

Children at Risk: A Review of the Mental Health of Unaccompanied Refugee Minors

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Abstract

War and conflict force many children to flee their homes without parents or guardians; these children are referred to as unaccompanied refugee minors. Such children are particularly vulnerable to traumatic experiences. The stresses of conflict, migration and assimilation often lead to varied mental health concerns and symptoms of trauma among refugee children. This review examines the following aspects of their mental health: (a) vulnerabilities and risk factors, (b) psychopathology, (c) resilience, and (d) effective treatments for this population. Stressful life events are risk factors affecting the psychological health of the unaccompanied refugee children. These vulnerabilities contribute to the increased prevalence of anxiety, depressive, and posttraumatic symptoms in this population. The symptoms vary based on factors such as environment, time since arrival, and resiliency. Effective treatments specific to this population remain few. Further research into the mental health of unaccompanied refugee children is necessary if society is to assist this population overcome the effects of the trauma.

Key Words:

children, refugees, mental health

War and conflict force many children to flee their homes without their parents or guardians; these children are referred to as unaccompanied refugee minors. According to the Secretary General of the United Nations High Commissioner for Refugees (UNHCR), “Unaccompanied children’ (also referred to as ‘unaccompanied minors’) are girls and boys under 18 years of age who are separated from both parents and are not being cared for by an adult who by law or by custom is responsible for doing so” (United Nations High Commissioner for Refugees, 2005, para. 1). Children under the age of 18 make up over half of the population of refugees. While the exact number of unaccompanied children seeking asylum is difficult to estimate, approximately 2-5% of refugees are children separated from their primary caretaker (Seglem, Oppedal, & Raeder, 2011). In 2015, UNHCR reported that there were about 98,400 unaccompanied children seeking asylum, which was a significant increase from previous years (United Nations High Commissioner for Refugees, 2015).

The trauma of forced migration, separation from parents/care-takers, and the additional loss of protection from their home country places unaccompanied refugee children in a vulnerable position, even prior to the asylum process. Upon arrival in an asylum nation, unaccompanied children must endure the complex process of asylum and resettlement. After being admitted to the territory of the asylum/host country, refugee children may be detained in detention facilities while determining their refugee status (International Committee of the Red Cross, 2004). According to the Convention on the Rights of Children (CRC), detention is meant to be a measure of last resort and should be for the shortest appropriate period of time (The United Nations, 1989). To determine the child’s refugee status, the child must make a sufficient claim of asylum to UNHCR. If the claim is not determined credible, the child may be refused asylum and not granted refugee status. This process often lasts several years as every attempt is made to reunify the child with family and determine the best interests of the child.

Upon receiving refugee status, the child may be repatriated to her/his own country if the nation is determined to be adequately stable and there is a possibility of family reunification or alternative placement. If the country of origin is unable to adequately care for the child, he or she may be integrated into the asylum country or resettled to a third country (International Committee of the Red Cross, 2004). If the children are resettled to a third nation, they are likely subjected to several vetting processes and cultural classes to prepare them for resettlement. The trauma of war or internal conflict, the uncertainty of the process of asylum, and resettlement help make unaccompanied refugee minors a particularly vulnerable population among asylum seekers and refugees.

The stresses of conflict, migration, and assimilation often lead to varied mental health concerns and symptoms of trauma among refugee children. Many studies suggest that refugee children experience high rates of posttraumatic stress disorder (PTSD), depression disorders, and anxiety disorders (Fazel, Reed, Panter-Brick, & Stein, 2012; Hodes, Jagdev, Chandra, & Cunniff, 2008; Seglem, Oppedal, & Raeder, 2011). There is also a significant risk of these symptoms and/or disorders becoming chronic. Unaccompanied refugee minors are particularly vulnerable to these mental health concerns as they do not have the social support or buffer that families provide. Psychopathology is more severe and more prevalent among unaccompanied minors when compared to accompanied refugees and adolescent non-refugees (Unterhitzberger et al., 2015). While there has been an adequate amount of research on the mental health of unaccompanied refugee children, there remains a demonstrable lack of a comprehensive review of the literature on their mental health following their resettlement. Thus, the purpose of this review is to examine the mental health of unaccompanied refugee minors following their resettlement to a third country. We will review the following aspects of the unaccompanied minors' mental health: (a) vulnerabilities and risk factors, (b) psychopathology, (c) resilience, and (d) effective treatments for this population.

