

MENTAL HEALTH CARE FOR REFUGEE CHILDREN IN EXILE

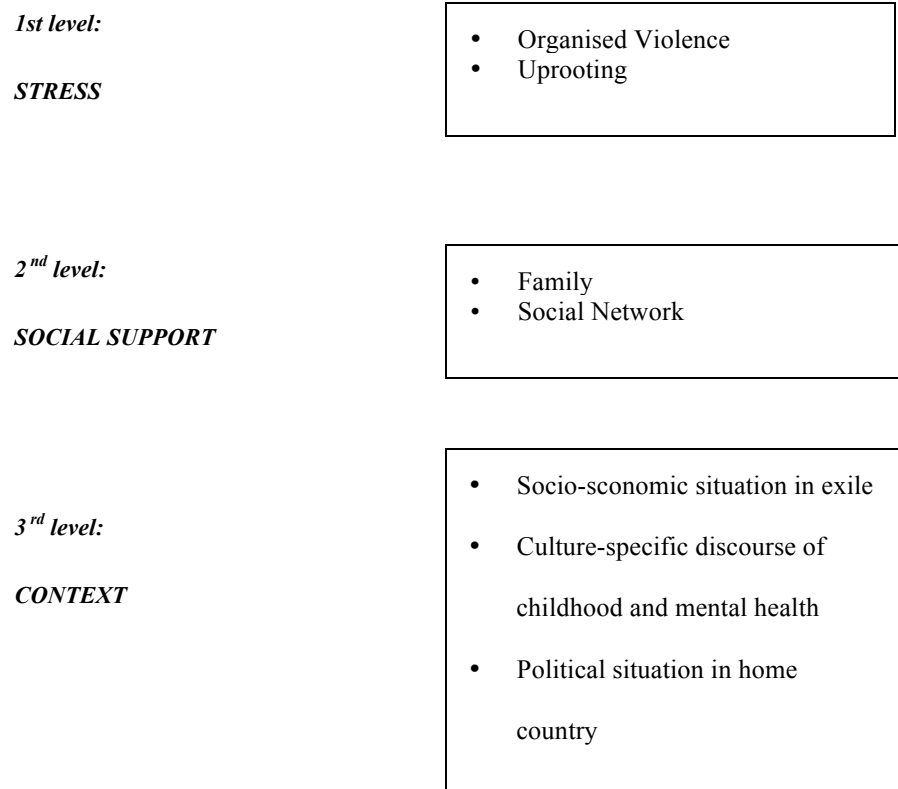
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The effect of warfare and political violence on the mental health of children has received increasing attention over the last few decades. In many recent armed conflicts the majority of the victims have not been soldiers, but women and children. Even when children and their caregivers succeed in finding refuge in another country, substantial psychosocial problems often remain as a result of pre-flight experiences and the difficulties of resettlement. Scandinavian studies of the mental health of newly settled children in families from the Middle East and Latin America have yielded broadly comparable results; with 35 - 50% of children being judged as suffering from poor mental health (Almqvist & Brandell-Forsberg, 1995; Hjern et al 1998; Ljungberg-Miklos, 1989; Montgomery, 1998; Svedin et al 1994). However, the psychosocial situation of the refugee child newly settled in exile is complex, and not all studies demonstrate such high rates of poor mental health. Studies of South-East Asian refugee children in Australia (Krupinski & Burrows, 1986) and Bosnian children in Sweden (Angel et al 2001) have indicated a general level of mental health which is actually better than that of the general child population in the country of reception.

Figure 1. presents an ecological model that identifies some of the major factors that should be taken into account in the provision of the mental health care of refugee children in exile (Bronfenbrenner 1986; Gibson 1989).

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Figure 1. An ecological model of the psychosocial situation of refugee children in exile



Level One: Stress

All refugee children have experienced *forced migration*. They have been forced to leave their home at short notice for reasons they may not understand. They are confronted with a new environment and with an unfamiliar culture and language. Several authors have described the child's reactions to these stressors as an "immigrant crisis" (Aronowitz 1984; Eisenbruch 1988).

