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Background Paper

***The Mental Health Impacts of Trauma on Refugee
Young People and Therapeutic Interventions
Promoting Resilience***

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This background paper has been prepared to inform discussion at this conference and does not necessarily represent the views of the Centre for Refugee Research.

The Mental Health Impacts of Trauma on Refugee Young People and Therapeutic Interventions Promoting Resilience

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The Mental Health Impacts of Trauma on Refugee Youth and Therapeutic Interventions Promoting Resilience

Introduction

The nature of war has changed so that children are no longer innocent bystanders. The battlefields are in homes, schools, and communities aiming at women, children, and youth as targets for forced military recruitment, torture, exploitation and gender-based violence (UNHCR 1994, WCRWC 1998). Of the world's estimated 27 million refugees and 30 million displaced persons, 80 percent are women and children¹ (UN 2005, Tuitt 2000). The majority of children and youth survivors of armed conflict have encountered not a single traumatic event but a succession of stressors and progression of violence. The violent death of a parent, witnessing of massacres, forced participation as child soldiers or prostitutes, terrorist attacks, incessant bombardments, physical and sexual torture towards a family member or self, and separation from family and friends are among the tragic experiences many refugee young people have endured (Thomas and Lau 2003, UN 2005, Harrell-Bond 2000, Pynoos et al 2001). In areas with prevalent incidences of malnutrition, economic dilapidation, and a shortage of food, the eruption of war exacerbates illness, family stress, poor educational and health services and the weakening of social systems (Save the Children 1996, Harrell-Bond 2000, Pynoos et al 2001).

Children and youth who are forced to flee their homes, their schools, and their support structures are in need of special consideration. If left untreated, experiences of profound psychological distress and ensuing lack of support impact on children and adolescents' development for their immediate survival as well as long-term recovery. This, in turn, impacts on the future of the post-conflict society (Save the Children 2005, Sims et al 2000, Pynoos et al 2001). Resilience in children and youth can be cultivated with supportive, psychosocial elements in the community and upon resettlement. Therefore, an expansion of programs addressing mental health issues for both children and adults, and culturally appropriate therapeutic interventions are of vital importance (Save the Children 1996, van der Veer 1998).

The aim of this paper is to explore the psychological impact of trauma on refugee youth with an

¹ with 65 percent being children (UN 2005)

overview of the grievous conditions in pre-migration refugee camps, the incidence of Post Traumatic Stress Disorder (PTSD) and developmental implications of psychological distress. The resettlement issues of acculturation including cultural bereavement and acculturative stress, and factors of resilience will be explored. Various therapeutic interventions used to promote resilience in refugee young people, incorporate the well-being of the entire family, and enhance community re-building will be highlighted as means through which to begin healing and reconciling the past. In order to gain a comprehensive understanding of the intricate issues in refugee camps and in resettlement, the psychological ramifications of trauma and the tremendous capacity for survival of refugee young people, the prime focus of this paper was a general analysis of these intersecting components. These issues will be addressed in the context of international laws and Australia policies appertain to refugee youth.

Background 1.0: Methodology

This paper was written as a background piece for the national conference on refugee resettlement, *Hopes Fulfilled or Dreams shattered? From Resettlement to Settlement: Responding to the needs of New and Emerging Communities*, jointly hosted by the Centre for Refugee Research, UNSW and the Australian National Committee on Refugee Women (ANCORW) and supported by a broad range of refugee service providers and community organizations. The conference outcomes will be documented and the papers, panels and workshop reports will be amalgamated into a thorough report with recommendations for policy makers and service providers, both in Australia and overseas (Centre for Refugee Research 2005).

The primary method for gathering relevant data was an extensive review of available literature. I chose to focus solely on the gathering of information and data available in journals, United Nations documents, online sources, texts, and compilations of articles in books rather than conducting interviews or performing a more qualitative study. This was in part due to the fact that the ethics clearance from UNSW was delayed as well as a combination of logistical factors and availability of service providers whom I could interview. However, I found the analysis of literature ample for purpose of this particular project.

The experience of children and youth in flight and in refugee camps, and the impact of consequent trauma was considered. The research on the psychological effects and developmental consequences of severe trauma, violence and upheaval on refugee youth was examined from a variety of sources. The process of resettlement and the concomitant aspects of cultural bereavement and acculturative stress were explored through literature reviews available in journals and specific articles in generalist texts on refugee issues. Within this section, I relied on the range of information publicly available from Australian agencies working with refugee youth such as Youth Action and Policy Association (YAPA), STARTTS, the Refugee Resettlement Advisory Council, and the Refugee Council of Australia.

The literature detailing the myriad of therapeutic approaches used to promote resilience and well-being of refugee youth and their families was drawn upon from journal articles,

compilations of articles in text books, case studies from service providers, agencies providing counseling to youth and families, and field handbooks.

It should be noted that at times, with the dearth of information and research on refugee young people, concepts were applied from findings on refugee adult populations. Where generalizations are made, most notably in aspects of resettlement, cultural bereavement, and the broad cross-cultural components of therapeutic interventions, it is important to recognize this distinction. In many of the sections, the children and youth are discussed together when appropriate and when examining the broad concepts in policy, aspects of trauma, and where it is necessary to generalize². In addition, the use of the term ‘counselor’ and ‘therapist’ on the section on therapeutic interventions are used interchangeably³.

² The Convention on the Rights of the Child (CRC) defines a child as “every human being below the age of 18 years unless under the law applicable to the child majority is attained earlier” (UNHCHR 1989).

³ Different countries have varying criteria and qualifications for mental health professionals.

Background 2.0: Literature Review

The majority of research in the area of the psychological impact of trauma on refugee children and youth focuses on aspects of PTSD in pre-migration and the ensuing symptoms and behavioral manifestations in resettlement. Thomas and Lau (2003) presented a thorough review of the major research findings regarding the psychological well-being of children and adolescent refugees and asylum seekers over the past ten years. This document provides an expansive examination of notable findings, a discussion of theoretical issues and methodological considerations, as well as the gaps of information on refugee children and youth where more research needs to be done. Yule (1998) also states that the amount of research that has been done with refugee children with regard to PTSD is very limited (Yule cited in Okitikpi and Aymer 2003).

Most of the research about the psycho-social effects of trauma in developing countries has been in Southeast Asia the majority based on Cambodian refugee adolescents particularly through the work of Kinzie. However, increasingly, in the past five years, the diversity of ethnic groups participating in studies has been growing, most notably from the conflicted affected populations from the former Yugoslavia, Afghanistan, Sri Lanka, Burma, and Central America (Silove and Kinzie 2001). The research by Kinzie et al (1986) has been the most comprehensive to date and informs additional studies in this area. Kinzie et al (1986) and Clarke et al (1993) have done groundbreaking work analyzing the effects of trauma, prevalence of PTSD and depression in refugee young people from Cambodia.⁴ Research indicates that the more severe and consistent the exposure to trauma, the more likely and acute the symptoms of PTSD (Kinzie and Jaranson 2001, Thomas and Lau 2003, Clarke et al 1993, Pynoos et al 2001). The developmental implications of trauma, violence and incidence of PTSD in children and youth have been documented (van der Veer 1998, Chauvin 2003) with particular attention to the emotional, cognitive, moral and biological consequences (Pynoos et al 2001, Raman and Goldfeld 2003, Fazell and Stein 2002, Rothe et al 2002, Clarke et al 1993, van der Veer 1998)

⁴ For more detailed information see Thomas and Lau 2003, Clarke et al 1993, Kinzie and Jaranson 2001, Pynoos et al 2001 among others

There is a body of literature addressing the adverse effects of refugee camp settings on children and youth (Save the Children 1996, WHO 1996, UN 2005, Mehraby 2005, Sims et al 2000, Fazell and Stein 2002, Pynoos et al 2001, Harrell-Bond 2000, UNHCR 1994 and WCRWC 2004). Much of this data, however, does not differentiate between younger children and adolescents. The breadth of information is focused on children while the special developmental needs of youth are often neglected. However, issues of forced soldiering, lack of education and training opportunities and particular vulnerabilities and frustrations of young people are identified (UN 2005, Harrell-Bond 2000, Pynoos et al 2001, WHO 1996)

One of the controversies indicated in the literature was the question and validity of labeling adolescent and children refugees with a rigid, clinical diagnosis and pathology of symptoms rather than as natural, innate reactions to extreme stress and trauma. It is suggested to develop a more holistic and culturally sensitive way of addressing these issues of mental health and psychopathology (Brough et al 2003, Ortiz 2001, WHO 1996, Save the Children 2005). The impact and implications of cultural bereavement on refugee communities is addressed although not with specific reference to its affect on young people (Eisenhruch 1991, Langer cited in Brough et al 2003).

There is an array of literature on the process of resettlement and the mental health implications for refugees and asylum seekers. UNHCR (2004) provides guidelines to governments and service providers with recommendations aimed at facilitating and minimizing the detrimental impact of stress and anxiety in resettlement (Bruce 2003, UNHCR 1994, UNHCR 2004). Van der Veer (1998) outlines a three-stage process of resettlement and the effects of culture shock on refugee communities. Acculturation and the associated consequence of acculturative stress was addressed in different research findings. The congruency between cultures and the host country's reception of the newly arrived as a determinant of the variation and severity of anxiety and depression in resettlement was highlighted (Brough et al 2003, Bruce 2003, Mitar 2005, Nwadoria and McAdoo 1996, Berry (1970) cited in Nwadoria and McAdoo 1996).

The youth experience in resettlement was only briefly touched upon in terms of intergenerational stress and conflict of identity development (van der Veer 1998, Mehraby 2005, Low and Nguyen 1997, Brough et al 2003, UNHCR 1994, Save the Children 2005). The unique needs of

unaccompanied minors was addressed in many studies, but the scope of this paper did not allow for an in depth discussion of this particularly vulnerable group (UN 2005, van der Veer 1998, Thomas and Lau 2003, Save the Children 2005). Many of the social service agencies working with refugee communities and Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) have compilations of resources, guides, facts, policy papers and basic information on the populations they serve, especially focused on refugee young people and their needs in resettlement (YAPA, STARTTS, CMYI, ChilOut, Refugee Council of Australia, Ethnic Communities Council, MRCs, DIMIA, Refugee Resettlement Advisory Council).

The adverse impact of detention centers on the psychological well being of children and youth in Australia has been well documented (HREOC 2005, Bhagwati 2003, Goode 2003, Zwi et al 2003, Chauvin 2003, Raman and Goldfeld 2003, Cemlyn and Briskman 2003, ChilOut 2005, Neumann 2004, Save the Children 2005) Unfortunately, the scope of this paper did not allow for a more thorough discussion on this charged topic, although the literature reflecting on the adverse impacts of detaining families is comprehensive⁵.

Aspects of protective and risk factors influencing resilience in youth have been cited throughout the literature pre- and post-migration. Some of these factors include issues of parental psychopathology and stress, availability of positive peer relationships, adequate education and health care, and personal disposition characteristics of the youth (Bought et al 2003, UN 2005, Save the Children 1996, Raman and Goldfeld 2003, WHO 1996, van der Veer 1998, Chauvin 2003).

