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Refugee children are generally considered to be at high risk for mental health problems because of the extreme stressors they experience in the pre- and post-migration periods. This paper summarizes current knowledge on the manifestations of emotional disorder among refugee children and on the associated risk and protective factors. Special attention is given to the interaction of culture with the specific family, social and cultural context of refugee children. Intervention and prevention services, as well as the implementation of community programs, are discussed.

Introduction

Wars are not a thing of the past. On the contrary, since the two world wars in the first half of this century, there has been a rise in the number of regional wars and internal armed conflicts, described as low-intensity wars. These conflicts have perpetuated and even increased the movements of refugee populations who, fleeing war, have gathered in bordering countries or embarked upon a long exodus toward Western countries.

Children make up half of the world's refugee population. Though they are of diverse cultural and social origins, all have left their home country involuntarily, and for many, the experience was marked by violence. This shared past, which often includes a difficult migration complicated by isolation and poverty, has led researchers increasingly to recognize refugee children as a group at particularly high risk for mental health problems (Eisenbruch, 1988; Williams & Berry, 1991).

Refugee children, like other immigrant children, must cope with cultural uprooting as well as numerous separations. As is the case with ordinary immigrants, the family plays a key role in the child's psychological adaptation to his or her new surroundings. However, given pre-migration conditions, which are frequently traumatic due to war or armed conflict in the home country, and a post-migration climate of uncertainty and instability, the refugee experience is unique in a number of ways.

The purpose of this article is to summarize the knowledge currently available on the subject of refugee children, to present the underlying issues and debates in this field of intervention, and to point out gaps in the existing body of research. The first section will consider the symptomatology of refugee children, taking into account both emotional disturbances and learning difficulties. This section will also examine the question of detecting these problems clinically as well as in the school setting. The second section will consider the risk and protective factors that appear to be particularly significant to refugee children. The presentation will distinguish among factors related to pre-migration circumstances, family and acculturation, noting the influence of the life cycle on each type of factor. The third section will examine the questions associated with the development of intervention and prevention services as well as the implementation of community programs. Finally, the concluding section will discuss some issues of research methodology in this area.

SYMPTOMATOLOGY OF REFUGEE CHILDREN

The literature on refugee children reports a wide range of symptoms: anxiety, recurring nightmares, insomnia, secondary enuresis, introversion, anxiety and depressive symptoms, relationship problems, behavioral problems, academic difficulties, anorexia, and somatic problems (Allodi, 1980; Arroyo & Eth, 1985; Cohn, Holzer, Koch & Severin, 1980; Gibson, 1989; Hjern, Angel & Höjer, 1991; Kinzie, Sack, Angell, Manson & Roth, 1986; 1989; Krener & Sabin, 1985; Williams & Westermeyer, 1983). Heightened separation anxiety and regressive behaviors have also been noted.

These symptoms can be grouped in two ways: either by taking a diagnostic approach that makes use of classification categories like those of the DSM-IV (American Psychiatric Press, 1994), or by adopting a multidimensional approach emphasizing descriptive categories.

FOR OR AGAINST DIAGNOSES

When the emphasis is placed on diagnosis, a certain number of refugee children meet the diagnostic criteria for post-traumatic stress disorder (PTSD), adjustment disorders or, as in the general population, other psychiatric diagnoses (Westermeyer, 1991). The advantages

of this approach are that it can detect, more specifically, serious problems that could benefit from therapy and provide indicators for differentiating between biologically based disorders and other problems (Espino, 1991; Kinzie et al., 1986, 1989; Ornitz & Pynoos, 1989; Sack, Clarke, Him, Dickason, Goff, Lanham & Kinzie, 1993; Sack, McSharry, Clarke, Kinney, Seeley & Lewinsohn, 1994).

Supporters of such an approach hold that school-age and even preschool-age children can suffer from post-traumatic reactions similar to those observed in adults, and that these may persist for months or even years (Udwin, 1993). Given the extent of traumatic experiences among children who have lived through war, these authors stress the importance of recognizing and giving these problems specific names (Bürgin, 1993).

This position is, however, far from being unanimously accepted. Certain authors, without rejecting the possible usefulness of a diagnostic classification, and in particular PTSD, emphasize the limitations of this type of approach, which does not account for all the effects of war on children (Jensen & Shaw, 1993). Indeed, war or armed conflict experienced by refugee children during the pre-migration period may lead to a disintegration of the social and cultural fabric and chronic deprivation, the consequences of which cannot be measured using diagnostic categories. Kestenberg (1993b) points out that a diagnosis of PTSD stresses the common characteristics of different groups of children, which could lead to less recognition not only of the diversity of symptoms exhibited by these populations, but of the link between these symptoms and specific contexts.

The question of whether a diagnosis of PTSD is culturally appropriate has also been raised in several recent papers. Rechtman (1992) states that there are risks involved in assigning "visits by spirits" experienced by Cambodian patients too quickly to the symptom category of nightmares. He stresses that patients do not report these nocturnal visits as pathological, but on the contrary, as normal in the circumstances surrounding the death of those who "come back," particularly when there has been no proper funeral. In this type of situation, labeling symptoms pathogenic by diagnosing PTSD could hinder the cultural problem-solving process (Kleinman & Good, 1985).