Many refugee children have been exposed to single or multiple incidents of political violence. For some children the threat of violence has been an important

part of their environment for long periods of time, forcing adaptations of a more “chronic” nature (Garbarino 1992).

Level Two: Social Support

A large body of research (Caplan 1981) supports the importance of social support systems for maintaining mental health. Most refugee families in exile leave important parts, or perhaps all, of their social support system in their home country. This makes refugees particularly dependent on the support of their nuclear family and the refugee community in the host country. Migration and exposure to organized violence can affect family interaction in a negative way, with significant effects on the mental health of children (Agger and Jensen 1989; Becker et al. 1987; Figley and McCubbin 1983).

Level Three: Societal, Cultural and Political Context

On a third level, the wider contextual factors of the psychosocial situation of refugees are considered; including obvious social factors such as employment, availability of school and day care services and housing. The legal status of the refugee family, the attitudes of the population in resettlement countries and the culture-specific discourses of childhood and mental health are other important contextual factors that shape the matrix for the interactions of the child with his environment in exile.

Another important dimension in the context of refugee mental health is the political situation in the home country. Ongoing events in the home country and relationships to the political movement, at home and in exile are important elements in the formation of plans for the future and giving meaning to past events (Barudy 1989).

In the following pages we will present some experiences from our work with refugee children focusing on different levels of this model. We will start with the traumatic stress approach, which has been very influential in Scandinavia. Then we will discuss an alternative approach based on social support and intervention on a societal level. Finally we will turn to the particular situation of refugee children that live illegally in exile, as an example of families for whom interventions on such a societal level are particularly important.

1. THE CONCEPT OF TRAUMATIC STRESS IN MENTAL HEALTH PROGRAMS FOR REFUGEE CHILDREN

American psychiatrists first used the term Post-Traumatic Stress Disorder (PTSD) in 1980 in order to describe the main elements of mental disturbances following psychic trauma (American Psychiatric Association 1980). It subsequently gained widespread use in adult psychiatric clinical work with trauma victims and is currently a major topic in adult psychiatric research. Child psychiatrists too, have noted that the mental disturbances of children show many similarities to those of adults, and began to use the concept of PTSD in clinical practice and research in the latter part of the 1980's (Eth & Pynoos 1985).

Epidemiological studies in Scandinavia have identified experiences of war and political persecution in the home country as important in posing a risk to mental health shortly after arrival in the resettlement country (Almqvist & Brandell-Forsberg, 1995; Hjern et al, 1998; Ljungberg-Miklos, 1989; Montgomery, 1998; Svedin et al, 1994). This has given the PTSD concept an important role in preventive efforts for refugee children in exile. During the last decade the PTSD concept has also been introduced by Western relief agencies into health programs for children in war and disaster situations in Western countries such as ex-Yugoslavia (Kuterovac & Dyregrov 1994), in non-Western contexts like the Middle East (Macksoud 1992), and in war-stricken African countries such as Mozambique (Boothby et al 1991) and Rwanda (Gupta 1996). Group methods adapted to the situation of asylum seekers in exile have been developed and were used quite extensively in Sweden with refugee children from Bosnia in 1993-94 (Angel & Hjern 2004).

The PTSD approach in mental health programs has been questioned from different angles. The next section demonstrates some aspects of the traumatic stress discourse that we have found problematic in our research and clinical work with refugee children in exile in Sweden and Kenya.

Trauma and the Long-Term Adaptation of Refugee Children in Exile

In a prospective study of refugee children from Chile and the Middle East in Stockholm, we had the opportunity to describe their mental health in relation to traumatic stress in the home country and time in exile. The study included 63 refugee children, 2–15 years of age when they first set foot on Swedish soil in 1986-87 (Hjern et al. 1998; Hjern et al 2000). Two-thirds of the children had personally experienced political violence during war and/or persecution in the home country. High levels of poor mental health were recorded during the children's first 18 months in Sweden; 46% of the children were rated as having poor mental health after 5 months and 44 % after 18 months in Sweden.