The importance and relevance of ethnic community ties and influence of culture in therapeutic interventions has been expanded upon in much of the literature on counseling refugee populations (Fazell and Stein 2003, Chauvin 2003, Ortiz 2001, Low and Nguyen 1997, Save the Children 1996, WHO 1996, van der Veer 1998, UNHCR 1994). In a therapeutic setting, the value of creating a safe environment, building trust and rapport, and allowing the process to unfold naturally was discussed (Herman 1992, Denham 2002, Turner 200, Mehraby 2005, Santini 1989, van der Veer 1998, Save the Children 1996, Ortiz 2001, Kinzie and Engdahl 2001,

⁵ See attachment on background information relating to the psychological impact of detention centers on children and youth and its effects on resettlement.

STARTTS 2002). Although a range of psychological approaches were considered, there was a paucity of research which specifically addressed the particular therapeutic concerns of refugee youth. A strategic framework and research data for the therapists and counselors when working with refugee youth is minimal with the majority of data gathered through personal reports and observations of common behaviors (Kinzie and Engdahl 2001). There also seemed to be a lack of substantive information on traditional healing practices with regard to mental health issues of refugee communities especially upon resettlement. WHO outlines some of the customs and rituals in its field manual on mental health of refugees (1996).

While much work is being done, there still needs to be more research on the long term effects of trauma, psychological distress, cultural bereavement, acculturative stress, the influence of culture pre- and post-migration and the various methods of effective therapeutic interventions specifically catered to refugee young people.

Background 3.0: Policy Review

3.1 International Guidelines for the Protection of Refugee Children and Youth

International conventions guided by the human rights standards in the Universal Declaration of Human Rights and specific human rights treaties, provide the framework for governments' responsibility, internationally and domestically, to safeguard the special needs of refugee children (UNHCR 1994, WCRWC 1998). The 1951 Geneva Convention Relating to Status of Refugees and the subsequent 1967 Protocol developed standards aimed at protecting refugees. Under the Refugee Convention, nation states are obligated to protect individuals who have a "well-founded fear of persecution for reasons of race, religion, nationality, or membership in a particular social group or political opinion"⁶ (UNHCHR 1996). Children and youth, however, are not explicitly recognized in the convention. As noted by Tuitt, children and youth are largely neglected from the prominent international refugee and human rights laws⁷ (2000, p. 150). The guidelines assume the child to be under the protective umbrella of the family unit; therefore, adult protection under the law is considered sufficient for the refugee children as well.

3.2 Convention on the Rights of the Child

In 1989, however, the Convention on the Rights of the Child (CRC) inaugurated a new vision of human rights that legitimized both the legal rights and developmental rights of children⁸ (UNHCR 1994, Robinson 2000, Save the Children 1996). The CRC distinguishes certain rights and principles compelling nations to provide for all children, including those seeking asylum and

⁶ The 1951 Refugee Convention and the 1967 Protocol (Relating to the Status of Refugees) set standards that apply to children in the same way as to adults: (1) a child who has a "well-founded fear of being persecuted" for one of the stated reasons is a "refugee", (2) a child who holds refugee status cannot be forced to return to the country of origin (the principle of non-refoulement), and (3) no distinction is made between children and adults in social welfare and legal rights (UNHCR 1994).

⁷ In Recommendation B of the Final Act of the Convention, Concerning Family Unity, nation states are expected to take effective measures to protect "refugees who are minors, in particular unaccompanied children and girls, with special reference to guardianship and adoption" (Tuitt 2000, p.151).

⁸ After over a decade, it is almost universally accept for the United States and Somalia

with refugee status (UNHCHR 1989, WCRWC 1998). In Article 22⁹, The CRC addresses the protection of children asylum seekers stating that

States Parties shall take appropriate measure to ensure that a child who is seeking refugee status... shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection or humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments (UNHCHR 1989)

The CRC incorporates the postulate of “the best interest of the child” and mandates, in Article 3.1, “in all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies, the best interests of the child shall be the primary consideration” (UNHCHR 1989, UNICEF 2005, WCRWC 1998). Article 37 of the Convention on the Rights of the Child prohibits detention of children except as a last resort and for the shortest appropriate period of time¹⁰. The importance of the community is recognized as being a supportive role in the lives of children¹¹. In addition, the CRC¹² appeals for NGOs and other appropriate welfare agencies to assist in the implementation and securing of these rights¹³ (UNHCHR 1989, UNHCR 1994, Robinson, 2000, UNICEF 2005).

Implicit in the Convention¹⁴, is the role of the family to act as a buffer for their children against abuses and provide a natural environment for growth and well-being of its children¹⁵ (UNHCHR 1989, UNICEF 2005, UNHCR 1994, Tuitt 2000). However, this is not always possible in volatile situations in conflict, refugee camps, detention, or in an unfamiliar, foreign environment

⁹ 22.2 addresses the importance of facilitating family reunification

¹⁰ It was until recently, July 2005, the Australian government’s policy, through the 1958 Migration Act, to hold asylum seekers, including children and youth in detention centers while their refugee status is being reviewed (ABC 2005). While children are granted access to education, they have few opportunities for constructive, socially appropriate activities. A violation of Article 28 (1) of the CRC¹⁰, in detention centers, children are deprived of adequate educational services and are kept in conditions that increase risk factors while impeding protective ones which promote resilience (Zwi 2003, Chauvin 2003, Goode 2002, UNICEF).

¹¹ Recognized in Articles 5, 13, 14, 15, 20, 29, 30

¹² in Article 19 (2.1, 2.2) and 33,

¹³ Obligations under the CRC compel the Australian government and social service agencies to protect the most vulnerable and marginalized and pledge to assist children to ‘fulfill their physical, mental, spiritual, moral and social development,’ and (Raman and Goldfeld 2003). There are increased demands on service providers while funding and resource allocation has been diminished (Cemlyn and Briskman 2003).

¹⁴ under Articles 3.2, 5, 14, 18, 27 and 29

¹⁵ Article 3.2 ensures child protection by “taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her.” Article 5 states that governments shall respect the “responsibilities, rights, and duties of parents... or members of the extended family or community as provided for by local custom...in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the children” (UNHCHR 1989).

in resettlement. War, trauma and uprooting leaves families broken, scarred and, at times, permanently destroyed which debilitates parents' or primary caregivers' capacity for securing their children's rights or attending to their needs¹⁶ (Tuit 2000). However, the CRC does emphasize that governments' need to support parents and families through providing the basic material needs, services and family support programs¹⁷.

Rights to health, education and to an adequate standard of living are known as "progressive rights"¹⁸ because they are meant to advance along with the economic development of the State (UNHCR 1994, UNICEF 2005). However, these social welfare rights should not be considered simple abstract principles. As they are rights deemed by international law, the prohibition against discrimination, in Article 2, obliges States to bestow the same benefits to all children, including those who are refugees on its territory, equally and without prejudice (UNHCR 1994). This issue as well as the government's responsibility to adequate service provision is particularly salient when considering the Australian policies of detention and varying visa classes assigned to asylum seekers and will be discussed in the ensuing section.

3.3 Other International Instruments Relevant to Refugee Children and Youth

In addition to the CRC, there are other international instruments that are germane when discussing the advancement of rights of refugee children and youth. UNHCR's "Refugee Children, Guidelines on Protection and Care" echoes the principles in the CRC, "one of the best ways to help refugee children is to help their families, and one of the best ways to help families is to help the community" (UNHCR 1994). The Guidelines are a comprehensive tool by which to gain a broader awareness of the intricate issues facing refugee children, young people and families while providing concrete frameworks and recommendations for facilitating programs when working with refugee communities (UNHCR 1994).

¹⁶ Parents, in general and when possible, maintain responsibility for the "well-being" of the children, as is also reflected in the CRC. However, in detention centers they are powerless and unable to act in the best interest of their children and they are not necessarily equipped to meet the emotional and developmental needs of their children (Zwi 2003, Raman and Goldfeld 2003). Furthermore, diametric to international law which protects family unity¹⁶, families in detention are sometimes separated which creates further trauma and places children and youth more at risk (Bhagwati 2002).

¹⁷ in Article 19

¹⁸ Articles 24, 28 and 27 respectively

UNHCR's "Policies and Procedures in Dealing with Unaccompanied Children Seeking Asylum," established in February 1997, delineate the decisive steps states should take to implement structured, comprehensive protection and assistance to unaccompanied minors¹⁹ (UNHCR 1997, WCRWC 1998). The Guidelines affirm the principles of child care and protection as articulated in the CRC as the standard for the rights of all children, including those who are refugees, moreover, they designate specific human rights violations against children warranting asylum protection. Amongst these are bonded labor, forced military conscription, rape and sexual assault, FGM, prostitution, and the deprivation of basic nutritional and medical needs²⁰ (UNHCR 1997, WCRWC 1998). Articles 13 of the International Covenant on Economic, Social and Cultural Rights (1976), article 28 of the Convention on the Rights of the Child, and Millennium Development Goal 2²¹ recognize children's right to education which is often denied in refugee camps and in detention centers upon resettlement (UNHCR 1976, UNHCHR 1989, UN 1990)

In an unprecedented move, in 1999, the Security Council adopted a resolution, Resolution 1261, regarding children and armed conflict with specific concern for forced military recruitment of child soldiers (UN 1999, Tuit 2000). The General Assembly on May 25, 2000, in an Optional Protocol to the Convention, increased the age of participation in conflict situations and recruitment into the armed forces from 15 years to 18 years old (UNHCHR 2002, UNICEF 2005). And, again, in April 2004, the Security Council unanimously brought forth a new Resolution on Children and Armed Conflict (Res. 1539). This resolution expands on a range of issues including additional efforts to impede forced recruitment of children into the military, the need for the UN to establish a cohesive monitoring and reporting system on violations against

¹⁹ The definition of an unaccompanied child is a "person who is under the age of 18... and who is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so (UNHCHR 1997).

²⁰ In Refugee Status Determination for Unaccompanied Children 8.7 (UNHCHR 1997)

²¹ Article 13 of the International Covenant of Civil and Political Rights states, "The States Parties to the present Covenant recognize the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms" (UNHCHR 1976). Article 28 (1) of the CRC designates, "States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity... (3) States Parties shall promote and encourage international cooperation in matters relating to education, in particular with a view to contributing to the elimination of ignorance and illiteracy throughout the world" (UNHCHR 1989). MDG 2 advocates for universal primary education and ensuring that all boys and girls complete a full course of primary schooling including eliminating gender disparity in schools (UN 1990).

children, later to be Resolution 1612, and the need for a deeper understanding of the trauma of and abuses against children during times of conflict²² (UN 2004, WCRWC 2004).

While the CRC offers an important theoretical and legal framework for the protection of children, immigration law of nation states is often where human rights, principles and domestic policies come into opposition. Promoting the best interests and well-being of refugee children and youth can be lost in the bureaucracy and politics of western countries of exile (Fazell and Stein 2002).

3.4 Australian Policy

The Australian Integration policy was initially implemented from the mid-1960s to 1973²³. The large number of migrants and refugees entering Australia experienced hardships as they began the process resettlement and required expanded assistance and welfare services. By 1973, the concept of ‘multiculturalism’ and policy bearing the name was being widely accepted. Diverse ethnic groups throughout Australia were forming associations to reflect their customs and traditions, maintain their languages, and promote their culture in conventional and governmental institutions (Mitar 2005). DIMIA describes Australia’s policy of ‘multiculturalism’ as

“the philosophy, underlying government policy and programs that recognizes, accepts, and celebrates our cultural diversity. The freedom of all Australians to express and share their cultural values is dependent on their abiding by mutual civic obligations (DIMIA 2003, Mitar 2005).