Other authors are much more critical of the diagnostic approach. Adam and Riedesser (1993), for example, assert that refugee children

should not be considered to be ill, but should be viewed as reacting normally to a severely stressful situation that produces psychological suffering. Richman (1993), in an effort to systematize criticism of a PTSD-centered approach, notes that the diagnostic approach results in the medicalization and oversimplification of the complex psychological reactions that surround a violent experience; aspects as essential as the meaning attributed to the war-related events are thus left in the shadows. In her opinion, diagnoses place children in a position where they are treated as passive objects of social conditions rather than viewed as playing a central role in organizing their experiences according to personal and collective representations (Baker, 1990; Punamaki & Suleiman, 1990).

Becker and his colleagues (1990) go so far as to declare that the use of psychiatric diagnoses, which label refugees with a "dis/order," mirrors the position of repressive powers, which justify their actions based on the claim that their victims are outside of the established order due to their racial, religious, or ethnic origins. They suggest that psychological and psychiatric therapy may occasionally become traumatic events by refocusing on the person as the origin of the problem instead of addressing the pathology within its social reality (Lykes & Farina, 1992).

Presenting Symptoms: Culture or Context

Another trend in the literature on refugee children supports a more descriptive approach to symptomatology, or interprets data descriptively in addition to encoding them in a diagnosis. Such an approach, which highlights the various ways that emotional problems are manifested, can be useful in the development of a strategy for detecting problems, as it favors the identification of clusters of symptoms that may be specific to a certain culture or context.

The literature reveals that there is far from unanimous agreement on the dominant characteristics of the symptom profile of refugee children. In fact, there are two conflicting schools of thought in the literature on young victims of war or armed conflict, regardless of whether they are refugees. One school approaches the question of symptomatology among children who have experienced war situations as part of a more general interest in the transmission of violent behavior. Some authors thus hold that war situations can generate

antisocial and delinquent behavior (Jensen et al., 1993). Study of this question, which dates back to the Second World War (Alcock, 1941; Lyons, 1979) has not, however, managed to provide evidence of a simple linear relationship between war situations and antisocial behavior in children. The focus of research on the social transmission of violence has since moved toward issues more concerned with children's level of social awareness, values and attitudes, as well as those of their surroundings (Jensen et al., 1993).

The other school of thought, with less of an underlying theory, reports a preponderance of internalized, anxiety, and depressive symptoms in refugee children who were highly exposed to war situations (Kinzie et al., 1986, 1989; Krupinski & Burrows, 1986; Rousseau, Corin & Renaud, 1989). The work of Kinzie and colleagues (1986, 1989) and Sack and colleagues (1993, 1994) describes the predominance of internalized symptoms among Cambodian refugee children and adolescents. The authors emphasize the differences between American children subjected to a significant stressor, whose symptomatology consists of behavior problems with acting out, and Cambodian children, who tend to internalize their problems. The latter exhibit avoidance behavior, minimizing symptoms and their social consequences. Considerable isolation and a feeling of subjective suffering thus dominate the symptom profile. According to Kinzie and Sack and their colleagues, these avoidance behaviors should be interpreted as a function of traditional Cambodian values, which tolerate little externalization of conflict in the form of behavior problems.

These observations support the findings of a study carried out by Weisz and colleagues (1989, 1987), which compared American children with non-refugee Thai children living in the United States. Weisz and colleagues note that the Thai children presented more internalized problems, indicating (according to the authors) the Thai children's willingness to control their emotions in accordance with their traditional Buddhist values. The American children, on the other hand, tended to externalize their feelings, displaying loss of control.

Studies conducted across radically different cultures and contexts have yielded similar symptom profiles among children subjected to the effects of disasters resulting from human activity. For example, in a study of children of Holocaust survivors whose parents were refugees, Axelrod and colleagues (1980) discovered a strong tendency to

internalize which these authors linked specifically to Jewish culture. However, a slight predominance of internalized symptoms was also found among Central American refugee children by Rousseau, Drapeau & Corin (1993a; Rousseau et al., 1989). It is hard to imagine that the cultural characteristics of emotional expression for Hispanic Central Americans could be responsible for their manifesting their emotional problems in this way.

The predominance of an internalizing symptomatology among groups of children from such different cultures calls into question the hypothesis that culture has a dominant influence on the presentation of emotional problems. On the other hand, these different populations of children have all experienced significant pre-migration trauma, characterized by an extraordinary amount of stress—whether in the case of the Pol Pot regime, the Holocaust, or conflicts in Latin America, the threat of extermination is involved, in reality as well as fantasy. It is therefore possible that the predominance of internalizing symptoms among refugee children is related to the particular context of acute stress generated by war and armed conflicts (Rousseau, 1993a).

LEARNING DIFFICULTIES

Among groups of children who have experienced acute stress, learning difficulties may be one of the most easily detectable signs of emotional problems. Despite this, the literature on learning difficulties among refugee children is scanty. Difficulties in learning are usually considered as just one aspect of the refugee child's symptom profile.

Several studies suggest the importance of the relationship between learning difficulties and emotional problems in refugee children. Most of these studies, however, rely either on small samples of refugee children referred to psychiatric clinics or on case histories, making it difficult to generalize from their findings. In a clinical study of 21 Southeast Asian refugee children referred to a children's psychiatric clinic by their schools or family doctors, Krener and Sabin (1985) found four main reasons for consultation: behavior problems (44%), learning difficulties (38%), somatic problems (22%), and depressive symptoms (17%). In a descriptive study of 28 adolescent refugees, Williams and Westermeyer (1983) noted that suicide attempts, disruptive behavior, problems at school, and psychosis are the most frequent reasons for consultation.