Vulnerabilities and Risk Factors

The UNHCR called unaccompanied refugee minors the most vulnerable group of refugees (Jensen, Fjermestad, Granly, & Wilhelmsen, 2015). Refugee youth, especially unaccompanied minors, are particularly vulnerable to traumatic experiences (Unterhitzberger et al., 2015). Unaccompanied children are at an increased risk of "military recruitment; sexual exploitation; abuse and violence; forced labor; irregular adoption; trafficking; discrimination; and lack of access to education and recreational activities" (United Nations High Commissioner for Refugees, 2005, para. 5). All these experiences contribute further to the risks experienced by unaccompanied refugee children.

Beyond the trauma of conflict prior to migration, many of these unaccompanied refugee children experience a myriad of stressful life events. These stressful events contribute to the mental health problems experienced by such minors. A study conducted by Jensen, Fjermestad, Granly, and Wilhelmsen (2015) was undertaken to examine the stressful life experiences of unaccompanied asylum-seeking children age 10-16 in Norway, as well as the mental health effects of these experiences. The researchers measured the severe life events and psychological symptoms of 93 unaccompanied asylum-seeking children. The average number of severe life events experienced by these children was 5.5; 68% of the children had experienced the death of an affectively close person, 63% had witnessed violence, and 62% had witnessed war. Among the other events, which contributed to the children's vulnerability, were drastic changes in families, separation from family against the child's will, physical violence to self, and even sexual abuse. As a result of these stressful and traumatic experiences, over half of those involved in the study were experiencing clinical posttraumatic stress symptoms, with 30% experiencing anxiety symptoms and 20% experiencing depressive symptoms. The researchers found correlations between the number of stressful life events and posttraumatic, anxiety, and depression symptoms. This suggests that these stressful life events are risk factors, impacting the

psychological health of the unaccompanied refugee children.

In a systematic review of the risk factors in resettled refugee children, Fazel, Reed, Panter-Brick, and Stein (2012) examined the key risk factors experienced generally by refugee children, which render the child vulnerable to psychological problems. Among the greatest risk factors, which apply to the unaccompanied refugee minor population, were exposure to pre- and post-migration violence, female sex, perceived discrimination, changes of residence in host country, and poor financial support. In another study looking more specifically at predictors of depressive symptoms (controlling for posttraumatic symptoms), researchers found that the only predicting factors for depressive symptoms within the resettled unaccompanied refugee minor population were sex and country of origin (Seglem, Oppedal, & Raeder, 2011). A similar study conducted with unaccompanied asylum-seeking adolescents in London also found the predictive factors of depressive symptoms to be gender and country of origin. The researchers also investigated the predictors of posttraumatic symptoms and concluded that low-support living arrangements, female gender, increasing age, and trauma events were all predictive of posttraumatic symptoms (Hodes, Jagdev, Chandra, & Cunniff, 2008). Thus, risk factors such as sex, country of origin, exposure to violence, and lack of support within the host country have been found to be predictive of posttraumatic, depressive, and anxiety symptoms. In future studies, research can be expanded to look more extensively at other pre- and post-migration factors, which may put a child at risk of experiencing these symptoms. Further research on risk factors could include language proficiency in the resettlement country, education level prior to displacement, discrepancy between assigned post-migration grade level and prior educational attainment of the child, and adverse childhood experiences. Future studies might also consider the mechanisms by which primary risk factors could impact the presence and severity of psychological symptoms. For example, is gender a risk factor due to stereotypes about women, biological or genetic protective factors, or greater

exposure to traumatic experiences? Examining these mechanisms would help increase understanding of the relationship between risk factors and the symptoms experienced by unaccompanied refugee minors.

