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Assessing the psychological distress and mental healthcare needs of unaccompanied refugee minors in the Netherlands

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Chapter 11

Discussion

This dissertation had four objectives; (1) to expound on the possibility to validly and reliably use standard psychological questionnaires in assessing the psychological distress of a culturally heterogeneous sample of Unaccompanied Refugee Minors (URM); (2) to determine the prevalence, severity and course of the psychological distress of URM living in the Netherlands; (3) to establish the needs, unmet need, and use of mental healthcare services among URM in the Netherlands; and (4) to evaluate to what extent the severity of psychological distress of URM is associated with their psychological adaptation in the Netherlands. Furthermore this dissertation was divided into two overarching parts; (a) the validation of psychological instruments to assess the mental health of Unaccompanied Refugee Minors (objective 1) and (b) to determine prevalence, severity and course of the psychological distress and the mental healthcare needs, as well as attitudes and adaptation of URM living in the Netherlands (objectives 2, 3, and 4).

This discussion, will briefly describe the design and sample of the main study. The discussion continues by highlighting the findings of Part 1 and addressing to what extent the first objective of the study was achieved. Then, the key findings of Part 2 are presented while examining to what degree the remaining three objectives were realized. The methodological limitations of the study will be touched upon and then the chapter proceeds to first bring forward the general implications of this study, and specifically for the clinical setting. Finally, the discussion concludes with suggestions for future research among Unaccompanied Refugee Minors.

Design and sample

The central study of this dissertation (URM and the Dutch Mental Healthcare Services) was epidemiological in scale, used multiple informants, and consisted of two assessment periods (follow-up study) with an interval of twelve months inbetween. The infrastructure that exists in the Netherlands, one foundation- Nidos- which provides legal guardianship to all URM residing in the Netherlands, made it possible to draw a representative sample of the total population of URM between the ages of 11-17 years and to carry out such a large scale study among URM. In other countries, this unique infrastructure does not exist making it (almost) impossible to gather information on the mental health of URM on such a large scale and utilizing information from different informants.

The main study took place throughout all provinces of the country during the years 2002-2004. Questionnaires were filled in by URM, their legal guardians, and teachers at both assessment periods after written consent was given by URM and their legal guardian. A total of 920 URM took part in the first assessment in 2002-2003 which was ten percent of the total URM population residing at that time in the Netherlands. During the second assessment period (2003-2004), 582 URM from the original 920 filled in the questionnaires for the second time. The URM that participated in the first assessment period had lived in the Netherlands between 4 and 24 months and represented approximately 50 different countries in total. Male-female ratio was approximately 70-30%. The average age was 16 years. Angola, China, Siërra Leone and Guinee were the most represented countries of origin in the sample. Prior to the start of the project, crisis mental healthcare was arranged at mental healthcare facilities throughout the Netherlands for URM if they experienced psychological distress as a direct result of participation in this research project. Fortunately, it was not necessary to make use of the crisis care. Before the actual project started in May 2002, a pilot study was conducted to (re-) test the research protocol and instruments (Bean, 2002b).

Part 1: Assessment of psychological distress among a heterogeneous URM population (Chapters 2-6)

Validation of self-report measures

Chapters 2 thru 4 report on the validation process (development/modification) for the three self-report questionnaires; Hopkins Symptom Checklist-37 for Adolescents (HSCL-37A) to measure internalizing and externalizing maladaptive behaviors, Stressful Life Events (SLE) to inventory the type of adverse life experiences, and Reactions of Adolescents to Traumatic Stress (RATS) which assesses the type of traumatic stress reaction(s). In the introduction of this dissertation, it was stated that the conceptual, scale, and norm equivalence of the assessment instruments that are utilized in a cross-cultural study should be evaluated. The scale equivalence of the self-report questionnaires was evaluated in chapter 2, specifically dealing with the practical feasibility of assessing psychological distress with a culturally diverse sample. From this chapter, it is apparent that when modifications are made to the standard lay-out (Likert scale, wording of questions, and bilingual presentation of items) and sufficient time is taken before the assessment begins to explain to the adolescents how to fill in a self-report questionnaire, scale equivalence can be reached for adolescents from a wide variety of cultures and backgrounds.

