Immigrant and refugee young people: Challenges in mental health

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It has been long recognised, and confirmed in over a decade of literature, that migration can be a stressful experience, although for each individual or family the disruption can vary greatly. Further, the reasons which have influenced the decision to migrate, the pre-migration status of the individual or family, the presence or absence of significant trauma in negotiating this major change, and the response of the new host society following resettlement will all contribute to the psychosocial adjustment.

The literature concerning migrant and refugee mental health has tended to focus predominantly on adults, although in the last five years more studies relating to young people (particularly refugee children) have emerged. These studies have related in particular to the trauma, often catastrophic, suffered by young refugees and children of war, and the possible consequences of these experiences — such as post-traumatic stress disorder, major depression, and even psychotic illness.

Guarnaccia and Lopez (1998) have pointed out that ‘children are at the same time both more vulnerable and more resilient in the face of changes brought by migration’ (p. 537). They believe that this vulnerability comes from children’s dependence on others during the migration process, but their flexibility of character and ability to learn new languages quickly are likely to enhance their resilience.

It is worth considering the difference between immigrant and refugee. Whilst the immigrant family has usually made an autonomous decision to migrate in the hope of improving the quality of life for themselves or for their children, refugees generally have fled their country to escape continuing trauma, imprisonment or death, often having witnessed brutality and the devastation of basic human rights.

However, in recent times, the distinction between the two groups may not be as clear as before. Many immigrants from developing countries seek to leave because of overwhelming poverty and extreme social disadvantage, or due to the threats they perceive to the safety, indeed survival, of their offspring. These differences between immigrant and refugee status are often more blurred than immigration officials acknowledge.
Important Influences on the Mental Health of Young Immigrants and Refugees

We know that a multitude of circumstances and experiences will have an impact upon the psychological well-being, or otherwise, of children and young people as they negotiate the transition to and resettlement in a new country (Kinzie, Sack, Angell, Manson & Rath, 1986). These will include the following:

- the circumstances surrounding migration;
- the interaction which the family had, firstly, with their society of origin and, subsequently, with their new society;
- the overall resources of the migrating family, not only economic resources, but the depth of their social skills and their understanding of the new society, its culture and social supports;
- the nature of the host community, its economy and social class structure, presence or absence of a like ethnic community, the community’s attitude — welcoming or discriminating towards immigrants; and
- the formal support systems available on arrival — that is, medical, educational, economic, social and cultural.

The adolescent years, in particular, are times of identity formation with identity resolution as a positive outcome, or ongoing identity diffusion with inner-directed conflict a negative outcome (Erikson, 1965; Bashir, 1993).

For many immigrant and refugee young people, a prodigious task can be the confident integration of an identity which is harmonious within oneself, within one’s family and cultural heritage, and also within the new host society. This is particularly so for an immigrant adolescent when the expectation from the family and traditional cultural network is inflexibly directed to the maintenance of the ‘old’ culture, while at the same time (and equally impelling) there is a different social pressure exerted by the peer group. The task of addressing the demanding developmental tasks of adolescence whilst living in two cultures — with not only two languages, but often very different behavioural patterns and social expectations — can be burdensome and distressing. Wrestling with such conflicts, some young people find it impossible to feel a part of either culture, as if out on the margin, with a developing sense of alienation. This may be followed by a reaction of considerable emotional distress and later by significant depression, all of which may be further reinforced in an environment where the young person feels, or is made to feel, racially or culturally very different.

Reviewing research on immigrant children Aranowitz (1984) considered the relationship between ethnicity and identity. He noted that self-deprecation and low self-concept were common among samples of immigrant youth who were members of a racial minority which was devalued in the host society. These complex
interactions may also effect the quality of acculturation which the adolescent negotiates in his new society, giving rise to the concept of ‘acculturative stress’, described in depth by Guarnaccia and Lopez (1998).

They note that acculturative stress will arise from difficulties and problems which young people encounter in their attempts to adapt to the new culture and may include:

- difficulty in learning the new language;
- perceived discrimination from the adoptive society because of significant differences in physical appearance and cultural practice;
- perceived cultural incompatibility between the ‘old’ and ‘new’ cultures, and their differing roles; and
- intergenerational difficulties between children and parents emanating from differences in acculturation levels between the generations.

Studies suggest that this acculturative stress may be offset in part by the availability of active support from the host community for new families and individuals. By gaining support and acceptance from a co-ethnic community organisation isolation is reduced, particularly in the early years following migration (Klimidis & Minas, 1995). It should be recognised that similar to an individual child or adolescent, the immigrant family unit undergoes a series of developmental changes and adjustments in its journey towards confident acculturation. The equanimity and success with which this task proceeds will exert an influence on the parallel developmental pathway of the young people within the family.