In 1993-94, 49 of these children were investigated again in parent, teacher and child interviews. The rate of poor mental health had fallen significantly to 24% in parent interviews and 18% in teacher interviews. Only one neurologically damaged child fulfilled the criteria of PTSD, and only another three children reported symptoms that indicated they might be re-experiencing or trying to avoid remembering traumatic events. Other symptoms related to PTSD such as fears, anxiety, sleep disturbances and being easily startled were common during the first 18 months in Sweden, but were rare in the follow-up study, six to seven years after settlement in Sweden. Instead, the most worrying signs among the refugee children in this follow-up research were many incidents of low moods and loneliness (Hjern et al 2000).

In 1994 Angel et al (2001) used the same methods to describe the mental health situation of 99 school-aged refugee children from Bosnia 12-24 months after resettlement in Växjö, Sweden. The general level of poor mental health was surprisingly low, no more than 11% were described as having poor mental health, despite fairly high levels of sleeping disturbances, separation anxiety and depressed mood. Children from the area of Prijedor in northern Bosnia, who had experienced very severe "ethnic cleansing" which often included experiences

from the concentration camps of Omarska and Trnoplje, were more often reported to be in distress with symptoms of PTSD as well as depression and anxiety. 4 years later (Angel et al, 2004) 11 of the Prijedor children were interviewed again and compared with age and sex-matched controls from the rest of the study population. Most of them (8) still had symptoms of reexperience and/or avoidance of memories of these events but only one fulfilled the full criteria of the PTSD-syndrome. Apart from the specific PTSD-symptoms, however, these children showed few signs of child psychiatric disturbances, neither in their own reports or in the reports of their parents. In the first study in 1994 the children from Prijedor had significantly higher scores of poor mental health than the “controls” but these differences had disappeared in the follow-up.

These studies - supported by many others - demonstrated that certain symptoms related to the PTSD concept are common among refugee children during the first years in exile. It seems difficult however, to make a clear distinction between cases with PTSD and children with no posttraumatic suffering. The situation is better described as a continuum of children who have similar symptoms of varying intensity. 5-7 years after settlement in Sweden, child psychiatric symptoms seem to be much less common despite few psychotherapeutic interventions, therefore suggesting that most children have the capability to recover from these symptoms without professional help. Specific symptoms related to distressful memories may remain but rarely seem to interfere with the activities of daily life. Subsequent studies in adulthood of children exposed to nazi persecution (Keilsson 1992; Moskovitz 1985), the Greek Civil war in 1948-9 (Dalianis-Karambatzikis, 1994) and Kampuchea (Kinzie et al, 1989) have demonstrated a similar capability of children to recover from, or at least live with, symptoms of traumatic stress.

Trans-Cultural Aspects of the Trauma Concept in Childhood

Childhood as a Social Construction

In meeting recently settled families from non-Western cultural backgrounds we are reminded of the importance of the cultural context in which child health is promoted in Europe. In a professional Western model children are seen as different from adults due to a set of biological and psychological - as opposed to social - characteristics. Children also tend to be seen as vulnerable and are attributed with special disabilities that make their protection and nurture a matter of great importance. Various periods and phases of childhood are considered to be universal and made up by recognizable developmental stages. For optimal development and health, a favorable set of personal, environmental and family conditions are required. Most of what is done in preventive programs has, in one way or another, to do with promoting these favorable conditions. In this work it is easy to forget that this social construction of childhood is historically and culturally tied to the social and economic conditions of Europe and North America in the last century (Boyden, 1994). Most refugee parents have some experience of the social construction of childhood in Western countries from

their home country, it is after all the dominant framework among well educated people in the world today, but may all the same feel alien to many aspects of Western child health programs. Not all parents in all refugee communities necessarily share the view that children are particularly vulnerable in situations of stress, which is an important assumption in most mental health programs for refugee children in Europe. The example of unaccompanied minors in Sudan, as described in another chapter this book, demonstrates that the cultural context of childhood may have very significant implications for how traumatic stress is perceived and expressed. Awareness of this culture-dependence is an important starting point for mental health programs for refugee children.