Chapter 3 and 4 investigate the conceptual and norm equivalence of the self-report questionnaires by using four large independent heterogeneous adolescent samples (thoroughly described in these two chapters) to examine the psychometric properties of the three self-report instruments. It was apparent from the endorsement percentages that the items on the questionnaires were relevant to the adolescents which filled in the questionnaire. Furthermore, it appears that in comparison with the other adolescent populations the magnitude and intensity of traumatic stress reactions and psychological distress (anxiety and depressive complaints) was greater for URM than for all other samples. In addition, adolescents having a Dutch or Belgian background reported a greater magnitude and intensity of maladaptive behavior (such as use of alcohol and drugs and having arguments) than adolescents coming from non-western countries which reported more emotional distress (i.e., sad, lonely, afraid). Only comparison of means and standard deviations were reported in this dissertation, the norms (percentiles) have been documented in the manuals of the pertaining instruments. The large differences in magnitude and intensity of types of reported psychological problems of adolescents from different populations led to the necessity to provide norms for each individual population, to fulfill the criteria for norm equivalence. It is crucial for future research with these instruments that the sensitivity and specificity be examined with a cultural sensitive diagnostic interview among adolescents from a range of different cultures.

The factorial validity, construct, content and criterion validity, internal consistency, test-retest reliability were all found to be satisfactory to good in spite of the heterogeneous nature of the sample populations. This finding is quite remarkable considering that many adolescents coming from developing countries have not had the same experiences (educational opportunities, economical stability, and parental guidance) as western adolescents have (Gibbons, 2004). It appears that the modified questionnaires that were used in this project are able to measure the constructs of psychological distress, maladaptive behaviors, and traumatic stress reactions among adolescents originating from different cultural backgrounds. However, the items/questionnaire were selected for this specific study because of their "cultural receptiveness" among adolescents coming from different societies (Chapters 2, 3, and 4 describe why these instruments were chosen). It would be premature to extrapolate the findings obtained with the self-report questionnaires used in this study to others if the conceptual, norm, and scale equivalence of those questionnaires were not thoroughly evaluated.

When all three of these instruments are utilized, a broad range of relevant traumatic events and trauma related psychopathology (emotional distress, maladaptive behaviors, and traumatic stress reactions) can be assessed among culturally diverse refugee adolescents facilitating the periodic monitoring of the mental health of URM. The periodic monitoring would not only allow for improved detection of psychological distress among URM, it also would make the application of timely and appropriate mental healthcare interventions

possible. This point is of the utmost importance because the significant adults in the lives of URM are not able to always accurately perceive their psychological distress (Chapter 8).

Validation of psychological measures for URM using adult informants

The well-known Child Behavioral Checklist (CBCL-Chapter 5) and Teacher's Report Form (TRF- Chapter 6) were utilized respectively with the legal guardians and teachers of URM to measure the psychological distress of URM from the perspective of significant adults. These two questionnaires have eight lower order subscales; withdrawn, somatic, anxious/depressed, social problems, thought problems, attention problems, delinquent, and aggressive. In addition, they have two broadband subscales, internalizing and externalizing which encompasses five of the eight subscales.

It was essential to assess the mental health of URM from the viewpoint of adults because they can give a more "objective" opinion and can also provide complimentary information that might (or might not) substantiate the self-reports of the adolescents. Certain types of maladaptive behaviors can be more accurately perceived by significant adults because of the nature of the behavior. For example, adults often report externalizing problems of adolescents more reliably than the adolescents themselves. However, it is well known that significant adults in the lives of adolescents under report internalizing problems in comparison with the report of adolescents themselves, because the adult is unaware of the emotional distress.

As has been commented on in these two chapters, there is much debate surrounding the construct validity of the CBCL and TRF, especially in a cross-cultural context. These instruments are the most widely used instruments to measure psychopathology in research among children and adolescent throughout the world, albeit that each of the 69 translations has not (yet) been validated and it is unknown if the translation process has followed the three overarching types of equivalence mentioned above. Nevertheless, the psychometric properties of these two questionnaires were thoroughly evaluated for use among URM and the psychometric properties were found to be moderate to good.

The results of the hierarchical confirmative factor analyses for both the CBCL and TRF support a one-factor and a two-factor structure equally well, not diverging from other studies. However, the Thought problems subscale of the TRF could not be verified suggesting that some of the problem behavior reported by teachers of unaccompanied minors differs from that of guardian reports or that the item constellation of the TRF is different for teachers of unaccompanied minors.

Moreover, the fit of the original individual eight first-order factor models of the a priori CBCL and TRF subscales were found to be moderate, however showing good to moderate internal consistency, construct and concurrent validity (except for the Thought scale of the TRF). This finding would emphasize that for the URM population, the broadband internalizing and externalizing scales would appear to be more valid and reliable than the eight subscales. The CBCL and TRF have emerged in this dissertation to be both reliable and valid measures for use by, respectively, guardians or teachers to assess the maladaptive emotional and behavior problems of unaccompanied refugee minors.