Guarnaccia and Lopez note that

often the first year is characterised by feelings of euphoria over the success of immigrating. The second year tends to be the most stressful as the impacts of acculturative stressors are fully felt. The third and subsequent years vary greatly in psychological outcomes depending on the interplay of family factors and contextual variables. The response of the host country is particularly critical to the psychological well-being of immigrant young people in the third and subsequent years (Guarnaccia & Lopez, 1998, p. 545).

Acculturation is not merely the ‘learning of a new culture but also deciding what is to be saved or sacrificed from the old’. There are three possible outcomes: retain the old; take up the new; or blend the two. Attempts by adolescents at too-rapid acculturation and acceptance into the peer culture of the adopted country (in some cases the more negative peer culture and behaviour) is likely to heighten the anxieties of the immigrant family, who, fearing a rejection of their ethnic heritage by their child, may in defence respond in an overly
constricting way, frustrating the adolescent’s developing independence by demanding (or trying to impose) a more rigid adherence to the behavioural code of the old country.

In some circumstances where children have preceded their parents as immigrants, the rapid acculturation perceived by the parents at subsequent family reunification has been a serious source of conflict, and, for some young people, lead to rejection from the family. Less commonly, the reverse may happen. For example, an adolescent, reared and nurtured by a grandparent in the country of origin, when reunited with his immigrant parents, can respond negatively to the ways of the new adoptive country. Disdainful of his parents whom he felt had rejected him by leaving him behind when they migrated, he may be slow to acculturate and intergenerational conflict may result (Bashir, 1993; Beiser, Dion, Gowiec, Hyman & Vu, 1995).

Not uncommonly, the resilience of the young immigrant and their skill at acquiring the new language, force a young person into a situation of role reversal. The adolescent is frequently required to provide parenting, not only to a parent, but to younger siblings as well. Immigrant families tend to value and foster close relationships between the generations and the wider extended family. However, the stresses of resettlement and the development of a marked disparity between each parent in adjusting to the new culture may result in marital conflict, violence, and separation, further increasing the role of parent on the immigrant youth (Bashir, 1988).

Other Common Stressors Impacting on Young Immigrants

Excessive and inappropriately high expectations are often placed upon the adolescent for scholastic achievement, to fulfil the hopes of the parents and to elevate the status of the family. In some circumstances, resentment may develop as the youth surpasses the parent, who may be unemployed, or may depend on menial work for survival. Financial struggles necessitating that both parents work may also impose deprivations on the young immigrant, and may also create an expectation that he will remain living within the family system for much longer than his Australian peers.

The existence of double standards between the sexes within patriarchal and traditional cultures (such as Arabic and some South-East Asian cultures) permits males greater social freedom, independence and educational opportunity, but places greater constraints on acceptable behaviour for females in whom virtuous conduct is seen to be a symbol of family honour. This may provide another source of conflict. Such attitudes may be further reinforced by the immigrant parents’ perception of a relatively permissive attitude towards girls in Australian society with its greater emphasis on sexual equality.
Deeper Dimensions – Culture, Youth and Mental Health

In some immigrant young women these dynamics are considered to have contributed to the development of isolation, identity difficulties, depression and eating disorders. A recent Australian research study has drawn attention to the fact that immigrant young women from both Mediterranean and Asian backgrounds are now developing anorexia nervosa, a disorder uncommon in their country of origin. The researchers have suggested that this is related to long-term, unresolved acculturative stress (Alexander, Kohn, Clarke & Feeney, 2000).

Localities of high ethnic urban concentration may attract racial prejudice from outside, but can also harbour intra- and inter-racial tensions within. Animosities of ethnic, political or religious differences, may erupt and adversely affect the adolescent’s self-concept within the context of peer relationships (Beiser et al., 1995). Prejudice may escalate in response to media portrayal of international conflict within the countries of origin, and, in times of economic recession, some disgruntled members of the host society may be more inclined to scapegoat and discriminate against those who are in any way perceived to be ‘different’, ‘foreign’ or ‘other’.

Migration and Psychiatric Disorder

The most common problems noted in school-aged immigrant and refugee young people are behavioural and learning difficulties, particularly among younger adolescents. These syndromes often co-exist and are driven by difficulties in the emotional and family life of the young person. Studies have noted in the assessment of these children that teachers tend to report more behavioural problems than parents. In adolescence, problems of identity are associated with some symptoms of anxiety and depression.

Early studies on migration and mental health suggested that an association existed between migration and psychiatric disorder. (Boman & Edwards, 1984). In recent years, attempts at cross-cultural research with young people have been undertaken, but the validity and reliability of the testing instruments are questionable across cultures — for example, the Diagnostic Interview Schedule for Children (the DISC). Whilst Achenbach’s Child Behaviour Check List (applicable up to the age of 16 years, which also has parent and teacher questionnaires) has a long history of use in cross-cultural research and has been translated into many languages, it is a measure of problem behaviours and does not provide a diagnosis. Diagnosis will depend on clinician interpretation which, together with the teacher check list, can be at risk for cultural bias, leading to over-diagnosis of a disorder.