Although multiculturalism is espoused, it is also contingent on manifold rules and laws of society that do not necessarily support equality and the principles of democracy such as practice of housing children and youth in detention centers and the hypocrisy of visa subclasses. Recently, the Australian government has been criticized for its treatment of asylum seekers and in particular the excessive concern for protection of its borders. Those who are the most affected are not would be terrorists or smugglers but the refugee communities who have fled violence and

²² The Convention Against Torture and Other forms of Cruel, Inhumane, or Degrading Treatment of Punishment (1984), in Article 14, mandates that governments should provide for proper rehabilitative services which extend to children and youth²² (UNHCHR 1987).

²³ Previous to the Integration policy was the Immigration Restriction Act of 1901 otherwise known as the White Laws which excluded those of non-European background from settling in Australia (Cemlyn and Briskman 2003)

oppression in their own homelands to seek legitimate refuge in Australia (Cemlyn and Briskman 2003).

3.4.1 Varying Visa Classes and Policies

Many refugees who arrive in Australia are referred from UNHCR under the Humanitarian Program which will allow them to receive a permanent resident visa. Others come with a valid entry visa and apply for asylum once they arrive in Australia. They are given ‘Bridging’ visas to allow them to remain in the country while their paperwork is reviewed and processed. Those refugees who flee their homeland, stay in a second country for over a week, and arrive in Australia without proper documentation are placed in mandatory detention. Once their status as a refugee is determined they are issued a ‘Temporary Protection’ Visa (TPV)²⁴ (Goode 2002).

3.4.2 Temporary Protection Visa Policies

On the 20 October 1999, the Minister for Immigration and Multicultural Affairs introduced the Temporary Protection Visa²⁵ as one of a range of measures aiming to deter asylum seekers arriving without authorization. Under this system, asylum seekers who have been successful in their applications for refugee status in Australia will no longer be allowed permanent residence but will be given a temporary entry visa which must be renewed after three years (Cemlyn and Briskman 2003, Goode 2002). However, asylum seekers who arrived formally and through legal channels will still be granted permanent residence visas²⁶. In September 2001 new legislation was introduced denying the likelihood that TPV holders would be eligible for a permanent visa and extended the use of TPVs through the introduction of two new temporary visa classes²⁷ (Cemlyn and Briskman 2003, Goode 2002). These different categories create two different classes of refugees having different entitlements. For example, TPV holders are denied access to services, legal status and family reunification²⁸ (Refugee Council of Australia 1999). Not only

²⁵ Subclass 785

²⁶ Visa Subclass 866

²⁷ Visa subclasses 447 and 451

²⁸ In addition, TPV holders are precluded from tertiary education because of the imposition of high fees, have limited access to social security, no automatic right to return to Australia, no family reunification and their eligibility for Medicare is subject to the lodgement of the permanent visa application (Refugee Council of Australia 1999).

are these discriminatory practices a violation of the 1951 Convention Relating to the Status of Refugees, Article 31²⁹, but they create additional stress on already traumatized communities (UNHCHR 1996).

It took 13 months for my application to be accepted by Department of Immigration and Multicultural Affairs (DIMA) but now it can take any amount of time. I think most people can handle around 6 months of waiting but after 12 months people have obvious depression, and after 2 years most people suffer permanent depression and damage to their mental well-being. It is my observation, that if you can survive the fear, uncertainty, lack of recognition, and rejection from the department and other parts of society, you must be very strong. But even if you survive, you still suffer some permanent damage...I had no choice but to come to Australia, it was the only valid visa I had, it was the only place I could go. Legally I was stuck with it. We are not queue jumpers - we are struggling with our lives (a refugee from China cited in Scattered People 2001)

3.4.3 Detention Centers

It had been the Australian government's policy, through the 1958 Migration Act, to hold asylum seekers, including children and youth, in detention centers while their refugee status is being reviewed (Minister for Immigration 2005, ABC 2005). The detention of children, including unaccompanied minors, is a violation of their rights under Article 37 of the CRC where detention is a measure of "last resort" and should be for the "shortest period of time." Detention centers, as denoted in Article 22 of the CRC, is contrary to providing "humanitarian" assistance and the "enjoyment" of rights under the law" (UNICEF 2005, HREOC 2005, Bhagwati 2002).

Australian policies regarding children in detention is beginning to change, however.³⁰ After increased pressure from advocacy groups, NGOs, professional organizations and lawmakers, on the 29th of July 2005, the Minister for Immigration, Amanda Vanstone, announced that all families with children³¹ who had been in detention had been moved into residences in the

²⁹ The 1951 Convention Relating to the Status of Refugees provides that States shall not impose penalties, on account of their illegal entry, on refugees coming directly from a territory where their life or freedom was threatened (UNHCHR 1996)

³⁰ The situation reached a crisis point after the Tampa boat incident in August 2001. The government refused to permit over 400 asylum seekers to come in to Australian territory. The "Pacific Solution" to the refugee crisis was introduced (Goode 2002).

³¹ There were 20 families, and 42 children who had been moved out (Minister for Immigration 2005, ABC 2005)

community. Under the nascent program, families will live in the community although still report to the Immigration Department regularly (Minister for Immigration 2005, ABC 2005). Funded by DIMA and in partnership with NGOs and the Australian Red Cross, housing, living expenses, and case management, will be provided for the families (ChilOut 2005). The placement of refugee families in community settings help reduce the risk factors in their lives so that youth begin to build resilience, establish peer support, feel a sense of belonging and gain dignity and respect (Chauvin 2003).

Findings 4.0: Psychological Impact of Trauma on Refugee Youth

Broken Childhood

War demolished part of my childhood. Five Years of my childhood I lived in scary times. We did not have games or parties. Everyday my family and I wished to stay alive. I lost my city, my home, and my friends from earlier childhood. Because of the war I live far from my native country

- Edvina Medina (cited in Pittaway et al 2001)

The Universal Declaration of Human Rights, in Article 25, establishes that mothers and children are entitled to special care and assistance and that all children have the right to protection (UN 2005). However, in conflict-ridden situations, protection is rarely guaranteed. Children and youth are thrown into dangerous circumstances with little to no warning or preparation and maybe separated from their parents and families who could offer some semblance of consolation or assist in their understanding and adaptation to the new and often hostile environment (Save the Children 1996, UN 2005, UNHCR 1994). The degree of trauma that has befallen refugee children and youth cannot be downplayed (Low and Nguyen 1997). Many times the risk factors are compounded by the injury or death of a family member, persecution, exposure to extreme brutality, inadequate substantive care, exploitation or physical/sexual abuse and denial of educational opportunities and health care (UN 2005). Even in the aftermath of conflict and there is a return to an ostensible safety in refugee camps, many children are experience rage, aggression and guilt (Southwick and Friedman 2001, Sims et al 2000). This section will highlight the experience and risk factors in refugee camps and the consequential psychological impact on refugee young people.

4.1 Refugee camps

The consequences of war can include displacement to a refugee camp in which refugees and displaced communities are deprived of a consistent social, economic and cultural environment (UNHCR 1994). During this period, families are living in chaos and uncertainty, not knowing if or where they will have to move again or if they will be awarded refugee status and resettled in a completely alien environment (Brough et al 2003, Low and Nguyen 1997). In addition, in the refugee camps, safety remains a major concern as clashes from the home country are often transplanted in the hierarchy and social structure of the camps. The presence of troops or United Nations staff and embassaries does not reduce the threat of violence (Sims et al 2000). Systems

of social protection collapse and there are often high levels of violence, substance abuse, child prostitution, increased HIV infection, sexual assault, domestic violence and child recruitment into armed forces. Moreover, there is a dearth of food, primary health care, hygiene, immunizations, and educational resources available to support the vulnerable communities (Save the Children 1996, UN 2005, Mehraby 2005). Prolonged malnutrition and lack of adequate hygiene can irreparably affect a child's brain development and, consequently, hamper ability to learn and process information³² (Harrell-Bond 2000, Pynoos et al 2001).

4.1.1 Education in Refugee Camp Settings

Youth who have not had access to primary education need interim educational opportunities and basic skill provision to aptly prepare them for a formal system of schooling in resettlement (WCRWC 2004). Most children and youth who are in school are in the early primary grades with only 6 percent of all refugee students enrolled at the secondary level. Teachers in emergencies must work under great adversity with overcrowded classrooms often with 100 or more students; multi-grade, multi-age classes; and threats to their own safety. In some cases, teachers have little training or education themselves and in most emergency and protracted camp situations, the majority of teachers are men, which can lead to lower enrollment of girls (WCRWC 2004).

4.1.2 Violence and Forced Military Recruitment

During armed conflict, as recreational or educational opportunities become sparse, adolescents may feel disillusioned, bored and apathetic about their future. Children and youth have few positive role models to whom they can turn for comfort or counsel. The military is seen by some youth³³ as a means to receive protection and obtain basic resources needed to help their family. The desire for power can be a persuasive force in situations where people feel powerless and vulnerable (UN 2005, Harrell-Bond 2000). Others may be forced to join the army³⁴ and are often

³² Refugees living in camp settings have a sub-nutritional diet lacking of micro-nutrients increasing susceptibility to infections and causing illnesses such as night-blindness, pellagra, and scurvy. In addition, health epidemics such as measles, dysentery, meningitis and cholera are prevalent, especially in the larger camps³² (Harrell-Bond 2000, UNHCR 1994).

³³ Especially those from impoverished and marginalized background and those who have been separated from their families (UN 2005)

³⁴ As mentioned earlier, it is a violation of international law to recruit a child under 18 to be a soldier (CRC article 38, Optional Protocol, Resolution 1539).

given the most perilous tasks such as mine detection and removal (Mehraby 2005). Adolescents, in particular, are at an increased risk of experiencing violence themselves and through attempts to defend members of their peer group or family who might also might be abused, tortured or facing political arrest (Pynoos et al 2001).

4.1.3 Family Disempowerment

Children may feel abandoned by adults and society for the failure to adequately protect them. When parents are stripped of their authority, this disempowerment may undermine children and youth's emotional wellbeing and development. Their roles as carers and providers are compromised as they become subordinate to a system over which they have no control. Parents face humiliation and are enervated on a daily basis, standing in line for food, seeking basic services and provisions, with their ability to provide for their family tenuous consistently in question. Sometimes a child or young person must take on adult responsibilities, trying to care for the younger siblings (Harrell-Bond 2000, UNHCR 1994). In addition, as international immigration standards are more stringent, parents often think that sending their children away is the safest solution for them. They retain the hope that their child, on his or her own, would have an increased chance of garnering refugee status, but it often creates more turmoil for the children. Separation from family may create long-term risks to children and youth including intense feelings of abandonment and estrangement and an increased vulnerability to being trafficked, sexually exploited, or being adopted illegally. Families should remain in tact if possible throughout the process of flight, seeking asylum and resettlement, as the security of the family unit appeases the anxiety of the children and youth and in emergency settings, family reunification should be a priority (Fazel and Stein 2002, UN 2005, Pynoos et al 2000, Save the Children 1996, UNHCR 1994).

