerland

S. J. Song (✉)
Department of Psychiatry, George Washington University, Washington, DC, USA
e-mail: suzan.song@post.harvard.edu

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However, while the concept of PTSD has become widely accepted in refugee mental health care in "resettlement countries," concerns remain to be voiced around the overtly strong focus on treating *symptoms in the individual* rather than using systemic approaches that expand the focus from the individual to that of *the family and community* [30, 43, 51, 57].

Theoretical concepts that get increasing scholarly attention include resilience and the socio-ecological model of refugee mental health and well-being. These concepts are not novel, but attempts to bring these thoughts within mainstream refuge mental health care are relatively recent [58, 65]. Such concepts largely still lack operational translation into evidence-based intervention approaches, although important recent advances are made [6, 22, 23].

Conceptual Debates in Humanitarian Mental Health and Psychosocial Support

Similar debates around trauma-focused versus community-based approaches, and clinical versus socio-ecological approaches, have marred the field of "mental health and psychosocial support" (MHPSS) in humanitarian settings [76]. The field of MHPSS was, and to a large extent remains, theoretically influenced by community- and recovery-focused approaches formulated by social psychologists, social workers, and social scientists [8, 9, 11, 60, 83]. The needs in massive humanitarian crises are often so overwhelming and accompanied by major ruptures in supportive social systems and formal services that strong triage is required. Assistance cannot be solely dependent on specialized clinical mental health workers [55, 56].

Of pivotal importance was the publication of the *Inter-Agency Standing Committee (IASC) Guidelines for Mental Health and Psychosocial Support in Emergency Settings* [33] that led to a (rather fragile) consensus among policy makers and practitioners [1, 74, 84]. A key notion in these guidelines is that interventions need to be situated within a multilayered system that integrates approaches to foster recovery of emergency-affected communities through strengthening social support and rebuilding of community structures with more clinical approaches for those with severe or disabling mental health conditions [81]. The IASC MHPSS guidelines greatly contributed to the consolidation of MHPSS as a field for interventions [31]. The model has been adopted by almost all major humanitarian actors including the World Health Organization, UNICEF, the United Nations High Commissioner for Refugees, and the International Organization for Migration and provides a unifying framework, despite significant differences in programming of these organizations [34, 54, 67, 70, 73]. However, the impact of the IASC Guidelines outside humanitarian emergencies is limited. Many mental health professionals working in refugee mental health are unaware of the guidelines or feel unable to use them clinically, as the guidelines are written for massive humanitarian crises with limited human resources. Not very helpful in this regard is the conspicuous absence of reference to psychological trauma in the IASC guidelines, which has prompted

critique from academic trauma researchers [12, 91]. Issues related to the utility of trauma-focused cognitive behavioral therapies in humanitarian contexts are unresolved and keep provoking heated discussions [47, 48, 75].

The Importance of Socio-ecological Approaches and Public Mental Health

Over the last decades, dozens of edited books about the mental health of refugees and other people affected by armed conflict have been published. Also, there are many books focusing on the mental health of children and young people affected by war. Some early precursors of this book address issues that are remarkably similar to the issues at stake in contemporary refugee mental health, such as the balance of psychosocial and mental health interventions, the importance of social support, the danger of addressing "symptoms" devoid of context [15], and the importance of social work and social policies [85]. A range of important publications in the early 2000s addressed the mental health consequences of collective violence in populations affected by armed conflict and incorporated the mounting critique on the way in which Western psychiatric categories were ascribed to refugee populations, while social, political, and economic factors that play a central role in refugees' experience were ignored [80]. In 2002, Joop de Jong [17] edited a book detailing work of the Transcultural Psychosocial Organization, a nongovernmental organization that he founded. The book details the pioneering approaches in the provision of mental health and psychosocial care for conflict-affected populations. His book does not specifically focus on refugees or children, but makes an important synthesis of the literature in the introduction chapter, placing interventions in a broad global public mental health perspective [16]. In the same period, Miller and Rasco [45] edited an important book that used a socio-ecological perspective in the conceptualization of mental health issues of refugees. It showcased, as in the book of de Jong, examples of how practitioners used such perspectives in their work. The books of de Jong and of Miller and Rasco made important theoretical contributions to the field and have deeply influenced our thinking. Several other books on the mental health of refugees or conflict-affected populations published in the same era either take more critical stances toward conventional paradigms in refugee mental health [8, 32] or use more conventional trauma-focused or clinical approaches [7, 38, 42, 87]. None of those books specifically focused on children, but publications on refugee and war-affected children see a similar oscillation around the same issues. There continues to be a lack of major breakthroughs despite re-emerging attention to the use of socio-ecological models of refugee mental health, incorporating resilience perspectives, considering the importance of daily stressors, and applying long-term perspectives [4, 25, 29, 35, 40, 59, 63, 64]. Overall, within the theory of child refugee mental health care, clinical and socio-ecological perspectives are gradually converging [79], but we have a long way to go to reach integration in programmatic praxis [44].