Attitudes Towards Discussing Past Suffering

The basic assumption underlining most PTSD-centered mental healthcare is that child victims of war cannot recover properly without emotionally ventilating, or 'working through' their war experiences (Summerfield 1999). In mental health programs with this perspective, working through is facilitated by offering children the possibility of expressing their experiences in drawings, drama, group discussions and so on. This principle is familiar to most members of societies with a strong Christian influence, where the importance of confession and sharing distress has been preached in Christian communities since 2-300 AD (Pennebaker, 1997). Though quite a few non-Western cultures have similar beliefs, many others discourage disclosure (Wellenkamp, 1997). Mozambicans, for example, talk about forgetting as their normative means of coping. Ethiopians call this 'active forgetting' (Summerfield, 1999).

In a study of Bosnian school children shortly after their arrival in Sweden, parents were asked about how they handled the traumatic events in the family (Angel et al 2001); 69% of parents said that they actively tried not to talk with their children about the war. The most common reason given for this was that they thought that their children were better off not being reminded of their suffering in the home country. When the data was analyzed for the effects of parental attitudes towards discussing the war, it was found that for children who had experienced many war stresses, talking about these experiences seemed not to ameliorate but to exacerbate their negative effects. This contrasts greatly with the positive effects of sharing distress found among British school children that survived a ferry disaster (Yule, 1992). These divergent effects of working through seem to indicate that the effect of a working through program in one context cannot automatically be translated to a different population with a different cultural discourse for dealing with painful memories.

Screening for Traumatic Stress

Mental health professionals who cross over to public healthcare tend to be strong advocates for screening in child health care programs. European child healthcare programs rely heavily on screening for problems like neuropsychiatric deficiencies, language problems and mental retardation. A number of other screening programs have been implemented in a small scale, such as screening for autism in babies and depression in infant mothers. What makes

screening such a natural public health activity for clinicians is its similarity to clinical work, in that it is individual oriented, and usually leads to a treatment for which a clinician is needed. Therefore it is not surprising that many mental health professionals in Europe are advocates for screening of refugee children for PTSD, so that suffering children and families can be offered an appropriate individual treatment.

Screening is a very common method in child health care in the Western world, and over the years much experience has been gained about when and how to use it. Criteria for those health problems that may require screening have been defined as follows (Hall 1996):

The problem should have a documented long lasting effect on the health or life quality of the individual,

There must be methods that can effectively separate potential patients from healthy individuals,

There is a treatment, which has been rigorously evaluated and proven to be effective,

There are enough resources to treat all identified potential cases.

In light of the studies mentioned above it is difficult to see that PTSD fulfills these criteria. Even the criterion for an evidence-based treatment for PTSD in childhood has been questioned in recent reviews (Pfefferbaum 1997). If we add the ethical dilemma of screening for a health problem in a refugee population that often is unfamiliar with the concept of traumatization and actively oppose working-through therapy, it must be concluded that there are few contexts where screening for PTSD is good practice.

2. AN APPROACH BASED ON SOCIAL SUPPORT AND INTERVENTION ON A SOCIETAL LEVEL

The fact that the discourse of traumatic stress in prevention of mental health problems of refugee children in exile has important shortcomings should not discourage us. Refugee children are children in a vulnerable position in their host societies. Health professionals can make important contributions to prevent that vulnerability to develop into mental health problems. There are alternative approaches to the trauma-approach. In the following we will give examples of these approaches that can be used in the creation of preventive mental health programs for refugee children.