4.1.4 Protracted Refugee Camps

The development of children and youth is intrinsically affected by prolonged refugee camp experiences where they might spend years in the artificial environment with few external resources to cultivate their minds or release their young energy. Refugee children and adolescents in these circumstances have restricted freedom of movement, grow up dependant on

inconsistent care and external support of aid workers, and often live in impoverished conditions with few leisure activities to keep them engaged (UNHCR 1994, Save the Children 2005). Many children and adolescents suffer from the adverse effects of extended refugee camps, particularly those who have been born in camps and have spent their entire lives there, and may have difficulty adapting when they finally leave the camps (UNHCR 1994)

4.1.5 Recommendations

Many of these complicated issues and mental health outcomes often are unresolved in refugee camps due to lack of resources and trained personnel available to address the overwhelming needs (WHO 1996, Save the Children 1996). There are not many programs that address psychosocial well being among the refugees children and youth in the camps and the few projects that do exist are only able to serve a small number of children. All though not addressing the mental health problems specifically, schools, play groups and organized activities can provide the physical and emotional structure and cognitive engagement that can help the refugee children to begin to resolve the trauma (Save the Children 1996, WHO 1996). Focusing on basic needs and prevention of further harm reinforces resilience. Salient factors in fostering well-being include a sense of safety and security, re-building trust in others, promoting familiar routines and normalcy, planning and participating in activities, establishing caring relationships with adult caregivers, enhancing self-esteem, and help in the development of a sense of identity (Save the Children 1996, UNHCR 1994).

Findings 5.0: Consequences of Trauma on Refugee Young People

What the eye sees, the heart never forgets.

-Malawian Proverb

Refugee children and youth have had to deal with a myriad of traumatic experiences and human rights violations while they are going through their own cognitive, emotional, social and physical development. The initiatory experiences and upheaval may influence their mental and emotional wellbeing as the impact of risk factors is cumulative; the more trauma to which they are exposed, the greater the incidence of psychological distress (Pynoos et al 2001, Pittaway et al 2001, Raman and Goldfeld 2003). The impact of trauma is not limited to those who suffer it directly, children and adolescents are affected by the responses of others in their family, community, and peer group³⁵ (Rothe et al 2002, Sims et al 2000, UNHCR 1994, Ortiz 2001). This section will discuss the detrimental health, emotional, developmental, and social consequences of prolonged trauma that affect refugee young people and their future if these needs are not addressed (Sims et al 2000, Raman and Goldfeld 2003). The concept of cultural bereavement will also be highlighted as an alternative view to western notions of pathology and a more culturally specific manner of coping with trauma.

5.1 Post Traumatic Stress Disorder (PTSD)

As a consequence of the crisis' they have endured, many children and youth may be prone to chronic depression and Post Traumatic Stress Disorder (PTSD)³⁶.

³⁵ Secondary trauma can be equally as devastating in children and youth as they are often dependent on adults who have also been traumatized and therefore are unable to meet their children's developmental needs (Sims et al 2000, Ortiz 2001).

³⁶ For example, in a study of Cambodian refugees, there were high incidence of severe depression, 68 percent, and PTSD, 37 percent³⁶ (Mollica and McDonald 2000).

Among the characteristic symptomology of PTSD are:

Symptomology of PTSD	
<ul style="list-style-type: none"> • sleep disturbances brought on by fears of the dark, nightmares and bed wetting; • vivid flashbacks and repetitive, intrusive thoughts about a traumatic event, frightful omens; • somatization³⁷/physical symptoms such as stomach and head aches and loss of appetite; • withdrawal and reluctance to connect with others; • elective mutism; • separation anxiety, not letting the parents out of sight, fear of abandonment; 	<ul style="list-style-type: none"> • difficulty concentrating with memory problems in mastering new and remembering old skills; • exaggerated fears and worry including a sense of pessimism about the future; • hypervigilance with an acute awareness to possible dangers in their new environment; • survivor guilt; • depression and suicidal ideation; • panic reactions; and • irritability, anger, and aggression

(DSM IV-IR 2000, STARTTS 2005, Herbert 1997, Thomas and Lau 2000, WHO 1996, Rothe et al 2003, Pynoos et al 2000, Denham 2003, Save the Children 2005).

While the extent of trauma exposure and strain varies cross culturally and per individual, the detrimental impact is universal³⁸. Research indicates that the more grievous and recurrent the incidents, the poorer one's psychological outcome in terms of onset and severity of PTSD symptoms³⁹ (Kinzie and Jaranson 2001, Thomas and Lau 2000, Clarke et al 1993). Moreover, reoccurrence or exacerbation of symptoms might surface in response to a trigger, or various stresses and anxieties in their daily lives (Pynoos et al 2000).

5.2 Developmental Implications of Trauma

As each developmental stage has biological, cognitive, emotional and social implications, the interplay between one's experiences and his or her biological growth is of consequence on the

³⁷ Somatization is the process where the individual feels pain or displays physical symptoms which have no medical or biological aetiology (Mollica and McDonald 2000).

³⁸ Moreover, the way in which trauma is experienced is affected by the age and developmental stage of the adolescent (Pynoos et al 2001).

³⁹ PTSD symptoms were demonstrated to be distinct from symptoms of depression and take different courses over time. It has also been shown that, concomitant with the existence of depression, the intensity of PTSD symptoms tended to lessen over time while depression might be present longer and manifest in different ways over different circumstances in resettlement (Kinzie and Jaranson 2001, Clarke et al 1993).

developing brain of children and adolescents (van der Veer 1998 p. 153, Raman and Goldfeld 2003). Children and young people who have survived such devastation and loss might have difficulty with the negotiation of developmental tasks resulting in potential developmental delays (Pynoos et al 2001, Raman and Goldfeld 2003, Herbert 1997). As one's environment influences the development of the brain, in contexts of extreme upheaval and uncertainty, the amalgamation of detrimental factors compound developmental problems and complications⁴⁰. Studies have indicated this neurological impact of trauma and the possibility of organic alterations in the brain due to extreme trauma (Mollica and McDonald 2000).

5.2.1 Neurological Impacts

Chauvin sites clinical trials that illustrate neurophysiological and neurochemical changes which occur as a result of unabating incidences of violence, abuse and suffering in childhood and adolescence⁴¹ (2003). Some of these include: constantly being alert for and wary of signs of danger; heightened 'fight/flight' adrenalin response that suppresses normal body functioning and affects the immune system; pituitary-hypothalamic and autonomic nervous system dysregulation⁴²; and the body's natural, protective response to slow the adrenalin reaction by changing the neurochemistry to calm its activity down which, in turn, can lead to numbness or depression (Chauvin 2003, Rothe et al 2003, Southwick and Friedman 2001). Sensitization⁴³ may cause an individual to be in a hyperreactive state in which he/she overreacts to minor stressors. The body continues to react as if a danger is present even when none exists in the current environment (Southwick and Friedman 2001). These physiological and neurological responses, without any positive, healthy, protective coping mechanisms in place, can lead children and youth to be more susceptible to increased anxiety, depression, impulsiveness, anger management issues, self-harming, extreme risk taking, sexual promiscuity and suicidal tendencies (Chauvin 2003, p41-43, Clarke et al 1993, Pynoos et al 2001).

⁴⁰ Those which have the greatest impact include the duration of the trauma; the age of onset of events; the presence of other risk factors and/or protective factors; and the well being of significant caregivers, most notably the mother (Thomas and Lau 2002, Chauvin 2003).

⁴¹ For example, chronic hypervigilance or avoidant coping mechanisms used to deal with trauma affects neurochemical changes in the brain during development (2003).

⁴² Dysregulation is the impairment of a physiological regulatory mechanism such as the metabolic rate and immune response (Wikipedia 2005). The break down of these functions might also lead to bed wetting and encopresis responses (Rothe et al 2003).

⁴³ Sensitization is the stressor-induced increase in behavioural or physiological responsiveness following exposure to subsequent stressors (Southwick and Friedman 2001)

Often children who seem obstinate and noncompliant actually have neurophysiological problems including compromised control over their reactions which would hinder their ability to regulate their impulses, aggression, and emotions (Southwick and Friedman 2001). These maladaptive coping behaviors may be automatic responses to perceived danger or threat as many refugee youth have been accustomed to pervasive suffering, rejection, fear, and unfulfilled hopes as a way of life (Sims et al 2000). As this population is particularly vulnerable, those working with youth from a refugee background, such as teachers, counselors, youth workers and community agencies, should be aware of these intersecting and complex forces and exercise a large degree of sensitivity and compassion in their practice.

5.2.2 Cognitive Impacts

In addition to the complex biological implications, emotional, cognitive, and moral development is hampered as the result of trauma. Damaging experiences and extreme suffering adversely impacts young people's self-perceptions and the expectations of others (Fazell and Stein 2002). For example, adolescent cognitive development may be impeded, especially with regard to insight and awareness into social constructs. Refugee youth are less able than other adolescents to view themselves and social interactions objectively and have more difficulty recognizing contradictory motives within themselves and others. This might cause them to make mistaken assumptions about people, misinterpret social actions, and place them at risk for being exploited or taken advantage of by peers. Moral development and consciousness may also be interrupted causing negative views of self, others, the world and the social contract (van der Veer 1998, Pynoos et al 2001, Clarke et al 2003). There needs to be more thorough understanding of developmental implications in children and adolescents that will help lead to more appropriate and effective interventions and healing.

5.3 Cultural Bereavement - Discussion

A refugee movement can disrupt nearly every aspect of a culture. The social upheaval caused by the involuntary movement of individuals, families and communities, can dramatically affect the coherence of their culture. Normal social rules, values and controls begin to break down when the social group which provides the framework for their application disintegrates. This may lead to feelings of cultural bereavement (UNHCR 1994).

The traditional mental health model tends to focus on the more scientific aspects of trauma and experiences of refugees assigning western-type symptoms such as PTSD and a plethora of anxiety disorders to what are often natural responses and visceral coping strategies to dire conditions. There has been increased discussion about the appropriateness of applying these notions across all cultures when the expression of trauma is innately rooted in cultural and social constructs of the refugee's country of origin (Mollica and McDonald 2000, Silove and Kinzie 2001, Save the Children 2005). Although psychological interpretations of trauma are valid, these views, in turn, may limit a more holistic understanding of communities beyond the definition of certain behaviors and distressed peoples (Save the Children 2005, Brough et al 2003). For example, as one refugee explained:

All the villagers have nightmares and trouble sleeping. Everyone is fearful of wandering too far from the village and no one talks about the bad things that have happened. It is better not to think about the past... We are always nervous, on guard, and suspicious... We have to be.. These things... are natural in all of us" (cited in Silove and Kinzie 2001).

Legitimizing the extraordinary experiences of refugee families and youth, it is important to look to other, more culturally rooted, models of trauma and healing. For example, Eisenhruch (1991) describes the concept of 'cultural bereavement' as the extreme loss of one's homeland, culture, and way of life. It can be expressed as a "strong idealization of reference persons, objects and situations" from the country of origin and the subsequent longing to recapture "the lost past and ultimately the survival of their culture." Reactions and emotions "reflect a profound communal suffering, the experience, the meaning, and the expression of which are culturally determined" (Eisenhruch 1991).