Guarnaccia and Lopez (1998) point out that approximately forty per cent of young people meet criteria for a psychiatric disorder when only symptom criteria are used. However, when functional impairment (how the young person is functioning) is taken into account, perhaps by using the Child Global Assessment
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Scale, the rate of psychiatric disorder falls by half to about twenty per cent, which is a considerable difference. Moreover, substantial differences were noted in check list ratings between a more acculturated adolescent (rating himself), his less well acculturated parents, and a teacher who applied different norms again in assessing the young person.

Some USA studies have noted that rates of disorder seem to increase with acculturation. In the case of adolescents, it has been reported that, with increased time in the USA, the rate of illegal substance use increases. Other perceptions have held that the first generation of immigrants enjoys a sense of euphoria and relief at resettlement accompanied by high motivation towards academic and vocational success (McKelvey & Webb, 1996). However, for many of the second generation still grappling with poverty and social disadvantage, motivation is reduced and disappointment sets in. Although these are interesting observations, it would be most inappropriate to generalise such observations to the Australian setting. These studies were based predominantly on immigrants to the USA from countries such as Cuba, Haiti and from South-East Asia. Even between the different ethnic subdivisions, significant differences occurred. However, these studies can serve as a stimulus for longitudinal research in the Australian setting, particularly to enable us to understand more precisely the key factors which facilitate successful resettlement.

In regard to the association of migration and psychiatric disorder in young people, there seems to be general agreement that, despite the stresses which may arise during the immigration process, immigration does not produce psychiatric disorder in young people. In a study designed to assess longitudinal changes in morbidity among Indo-Chinese adolescents and young adults in Victoria, Krupinski and Burrows (1986) reported that rates of psychiatric disorder at the initial interview were twice those found in the Australian population of the same age and sex. Two years later at follow-up, the rate had declined to one half the figures quoted in the community health surveys. I have referred earlier to the pitfalls in making a hasty diagnosis based on check lists and questionnaires (and even a structured psychiatric interview) without an understanding and appreciation of the cultural components of the child’s and family’s life. An important element to consider also in the assessment of the young person’s mental health and well-being is the extent and quality of their self-esteem. This is integrally bound up with how they believe they are considered and accepted by their peers, their teacher and their school environment. Behavioural problems and learning difficulties have long been noted as the more common difficulties of young immigrants. However, a Canadian study has demonstrated that an influential factor in this regard was the persistent poverty and social disadvantage among the affected immigrants, rather than the issue of migration. The prevalence of behavioural and mental health problems also correlates with poverty and a problematic environment in non-immigrant populations (Beiser et al., 1995; Krupinski & Burrows, 1986).
The many subtle components to be elicited from a sensitive and comprehensive history highlight the value of an interpreter skilled in understanding mental health as well as sociocultural issues. Thus there is a serious obligation on the part of the mental health professional to work as part of a tripartite model with the client and the interpreter. As an integral member of the mental health team, it is useful for the clinician to meet with the interpreter before and after the assessment interview, to receive cultural and historical interpretations which the clinician may not have observed, nor appreciated. This provides an important source of continuing education for any clinician outside the ethnic culture, no matter how experienced in mental health. However, the health professional must remain aware that confidential information relating to the client must be maintained.

Whilst the prevalence of psychiatric disorder in immigrant children is probably no greater than in the wider population, refugee young people are significantly more vulnerable to a range of mental health problems, although not all young people exposed to trauma will go on to develop mental health problems. Risk factors for psychiatric disorder in young refugees include:

- exposure to violence; and
- absence of family or kinsfolk to provide some buffer to catastrophic experiences (as well as their contributions during the pre-migration and trans-migration experiences).

Loss is an experience common to most migrants, but for refugee youth this experience has often been catastrophic — possibly involving brutality, starvation and prolonged exposure to danger.

The special health problems, both physical and mental, of refugee children have attracted greater attention in recent years as substantial numbers are being resettled in Western countries. Whilst the physical health characteristics of immigrant young people tend within a short time to resemble the pattern of peers in the adoptive country, surveys of refugee children in holding camps or on first contact with health workers reveal the whole range of paediatric disorders characteristic of developing countries: including under-nutrition; parasitic infestations; anaemia; the sequelae of measles, encephalitis, malaria, pneumonia, tuberculosis, and diarrhoeal diseases; and recently, with the Kosovar children, rickets. Provided with the better health care of the more affluent countries of their adoption, these children soon achieve a physical health status similar to their peers, except where irreversible damage has been done, such as in cerebral or orthopaedic complications often resulting from the absence of essential medical care.