Social network

The social network provides social support; this can include a mother and a father, grandparents, aunts and uncles and cousins, friends and their relatives, schoolteachers and day-care personnel, neighbors, social workers, nurses and doctors and so on. There are people you know and who know you and who know each other. There is a language and a landscape you are acquainted with that helps you create a somewhat predictable world. Many channels and persons provide for a child's need for support, joy, play, consolation, education,

governance, food for growth, self-respect and development. These people support each other; when one fails there is often another one to help; what one cannot give, another can. In everyday life you tend not even to think about it.

The refugee child has to leave this well-known world. For reasons that are not always clear to him, the family settles in a new country. Gone is most of the network. In exile the refugee family is left on its own to recreate a functioning social support system. This is no easy task in a new country with an unfamiliar culture and language. Facilitating the recreative process and finding a constructive role for the health professional in this new social support system are important aspects of mental health care programs for refugees.

The Refugee Community

The refugee community is important for the well being of refugees (Angel et al, 2001; Stubbs & Sorya, 1996; Richman, 1998). On the one hand being a part of a community helps to maintain a valid political and religious meaning system, which is crucial for political refugees. The community also offers a social matrix where the lost social network can be reconstituted, and experiences of loss and persecution expressed and shared. On the other hand, some communities sometimes crumble under the heavy load of life in exile and create destructive social patterns where powerlessness, poverty and frustration create hostility towards newcomers. Assisting in the creation of strong communities is a key area in prevention of mental health problems in refugees.

Social work methods for community work and community development have been developed in deprived areas in big cities in Europe. These methods have also been found to be appropriate for social work with refugee communities (Stubbs & Soraya, 1996). Political refugees are by definition often quite experienced organizers and used to expressing themselves politically, which may be why this approach is often so well accepted by refugee populations. Community projects usually have a broad approach where refugees set the agenda themselves. The focus is often on practical aspects of life such as housing, education and employment. From a psychosocial point of view it seems evident that these projects help to create a more healthy social environment where frustration can be channeled into constructive political terms, while simultaneously creating a sense of autonomy and self-respect.

Health professionals from the refugee population can be an important nucleus for community projects with a focus on health. There are good examples of this kind from the Latin American community in Belgium as well as from the Bosnian community in Sweden. In a similar manner community projects may focus on the needs of the children in the refugee community. COLAT, a Latin American collective in Leuven, developed ways of supporting Latin American children in exile by creating *talleres* (workshops) in the early 1980's (COLAT, 1982). In the *talleres* children meet once a week in different kinds of creative activities that include learning songs and dances from their home country. During the summer the groups go to camp together with a similar curriculum. Many refugee communities use similar kinds of child groups to create social support within the framework of a religious, political or sports organization.

Supportive Environments

Children in most northern European societies spend a considerable part of their childhood in institutions like day care, schools, and after-school homes. How newly settled refugee children are cared for within these institutions should be of major concern for preventive mental health programs. In many Swedish schools there are introduction classes where newly settled children are taken care of in small groups until the children know the language well enough to be integrated into normal classes. From a psychosocial viewpoint these introduction classes can be seen as supportive environments where a caring adult gives the children individual attention and support. Teachers in smaller introduction classes also have much more opportunity for parent collaboration and support.

Day care centers for full day or half day care for pre-school children is another key arena for newly settled refugee children. Many parents and children need considerable time to get acquainted with this kind of group care, which is quite often a completely new experience for them. But for children in the transitional situation of the newly settled refugee child, a well-functioning day care center can be an extremely important island of stable social relations and play.

Host Families

Sometimes refugee families settle in areas where there are few compatriots. These families are easily isolated and might need help to break this isolation. Awarding each refugee family a host family in the receiving community is one way of facilitating the creation of a social network. The host family can also serve as a useful informal guide into the new society.

The Role of the Health Professional

Child health professionals, such as nurses in schools and child health centers have an important role in the social support system of the newly settled refugee family. They offer the possibility for children to meet other children in different activities, and can provide information for parents such as where to go when children are ill or in need of psychiatric counseling. In individual or group conversations they can provide social support and an important platform for discussion about how to cope with being a parent in a new society with an unfamiliar culture.