Langer affirms that a broader perspective must be examined to have a more lucid understanding of refugee trauma which ultimately arises out of "the intersection of history, social structure and biography – an intersection that does not cease when refugees leave their homeland" (Langer 1990 cited in Brough et al 2003). Service providers and society as a whole needs to begin to understand the profundity of refugee trauma, apart from external symptomology, without judgment or stigma. Elie Wisel eloquently articulates the misconceptions of expressions of loss:

When human beings tell victims who have suffered excruciating pain and loss that their pain and loss were illusions, they are committing the greatest indignity humans can inflict on another. They are treating the victim as if they are a

product of some diseased mind. There is perhaps a greater baseness, those who believe that the victim is a product of a diseased mind and that their pain and suffering are illusions.

The conservation of and right to participate in a cultural life are recognized human rights⁴⁴ (UNHCHR 1976, Save the Children 2005). Cultural practices and coping mechanisms are authentic means through which to cope with symptoms of PTSD, heal from past trauma and adapt to the uncertainty of resettlement (Denham 2003). Expressions of the sense of loss for their culture and traditions might surface through more traditional manifestations⁴⁵ such as being possessed by spirits, hearing voices of ancestors, or seeing daily reminders of the cultural past (Eisenhruch 1991).

Refugees are often categorized by their experiences during and after conflict with little reflection on their lives and roles in their community before the upheaval and trauma occurred. Mollica and McDonald argue that the international community must “re-conceptualize” refugees’ experience to incorporate the vital role they will play in their society’s rebuilding and rehabilitation (2000). Awareness of cultural bereavement and broader social issues as separate from pathology can be used to facilitate work with refugee youth and families. Through normalizing their feelings and establishing traditional outlets for healing, the daunting course of resettlement will be mitigated (Brough et al 2003).

⁴⁴ Article 15 in the International Covenant on Economic, Social and Cultural Rights (UNHCHR 1976).

⁴⁵ For example, somatization of anxiety and depression is relatively common among South East Asians while guilt is not an emotion which is often experienced in the culture (Eisenhruch 1991).

Findings 6.0: Resettlement

*Banished from their homes
lucky to be alive
thrown into the unknown,
nowhere to go.
At the mercy of the world
They are the refugees*

- Jelena Jovic (cited in Pittaway et al 2001)

UNHCR defines resettlement as:

Resettlement involves the selection and transfer of refugees from a State in which they have sought protection to a third State which has agreed to admit them – as refugees - with permanent residence status⁴⁶. The status provided should ensure protection against refoulement and provide a resettled refugee and his/her family or dependants with access to civil, political, economic, social and cultural rights similar to those enjoyed by nationals. It should also carry with it the opportunity to eventually become a naturalized citizen of the resettlement country (UNHCR 2004).

Resettlement is a layered process which begins much earlier than arriving in the country of exile. While adjustment difficulties are common with newly arrived migrants, who have had some relative semblance of choice, most people become socialized to and identify with the norms, symbols, and behaviors of the host society. In the case of refugees and asylum seekers, where flight has been forced and there is lack of choice in where they were sent in exile this process of acculturation may take longer (Nwadoria and McAdoo 1996, Denham 2003, UNHCR 2004). This section will address the phases of resettlement, the process of acculturation and acculturative stress and ways by which to mitigate the process.

6.1 Three Phases of Resettlement

Van der Veer documents three phases of resettlement and uprooting of refugee populations, which can be applied to youth; the first phase is pre-trauma and ensuing period of incisive trauma in their home country; the second phase includes exile and migration out of their familiar environment into a series of displacements and in to refugee camps in neighboring countries; phase three is the process of resettling in a foreign country and coming to terms with the past and looking towards the future (van der Veer 1998). During this process, an initial reaction might be

⁴⁶ As was previously discussed, this is in contradiction with Australia's TPV policies in which asylum seekers are not granted permanent residence even after they have been granted refugee status.

relief to have escaped the ordeals and violence at home and hope for a new beginning. Subsequently, reality sets in and feelings might turn in to fear of being expelled from the country of asylum, hopelessness, uncertainty, frustration and anger. Government policies, lengthy waiting periods for their status as asylum seekers to be processed, and being unable to make future plans may lead to further psychological distress (van der Veer 1998, Bruce 2003, Low and Nguyen 1997, Silove and Kinzie 2001, UNHCR 2004). Once, or if, permanent residence is granted, refugee children, youth and their families may still undergo insecurity as they cope with adapting to the intricacies of a new country and to a new people.

6.2 Resettlement Guidelines - Discussion

The process of resettlement and being moved to a new country of exile is done amidst the undercurrent of trauma and bereavement for refugee youth and families. Often post-migration stress, such as threat of repatriation, obstacles to accessing welfare services, and housing and employment insecurity, is associated with higher levels of PTSD, depression and anxiety (Silove and Kinzie 2001, Okitikpi and Aymer 2003). UNHCR outlines a series of goals aiming to assist in adaptation and integration of refugee populations upon resettlement in a host country. Some of the recommendations include for governments to provide assistance programs which not only address the basic economic, social, and welfare needs, but also the less tangible aspects which include issues of dignity, security, maintaining respect, and promoting capacity to rebuild their lives,⁴⁷ thereby minimizing the affects of acculturative stress (UNHCR 2004, Bruce 2003).

6.3 Acculturative stress - Discussion

⁴⁷ Among the recommendations to service providers that work with refugee youth are: to promote family reunification and restore supportive relationships within the families; to encourage making connections with welfare workers who can provide additional support; to foster cultural and religious tolerance and to restore attachments to and participation in community activities; to counter racism, discrimination, and xenophobia while advocating for a receptive and open society; to support the building of strong, unified refugee leadership ;and to advance conditions that support positive environments for all refugees regardless of age, gender, family status and past experiences (UNHCR 2004, Bruce 2003)

Acculturative stress can occur throughout the acculturation⁴⁸ process of adjusting and can be manifested in a multitude of ways. Some of the common challenges include adapting to the physical and environmental changes; new foods and eating habits; contradictory interaction styles; foreign social norms and conflicting values; different child rearing practices, celebration practices and customs of dress; uncertainty of housing, employment or schooling; and worry about those left behind (Nwadoria and McAdoo 1996, Thomas and Lau 2002, van der Veer 1998, Denham 2003). The variation and severity of acculturative stress has to do with the level of congruency between the two cultures as well as the way in which the new communities are received and viewed by the host country. Often refugees encounter unreceptive welcome and face intolerance, racial discrimination, xenophobia, and misconceptions about their culture. Inner conflicts about new values, norms, and traditions that might be in opposition from their own compound the sense of loss and frustration (van der Veer 1998, Mitar 2005) As refugees may have fewer options and scantily allocated resources available to them in easing the assimilation process, stress and anxiety is augmented⁴⁹ (Nwadoria and McAdoo 1996). One refugee from Sri Lanka describes his process,

I am very new to this country. Because I don't have anything I am like a beggar. I am only lonely ... I haven't bring anything, only a little money, some clothes now what I am wearing is what I have got so that is very hard to see after the life I spent in my own country with big status (cited in Scattered People 2001).

Culture shock can reflect this state of loss and maudlin remembrance of the past. Refugee families lose their homes, members of their family and friends, the respect within their own communities, social outlets, ability to communicate with ease, and a sense of independence (van der Veer 1998). Stress is created as the traumatic past merges with the confronting issues of the present and pervasive worries about the future (Brough et al 2003). Each individual and family will have complex feelings about being resettled and rebuilding their lives in a foreign environment which may be inseparable from the broader social and political influences of their

⁴⁸ Berry (1970) defines acculturation as the change which results from continuous, firsthand contact between two cultural groups. He lists several that are likely to occur. First, physical changes in housing, increased population density, and pollution; and second, biological changes, due to differences in types of food. However, the most crucial changes are cultural: political, economic, technical, linguistic, religious, and social institutions become altered as new ones take effect; interpersonal and intrapersonal relationships become established. Such psychological and behavioral changes always occur as individuals adapt to their new milieu (Berry cited in Nwadoria and McAdoo 1996).

⁴⁹ This is especially true for asylum seekers who are on TPVs

past and the context of their current situation (Bruce 2003, Brough et al 2003). For some, the experience will be welcome as they fluidly join society as a new member, for others it will be more frightening often riddled with an amalgam of issues of acculturative stress⁵⁰.

6.4 Recommendations – Discussion

Brough et al argue that while it is important to have an awareness of the way refugee youth and communities adapt to a new culture, from a broader public health perspective, it is also crucial to acknowledge the value of adapting the environments into which refugees are settling to help support and facilitate their transition (2003). Within this framework, opportunities should be created to grant refugees the ability to work, participate in training or educational programs and promote a participatory model of re-building community and healing. Moreover, allowing communities to take an active role in their recovery re-establishes their sense of dignity and purpose (Mollica and McDonald 2000, UNHCR 1994).

⁵⁰ Acculturation occurs on a continuum depending on each individual, his or her history, culture, and the support networks surrounding him/her. Adaptation, or integration describes the process when refugees maintain their cultural identity, are involved with social networks with those from their own home country and are also able to integrate into the host community creating a bi-cultural lifestyle. Partial adaptation is characterized by the selective assimilation in their new environment, absorbing some aspects of the culture while rejecting others. Over-adjustment, or over-assimilation, exists when the norms and values of host society are assumed completely while the cultural traditions of origin are rejected. Lastly, de-culturation is when refugees strike out against the new way of life, have feelings of identity confusion and become alienated from both their own culture and that of the larger society (van der Veer 1998, Nwadoria and McAdoo 1996).

Findings 7.0: The Refugee Youth Experience in Resettlement

The phenomenon of exile, and I've seen it as a metaphysical phenomenon. I feel as if I've been exiled from a state of identity. When I was little there was a shared identity between the world and me: I was the world; the world was me. There was no difference... So I guess you would say I've been exiled from Eden, the Garden.

- Li-Young Lee (Kaminsky and Towler 2005)

Youth are at a developmental stage when they are transitioning from emotional dependence on parents or adult caregivers, to interdependence, and eventually independence with a stronger sense of self and identity as an adult with their own values and beliefs. These changes in physical, emotional and cognitive development coupled with family expectations and influences of peer groups may cause additional stress on the refugee young people and are intensified with the transition to a new culture (Refugee Resettlement Advisory Council 2002, van der Veer 1998). These challenges may interfere with their identity formation as they struggle to navigate the competing values of their country of origin with those of the mainstream in a new country (Brough et al 2003, Mehraby 2005). According to research from the Kings' Fund in the UK, identity issues arising from loss of nationality status, immersion in a new culture, and feeling different from other people are at the core of the issues faced by refugee young people (Save the Children 2005). This section will discuss these factors with reference to education, family, intergenerational conflict and bi-cultural identity.

7.1 Education

Educational opportunities for refugee youth, as a result of displacement and lack of resources in refugee camps, might have been sparse or completely non-existent (Brough et al 2003). Moreover, the pervasive trauma that they have experienced might have impacted on their ability to concentrate, have caused memory difficulties and created additional anxiety in school situations (West 2004). Often youth are placed in the school system immediately upon arrival without any adjustment period. Some young people may not yet be able to read or write in their own language and are being required to learn new concepts in a second language (Mehraby 2005, YAPA 2004). One refugee youth had changed schools a number of times during the

period of displacement before settling in Australia and explained, “The depression that I had is because how I feel about the gap in my education... I found it difficult to cope with that and it effected my educational progress” (Sudanese refugee youth cited in Brough et al 2003).