Psychopathology and Symptoms of Trauma

Short Term

The psychological symptoms of the trauma and conflict experienced by unaccompanied refugee minors vary based on factors such as environment, time since arrival, and resiliency. In this section we will examine the varied symptoms and the psychopathology of unaccompanied refugee children, beginning with the symptoms experienced upon arrival. Vervliet et al. (2014) conducted a study on the mental health of unaccompanied refugee minors arriving in Norway and Belgium. This study examined the children's psychological states right at the time of their arrival in the host country. The researchers found high prevalence of psychiatric disorders among the unaccompanied children. Specifically, 44% of the total group met the clinically severe cut-off score for depression, 38% for anxiety, and 53% for posttraumatic stress disorder. Thus, the conflict and migration process experienced by unaccompanied refugee children seems to have contributed to the increased prevalence of anxiety, depressive, and posttraumatic symptoms in this population, especially in the short term. These symptoms may persist, thus creating enduring or long-term emotional and mental problems.

Long Term

The long-term symptoms experienced by unaccompanied refugee children seem to vary based on the time since arrival and the support given by the host nation. In a study on Afghan unaccompanied refugee children resettled in the UK, researchers found that increased time in the country correlated with an increase in behavioral problems (Bronstein, Montgomery, & Ott, 2012). This suggests that time, especially time in country, has an effect on the mental health

symptoms of the unaccompanied refugee children.

In an effort to explore the long-term symptoms of trauma, a longitudinal study was conducted with a population of unaccompanied refugee minors in Europe. Assessments of mental health symptoms and daily stressors were measured at arrival, six months, and 18 months. There were no significant changes in the mental health of these unaccompanied children over time, suggesting that the symptoms experienced by unaccompanied refugee children may be persistent even after resettlement in a host country (Vervliet, Lammertyn, Broetaert, & Derluyn, 2014).

This persistent mental health trajectory is not consistent in the literature; however, the trajectory seems to depend on the social support offered to the child. One study was conducted by Loughry and Flouri (2001) on the behavioral and emotional problems of former unaccompanied Vietnamese refugee children a few years after the children had been repatriated to Vietnam. The researchers compared this population with other minors who had never left Vietnam. These two groups were evaluated using a youth self-report, a self-efficacy measure, and a social support measure. Surprisingly, there were small differences between the two groups. There was little difference in the social support of the two groups. Ultimately, the researchers concluded that the time the children spent as unaccompanied minors in refugee camps in South East Asia did not lead to increased behavioral and emotional problems. This study suggests that if similar levels of social support are given to children post-migration, they may not experience the persistent mental health trajectory described in other research. The difference in long-term symptoms is also likely due to the repatriation of the Vietnamese children to their country of origin, adding to their social support. This social support buffer is unfortunately more difficult to achieve if the child is resettled to a foreign country.

Resilience

Despite a high prevalence of mental health disorders among unaccompanied refugee minors,

these children may demonstrate incredible resilience and are capable of functioning at a high level (Carlson, Cacciato, & Klimek, 2012). A study was conducted by Huemer et al. (2013) with forty-one unaccompanied refugee minors who had immigrated to Austria. The study examined the children's resilience after experiencing high levels of trauma. The children were administered multiple assessments to measure personality and describe symptoms. According to the researchers, despite the stressors experienced by the children, they reported low levels of symptoms of psychopathology. Interestingly, however, the children also reported higher levels of symptoms in the years leading up to study. This suggests that the children experienced greater levels of anxiety and depression during the stressful experience of conflict and migration. The authors suggest that the children are in a recovery pattern, meaning that they may struggle with moderate symptoms of trauma and eventually adapt back to their level of mental health prior to the trauma.

One unaccompanied child's experience with trauma may not be the same as another's. In a study on the resilience of Afghan youth with traumatic experiences, Panter-Brick, Grimon, Kalin, and Eggerman (2014) found the children's experience with trauma to be heterogeneous. In interviews and assessments with over 300 Afghan youth, the researchers found that recall of trauma is malleable and that the youth significantly altered their memories of trauma. This suggests that children who have experienced trauma may be resilient despite traumatic pasts and have a different mental health trajectory.