Why This Book?

We have learned much from the books and articles that we briefly referenced above. So, one could argue, why a new book? We feel the answer is in bringing together a variety of approaches within a single volume that is easily accessible to mental health practitioners. We distinguish five key features that, taken together, we hope gives this book an added value.

Using a Global Perspective

Academic texts often distinguish between child refugees in low- and middle-income countries and those in resettlement settings in high-income countries [24, 52]. There are good reasons to do this. For example, the situation of a South Sudanese child in a refugee camp in northern Uganda differs dramatically from the situation of a resettled South Sudanese refugee child in a country like Sweden: the problems are different. The available resources are different. The social context is different. But what about a South Sudanese refugee who lives for many years in the Egyptian metropolis of Cairo? Or a South Sudanese refugee child in a transit center in Southern Italy? In a globalizing and increasing interdependent world, the sharp distinctions between "here" and "there" are becoming blurred. The refugee in Uganda may well be in close touch with relatives in Egypt, Italy, or Sweden through social media and the Internet. Of more importance than being a refugee in a transit country or having arrived as an asylum seeker in a host country is the context in which children live. For example, keeping children in immigration detention leads to poorer mental health outcomes [18, 27, 39, 49, 53].

Borders are becoming blurred and porous, despite desperate attempts of governments to erect walls and fences. This book therefore chooses a global perspective: in all chapters the authors attempt to provide information that is useful *across settings* without sharply dividing the world simplistically into "low- and middle-income" or "pre-migration" on one side and "high-income countries" or "resettlement countries" on the other.

Blending Research Findings with Clinical Wisdom

Research into refugee mental health is booming. As described above, there are many systematic reviews on a range of relevant research topics such as mental health epidemiology and therapeutic interventions [24, 41, 50, 52]. These data are tremendously important and exciting, albeit sometimes written in rather dense and scholarly manners. There are also publications such as manuals, to assist clinicians in providing mental health care for child refugees [13, 19, 88, 89]. There are also practitioner reviews that provide a synthesis of key clinical issues to practitioners

[20, 37, 78] and policy- oriented programmatic guidance for work in humanitarian contexts [2, 33, 62]. In the current book, we aim to blend all these perspectives into a cocktail with many different ingredients that is easily digestible and, as we hope, gives the reader a taste for more.

Linking Treatment of the Individual with the Context of Family, Community, and Society

Mental health treatment is more than what happens between the walls of a consultation room and can also include activities within communities, schools, and people's homes. In humanitarian settings, MHPSS programs are often broadly conceptualized to include activities that can be done by nonspecialists in nonclinical settings [77]. The field of humanitarian MHPSS has developed strong intersectoral ways of working that we feel could be useful for high-income settings as well, particularly where refugee mental health in high-income settings is often dominated by trauma-focused approaches.

Considering a Range of Clinical Issues

A popular but erroneous assumption is that psychopathology of refugees is necessarily related to having experienced traumatic events and that the clinical issues are mainly related to psychological trauma. Another common erroneous assumption is that traumatic events predominantly occur in the country of origin. In our clinical experiences, refugee children struggle as much with issues that happened during the perilous journey to safety and after having arrived in presumably safe countries. Without a doubt, the horrific events that a sizeable group of refugee children went through have an important impact on their mental state. But other psychopathology is caused by, or mediated through, the current context in which refugee children live – often characterized by instability, socioeconomic hardships, marginalization, and loss of agency.