Language barriers, foreign systems of schooling, and different ways of teaching and thinking about problems create challenges for refugee youth in their new educational environment. Many of the young people develop good verbal and English language skills, but have considerable knowledge gaps in subjects such as math, science, or world history. As adult caregivers and older siblings may not be able to offer much academic support if they, too, have had limited language ability and education, it may be a struggle for the youth to progress, let alone to catch up with their classmates academically. Out of frustration, lack of support and trepidation, young people might drop out of school altogether. Also some refugee youth might leave school in order to financially assist their families or help bring other family members to the new country (Goode 2002, YAPA 2004). School, however, can be an efficacious tool for promoting resilience and well-being in adolescent refugees. A positive and encouraging school environment might increase a sense of belonging, build peer relationships, expand possibilities of success and being recognized for achievement, and help establish a sense of order, rules and consistency (West 2004).

7.2 Family

Resettlement and acculturation can place a great deal of strain on families. Family dynamics often change with a loss of extended networks and the death of individual or multiple family members. Youth may have had to assume increased responsibility within the family unit as parents struggle to settle into a new country and meet their family’s basic needs. Role reversal and identity confusion is common as refugee young people hold the additional burden of being the main link between their parents and the new culture (Low and Nguyen 1997, Mehraby 2005). Youth may be asked accompany their parents to appointments and to interpret or translate important materials such as information regarding housing, employment, and education. These roles leave little time for young refugees to participate in social activities, focus on their own schooling, and individuate from their parents (YAPA 2004). Family conflict and domestic violence, which could have been present in the family in their home country, might be develop or

be exacerbated with the compounded stress in resettlement. If separation or divorce occurs, young people could experience family dissolution with a further sense of isolation, loss and abandonment (Brough et al 2003). It is therefore crucial to take a family systems approach to working with youth in the healing process⁵¹.

7.3 Intergenerational Conflict and Bi-Culturism

In resettlement, children and youth from refugee backgrounds frequently lose their sense of culture more quickly than adults (UNHCR 1994). In order to fit in as easily as possible, many youth embrace a bi-cultural identity. However, intergenerational conflict may ensue as parents expect their children to maintain the more traditional values and roles of their home country while young people feel pressured from friends and the influx of western media to adopt pop-culture values (Brough et al 2003). There is a clash between parental ideas and the adolescent's developmental need to grow and assert independence. Therefore, young refugees are often caught between two worlds in their attempt to find a community to which they belong. They may feel guilty about forsaking their traditional culture yet become isolated from peers if they do not meld with the mainstream culture. Some are able to find a compromise and integrate the new societal ideals with their heritage and traditional culture (Brough et al 2003, YAPA 2004). Culturally appropriate therapeutic interventions will help to link the dichotomous worlds acting as a bridge between family members and refugee young people.

⁵¹ This will be discussed further in the section on therapeutic interventions

Findings 8.0: Resilience

Mental health means much more than just the absence of mental illness. It is about physical and emotional well-being, about having the strength and capacity to live a full and creative life, and also the flexibility to deal with its ups and downs (Save the Children 2005)

Reactions to trauma and stressful events vary between individuals and depend on the balance between ‘stress factors’ and ‘protective factors’ in their lives (van der Veer 1998). The interaction of risk factors and protective elements in refugee youths’ lives interplay to either support or hinder their adjustment to extreme change and adversity (Raman and Goldfeld 2003). Stress or risk factors can be used to describe features that interfere with healthy personality development to make young people more vulnerable. Protective factors may include personal attributes such as intelligence, positive self-image, social responsiveness, feelings of inner strength and ability to hope for the future despite dire circumstances (van der Veer 1998).

8.1 Stress Factors or Risks to Resilience

Some of the most common stress factors which impede refugee young people’s capacity for resilience in include:

Familial Aspects	Community & Environment	Individual Components
<ul style="list-style-type: none"> • Single parent • Parental depression or anxiety • Substance abuse/ domestic violence in family • Divorce • Death of family member • Social isolation • Unemployment • Poor discipline and supervision • Neglect/abuse • Little involvement in children’s lives 	<ul style="list-style-type: none"> • Poverty • Crime and violence • Lack of support services • Discrimination • Inappropriate educational opportunities • Lack of positive adult role models • Lack of supportive peer group • Poor living conditions • Inadequate health care 	<ul style="list-style-type: none"> • Issues at birth – low birth weight, premature birth, • Insecure attachment with mother • Lack of social skills • Poor decision making ability • Little empathy for others • Feeling alienated • PTSD and depression • Impulsivity

(Adapted from Chauvin 2003, Raman and Goldfeld 2003, WHO 1996)

8.2 Protective Factors Promoting Resilience

Resilience can be nurtured and cultivated when the proper systems and protective factors are in place. Protective elements have been found to have similarities across cultures and experiences of refugees. As this is the case, the protective elements should be cultivated and developed increase resiliency and healing for refugee youth (van der Veer 1998).

Familial Aspects	Community & Environment	Individual Components
<ul style="list-style-type: none"> • Caring, supportive family Healthy adult caregivers • Positive relationships between family members • Effective parenting skills • Family receiving appropriate support services including mental health 	<ul style="list-style-type: none"> • Basic needs being met, food, clothing, medical care, housing • Participation in community groups • Strong cultural identity and pride • Secure access to housing in a safe environment • Employment stability with at least one adult member working • Attending school and receiving academic assistance • Knowledge and access to welfare services including health care and counseling • Positive peer relationships 	<ul style="list-style-type: none"> • High self-esteem • Adequate problem solving and decision making skills • Having a positive mentor and/or good role models • Hopefulness about the future • Empathy for others • Sense of responsibility and values • Academic pursuit and achievement • Sense of belonging in a peer or cultural group

(Adapted from Chauvin 2003, Raman and Goldfeld 2003, WHO 1996)

Discussion 9.0: Therapeutic Recommendations for Healing

The significant problems we face in life cannot be solved at the level of thinking that created them.

-Albert Einstein

Addressing the treatment needs of refugee youth can be challenging as they do not easily fit within neat clinical categories nor can the needs be handled piecemeal without a sense of collaboration and engagement with the community⁵². A myriad of therapeutic approaches, including individual, family, group, and school based interventions has proven to be effective in the treatment of extreme trauma with youth⁵³. The combination of long term, developmentally appropriate, and multimodal approaches, in addition, will help to increase resilience and stimulate healing⁵⁴ (Fazel and Stein 2003, Chauvin 2003). It is equally as vital to incorporate indigenous methods of healing, building on the strengths of the elders and healers from the local community (Mollica and McDonald 2000). This section will discuss the various therapeutic components to healing which include building relationships and rapport, integral cultural considerations, phases and strategies in working with trauma survivors, and the important role of the family.

9.1 Building Relationships

Interventions that have the most value are those are based on relationships and sense of community. Without building trust, rapport, and reciprocal respect, effective counseling is

⁵² The need for extended cross-cultural services is also highlighted in the CRC in Article 18 which states, “States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.” And 18.3 maintains, “States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.” Article 30 addresses the importance of culture, “In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language” (UNHCHR 1989)

⁵³ Pharmacotherapy, most notably the use of anti-depressants, can be useful when refugee youth experience severe anxiety or depression. Physiotherapy may also be beneficial to address pain resulting from musculoskeletal injuries and/or psychosomatic symptoms (STARTTS 2002, van der Veer 1998).

⁵⁴ Cognitive behavioral treatment, psychodynamic therapy, trauma counseling, eye movement desensitization and reprocessing procedure (EMDR), and using interactive therapies including play, art, music, and story telling are among many approaches that have been utilized for refugee youth (Fazel and Stein 2003, Ortiz 2001, Mehraby 2005). After the immediate clinical symptoms of PTSD, depression, anxiety are addressed, the psycho-social issues such as reducing risk, changing maladaptive coping mechanisms, and restoring family systems should come in to play to best handle reoccurring anxiety and stress (Sims et al 2000, Chauvin 2003).

impossible (Denham 2003). In order to begin the process of building trust, refugee youth and their families need to have secure access to community programs with a diverse range of professionals and service including interpreters, legal/immigration teams, NGOs, ethnic and cultural community support groups, and integrated case managers⁵⁵. It is particularly beneficial if mental health services are provided on site in youth agencies, school counseling offices or youth-friendly community based organizations as they are less intimidating and more accessible (Chauvin 2003).

In order to best serve the needs of the youth, it is appropriate to view their reactions to the trauma they've endured from a holistic perspective. The therapeutic process must be infused with the principles of empowerment, respect, and honoring the community's traumatic pasts (Ortiz 2001). Establishing a safe space for refugee children and youth to express their feelings, tell their stories and be themselves will begin the process of creating trust and building positive relationships. It is important for them to gain control of their lives, to find meanings to what has happened, and develop appropriate and effective ways to cope with the grief and loss that they have endured (Ortiz 2001, Low and Nguyen 1997). Ortiz argues that survivors of trauma, and torture in particular, work most effectively with flexible, compassionate therapists who are in tune with the unique emotional needs of refugees and have a broad awareness of refugee and humanitarian issues in a human rights based framework of practice. She maintains that the best therapist is one who "does not determine the action, but points the way to various alternatives" (2001). The clients and/or family make important decisions in how they would most benefit from counseling and are able, therefore, to gain a sense of control and feel empowered by their choices (STARTTS 2002). This is especially important for those who have suffered tyranny and feelings of powerlessness throughout their journey to resettlement.

9.2 Cultural Considerations

One's cultural background influences personal development and personality characteristics. As mentioned previously, these cultural components often are reflected in ways in which refugee youth cope with stressors, anxiety, and grief. However, the influence of culture is not blanket

⁵⁵ This is also why Australian policies of differing visas categories which afford unequal service provision is detrimental to the mental health of refugee youth.

determinant of how those from a particular background will behave as each individual will have many factors that intertwine to define his/her personal identity. Van der Veer argues that beyond cultural distinctions, the needs, feelings and vulnerabilities and ways people handle psychological trauma is not culturally specific (1998). Successful programs addressing mental health issues will take into account the intricate nature of each refugee young person, his/her culture, and what approach will be most beneficial to enhance resilience and wellbeing. These should incorporate cross-cultural teams who are sensitive and aware of the clients' background, political history, traditions, and who have extended networks in the different ethnic communities⁵⁶ (Save the Children 1996, Fazell and Stein 2003, Low and Nguyen 1997, Ortiz 2001, Mehraby 2005). Some multicultural elements to consider include: child rearing practices and discipline; knowledge about attitudes toward unaccompanied minors or orphaned children and the responsibility to care for them; the attitudes towards widows, their rights to remarry and how it affects the children; ceremonies and rites around reaching adulthood; beliefs about death, burial and mourning; and practices that support spiritual and psychological healing (Save the Children 1996, WHO 1996, UNHCR 1994). It is important to note that western notions of counseling might not be in harmony with the methods an elder or traditional healer might perform in the refugee's home country (van der Veer 1998). Many cultures prefer to handle issues within the family or community and might not initially be comfortable with outside assistance or intrusion into the personal realm of the family unit. Education about the concept of counseling and what it entails will help allay certain misconceptions or fears (Ortiz 2001).