While the research on the resilience of unaccompanied refugee children is hopeful, only a portion of children are capable of such resilience (Bronstein, Montgomery, & Ott, 2012). Support and treatment of unaccompanied refugee children are necessary in cases where such resilience is not present. In fact, such support will likely facilitate the resiliency of the children to overcome the effects of trauma. Further research is needed to study the effects of social and governmental support on the resiliency and recovery of unaccompanied refugee children.

Treatment

The literature thus far examined suggests a need to address the mental health concerns and symptoms of trauma experienced by unaccompanied refugee children. Research regarding treatments for accompanied refugee minors demonstrates the efficacy of cognitive behavior therapy (CBT). Several of these studies report significant reductions in psychological symptoms (Tyrer and Fazel, 2014). However, these studies do not examine the unique challenges faced by unaccompanied refugee children. Research on treatments for unaccompanied refugee children is scarce. One of the few empirical studies into a specific treatment method for unaccompanied refugee children focuses on treating posttraumatic stress symptoms (Unterhitzberger et al., 2015). The researchers evaluated the effectiveness of trauma-focused cognitive behavior therapy (TF-CBT) on a small sample of unaccompanied refugee adolescents. TF-CBT is a cognitive behavioral therapy shown to be effective among traumatized youth. In the study, the unaccompanied minors reported several traumatic experiences and posttraumatic stress symptoms prior to treatment. In the post-treatment evaluation, TF-CBT was determined to be a feasible treatment as it was effective in reducing the posttraumatic stress symptoms of all the participants. However, the results of this study cannot be generalized to the entire population of unaccompanied refugee minors as it was based on a small, relatively homogenous sample. Thus, a more extensive study, which includes a control group would be necessary to adequately determine the effectiveness of TF-CBT.

Another treatment study (Kohli & Mather, 2003) focused on therapy techniques used by social workers in the UK working with resettled unaccompanied minors. The focus of these techniques was to teach self-healing. One of the ways to do this was by assisting the child to have a sense of belonging, to an adult, to a family, and to a community. They also found it helpful to allow the child to think about their experiences in a safe environment. They focused on the agency

of the child, allowing her/him to play an active part in making choices. Finally, the social work group found it important to focus on cultural integration so that the child feels a sense of connection and community. The treatment of children dealing with the trauma of displacement and resettlement is a complex process that requires further attention.

While these studies are encouraging, there remains a large gap in the literature for qualitative studies examining effective treatments and therapies with this young refugee population. In a systematic review of the psychological interventions used with unaccompanied refugee minors, Anders and Christiansen (2016) conclude that there is a deficiency of methodologically sound research in the field. This lack of adequate population-specific research has serious consequences. Bean, Eurling-Bontekoe, Mooijaart, and Spinkhoven (2007) examined the use of mental health services among unaccompanied refugee children and found that almost half of the 920 unaccompanied refugee children interviewed reported that their mental health care needs were not met. This is a disturbing assessment of the lack of adequate treatment provided to these vulnerable children.

Limitations and Future Directions

Further research into the mental health of unaccompanied refugee children is necessary if professionals are to assist this population in overcoming the effects of trauma. Much of the research conducted thus far on resettled unaccompanied refugee children has been carried out in European host countries. Further research is needed in other resettlement countries, such as the United States, as resettlement policy affects the support given to the children. A comparative study of countries on the inclusiveness of resettlement policy and the availability of mental health treatment would be useful to more fully understand the consequences of national policy on mental health. It would also be beneficial to look at specific policy measures such as foster care systems, financial support, educational support and community involvement

and any associations with the prevalence of psychological symptoms of the unaccompanied refugee minors. Such studies would develop our understanding of the psychological consequences of national policy and the unique environments into which unaccompanied children are placed upon arrival.

An important limitation regarding the mental health of unaccompanied refugee children concerns the small sample sizes of the majority of studies included in this review. Because of the vulnerability of children and the small proportion of unaccompanied children in the large total refugee population, it is difficult to obtain sufficiently large sample sizes. If between-group comparisons of age, country of origin, time in host country, etc, are to be conducted, the research must include larger samples. These children come from a variety of circumstances and are put into a variety of environments following resettlement. Such a heterogeneous group requires large sample sizes to examine the unique aspects of mental health that these differences present.