In summary, the initial psychometric properties of the self-report, guardian report and teacher report questionnaires were good, despite the large amount of heterogeneity in the URM sample. It appears that the first objective of this dissertation has been achieved. This finding is of primary importance in the evaluation of the mental health of URM and lays the foundation on which further research can be done using these instruments. As far as is known, this is the first study in which the psychometric properties of self-report, guardian and teacher reports of the mental health of a culturally diverse population of URM have been thoroughly examined.

Part II: Severity of psychological distress, mental healthcare needs and psychological adaptation among URM in the Netherlands (Chapters 7-10)

Theoretical considerations

URM, just as any other adolescent, have the right to life and to be able to develop to their fullest potential (Article 6, CRC, 1991). The results of Chapter 7 and 8 indicate that the mental health and the emotional development of URM as a specific adolescent population are

at great risk. Having experienced a great number of adverse life events and being of an older age proved to be salient (risk) factors for psychological distress of URM throughout this dissertation. Due to the vast and pervasive effects of traumatic stress upon the entire development of children and adolescent, (emotional, cognitive, biological, and neurological) these findings are not unexpected and have been discussed in Part II of this dissertation. However, what has not been discussed in this dissertation is the *cognitive* ability of URM to understand their current situation and psychological distress based on theoretical underpinnings.

From a western perspective, adolescents should be cognitively functioning at the formal operations stage (reasoning abstractly) (Piaget, 1972). Regarding their moral reasoning abilities, they should be thinking at the post-conventional level (developing their own moral principles) (Kohlberg & Gilligan, 1971). However, most of the studies that have been performed to test these theories have been done among western adolescents (10% of the total adolescent population of the world) (Gibbons, 2004). There are studies that have shown that individuals, who come from developing countries, since they have not enjoyed higher educational opportunities, might function at lower levels or different levels of cognitive and moral reasoning than western individuals (see Berry, Poortings, Segall, & Dansen and/or Gielen, 2004 for a discussion).

Furthermore, Elkind (1967) proposed adolescence is still a time when individuals fail to put their own thoughts into the perspective of others (egocentricity). The young person acknowledges the thoughts of others, however “he/she fails to differentiate between the objects toward which the thoughts of others are directed and those which are the focus of his/her own concerns” (Elkind, 1967, p.184). Moreover, adolescents that experience traumatic stress reactions and depressive symptoms have been found to engage in rumination and catastrophic thinking (Pynoos, Steinberg, & Picentini, 1999) as well as a generalized sense of hopelessness (Nolen-Hoeksema, Girgus, & Seligman 1986; Salmon & Bryant, 2002) which all can inhibit clear cognitive reasoning. Furthermore, hyperarousal, one of the symptom clusters of the DSM-IV diagnosis for PTSD, can interfere with the ability to concentrate, and in turn in the ability to retain (new) information.

As outlined above, the adolescence period itself is one in which cognitive processing of information is not yet at a level as that of an adult. Therefore, it is plausible that URM would be functioning at a different (lower) cognitive level than their western adolescent peers, that their thinking and appraisal might be distorted by their negative affect, and that their ability to retain (new) information is limited due to concentration difficulties. The findings of Part II of the dissertation should be seen in the light of these theoretical considerations. The cognitive functioning and moral reasoning of URM will need to be scientifically examined in future research to be able to fully understand how the cognitive functioning and moral reasoning of URM influences their perception of emotional well-being, functioning in educational settings, and adaptation to their current situation in a host country.

Associations between subjective and environmental factors and psychological distress

In this dissertation, subjective factors (such as feeling safe) (Chapter 10) and/or environmental factors (such as the type of residential setting, living with a family member, not being transferred, following formal education) (Chapter 8) also played an important role in the reporting of psychological distress by URM. These environmental and subjective factors might either have a positive or negative association with the development of the mental health of URM. The protection of the physical integrity and security of URM is a basic condition that should be met irrespective of the form of residential setting provided in their reception so that the process of stabilisation of psychological problems can begin. Less emotional problems were found among URM which lived in small-scale residential settings with permanent adult supervision (with kinship/non-kinship foster care or small children groups) than URM from other types of residential settings with less personal supervision. This could mean that the mental health of URM might be improved when they are housed in small-scale residential settings. Having family members in the Netherlands was found to be a protective factor for the mental health of URM. This finding underlines keeping child-families (children from the same family) together and/or other family members in the Netherlands.