Intervention on a Societal Level

There are few children in Europe today whose living conditions are as much defined by specific regulations and policies as those of refugee children. Immigrant and refugee policy is usually made with adult refugees in mind, and the fact that some 25-30% of the populations are children is usually forgotten. Child health professionals have an important task in getting involved in the process of legislation as well as the creation of refugee reception programs in the local community that respect the need for adequate health services, structured

activities for pre-school children and good quality education for the older children.

3. A PROGRAM FOR REFUGEE CHILD HEALTH IN STOCKHOLM

When the authors of this article were given the responsibility of developing a public health strategy for the reception of refugee children in the greater Stockholm area, an approach based on social support and societal intervention was preferred to a trauma-centered approach. In this strategy all newly settled refugee children are considered to be in a position of vulnerability, and interventions target all children in the refugee population (see Table 1.).

Table. 1 A Population-Based Mental Health Programme for Refugee Children in Exile

<p>1.Introduction: (schools, child health care centers, government agencies etc): information (including possibilities for psychiatric and child psychiatric treatment) update of basic child health programmes.</p> <p>2.Parent support: individual support through child health nurses parent groups</p> <p>3.Supportive environments: introduction classes in schools (to provide individualised support and teaching during the first months/year in the new country) nursery school programmes network facilitation: aid to create organisations, contact families</p> <p>4.Basic child health and medical care for 'illegal' children: child health centre for "illegals" network of health professionals</p> <p>5.Secondary care: ('Experts') educates and guides the first line investigates and/or treats patients who are put forward by their parents or in their daily environment (school, day care) advocacy</p>

Introduction and Information

Existing child and school health institutions were given the task of introducing the newly settled refugee families and their children to the health system in Stockholm. Basic child health programs like vaccinations; injury prevention, dental health and basic medical screening were updated. Screening for certain infectious disorders like hepatitis B and tuberculosis was arranged in collaboration with local health centers.

Information was given about the possibilities of group activities for the children, and nurses were encouraged to assist parents in getting children enrolled in those services available. Information about the nature and availability of child psychiatric care in Sweden was given in the context of general questions about the health of the children. No screening for mental health problems took place, but when parents or children themselves expressed a wish to get in touch with child psychiatric services, they were helped to do so.

A poor system of information regarding the whereabouts of asylum-seeking children in their journey from the national immigration services to primary care was identified as a major obstacle for asylum-seeking children to get in touch with child health centers. This system was improved by establishing a direct link between child health services and immigration services, which meant that most asylum-seeking children could be, offered a child health center appointment within a few weeks of settling in Stockholm.

Parent Support

Nurses in child health centers were encouraged to establish a continuing dialogue with refugee parents. Visits for vaccinations and other basic child health care activities form a good framework for discussing themes related to parenthood and child health in the Swedish society. To this end parent groups were organized in areas where refugee families were clustered in transitional housing.

Supportive Environments

In the greater Stockholm area a lack of group activities for asylum-seeking pre-schoolers and the lack of introduction classes in certain communities were identified as the major weaknesses in the school system for newly settled refugee children. Advocacy for such possibilities was an important part of the mental health program and was quite successful for the pre-schoolers.

Secondary Care: 'Experts'

The mental health program for refugee children in Stockholm was based around a small nucleus of professionals with a particular interest in the situation of refugee children. This group tried to develop appropriate methods that could be used in primary care settings, such as a structured introduction program for refugee children in child health and school health centers, and parent groups. Information about the psychosocial situation of refugees and working methods was documented in pamphlets that were distributed to the primary care centers in Stockholm and used in a series of seminars for primary carers. The group also provided advice for primary care professionals by telephone and undertook frequent visits to key centers in areas with many refugees.