Other limitations to the methods of current research include the method type and the measures used. Many of the studies reviewed used a cross-sectional research method. While this method is beneficial in some regards, it does not speak to the causal factors contributing to the mental health of the children. More longitudinal studies are required to examine the causal effects of traumatic or stressful events and long-term benefits of current intervention and treatment strategies. If longitudinal studies are not feasible, the time in the resettlement country could also be included in future studies to directly examine risk factors as they occur. There is also a need to standardize the measures used in research on refugee children. Most of the measures used in much of the current research are developed using children and adolescents from western countries. In future research, the measures used to establish psychopathology should be culturally and linguistically appropriate to account for these extraneous variables. Measures of psychopathology should also be standardized across studies to more easily compare different samples. These adjustments would be of benefit to the methodology of future research in the field.

Another important area, which requires more attention, is resiliency and coping factors impacting unaccompanied refugee children. Resiliency is an emerging area of interest in the field of unaccompanied refugee minors. One important aspect of coping and resiliency that has yet to be fully examined is the impact of religious, spiritual and cultural beliefs and communities on the ability of these children to cope with the trauma and change. This could be an important area of research as these children have lost their parents, families, and perhaps their sense of identity. Religious and cultural communities could help to create the necessary social support needed for these children to develop. This social support could act as a buffer against the trauma of forced migration and could help to reduce the psychological symptoms unaccompanied children typically face.

As discussed in the previous section, much research has yet to be done regarding evidence-based interventions and treatments for unaccompanied refugee children. As preliminary research on TF-CBT seems to be promising, this treatment method needs more extensive, psychometrically sound evidence to support its use with this population. Such studies should include larger and more diverse samples, and control and comparison groups to account for extraneous variables, which may be affecting the participants' recovery. Other treatments and interventions used with accompanied refugee children, such as narrative exposure therapy for children (KIDNET) and different forms of art therapy (Tyrer and Fazel, 2014), should be methodologically studied with a sample of unaccompanied refugee children. The unique risks faced by unaccompanied refugee children create a need for specific research into the most effective treatment methods for this unique population. Their unique needs require greater attention by researchers, service providers, and policy makers if these children are to cope with trauma to which they have been exposed.

Conclusion

Unaccompanied refugee minors are a particularly vulnerable portion of a refugee

population that is already experiencing high rates of mental health risks. These children are displaced from their homes, separated from their support systems, and left to navigate a foreign country, largely on their own. Their stressful life events leave them vulnerable to mental health concerns. Risk factors such as sex, country of origin, exposure to violence, and lack of support within the host country seem to be predictive of posttraumatic, depressive, and anxiety symptoms. Due to their vulnerable position, there is a high prevalence of psychiatric disorders among newly-arrived unaccompanied refugee children. These symptoms vary depending on time in country and the resiliency of the individual child. The symptoms may be persistent even after resettlement. Social support after resettlement, however, seems to help reduce or eliminate emotional or behavioral problems beyond the rates expected in a typical population. In terms of treatment, the TF-CBT method was determined feasible in reducing the symptoms of trauma. Other therapy techniques focusing on self-healing were also found to be effective treatments.

Moving forward, there is a need for further research concerning the links between mental health risks and the symptoms experienced by unaccompanied refugee minors. There is also a need for research on the effects of social and governmental support on the resiliency and recovery of unaccompanied refugee children. Most especially, there is need to examine other treatment options specific to this unique population. Unaccompanied refugee minors are particularly vulnerable to the effects of trauma without the social support of a family to act as a buffer. On a local level, members of the community should seek to welcome these children, help them adapt, and give them social support. Nations should seek to create policy that adequately addresses the mental health needs of the unaccompanied children. Governments should also seek to provide unaccompanied refugee children with an environment in which they may be able to cope with the trauma of resettlement. International organizations, such as UNHCR, should seek to reduce the stressful life events occurring after displacement by ensuring

the child is promptly placed in a situation that is in the child's best interest. Unaccompanied refugee children at risk are deserving of our research pursuits, our services, our attention, and our empathy.

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