Therefore, refugee mental health should not be seen as a subsection of psychotraumatology. The whole spectrum of mental health conditions is relevant to refugees. The World Health Organization estimates that around 22% of adult populations exposed to collective violence develop clinically relevant mental health conditions [14]. Prevalence rates of PTSD but also of other anxiety disorders, depression, complicated grief disorder, and psychotic disorders increase significantly. These data are for adults, but we have no reason to believe the picture will be dramatically different for conflict-affected children. Therefore, we felt it was important to integrate information on a wide range of mental health issues such as grief, depression, anxiety disorders, severe mental disorders, substance use disorders, and developmental disabilities.

Making the Text Accessible for Nonspecialists

Regularly, we are approached by clinicians and aspiring researchers in the field who would like to get involved in working with refugee children. We feel that many of the extant literature is not very accessible to them because of the length of texts and the specialized focus of many. We felt an introductory text was needed that could provide readers who are relatively new to the subject a concise overview of the state of the art, without discussing topics so much in depth that readers would lose attention. The current book aims to synthesize current knowledge and good practices on the topic in a way that does not yet exist, as far as we know. What we had in mind is the kind of book that we wished we could have read when we started our work with child refugee mental health.

Defining the Core Concepts

What Is a Refugee?

An unprecedented 70.8 million people around the world are forcibly displaced from their homes due to armed conflict and situations of generalized violence [71]. Half of the 25.9 million refugees are under the age of 18 years old, making mental health of refugee children a major and growing public health problem.

Refugees are defined as persons who have been forced to leave their country to escape war, violence, conflict, or persecution and have crossed an international border to find safety in another country. The 1951 Refugee Convention is a major international legal document that defines a refugee as: "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" [68]. It is sometimes assumed that all refugees have fled war. However, people can also become refugees because they are political activists, have experienced sexual and gender-based violence, or were persecuted due to religion or sexual orientation. An asylum seeker is someone who requests international protection, but whose application still has to be processed. An internally displaced person is someone who is forcibly displaced within the borders of their country. This book focuses on refugees, asylum seekers, and internally displaced persons but not on migrants (i.e., persons who voluntarily cross borders in search for employment or education).

Many refugee children flee together with their parents, but others arrive as unaccompanied or separated children (UASC). "Separated children" are separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. They may be accompanied by other adult family members. "Unaccompanied children" are separated from both parents and other relatives and, as consequence, are not cared for by an adult who, by law or by custom, is responsible for their care [72].

What Is a Child?

As explained in Chaps. 1 and 2 of this book, the definitions of who is considered a child and who is an adult vary considerably. In this book we use the United Nations definitions of childhood (see Box 1.1) for reasons of consistency within the text. The children and adults with whom we work may have different definitions, highlighting the notion that childhood is a cultural construct that has different meanings based on context and environment.

Box 1.1 Definition of Childhood Terms

Children	0–18 years old
Adolescents	10–19 years old
Youth	15–24 years old

Sources: [66, 69]

What Is the Migration Trajectory of a Refugee?

Just as the reasons for becoming a refugee are varied, so are their experiences of the journey to safety. Often the refugee trajectory is defined as a linear process of premigration (the baseline situation at home that is disturbed by violence or other causes), migration (flight from the home country to a new country, with transitory stays in a refugee camp), and resettlement. The trajectory of many refugees is, however, less straightforward, much more complex, and often nonlinear. First, only a minority of refugees ever get resettled in a third country. Many others stay for long periods in refugee camps, informal settlements, or in rented settlements in urban settings, therefore being a refugee or asylum seeker for years or decades. Resettlement is only one of the solutions, the others being local integration, or return to the country of origin when conditions have improved. The experience of many refugees includes multiple migrations and, sometimes, long-term detention by governments, such as happens with "offshore detention" of asylum seekers arriving by sea in Australia, or by smuggler, traffickers, and armed groups such as happens in the Sahara and Northern Africa. Another misconception is that the transitory phase of refugee is mostly through stays in refugee camps. In reality, most refugees live in urban settings or integrated in rural communities.

What Is Trauma?