In certain areas with many refugees the group worked closely with schools and day care centers, providing support to teachers and performing individual investigations of children with who had been identified as having particular learning and emotional problems.

A very important task for the expert group was advocacy. This advocacy operated on a local level, in trying to improve the school and day care situation through identifying weaknesses and suggesting alternatives, and on a political level, where advocacy for the rights of 'paperless' children for medical care and education was the most important demand on the agenda.

4. MENTAL HEALTH CARE FOR 'PAPERLESS CHILDREN'

Refugee children that reside illegally ('paperless') in Europe stand out as a group where action on a societal level is particularly urgent. In northern Europe this group of children is made up mainly of children in refugee families whose application for asylum has been turned down. In southern Europe these children can be counted in hundreds of thousands, a considerable proportion being refugees from war and persecution in the Balkans, Africa and the Middle East (Hjern & Bouvier, 2004).

Many European societies today grant certain basic rights for medical and health care and education to children who are residing illegally in their society. Spain and Italy are examples of societies where ways have been found to accommodate this group of children inside the public health and medical care system as well as in the public school system. Sweden recently created possibilities for state-funded health and medical care for these children but left out rights to education.

The life of 'paperless children' is defined by their lack of basic rights of housing, of education, of food and proper clothing. They move from place to place; their houses never become homes. Children have to keep in-doors, keep silent, and not attract attention. They do not have enough money. They lose the friends they had, and in losing their school or day-care, they lose acquired knowledge. All the needs formerly provided by many persons and channels now have to be provided by the parents who are sad, afraid and poor.

The 'paperless child' has almost never asked to become a refugee, and has had few, if any, possibilities to influence either the situation in his homeland or the decision to flee and hide. He is obviously a suffering, unprotected, innocent third part in the conflict going on between his parents and the State. Humanity demands the creation of special rules and laws of protection for these children.

Strange as it may sound, the very efficiency and logical consistency of the modern State may make the situation of these children even more difficult. If, for example, there is a decision to expel the family there is no exception, no special rule for the child. If he is not wanted by the State he cannot expect to be wanted by any of its official ramifications, may it be the police, education or the medical sector. Former societies were less efficient, less logically congruent and strangely enough more human. There were no resources to chase everybody everywhere; every civil servant did not always behave exactly like everybody else. There was a space for practical reasoning, exceptions, illogical decisions and mercy. For -as Dostoyevski put it - 'You have only facts, no affection, thus it becomes wrong'.

In pre-modern societies, rules promoted by morals were not necessarily rules of the State and sprang from goodwill, not from logic. You could not chase and kill an enemy inside a church but left your weapons before entering. You could not rob and kill a foreign traveler in alien lands; you had instead to provide food and shelter. Safe havens were created as the result of individual's own experiences and sense of vulnerability on the roads in unfamiliar surroundings. Such safe havens should be provided for the 'paperless child'. He should be able to go to school or to Kindergarten and to attend medical care without fear. He should never be regarded as a possible hostage to enable the seizure of his

parents. Either the State must be less efficient in these matters, or better still; it should take a decision to provide the child with such safety.

Finally, these problems are, as already Henry Dumond realized, also problems for professionals taking care of the children. Health professionals should care for clients regardless of social, religious or legal status. The medical professional oath solemnly states that, 'The doctor should let himself be lead by the commandments of humanitarianism and honor, and the health of his patient should be his primary goal'. The 'paperless' child tests the humanitarian standards of the professional as well as of the State. If we cannot stand the test today when it actually costs us so little, how will it be in hard times? When those unwanted by the State seek our help, must we stand up for the opinions of this State? Does everyone always have to obey? What happens then with health professionals? Do we break the confidence of our patients? It is obvious that child health professionals have a duty not only to provide care for individual 'illegal' children, but also act on the policy level. Those politicians responsible should not be allowed to forget that these children exist, that they need better health and medical care than any other children in our society because of their very harsh living conditions, and that the UN Convention of the child grants them these rights.

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