From these studies, it appears that for some groups of refugee children, learning difficulties are one of the main reasons for consultation or referral to mental health services, and that the school plays a central role in the referral process. A study of 156 refugee children from Central America and Southeast Asia revealed that, despite comparable academic performance, schools identified more learning difficulties in the Central American children (Rousseau, Drapeau & Corin, 1993b). Even though the Central American children presented with more internalized problems, it was their behavior—more extroverted, and in particular, more hyperactive than that of their Asian peers—that seemed to lead their teachers to perceive them as being more disruptive. Since teachers have mainly pedagogical solutions available, they tend to classify these students as having problems in learning. We may therefore wonder to what extent cultural differences in the way emotional problems are manifested influence the perception of these problems by the school, whether in making referrals or attributing learning difficulties to children, both of which can have a serious impact on their future.

Some authors claim that the academic performance of refugee children is directly affected by aspects of their pre- and post-migration experience (Irwin & Madden, 1985), although there is no universal agreement regarding the impact of the migration process or trauma on the children's ability to learn (Rumbaut, 1991; Sack, Richard, Kinzie & Roth-Ber, 1986; Terr, 1983). Among Cambodian children who had undergone major trauma, Sack and colleagues (1986) noted symptoms mostly in the depressive range, such as emotional withdrawal or daydreaming, with no effect on the children's academic performance. These apparent contradictions in the literature suggest that other factors affect the impact of the refugee experience on academic performance. The interaction between characteristics of the refugee child's experience and culture may be particularly important in explaining this variation. The methods used to measure learning difficulties may also contribute to these contradictions. For example, based on data on the English-language performance of adolescent Khmer refugees, Clarke and colleagues (1993b) noted the inappropriateness of standardized tests, which clearly underrated their intellectual abilities. These authors pointed out the need for system-

atic studies of learning issues that also address the biases of traditional assessment instruments.

RISK & PROTECTIVE FACTORS FOR REFUGEE CHILDREN

A refugee's situation is special in that it encompasses the acculturation-related difficulties inherent in all migration, particular stresses related to the war experienced in the home country and the actual experience of being a refugee.

This experience of becoming a refugee—before, during and after migration—has a double impact on the child: on the one hand, situations and events may directly affect the child by causing trauma, losses, and so on; on the other hand, the same circumstances may affect the child indirectly by upsetting the family and social structure. In the sections that follow, I will discuss risk and protective factors that may affect refugee children and adolescents. Some authors prefer an approach to risk and protective factors that clearly distinguishes between the two. Rutter (1987) questions this approach, asking whether it introduces anything more than a semantic distinction. He argues that it would be better to examine the mechanisms that generate risk or protection rather than a static list of factors. These mechanisms vary from one culture or context to another. For example, in some cases, acculturation may be a protective factor (Berry, Trimble & Olmedo, 1986), while in others it may essentially be a risk factor (Eisenbruch, 1988). I have therefore decided not to review risk and protective factors separately but to approach the issue by considering the three main types of factors that generate risk or protection for refugees: those associated with migration, the family and acculturation (Lee, 1988).

FACTORS ASSOCIATED WITH MIGRATION

The circumstances and process of migration itself present a wide range of risk and protective factors for refugee children.

Traumatic Pre-migration & Post-migration History

The situation of war or armed conflict during the pre-migration period is, without question, the most frequently mentioned risk factor in the literature (Arroyo et al., 1985; Espino, 1991; Garmezy & Rutter, 1985; Malakoff, 1994; Melville & Lykes, 1992). The trauma can

be direct and severe, as in the case of children in Nazi concentration camps or in Pol Pot's camps (Freud & Burlingham, 1944; Kinzie et al., 1986, 1989); more often, however, the children seem to react more to the anxiety expressed by their parents or to separation from people who are important to them (Garmezy et al., 1985). In fact, although we discuss the issues of trauma and the impact of separation separately in this paper, this distinction is largely artificial, since separation from parents places many refugee children in a situation where their lives are in danger (Sack et al., 1994) and since separation itself is frequently traumatic owing to the violent circumstances in which it occurs. Among the other potentially traumatic aspects of migration are difficulties faced during the journey out of the home country, and fear and uncertainty with respect to the future (Ganesan, Fine & Yilin, 1989).

The short-term consequences of trauma have been well described (Allodi, 1980; Cohn et al., 1980). In Montreal, an exploratory study of Latin American refugee children who had recently arrived in Canada found a significant link between the severity of war-related trauma and the presence of anxiety and depressive symptoms (Rousseau et al., 1989). Long-term consequences, however, have not been well established. Some authors maintain that psychic trauma frequently persists, regardless of the child's age at the time of the trauma (Dreman & Cohen, 1990). On the basis of clinical and research experience with Cambodian adolescents, Kinzie and colleagues (1991) state that trauma deeply affects their development for a long time, and contributes to a fluctuating symptom profile of depression and PTSD, without, however, being expressed in the form of antisocial behavior. In contrast, other research stresses that, with time, both adult and child refugees become ordinary immigrants, as the traumatic experiences of the past give way to the concerns of the present (Rumbaut, 1991). In a longitudinal study of Indochinese refugees, Krupinski and Burrows (1986) found that traumatic events experienced in the home country did not appear to be related to the emotional problems of adolescents and young adults, whereas they did have a significant impact on children. The high rate of attrition of subjects in this study, however, makes interpretation difficult.