9.3 Therapeutic Phases and Strategies

There are a wide variety of therapeutic approaches to working with refugee youth⁵⁷. Herman suggests three phases of intervention for effective treatment of torture and trauma; creating safety and trust, clinical intervention and re-integration (Herman 1992 cited in Denham 2002, Turner 2000, Mehraby 2005). Santini, using a psychodynamic approach, describes five stages a client might go through; distrust of the therapist, catharsis and reduction of symptoms, a working through of issues, the ensuing behavioral changes, and ultimately restoration (Santini 1989 cited in van der Veer 1998). Both processes highlight the establishment of safety, a sense of refuge

⁵⁶ Often an interpreter will need to be used. Refer to van der Veer for a more in depth discussion of this topic (1998, Chapter 4)

⁵⁷ Unfortunately, the scope of this discussion will only allow for a cursory description of a few

and trust as primary components in the initial stage of treatment. Apprehension and mistrust can be protective and intuitive responses to trauma. Refugee young people who have consistently experienced violence often feel a profound loss of trust in people. Youth may often test the counselor's credibility and sincerity (van der Veer 1998, Denham 2002, Turner 2000, Mehraby 2005). Compassion and relationship building will help renew the capacity and willingness to have confidence in others again and encourage long-term resilience (Save the Children 1996).

With sensitivity to cultural expressions of psychological distress, it is salient to honor the young people's account of the past and their beliefs about what occurred. Within this process, the unique meanings the trauma symbolizes to the youth are uncovered, pointing out and linking how they are currently reflected in the present (Turner 2000, STARTTS 2002). Through this process, it is hoped that refugee youth and survivors of trauma may feel released from their feelings of guilt and self blame, and understand that their symptoms might be common responses to the extreme situations in which they were placed (STARTTS 2002).

The awareness raising processes that began in the initial phases of establishing trust and rapport are then explored more deeply in the ensuing stages of therapy. According to Herman (1992), specific clinical intervention methodologies are used to delve into these traumatic events and experiences (cited in Turner 2000) and Santini (1989) expands her therapeutic process into three more detailed phases⁵⁸. Within this intermediate stage of processing and beginning to heal, it is a time of remembrance and mourning, consistent with the cultural expectations of the survivor and guided by the needs and capacity of the individual (Denham 2002). The final stage according to these frameworks is the process of (re-) integration, re-connection and restoration (van der Veer 1998, Turner 2000, Mehraby 2005). During this time, the past is revisited and emotions are reconnected in a way that allows the individual to move on and express the feelings more productively in the present (van der Veer 1998).

⁵⁸ These include cathartic release of emotion, analyzing the traumatic experiences and their consequences on current behaviors, and addressing attitudes and behavior in a social context with family, the work environment or with friends (cited in van der Veer 1998).

9.4 Important Role of the Family

In working with refugee youth, integrating the family is a critical component. Often parents have feelings of powerlessness when they are unable to protect their children from danger and they might become overprotective of their adolescents' lives. This exertion of control may disrupt the normal developmental stage of individuating from the family and could elicit resentment or tension between family members (Ortiz 2001, Refugee Resettlement Advisory Council 2002).

Many parents do not wish to discuss incidents of the past and the burden often rests on the children to bear the familial grief (Ortiz 2001). Transgenerational trauma may also pass from parents to children causing youth to assume responsibility for the parental depression, anxiety, and bereavement (Low and Nguyen 1997, Brough et al 2003). One young refugee woman from the former Yugoslavia shared,

The major problem I had (and still have) is living and dealing with my mother's disorder (PTSD)... This makes it difficult to cope, because I attend school, trying to get things done around the house to make it easier for her. However, it is not that easy: it is very stressful to see her almost destroy herself (cited in Brough et al 2003).

The process of recovery and healing is one for the entire family. Encouraging the family to reconnect with their past, and begin talking about their experiences might increase understanding about the trauma. New communication strategies within the family can be explored as well as skill building in re-establishing trust, breaking through isolation, being supportive of each other and coping with the new stressors in resettlement. It is hoped that all the members will gain a more lucid perspective of the reasons why problems arise will be less apt to blame each other for their own feelings and frustrations (van der Veer 1998, Ortiz 2001, STARTTS 2002).

Familial interventions can also be aimed to build protective factors in the family and minimize risk factors. Emphasizing the strength and resilience of the family, the importance of a cohesive unit and developing self-esteem and respect in each family member will facilitate positive outcomes in therapy. In order to foster increased compassion in the family, discussing family patterns, roles, issues of contention, and communication techniques will stimulate awareness and new ways of working together more productively (van der Veer 1998).

Discussion 10.0: Therapeutic Interventions

It takes two to speak the truth. One to speak, and another to hear.
-Henry David Thoreau

This section will discuss a few of the wide range of therapeutic approaches to promoting resilience and healing for refugee young people. As was previously highlighted, there are an array of techniques, philosophies and models to mental health counseling. Some approaches that have been efficacious when working with youth survivors in particular include art therapy, traditional healing practices, and a community development model of intervention. While more research needs to be done on complimentary styles of therapy specific for refugee youth, this paper takes a cursory glance at some of the multi-faceted approaches. The section concludes with a brief discussion of issues that might affect therapists or service providers who are working with refugee young people.

10.1 Art Therapy

Therapeutic approaches using the arts can provide a supportive, structured, and creative environment for the processing of emotions and feelings, identifying strengths and assets, and exploring issues related to identity, communication, relationships, past trauma and worries about the future. According to Coming Up Taller⁵⁹,

The artistic experience entails repetition of actions, thoughts or emotions, over which the adolescent gains increased tolerance or mastery. While providing a means to express pain and unfulfilled longings during a distinct maturational phase, the arts simultaneously engage the competent, hopeful, and healthy aspects of the adolescent's being (Grant Makers Health 2003).

The use of art and nourishing one's creativity in healing is a powerful tool and a non-intimidating technique used to help refugee young people express painful emotions. For instance, drawing offers youth a focal point through which to talk about traumatic experiences creating a 'pictorial representation' and sense of distance from what happened to them (Rothe et al 2002).

⁵⁹ a 1996 national study of arts programs for at-risk youth conducted by the President's Committee on the Arts and the Humanities (Grant Makers Health 2003)

In this regard, aspects of the youth's past may be explored that may have been too difficult to discuss in session. Rothe et al explain that through drawing or art the young refugee is able to reestablish conscious awareness, develop a more structured view of the trauma and thereby promote their ego strength and identity (2002). Many times refugee young people, especially girls under the guidance of elder women, respond to the loss of their culture by embracing traditional crafts and artifacts such as needlework, painting, weaving, working with clay, or dress making (Denham 2003). The dual purpose of re-connecting with their past and expressing loss and unity within their community is served.

Music is another form of art therapy which has proven to be effective in treating and working with refugee youth and communities both on its own or adjunct to other treatment modalities. As music therapy is powerful but non-threatening, it is particularly felicitous for young people who have been resistant to other forms of therapy. Research⁶⁰ indicates that music and singing have distinct physiological and neurological impacts that have a calming effect and enhance well-being. Singing, for example, promotes deep and controlled breathing, integrating both hemispheres of the brain, and stimulates creativity to prompt the healing process (Zubovic 2003). Gfeller discusses the use of music therapy in a cross-cultural context and that "music, through its infinite variety and adaptability, as well as its potent historical and cultural tradition, is a powerful therapeutic resource for emotional expression and reality-based socialization" (Gfeller 1990 cited in Zubovic 2003). Zubovic writes about the Blue River Choir, also known as the Bosnian Women's Choir, based in New South Wales, as a model example of the healing nature of music on refugee communities. The women in the choir have reported to have regained a sense of community, renewed feelings of hope, and have been more responsive to their children and their families in the process (2003).

10.2 Traditional Healing Practices

Many refugee youth and families who are accustomed to going to a traditional healer for illnesses might be unfamiliar with, and wary of, western-style medical care (WHO 1996). There is a diverse range of cultural traditions surrounding health and mental health issues and each

⁶⁰ Zubovic discusses some of the relevant and current research in her article (2003).

society and community have a unique methods and beliefs around traditional healers⁶¹. One example of a traditional therapy widely used in conjunction with western counseling is massage. Traditional massage is used to focus on certain areas of the body where there are energy centers, charkas or points of circulation. This is especially useful for somatization symptoms of headaches, body tension and nervousness as well as treating injuries associated with torture (STARTTS 2002, Denham 2003, WHO 1996). As mentioned previously, traditional music, dance and other arts are significant representations of culture handed down from one generation to the next. In refugee situations and in resettlement, the encouragement of continued practice and training in such traditional arts as well as the celebration of traditional events and festivals is vital to the healing process (UNHCR 1994).

Many traditional healers are spiritually and culturally in tune with what a refugee youth and family is going through. Often communities feel more comfortable speaking with elders whom they hold in high regard. They can act as supportive counselors with whom refugees can discuss their anxieties, fears and thoughts about the past. Often, those treated with a blend of traditional medicine and western therapies will be more likely to recover, work through past trauma and feel a sense of hope for the future than those who only are treated medically (WHO 1996).

10.3 The Community Development Approach with a Rights-Based Framework

A community development as a therapeutic intervention builds on local culture and realities of refugee youths' current situations, and uses a holistic approach to attend to their best interests. A human rights based framework asserts that the principles of human rights and community development are not separate entities and is guided by legal and empowerment foundations with community participation and capacity building as core components (Frankovits 1996). The rights based approach is comprehensive with notions of justice, dignity, the regulation of power and the insurance that basic needs, such as food security, housing, primary health care, and education,

⁶¹ Some of examples of indigenous practices used in healing trauma and coping with extreme stress are cited by The World Health Organization (1996); healers using a trance-like state to ask advice from the gods and seek knowledge about the nature of the illness and its prognosis or hope for the future; shamans assisting individuals to bring back a lost soul that might have wandered off, losing its way, causing the person to become ill; the use of magic as a cure to counter supernatural powers or to ward off black magic as some believe that mental distress can arise when a foreign spirit is introduced by black magic into the body; fortune-tellers or psychics may assist people in regaining a sense of hope or help to create future goals to look towards.

are being met (Sano 2000). Community development, with a rights based approach, therefore, is vital in supporting social institutions, welfare agencies and programs geared to protecting and promoting the well-being of refugee youth. Therapeutic approaches which integrate these aspects, as mentioned previously, are more holistic and will empower the young people to regain a sense of control, develop more fully as individuals and promote a building of trust within their community.

Save the Children uses a community-based approach to psychosocial programs in refugee camp settings and these concepts such as capacity building, awareness raising, and addressing social and cultural rights can also be applied to service provision in communities in resettlement. One of the primary considerations is to ensure the involvement of women in decisions about their families and children. Supporting women's health and mental health needs will ultimately promote the welfare of the entire community (Save the Children 1996). UNHCR also provides guidelines to community re-building and development, stressing the importance of settling refugees in communities that parallel those in their country of origin. It is recommended to furnish living arrangements whereby extended families and members of the same village are able to reside in proximity to each other. The supportive environment and extended network will nurture healing and allow for cultural expressions of pain and loss without fear of judgment (UNHCR 1994). Moreover, religious festivals and rites of passage in the community, such as birth, transition into adulthood, marriage and death, help unify a population and support psychosocial development of individuals within that community (UNHCR 1994).