There is a popular notion that all refugees are "traumatized" and victimized based on their experiences in their home country. Disorders such as PTSD, depression, and anxiety have shown to be high in this population, though with extremely variable prevalence rates and few longitudinal understandings of the mental health process

over time. These disorders fail to encapsulate the acculturation stress, cultural bereavement, traumatic loss, despair, and hopelessness that people may experience, as well as the loss of social and cultural connectedness and a sense of belonging. The term "traumatized" or "victim" can be disempowering and stigmatizing for the child and family that have been exposed to potentially traumatic events. We therefore prefer the term "traumatic" as an adjective above "trauma" as a noun. Exposure to potentially traumatic events may lead to response that can be called "traumatic" in one child, but not in another. Moreover, the focus on potentially traumatic experiences that lead to refugee status may overlook and undervalue the importance of the attrition stressors that affect the mental health for the refugee child. Such stressors related to uncertainty about the future, legal status, loved ones, as well as discrimination, acculturative stress, and ambiguous loss of loved ones, play a large role in the development and maintenance of poor mental health for refugee children.

How This Book Is Organized

The book is set up in four main parts to provide a comprehensive approach to the understanding of child, adolescent, and family refugee mental health. The first part provides an overview of concepts that are fundamental to the care of child and adolescent refugees through a research and public health lens. Bennouna, Stark, and Wessells describe the population of refugee and war-affected youth from a socioecological framework. While multiple academic fields have agreed on the importance of the sociocultural context in the pathways to poor child and adolescent mental health, Reis, Crone, and Berckmoes critically examine how to unpack "context" and "culture" for refugee youth. Understanding how both context and culture can be used to support resilience in refugee youth and families can be useful in both practice and policy. Vindevogel and Verelst describe the use of a resilience framework for refugee youth in a humanitarian context. Since the strongest evidence for promoting the mental well-being of war-affected youth is on family-level variables, understanding the role of family as both sources of support and strain can be critical when working with refugee youth and families [63, 64].

The second section of the book shifts from academic and humanitarian public mental health approaches to integrating clinical, practical guidance on important principles to consider in the mental health assessment of refugee children, adolescents, and families. Song and Ventevogel and Song and Oakley use their clinical expertise to provide clinical guidance for practitioners. As many clinicians are working in humanitarian contexts, we also asked Snider and Hijazi to discuss the UNICEF operational guidelines on how to support community-based mental health and psychosocial support that can be scaled up based on current evidence for the implementation of programs in humanitarian settings.

The third part of the book discusses symptom clusters commonly seen in refugee children and adolescents. We are grateful to have seasoned clinicians that can discuss nuanced issues with this population. Jones uses her breadth of clinical care in humanitarian settings to help practitioners engage with grief and loss with refugee

children and families; Rousseau and Gagnon discuss not only how to understand but also how to address the impact of stress and traumatic events on children; and Ventevogel and de Jong highlight the depression and despair that some youth and families may experience in their chapter on emotional disorders in refugee children. We also include chapters on topics that have a growing body of clinical research and are in dire need of clinical intervention. Greene and Kane provide a review of substance abuse in conflict-affected children. Cavallera, Nasir, and Munir give a practical guide to the assessment and management of children with developmental disabilities, particularly in humanitarian settings, and Liu and Chowdhary discuss severe mental illness and neuropsychiatric disorders among refugee children.

The fourth part of the book integrates the theory, research, and clinical approaches to provide practical examples of how to use a family- and strengths-based approach toward the assessment and care of mental health problems for refugee children. Dybdal describes an intervention by Save the Children in Denmark that enhances resilience in unaccompanied young men. Mooren, Bala, and Van der Meulen underscore the need for family-centered approaches with refugee youth and ways to engage family in humanitarian contexts; and Frounfelker, Mishra, Gautam, Berent, Abdi, and Betancourt are exemplary in their collaboration between researchers and community members in using family-centered approaches for child refugee populations.

What This Book Hopes to Accomplish

We hope this text will provide practical, clinical guidance on how to assess and manage mental health conditions in refugee children/adolescents and their families. Our wish is to introduce clinicians to new ways of thinking that combine the insights of a strengths-based and resiliency approaches and family-centered approaches with practical guidance for clinicians of various skill levels. We equally hope to remind researchers and policy makers of the clinical realities in working with refugee children. Finally, we hope that the book can contribute to a further advancement of the field of child refugee mental health care as it is our strong conviction that humanitarian workers, mental health clinicians, and researchers alike can benefit from using a framework that incorporates clinical approaches to mental health problems with notions of resilience, family-centered care, and awareness of context and culture.

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