Taking a cross-cultural perspective, Rousseau and colleagues (1993a) compared 156 Central American and Southeast Asian refu-

gee children who had been in Canada for at least two years (on average, five years). The severity of trauma experienced by the families, occurring before and after the birth of the child, accounted for a significant proportion of both internalized and externalized symptoms in the Central American children. Among the Southeast Asian children, whose families had experienced comparable traumatic events but who were less directly exposed, trauma did not appear to be significantly related to emotional problems (Rousseau, 1993b). These findings confirm the importance of the degree to which children are directly exposed to war, which is often defined in terms of geographic proximity (Jensen et al., 1993), and suggest that social and cultural context influence familial transmission of psychic trauma. This may partially explain the differences observed in the persistence of trauma as a risk factor for refugee children.

On the whole, longitudinal studies that examine the long-term consequences of traumatic pre-migration events focus on whether on the effects of trauma persist or diminish over time, and emphasize the role of the characteristics of the trauma. Despite methodological weaknesses in some of these studies, the contradictory findings suggest that attention should shift toward investigating the role of specific psychosocial factors other than trauma which, in interaction with cultural variables, may be associated with the relative severity of the long-term effects of trauma.

The research literature addresses two groups of factors that can exacerbate or attenuate the consequences of trauma: family and community. In some cross-cultural studies, a good relationship with parents prior to the traumatic events and the presence of a community to provide support and role models for children appear to act as protective factors in this type of extreme situation (Garmezy & Rutter, 1983, 1985; Tsoi, Gabriel & Felice, 1986).

It has been suggested that the culture of origin may also modify the impact of trauma by influencing the significance attached to it. For example, in keeping with the convention adopted by Amnesty International, quotation marks are used to refer to people in Central and South America who have "disappeared," in order to imply that the powers that be have caused the "disappearance" to create fear, uncertainty, and social paralysis. These "disappearances" often have a connotation of torture and execution in Central and South America.

In Cambodia, many people disappeared while the Khmer Rouge were in power, due to massacres and families being torn apart, but these disappearances, though difficult to cope with, were not necessarily associated with the idea of prolonged suffering of those who had disappeared. From a different perspective, in analyzing the Latin and Khmer etymologies of the words for torture, Mollica (1988) notes that the Latin *torquere* means to cause harm to someone, implying exterior causality, whereas the Khmer *karma tierun* contains the root word *karma*, indicating a relationship between the person's suffering and destiny. Similarly, the personal, family and community meaning assigned to rape, which is very common in wartime, also varies from culture to culture (Lefley, Scott, Llabre & Hicks, 1993).

Recent studies that attach special importance to the cultural aspect of the refugee experience point out that the process of acculturation is a factor that, depending on its characteristics, can also moderate the effect of trauma. Melville and Lykes (1992) report that exile, while considerably diminishing the immediate fears of Guatemalan Indian children, also appears to make them more vulnerable by potentially cutting them off from their ethnic identity. In a study of two groups of adolescents, unaccompanied minors who fled Southeast Asia to the United States or to Australia, Eisenbruch (1990) found that those who went to Australia showed fewer symptoms than did their peers in the United States. According to Eisenbruch, in Australia there is less pressure to acculturate and there are more traditional resources available, such as *kru khmer* (healers), Buddhist monks and rituals—which may explain the difference in their adjustment.

It is important to point out that while some features of the acculturation process may influence integration of the traumatic experience, other authors (Clarke, Sack & Goff, 1993a) show that traumatic experiences and the symptoms associated with them also influence the degree of distress felt while getting settled in the host country. It is therefore possible that there is a two-way relationship between trauma and the stress of acculturation.

Separation

Separation has been identified as one of the key elements of the process of migration; this is particularly true when people flee the country as a result of armed conflict, as separation is an everyday reality of war. Many authors highlight the importance of separation to

refugee children (Arroyo et al., 1985; Barudy, 1989; Carlin, 1979; Charron & Ness, 1981; Ganesan et al., 1989; Krener et al., 1985). In the literature, depression, anxiety and problems of adjustment are generally the best-known consequences of this type of separation, among adults as well as children. In children, learning difficulties and heightened separation anxiety are also evident (Krener et al., 1985).

In another report on the study of 156 refugee children mentioned earlier (Rousseau, 1993b), the authors investigated the effects of separation as a function of five key factors: the child's stage of development at the time of the separation, the length and number of separations, the relationship between the child and the person from whom he or she was separated, and the cause of the separation. The data suggest that separations have a significant impact on children's emotional and learning difficulties. The significance of the factors and associated symptoms varied, however, with the child's culture (Central American or Southeast Asian). Among Central American children, separation from parental figures was strongly associated with learning difficulties, whereas for the Southeast Asian children, separation from parental figures was associated with internalized symptoms. As well, separation from attachment figures, which was very important in the case of the Central American children, was not important for the Southeast Asians. Separation, then, while remaining a key factor in the mental health of refugee children, does not always evoke the same response in this population; its consequences are moderated by interaction with the child's culture.

The influence of adolescence on the impact of separation appears to manifest itself at two levels: for one thing, the psychological processes associated with adolescence may reactivate past separations, and for another, the symptoms associated with separation are different. Tobin and Friedman (1984) describe adolescence as a second period of individuation and separation, during which the experiences of the first years of life are reworked and consolidated. In their opinion, the separation and individuation of adolescence is more difficult for adolescent refugees who have had to face repeated separations from their family. The adolescent's gradually increasing independence may cause him or her to reexperience painful separations of the past, especially if he or she or the family suffered major trauma (Lee, 1988). Other research suggests that the emotional difficulties associated with sepa-

ration may, in certain cases, take on new characteristics during adolescence. Based on clinical cases, Kinzie and colleagues (1991) describe antisocial behavior in Cambodian adolescents and young adults who, because of the war, had lost their primary attachment figure; they were raised by substitute parents or separated from their parents before they were two years old, for example. Given that this type of symptom is uncommon in this population, these authors suggest that more in-depth study of the long-term manifestations of such losses in childhood is needed. These findings are consistent with the observations of Burke (1982), who, in a study of a West Indian immigrant population, reported that delinquent behavior among adolescents was associated with separations from parental figures in early childhood or adolescence.