The results of this study further indicated that remaining in one residential setting also protected the mental health of URM. Staying in one environment for a long period of time gives URM the possibility of building and sustaining social contacts, attending one school, and/or continuing psychosocial interventions or treatments that have been initiated. Young people who attended school reported lower psychological distress scores than the URM which did not (Chapter 10). Working on acquiring a trade (profession) is essential in all cultures and is a key development task of adolescence. Following a vocational training gives structure, creates stability, and gives URM the peace of mind that they will be able to provide for their own (and familial) material needs in the future. The URM which showed the least amount of interest in receiving an education also reported higher externalizing problem behavior (Chapter 10). It is possible that URM with an inclination to “act out” their distress are not capable of making and completing long term goals because of a low tolerance for frustration. Special attention should be given to URM with externalizing problem behavior so that they will receive appropriate guidance in the acquisition of skills which will enable them to structure to their lives.

Prevalence, course and severity of psychological distress

This dissertation has brought forward and established that this specific adolescent population appears to be a high risk of developing chronic mental health problems (problems such as chronic anxiety, depression, and traumatic stress reactions) (Chapter 7 and 8). High severity levels reported at the first assessment period were the most important predictors of the severity levels of psychological distress at the second assessment, confirmed by guardians and teachers (Chapter 8). This indicates that URM might not eventually be able to function self-sufficiently and/or to be able to fully (re) integrate into society (the Netherlands or another country). The nature of the psychological distress of URM may form a serious impediment in the daily functioning of these young people and in their further development, both on the short and long term (Sack et al., 1993). In several studies, the effects of (organized) violence have been observed to penetrate the entire lifespan (Sagi-Schwartz et al., 2003) and the well-being of sequential generations (Transgenerational effect) (Danieli, 1980; Rosenheck & Nathan, 1985; Solomon, 1998; Rostenthal, 1998).

A great amount of literature concerning the stimulation of resiliency among children and adolescents signifies that a safe, stable, supporting and pedagogical environment is vital for healthy psychological development (e.g., Rutter, 1979; Garmezy, Mast, & Tellegen, 1984; Haggerty, Sherrod, Garmezy, & Rutter, 1994; Tiet et al., 1998). It is therefore probable that if URM are allowed to live and mature in a residential setting which provides pedagogical support, stability, and is cognitively stimulating, the social and emotional adjustment of URM can be strengthened.

Mental healthcare needs of URM

The majority (60%) of URM suffering from high levels of psychological distress also have reported mental healthcare needs (Chapter 9). This percentage is in stark contrast with the 8% of their Dutch peers who reported to suffer from psychological distress or reported maladaptive behaviors. URM who reported a need also reported significantly higher levels of internalizing distress and traumatic stress reactions than the Dutch adolescents with a mental health need which reported significantly more externalizing behaviors (Chapter 9). Furthermore, although URM reported a greater need, Dutch adolescents with a mental health need reported more use of mental healthcare services.

In the (Dutch) report written on the present study “URM and the Dutch MHS” (Bean, Eurelings-Bontekoe, & Spinhoven, 2005), 70% of the URM indicated that they have spoken with someone concerning their psychological problems (data not mentioned in this thesis). This act, in itself, requires a certain degree of trust. People who have experienced traumatic events can have their trust in others be shattered (Janoff-Bulman, 1992). To function competently in any society, it is important to have trust in others. Acknowledging psychosocial problems to someone else is a very big step in a process which can lead to adequate care (a sign of independence). URM spoke with their guardians or teachers about their problems, but also with friends, lawyers, teachers, general practitioners, and religious leaders. Both URM and guardians reported that loneliness was one of the most endorsed symptoms (Chapter 8). It is important that URM are assisted and actively stimulated to build a

social network to prevent isolation. Such a network consists, preferably, of young people and adults from their own culture and young people and adults from the Dutch society. In a strong social network, URM can (again) learn to trust others. Moreover, a social network can serve as a source of emotional support during an extremely difficult period in the lives of URM.

The significant adults in the lives of the URM (guardians, residential staff, and teachers) are often not aware of the mental healthcare needs or the pervasiveness (70%) of the psychological distress among URM leaving the greater portion (50%) of the mental healthcare needs of URM unmet (Chapter 9). As has been reported earlier, this phenomenon is the norm instead of the exception in research among adolescents which may have a negative effect on the long term mental health of adolescent into adulthood. It appears that the third objective of this dissertation has been adequately met; the determination of the mental healthcare needs, unmet needs and use of URM.

Adaptation and attitudes of URM to their current situation in the Netherlands

In chapter 10, the majority of URM living in the Netherlands have reported positive attitudes about their experiences in the Netherlands. The most important wish of many URM was to work on a good future/obtain a profession (trade). Half of the URM in this study were uncertain about their futures for the coming 10 years. If URM reported negative attitudes, they also reported more often high levels of internalizing distress or externalizing maladaptive behaviors. Furthermore, URM who wished for a normal life/to feel emotional better reported higher levels of all types of psychopathology.