10.4 Issues for Service Providers

*Somewhere we know that, without silence, words lose their meaning; that
without listening, speaking no longer heals; that without distance,
closeness cannot cure*

-Henri Nouwen

It is a challenge to maintain composure and clinical objectivity when working with survivors of extreme trauma, especially refugee children and youth. Their pain and suffering is so palpable, it is difficult, and often inappropriate, to maintain rigid therapeutic boundaries. At times, those who work with refugee populations might experience a range of emotions including burnout,

depression, countertransference,⁶² ambivalence towards or over identification with clients, intolerance of others, problems in personal relationships, and difficulties in sleeping (van der Veer 1998, Kinzie and Engdahl 2001, Kohli 2003). The therapist should learn ways to cope with these reactions and have means through which to debrief and regain sense of self. It is vital to have a team of colleagues with whom to discuss sensitive issues and share concerns, frustrations and worries (van der Veer 1998, WHO 1996). In order to provide quality, ethical treatment, the counselor, social worker or youth worker must take care of him/herself, replenishing depleted energy. A mentally exhausted therapist will not be effective and, in fact, may have a detrimental impact on a client. Refugee workers need to take time away from their work, create healthy and appropriate boundaries, and have a balance in their own lives (WHO 1996). In addition, agencies should provide proper training and continual professional development for those who are working intimately with refugee youth and families⁶³ (Save the Children 1996).

As working with asylum refugee youth and families can be overwhelming, there is a great need for comprehensive services, but often they are scattered and inaccessible to those who need them. Many welfare and youth workers may feel powerless in trying to address the range of issues in the families and provide appropriate referrals to other agencies when there is little collaboration (Kohli 2003). In addition, service providers often work in contexts where the government is inconsistent with funding and vague about accountability for protecting and providing for refugee communities (Okitikpi and Aymer 2003). Okitikpi and Aymer argue that there should be a requirement that welfare services for refugees is subject to the same scrutiny of quality assurance as it is with other services⁶⁴ (2003). It is hoped that the government will take more responsibility, in line with international standards, to provide for the unique needs of refugee young people and families.

⁶² Countertransference is a broad term used to describe the emotional reactions a therapist has towards a client (Kinzie and Engdahl 2001).

⁶³ To counteract work pressures, maintain motivation and prevent burnout, staff should work together to develop an environment that assures professional debriefing, emotional support and outlets to guard them against mental and physical exhaustion

⁶⁴ The issue of comprehensive, collaborative service provision and the responsibility of the government is a topic which warrants much more discussion than what can be provided in the scope of this paper. However, it is a lively and current debate which will be on-going needing further analysis.

Conclusion

In the wake of chronic upheaval, refugee young people should be seen as survivors and be recognized as active participants in the rebuilding of their communities (UN 2005). Despite their respective pasts, many refugee youth look towards a future with possibilities as they attempt to create a life for themselves in a new society (Brough et al 2003). Psychological distress can be mitigated and resilience fostered through creating conditions favorable for development such as a supportive family environment, stable, caring relationships with adult caregivers, encouraging community building and interaction, and providing opportunities for advancing skills and interests (Save the Children 1996, van der Veer 1998). Children, young people and families who have experienced reoccurring episodes of conflict, destruction, and abuse are in danger of becoming caught in the cycle of violence. Therapeutic interventions aimed at strengthening protective factors support the building of more peaceful communities (Chauvin 2003).

There is a tendency to place the burden on the already laden refugee populations to create their own support structures and blame them for their perceived inability to adjust in resettlement. It is salient to individualize the experiences of refugees and work with families and youth within a context of understanding and with a holistic perspective. In refugee contexts and in resettlement, adolescents need the ‘special care and assistance’ as granted through the CRC: they are still developing their identities and learning how to navigate what has been a cruel reality for them and their families. When their circumstances as displaced refugees strip away the structure they need to grow and feel safe in their environment, it can be difficult for them to adapt and find their way. (UNHCR 1994) However, the intrinsic resilience of the human soul has shown that the capacity to heal exists in everyone.

The more malleable notion of cultural bereavement accommodates and reflects the individual and community experience and de-pathologizes the rigid diagnostic criteria of many of clinical disorders. It will be important to integrate a model which treats severe psychic trauma and its symptomology yet also realizes that the responses, patterns and coping mechanisms that many young refugees exhibit are natural, normal, reactions to their extra-ordinary, tragic experiences.

Resilience will prevail when, despite horrendous circumstances, children and youth develop into well functioning, engaged members of society (Raman and Goldfeld 2003). This paper touched upon on many of these complex and penetrant issues but there needs to be more extensive research on providing comprehensive programs catered to promoting resilience and negotiating the interplay between the complex factors affecting refugee young people's lives. As Suzuki Roshi articulates, "To realize that things are one is a very sympathetic understanding. But how to treat things one by one, each in a different way, with full care – that, I think, is your practice" (cited in Chavis 2005). Integrating culturally appropriate therapeutic interventions, engaging the entire family, with a community development, rights based approach will begin the healing process.

Appendix I

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- (2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- (2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
- (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
- (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
- (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
- (3) inability to recall an important aspect of the trauma
- (4) markedly diminished interest or participation in significant activities
- (5) feeling of detachment or estrangement from others
- (6) restricted range of affect (e.g., unable to have loving feelings)
- (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

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Appendix II

Detention Centers – Brief Review of Policy

The lamentable conditions in detention centers, with little regard for nurturing the positive development of youth and children, became clear in 2002, the Regional Advisor for UN High Commissioner for Human Rights Honorable Justice Bhagwati, visited The Woomera Housing Project as a part of the Woomera Immigration, Reception and Processing Centre in South Australia⁶⁵. In his report, he described his experience at the Australian detention center where he:

“Saw young boys and girls, who instead of breathing the fresh air of freedom, were confined behind spiked iron bars with gates barred and locked preventing them from going out and playing and running in the open fields. He saw gloom on their faces instead of the joy of youth. These children were growing up in an environment, which affected their physical and mental growth and many of them were traumatized and led to harm themselves in utter despair” (Bhagwati 2003).

Often, children and youth must spend prolonged periods of time in a detention center where they are bound by bars and surrounded by concrete. Their lives take on a punitive nature rather than one conducive to healing and beginning to cope with the trauma they have only just endured. Many children and youth suffer from nightmares, regressive behaviors such as bedwetting and tantrums, and express suicidal thoughts as a consequence of being in detention (Goode 2003). Justice Bhagwati reported that “the education services are at best wholly inadequate” (2003). In May 2004, the Human Rights and Equal Opportunity Commission’s (HREOC) National Inquiry into Children in Immigration Detention Report – A last resort?, found Australia’s immigration detention policy did not support the mental health of children and youth, failed to provide adequate health service and educational opportunities and did not protect the interests of unaccompanied minors and those with disabilities. In addition, the report criticized the government’s failure to implement the recommendations by professionals in the health and mental health fields which described detention as ‘cruel, inhumane and degrading’ thereby detrimental to the well-being of children and youth. (HREOC 2005).

⁶⁵ This detention center was where many detainees, including children and youth, held a 15 day hunger strike in 2002 after several riots and protests in late 2001 (Goode 2002).

While children are granted access to education, they have few opportunities for constructive, socially appropriate activities. A violation of Article 28 (1) of the CRC⁶⁶, in detention centers, children are deprived of adequate educational services and are kept in conditions that increase risk factors while impeding protective ones which promote resilience (Zwi 2003, Chauvin 2003, Goode 2002, UNICEF).

Parents, in general and when possible, maintain responsibility for the “well-being” of the children, as is also reflected in the CRC. However, in detention centers they are powerless and unable to act in the best interest of their children and they are not necessarily equipped to meet the emotional and developmental needs of their children (Zwi 2003, Raman and Goldfeld 2003). Furthermore, diametric to international law which protects family unity⁶⁷, families in detention are sometimes separated which creates further trauma and places children and youth more at risk (Bhagwati 2002).

Strangely enough, while in detention, as the centers operate under federal governance, the Minister for Immigration has guardianship rights of asylum seeking children and youth, not the parents. These policies are complicated even further by the fact that child protection laws, such as the Children and Young Persons (Care and Protection) Act 1998 (NSW), are under state legislation. These contradictions create a quagmire for child welfare and health care workers as they try to serve children and youth and provide for their emotional, medical and developmental needs (Zwi 2003). In May 2002, a collaboration of healthcare workers recommended to the HREOC Inquiry into Children in Immigration Detention that children should be held in minimal detention for processing purposes only and then released without hesitation (Zwi 2003). Rather than being nurtured and supported and care after a series of baleful experiences, children and youth in detention, the longer they remain behind bars, are exposed to additional risks and more prone to long term psychosocial issues. Obligations under the CRC compel the Australian government and social service agencies to protect the most vulnerable and marginalized and pledge to assist children to ‘fulfill their physical, mental, spiritual, moral and social

⁶⁶ Article 28 declares that states realize the right to a child’s education and that they should hold “a view to achieve this right progressively and on the basis of equal opportunity...” (UNICEF ***)

⁶⁷ The issue of family unity and family life as protected by Article 23 of the International Covenant on Civil and Political Rights, article 10 of the International Covenant on Economic, Social and Cultural Rights and article 18 of the Convention on the Rights of the Child is of particular concern

development,' and (Raman and Goldfeld 2003). There are increased demands on service providers while funding and resource allocation has been diminished (Cemlyn and Briskman 2003).

Recent Developments

Australian policies regarding children in detention has changed, however.⁶⁸ After increased pressure from advocacy groups, NGOs, professional organizations and lawmakers, on the 29th of July 2005, the Minister for Immigration, Amanda Vanstone, announced that all families with children⁶⁹ who had been in detention had been moved into residences in the community. Under the nascent program, families will live in the community, but still report to the Immigration Department regularly (Minister of Immigration 2005, ABC 2005). Funded by DIMA and in partnership with NGOs and the Australian Red Cross, housing, living expenses, and case management, will be provided for the families (ChilOut 2005). The placement of refugee families in community settings help reduce the risk factors in their lives so that youth begin to build resilience, establish peer support, feel a sense of belonging and gain dignity and respect (Chauvin 2003).

In 2002, the National Project for State and Territory Settlement Planning Committee is 'Promoting Awareness of Needs of Newly Arrived Young People, Particularly Refugees'. The National Settlement Project 2002 seeks to revamp the coordination of transition, settlement, support services available to recently arrived refugee youth. Among the project are identifying existing services, educating service sectors such as housing and employment agencies about youth settlement needs and creating communication strategies and increased coordination between agencies (Refugee Resettlement Advisory Council 2002)

⁶⁸ The situation reached a crisis point after the Tampa boat incident in August 2001. The government refused to permit over 400 asylum seekers to come in to Australian territory. The "Pacific Solution" to the refugee crisis was introduced (Goode 2002).

⁶⁹ There were 20 families, and 42 children who had been moved out (Minister of Immigration 2005, ABC 2005)

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