The long-term impact of separations in childhood has been established a number of times in the general psychiatric literature (Brown, Tirril & Bifulco, 1986). The only existing longitudinal study on the subject involving adolescent refugees (Krupinski et al., 1986) indicates that separation from the family has a major impact during the first year of being a refugee, but that, after that point, this type of separation no longer has a significant influence on psychological problems. Krupinski and Burrows do not, however, take into account separations in early childhood. In a study of Southeast Asian adults, Rumbaut (1991) observed a similar phenomenon: the effect of separation disappears over time.

As is the case with trauma, disparities exist in what is known about how the impact of separation persists or diminishes over the long term, both among refugees in general and adolescents in particular. Apparent discrepancies or contradictions between studies can be explained by the fact that studies have measured different types of separation (Williams, 1991; e.g., from attachment figures in adolescence or adulthood, or from parental figures in early childhood) and by cultural variability in the response to separation. This variability may be a function of the meaning associated with separations or the availability of substitute figures, depending on the context.

Unaccompanied Refugee Children

Unaccompanied refugee children have traditionally been considered to be at higher risk for mental health problems than those who are

accompanied (Ressler, Boothby & Steinbock, 1988). This claim is based on the recognition of the extreme nature of the stressors endured by these children: loss of significant relationships, loss of a familiar environment and trauma of varying degrees of severity associated with the war or conflict in their home country, as well as with migration itself.

Most research on the mental health of unaccompanied refugee children focuses on groups of children and adolescents only a minority of whom were separated from all parental figures (Do-Lam, 1988; Kinzie et al., 1986; Looney, Rahe, Harding, Ward & Liu, 1979; Sack et al., 1986); very few studies focus specifically on unaccompanied refugee children (Ressler et al., 1988).

There is a consensus in the literature regarding the severity and acute nature of the symptoms displayed by unaccompanied refugee children. Many authors report an increased incidence of depression, behavioral problems and somatization among young unaccompanied refugees, highlighting the significance of suicides and transitory psychotic episodes (Charron et al., 1981; Looney et al., 1979; Pask & Jayne, 1984; Rahe, Looney & Ward, 1978; Ressler et al., 1988).

The majority of unaccompanied refugee children referred to in the literature are male adolescents. The overrepresentation of boys reflects the fact that this particular refugee experience is not the result of chance: either the family or the adolescent makes a choice, the goal of which is frequently to remove boys from a war situation where they are perceived to be in particular danger, or to send abroad those children who seem most capable of preparing for the future by supporting the family financially. Pask and Jayne (1984) and Do-Lam (1988) underscore the burden that the family's expectations place on these adolescents.

According to the literature, it is the interaction between traumatic experiences and multiple separations that increases the mental health risk to unaccompanied youth (Ressler et al., 1988). Eth and Pynoos (1985) state that children are particularly vulnerable to the burden of grieving combined with integration of the traumatic experience. The necessity of relieving the anxiety brought on by the trauma may complicate the grieving process and may considerably increase the possibility of pathological grief. In the case of unaccompanied children, this grief is not only for the loss, permanent or temporary, of

family and friends, but also for the loss of all the child's cultural references. Based on the premise that major separations experienced in this context are always cause for extreme grief, observations, mainly of young Asians, have been generalized to all unaccompanied youth. The validity of this generalization is questionable where certain cultures are concerned. Foe example, a significant number of separations are regular occurrences in nomadic societies—a situation that would be considered traumatic in many sedentary societies (Saladin d'Anglure, 1988).

Adaptive strategies used by young refugees to cope with these major losses are structured around specific acculturation processes (Camilleri, 1973), with the goal of lessening potential tension and striking a balance between the demands of external reality and the need to establish continuity with an internalized past. Do-Lam (1988) emphasizes that these strategies are based on behavioral models in keeping with the values of the culture of origin, permitting a strengthening of identity. The need to retain a link with the past may help to explain the results of numerous studies, which have demonstrated that the prognosis for adjustment and the mental health of unaccompanied children is better when they are placed in foster families of the same ethnic group (Linowitz & Boothby, 1988; Pask et al., 1984).

Factors Associated with the Family

Fleeing one's country and immigrating cause an upheaval of the entire family environment; the family is subjected to stress, which can reinforce, change, or destroy the family structure (Sluzki, 1979) either by changing the composition of its members or by destabilizing the family dynamics. We will first look at the factors that generally have an effect on children, whether positive or negative: parental characteristics and family structure. Then we will consider intergenerational conflicts, particularly those associated with adolescence, which have a number of specific characteristics where refugees are concerned.

Parental Characteristics

There is no doubt as to the importance of the presence of a parental figure in buffering the effects of flight and resettlement. Among Cambodian children who lived through Pol Pot's camps, Kinzie and

colleagues (1986) note the protective effect of reestablishing contact with at least one family member.

The day to day availability or unavailability of parental figures also seems to play a crucial role. Refugee parents may frequently be physically unavailable because their difficult economic situation forces both of them to work long hours, or they may be psychologically unavailable. Sigal and colleagues (1973) showed that in families of Holocaust survivors, the parents' extreme preoccupation made them emotionally unavailable and was associated with higher levels of symptoms in their children. Parental depression and anxiety, secondary to a traumatic pre-migration situation or to post-migration difficulties, are often associated with more serious symptoms in the children (Meijer, 1985).