The psychosocial adjustment and propensity for mental health problems in young refugees are more complex. Particularly important is the prevalence of depressive disorder and psychosomatic problems, school-related and behavioural problems being secondary developments. The common experience of disruption in
family support, particularly with the loss of parents at an early age, has been considered a major contributing factor to this significant prevalence of depression which may often exist in a ‘masked form’. Examples of ‘masked’ depression include complaints of bodily symptoms for which no cause is found, and behavioural disturbances or isolation without strong evidence of depression.

The characteristics of chronic depression, survival guilt and post-traumatic stress syndrome with delay of symptom manifestation in some cases of up to two, or even four, years after arrival, have been common findings among young detached refugees. These young people revealed feelings of bewilderment, apathy, hopelessness, suicidal thoughts, appetite loss, sleep and concentration problems, and an inability to progress in their language lessons disproportionate to their intelligence. Many were disadvantaged by considerable educational deficits from years of missed schooling in their homeland. (In some cases a confusion of actual birth date and age complicated class placement and peer relationships.) For others, devotion to school work and a visible respect for authority disadvantaged them in establishing friendships with local peers. Such friendships have been cited by several workers as providing a buffer against mental health problems. An Australian report notes the vulnerability of older students attempting to succeed in academic studies whilst working long hours in menial employment to gain money to send to parents (Clark, Sack, Ben, Lanham & Him, 1993). In some particularly detached refugees, where supports and achievements are lacking, depressive defences may break down with loss of control and oppositional behaviour giving way to serious conduct problems, substance misuse and delinquency. Profoundly depressed young people may ultimately access juvenile justice facilities.

In the refugee population, whilst depression is by far the most frequently noted psychiatric disorder, somatisation is acknowledged as the most common form of its expression. Bodily expressions of distress are often more acceptable to groups of non-English speaking background, particularly Asian, than emotional complaints which may be regarded as culturally unacceptable and likely to bring discredit on the family.

The interpretation of psychotic phenomena can pose major diagnostic difficulties to the most astute clinician unless familiar with the transcultural issues influencing the patient. Some presentations of post-traumatic stress syndrome with emotional numbness, intrusive thoughts, recurrent bad dreams, flashbacks, and in some sufferers, pseudo-hallucinations, may be difficult to differentiate from schizophrenic disorders.

The intensity of trauma experienced may not reflect the intensity of symptoms which follow. In a study of Cambodian adolescents exposed to massive trauma, symptoms of post-traumatic stress disorder and depressive symptoms were common. Many had been subject to prolonged physical brutality and forced labour, but had internalised their feelings and after release demonstrated no overt
behavioural problems. They coped with their distress by emotional withdrawal and daydreaming (Guarnaccia & Lopez, 1998: Krupinski & Burrows, 1986; Mollica, Poole, Son, Murray & Tor, 1997).

Universal themes have been identified which are common to trauma survivors: fear of doing harm to others, such as relatives and therapists in retelling their story; feelings of loss of control, rage and shame over their vulnerability and helplessness at the violation of their rights, at their failure to save others, and at a loss of innocence.

Summary

In the past three years Australia has witnessed the exposure of pockets of prejudice, discrimination and scapegoating. Attempts to create an inferior underclass can have profound and negative consequences for young people seeking to integrate their sense of identity, struggling with developmental demands, and fighting an encroaching depression.

Always guaranteed sensational and often exaggerated coverage in the media are the activities of young people in groups, particularly when the existence of ‘gangs’ is raised. Whilst in no way condoning dangerous or lawless behaviour from any community group, youth or adult, it is important to attempt to understand the origin of such developments.

The imperative lies in prevention and in early intervention. Raphael (1998) has drawn attention to the commitment which must be made by all sections of the community — government and non-government — towards investment in our young people. The critical task will be to involve the parents in the programs which will reduce the risk of ongoing mental health problems. Immigrant parents are often reluctant to seek help from health or welfare agencies, or even to attend parent — teacher meetings at schools. Reasons for this may include English language deficiency, limited self-confidence, and the fact that seeking outside help in many cultures (particularly for reasons of mental health) is considered shameful and potentially humiliating.

In this chapter I have concentrated on the complex tapestry of contributing experiences, stages, and sometimes traumatic factors which effect our young immigrants and refugees. I have no doubt that with an awareness of, and sensitivity to, these issues the process of assessment of young clients and their families, along with understanding and empathy, will help give a sense of direction in practical interventions and counselling.

We all acknowledge that these challenging times in contemporary Australia have added additional stresses which call for strong advocacy from intelligent, knowledgeable and committed professionals — monitoring and improving public policy and striving for excellence in the clinical application of our services.
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In conclusion, we should not forget ourselves, the workers, who carry the responsibility of heavy caseloads so many of which constantly touch our inner selves. It is an enriching professional experience to have opportunities for supervision or regular discussion with a trusted colleague.

References