Family Structure & Characteristics

In the case of refugees, even more than with ordinary immigrants, the family structure is liable to be torn apart through separations and reunions, which modify the family dynamics and the roles of each family member (Barudy, 1989; Gilad, 1990; Williams et al., 1991). The immigration policies of Western countries have an effect on family reunification. The very long administrative delays create a climate of uncertainty, which plays a part in the weakening of family ties (Sussman & Settles, 1993).

A supportive family environment is one of three protective factors that Garmezy (1983) defines in a review of the literature on children exposed to significant stress, such as separation or war (see also: Garmezy & Rutter, 1985). A certain degree of cohesion and a limited amount of conflict seem to be conditions of this support. Garmezy's (1983) detailed review of the issue indicates that family characteristics can play an essential protective role, before, as well as after the stressful events (Hicks, Lalonde & Pepler, 1993).

Culture seems to be one of the elements that has a significant influence on how families adapt to both stress and new situations. The literature points to marked differences in the manner in which families of different cultures react to the refugee experience and to acculturation, which frequently disrupts the family, as its characteristics are redefined far from familiar cultural landmarks.

Studies on Southeast Asian refugees highlight the importance of family cohesion. Strong ties bind the family more closely and each member has strong moral obligations toward the others (Krener et al., 1985; Simon, 1985; Tsoi et al., 1986). Data gathered on Southeast Asians in Montreal help to qualify this oversimplified view (Rousseau et al., 1993b): the strong family cohesion found in Southeast Asian families, which plays a protective role for children, may in return lead to a higher rate of depression in the parents when the extended family is reunited, probably due to the obligations that this entails. Research on refugee families from Central and South America has placed particular emphasis on the disorganization of the family that occurs when people become refugees (Bottinelli, Maldonado, Troya, Herrera, & Rodriguez, 1990; Farias, 1991; Leslie, 1993). Rousseau and colleagues (1993b) report that, in Central Americans, the level of conflict increases significantly with the intensity of the trauma experienced by the family; this provides a good illustration of the relationship, reported among Latin Americans, between domestic and state-sponsored violence (Jenkins, 1991).

Factors Associated with Acculturation

In refugee children, stresses associated with acculturation involve two types of factors: those related to the child, his or her family and community of origin; and those related to the host society, both its institutions, such as schools, and the community of which the child will become part.

Lee (1988) discusses a number of the factors related to the child and the family: the importance of the child's age upon arrival in the host country, the number of years spent in the host country, and the extent of parents' and family members' acculturation. Other research mentions the possible impact of an external environment experienced by the child as discriminatory or rejecting (Williams et al., 1983). In a review of the literature on stressors of childhood, Garmezy (1983) notes the protective nature of a supportive external environment (friends, teachers, etc.). The importance of factors related to the external environment depends upon the age of the child. With preadolescent school-age children, most of the stresses of acculturation are mediated by two main authorities—the family and the school—whereas during adolescence, the influence of peer groups becomes central.

An adolescent is confronted with fundamental issues like separation, identity and sexuality. These issues interact crucially with various problems related to being a refugee, such as loss, grief, psychic trauma, and lack of cultural continuity (Tobin et al., 1984). In addition to dealing with internal upheaval, the adolescent refugee must adapt to a new environment that replaces the childhood environment made up essentially of the family and a small school. The demands of this new environment interrupt the moratorium of which the adolescent feels the need in order to be able to integrate aspects of identity already acquired (Erikson, 1972).

Eisenbruch (1988, 1991) introduces an interesting perspective in discussing the relationship between acculturation and mental health of adolescent refugees with respect to cultural bereavement. He suggests that a policy of rapid integration does not make sufficient allowance for reexamination of the past, however painful it may be, so that refugees can grieve for all the losses they suffered during the pre- and post-migration periods. Eisenbruch (1988) stresses the protective effect of strong ties with a cultural and religious tradition (see also Williams & Berry, 1991), inasmuch as these ties help restore continuity between past and present. Along the same lines, Latin American authors, Lira and Weinstein (1984), emphasize the therapeutic effect of social and political solidarity among people from the same country, which can also be interpreted as a way for the refugee to restore continuity with the past in order to deal with the disruption and loss resulting from exile. With refugee children and adolescents, the culture of origin may therefore be essential to the integration of traumatic events and losses indissociable from the refugee experience, which significantly modifies the impact of the acculturation process.

Establishing continuity with the past is necessary for the grieving process. Adolescent refugees face the added developmental problem of integration into the host society because of the increasing importance of peer groups and the external environment. In a study of Southeast Asian adolescents, Jupp and Luckey (1990) reported that these refugees have few friends from the host country and that their isolation is a risk factor. For Vietnamese adolescents, poor relationships with classmates from the host country are one of the most important factors in predicting emotional distress (Charron et al., 1981). On the other hand, a recent study of adolescents living in a

multiethnic Montreal neighborhood (D'Kissy, Dolce, Filion & Vendette, 1990) shows that the close friendships formed by adolescents, and in particular those of Asian origin, tended to be with others of the same ethnic origin, although they did not consider living in a diverse cultural milieu to be a problem. The acculturation process influenced academic success as well as the refugees' adjustment to school.

Traditionally, good academic performance in children and adolescents is associated with a high level of acculturation in their parents (Berry et al., 1986). Certain studies, however, point to the need to qualify this assertion. Rumbaut (1991), for example, notes that the academic performance of Southeast Asian adolescents is better if the parents are attached to their culture and their community of origin. He hypothesizes that traditional values of obedience and respect are conducive to academic achievement.

Intergenerational relations reflect the threefold problem facing adolescent refugees: (1) the developmental task of adolescence itself; (2) tensions created by the difference between their own and their parents' degree of acculturation; and (3) the specific dilemmas of refugee status. Douville (1985) feels that adolescent refugees have three basic options: they can switch from one cultural system to the other according to their parents' wishes, switch cultural systems out of defiance, or stick with the traditional model. Many authors note the conflicts that arise when adolescent refugees acculturate more quickly than their parents do (Charron et al., 1981; Ganesan et al., 1989; Jupp et al., 1990; Szapocznik & Kurtines, 1980).

The subjects of conflict between refugee parents and adolescents vary with their culture, and also frequently with the sex of the adolescent. For Southeast Asian refugees, Lee (1988) notes three major sources of intergenerational conflict: dating and marriage, career choices, and role reversal. This role reversal, which promotes adolescents to the rank of adult and infantilizes their parents, who depend on the adolescents to forge relations with the host society, has also been considered crucial in the family dynamics of Latin American refugees (Barudy, 1989).

Intervention & Prevention

The debates running through the fields of intervention and prevention work with refugee children reflect the ideological and therapeutic debates that surround the symptom-centered approach discussed above. The main focus of intervention varies, depending on whether the preferred approach centers on illness at the individual level or pathology at the social level, a phenomenological view of the symptoms, or an understanding of the meaning of these symptoms in the history of the person and his or her community.

The prevailing trend, in Western countries, favors a traditional organization of psychiatric, social and academic services adapted to the problems specific to refugee children. The aim of this approach is to make Western therapies such as drug treatment, counselling and education more culturally sensitive (Westermeyer, 1991). Service providers that work with newly arrived refugee families often use interpreters. Working with interpreters is complex and never has to do solely with language. It must be based above all on an alliance between the clinician and the interpreter, who thus becomes part of the therapy team (Westermeyer, 1990). Professionals working with refugee children need training in cross-cultural therapy and experience with trauma and post-traumatic response, and must establish ties with the refugee communities, and perhaps even incorporate traditional forms of care into therapy (Leiper De Monchy, 1991). Richman (1993) rightly points out the difficulties of such a task in health systems in developed countries, where Western psychological paradigms are predominant. She emphasizes that in the West, individual therapy, which concentrates on talking about the trauma experience in a therapeutic setting, is the cornerstone of treatment for victims of violence and extreme stress (Pynoos & Eth, 1985). She questions the advisability of taking such an approach across the board with children who have been through war, saying that denial and silence are sometimes useful strategies for coping with long-term stress, and that the one-to-one therapist-patient relationship is not necessarily acceptable or appropriate in such situations.

Much of the research on children who have experienced war, whether or not they are refugees, focuses on the question of whether to break the silence surrounding war and repression that has become part of family and social relationships. This debate, which arose from

clinical experience and research involving Holocaust survivors, their children, and their grandchildren, as well as the descendants of Nazi perpetrators, is far from being resolved.

Most Latin American authors consider social silence to be a consequence desired by oppressive political regimes. This silence, which is the result of broken social ties (Vinar & Vinar, 1989), self-perpetuates even after the fall of the dictators and is a burdensome legacy for future generations (Vinar et al., 1989). Given this situation, Becker and his colleagues (1990) suggest that group therapy, with children and adolescents, creates space to hold past experiences and all the associated emotions, allowing symbolization work to begin. Lira and Weinstein (1984) consider that "giving testimony" is in itself therapeutic, as it is not just a breaking of the silence, but simultaneously an instrument of struggle and protest against the aggressor and an act of recognition of the emotional hurt.

The type of therapy preferred by these authors combines social and political perception with a psychodynamic understanding based on a linking of therapeutic and sociopolitical realities (Vinar et al., 1989). This introduction of a social dimension, indeed of what could be called a mission, into therapy can also be found among clinicians who have worked with Holocaust survivors. According to these authors, intervention for children who have experienced personally or indirectly through their parents, a situation of extreme inhumanity such as war or the Holocaust, must prevent anything similar from happening again (Kestenberg, 1993a). Herzog (1993) states: "Our task is to use the massive hurts which we study and observe in the service of a new kind of interplay in which the past is not reenacted but rather remembered to guard the present and the future" (p. 20).

Without therapy of this type, children may, in the words of Bar-On (1993), become "unintentional transmitters of undiscussable traumatic life events." Based on his experience working with groups of Jewish and German youth, this author emphasizes the value of working things through collectively, maintaining that only by restoring a climate of trust can the participants move beyond the pseudo-talk created around undiscussable events. Therapy with this approach, whether individual or group, is based on an understanding of human disasters that is at once psychodynamic, social and political, and viewed within a historical perspective.

Intervention for refugee children can also take the form of community or school programs. Many of these programs, which are often small scale, have the advantage of having been developed locally, keeping in mind the specifics of a particular culture and context. The program "Our Origin, Our Exile, From One Child to Another" (Lopez & Saenz, 1992), for example, was developed with Mayan refugees in southern Mexico, and was implemented by grassroots health workers. In the support materials, children's drawings and central themes touch on loss of land, the crop cycle and the prospect of going home. The goal of group discussions is to help children work out their grief, provide meaning and continuity to past experiences, and imagine a possible future.

In the United States, Duncan and Kang (1985) developed a program to facilitate "cultural bereavement" (Eisenbruch, 1988). The program includes the placement of unaccompanied children from Cambodia with foster families of the same ethnic origin, the use of Buddhist rituals to honor the dead, and the involvement of Buddhist spiritual leaders. Follow-ups of children who had been through the program suggest a reduction in sleep problems and visits from spirits, signs of partial resolution of grief and greater attachment to members of the foster family (Williams, 1991). What makes this type of therapy valid also limits its application: while the process is transferrable, few, if any, of the instruments and activities devised can be transferred. In addition, very little is known about the impact of these programs because they are often not well documented or evaluated.

In an effort to systematize the knowledge of refugee fieldworkers, Farias and Miranda (1994) put together a collection of experiences of those working with Central American refugees. The purpose of the book is to make a variety of little-known experiences (such as grassroots health worker training and self-help groups) better known. A comparison of all these approaches and their impact on children in different environments remains to be done.

Regardless of the approach, it is important to keep in mind that an intervention or prevention program is never neutral. Centlivres (1988) calls attention to the situation of Afghan children in refugee camps, torn between Office of the United Nations High Commissioner for Refugees (UNHCR) and *madrazas* schools. UNHCR schools offer a form of asylum, as the teaching materials that they use surround stu-

dents with images of childhood in a world away from conflict. The *madrazas*, which are intended to be modern-day manifestations of Islam, immerse the children in a militant and political atmosphere. In these two educational systems for Afghan children, it is the students from the real *madrazas*, receiving purely religious teaching, who seem surest of their role in the Afghanistan of tomorrow—and of their combat duties. The choice of one system or the other is necessarily ideological. Centlivres points out that even if education, children's rights, health, liberation and religion are the declared values in discussing the care of refugee children who are victims of conflict, it is the children themselves who are at stake and organizations compete for them.

In Western countries, there is frequently a gap between what is said about the protection of refugee children and unaccompanied minors and the administrative policies of immigration services. If we wish to engage in prevention work with these children, a necessary first step is to recognize the political, social and cultural issues behind our policies of asylum, settlement and integration of the children and their families. For example, investing in pilot programs in schools to help children integrate can never replace an overhaul of family reunification policies in order to minimize the harmful effects of extended separations on children. Too often, unfortunately, small, more highly visible actions help governments avoid dealing with more basic problems that are politically more sensitive.

Mental health intervention for refugee children cannot be confined to a psychiatric approach centered on psychopathology (Becker et al., 1990; Jensen et al., 1993; Punamaki, 1989; Rechtman, 1992). Cultural, social, political, and even historical dimensions must be incorporated. The complexities and specifics of the microcontext must be considered, without losing sight of its position at the macroscopic level. This perception of the situation allows the focus to be placed on the process of healing and repair specific to each group of children, based on the reconstruction of a universe of meaning and the reestablishment of networks of emotional ties and a social fabric.

METHODOLOGICAL ISSUES & FURTHER RESEARCH

The difficult and unstable situation of refugee populations and the complexity of the question mean that research on refugee children has to contend with certain methodological limitations.

First, for reasons of accessibility, the vast majority of published studies on refugee children has been carried out in Western countries using fairly small clinical populations. Studies of the general population are rare and, in most cases, cannot be compared with an appropriate control group, since one is not usually available (Jensen et al., 1993). The cultural origins of the groups studied, like the time elapsed since their arrival in the host country, vary considerably from one study to another, making it virtually impossible to replicate the data, and thus limiting the possibilities of generalizing from them. Furthermore, most studies are cross-sectional, and do not allow an analysis of the impact of the children's experience as refugees on their adaptation throughout their development, and on their future as adults. The very high attrition rates of some longitudinal studies (Krupinski et al., 1986) show the problems involved in doing follow-up with a population that may be very mobile, or reticent when it comes to anything that reminds them of the past (Rousseau, 1994).

Because these factors are usually present in varying combinations, it can be very difficult to interpret the data: are the psychopathology or adjustment problems observed attributable to cultural differences, to being in a social minority, to the immigration process, or to the pre-migration experience?

Other methodological limitations stem rather from the culturally biased nature of the measurement instruments available (Hughes & DuMont, 1993). The validity and reliability of quantitative instruments is rarely determined for non-Western cultures. Designing a validation process is a complex task (Mollica, Caspi-Yavin, Bollini, Truong, Tor & Lavelle, 1992), especially since it must take into account the great diversity of refugees' cultural groups of origin.

These methodological shortcomings and the review of the literature reveal three important avenues for further research:

(1) Longitudinal studies are needed, particularly of general populations, in order to determine the long-term consequences of these young people's experiences as refugees and the interaction between these experiences, their consequences and developmental variables.

(2) Methodological choices also need to be reviewed in light of the psychometric limitations of available instruments in a cross-cultural context and the need to expand research questions beyond

the mere presence or absence of psychopathology (Richman, 1993). The development of qualitative methods appears to be of particular interest, since they would not only help determine contextual and cultural variations that characterize the child's environment, but provide access to the child's intrapsychic world (Rousseau, 1994). Moreover, as Maton (1993) points out, a bridge between ethnographic and empirical methodology is needed; this bridge may be a strategy for dealing with problems of validity that stem from the gap between the culture of the subject of the study and the culture of the researchers and their institutions. These considerations should also extend to the issue of assessments in clinical or school settings.

(3) It is essential to document, first anecdotally, then more systematically, the various types of therapy and prevention efforts employed with these populations. Particular attention should be paid to therapeutic processes that facilitate healing and bereavement in refugees' cultures of origin and to programs that are intended to help reconstruct a universe of meaning and collective solidarity for the families and communities of these children.

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