The results of chapter 10 further describe a theoretical framework in which the high severity levels of psychological distress can be placed. It was apparent that approximately one third of the URM in this study did not report severe levels of traumatic stress reactions or another type of psychopathology. However, some of those who did report severe traumatic stress reactions (57%) did so in conjunction with severe internalizing distress, externalizing distress or both forms of broadband psychopathology. In this chapter, the conclusion is reached that in spite of overwhelming adversity and high levels of psychological distress, the majority of adolescent URM are working on age appropriate developmental tasks such as planning their futures and getting an education. Nevertheless, the positive adaptation of the group of URM which reported high severity levels of comorbid psychopathology seems to be compromised. In this study it was not clear which came first, the high severity levels of psychological problems which in turn led to adaptational compromises or compromises in adaptation which led to high severity levels of psychological problems. In future studies, it will be necessary to sort the direction of the association between mental health and adaptation among URM.

Methodological Limitations

This research project, just like every project, has its specific methodological limitations. The first, and perhaps most important one is that no standardized diagnostic interview was utilized to be able determine to what extent URM meet the criteria as described in DSM-IV for psychiatric disorders. Because of this limitation, the sensitivity and specificity of all the instruments that were used in this study could not be ascertained. The second limitation was the language barrier(s) and limited concentration capacity of URM which prohibited the administration of additional questionnaires (for personality traits, social functioning, and/or psychological adaptation skills) that could have further verified the present findings or enlarged the implications of the study.

Thirdly, only two assessment periods were utilized in this research project. Evaluating pre-study (before flight to refuge) psychopathology, which has been regularly found as an important predictor of mental health, could have shed more light on the developmental processes that lead to resilience or vulnerability. However, that information would have been extremely difficult to collect among URM which have lost their parents and come from countries where that sort of information is not documented or has been lost due to war/political unrest.

Fourth, there was no way to substantiate that the reported stressful life events among URM were actually experienced. A reliable source that could have corroborated the experiences would have strengthened the validity of the reports of URM. Finally, this study was quantitative in nature. Obtaining quantitative basic information on the mental health of

URM was of great practical importance for those involved in the mental healthcare-giving chain of URM. However, qualitative information is necessary to better understand how the diverse cultural backgrounds of URM affect their resilience and developmental processes.

General Implications

The results of this dissertation raise at least one very essential question; how do host countries such as the Netherlands need to address the great psychological and mental healthcare needs of URM? Is it realistic or practical to refer large numbers of URM which are residing in the Netherlands to mental healthcare facilities and expect that their needs will be fulfilled and that their severity levels of psychological distress will be reduced? To be able to answer this question, it is important to briefly reflect on the knowledge that has been collected over the years concerning the nature of traumatic stress reactions and the effectiveness of the currently utilized treatment methods for psychiatric complaints.

A leading expert in clinical research of long-term cognitive, behavioral, emotional, social, and physiological effects of neglect and trauma among children and adolescents concluded that “.. We fail maltreated children in many ways, not the least of which is an appalling lack of effective therapeutic services for these children. Most of these children have limited access to therapeutic services. Those who do get therapy get too little, too late; how can we possibly expect 45 minutes a week with a therapist to heal a child after years of chaos, threat, humiliation, degradation, and terror?” (Perry, 2006, p. 29). At this moment, there is little scientific evidence which substantiates that curative methods for the treatment of long-term (chronic) traumatic stress reactions are effective among refugee adolescents (AACAP, 1998; Lustig et al., 2004). Cognitive Behavioural Therapy (CBT) is the most studied and has been found to be the most effective type of treatment. Recently there have been several studies published using manual-based CBT interventions with adolescents in general (e.g., Cloitre, Koenen, Cohen, & Han, 2002; De Rosa, et al., 2005; Ford, Marisol Cruz, Mahoney, 2005; Miller, Rathus, & Linehan, in press). Furthermore, there has been an increase in the literature on school-based psychosocial interventions for refugee and immigrant youth (e.g., Entholt, Smith, & Yule, 2005; Layne et al., 2001; O’Shea, Hodes, Down, & Bramley, 2000; Neugebauer, 2003; Stein et al., 2003; Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005). Only a few interventions among refugee adolescents have thoroughly examined the (positive) effect of the intervention on the mental health of refugee children (e.g., Entholt, Smith, & Yule, 2005; Rousseau et al., 2005; Stein et al., 2003). However, Salmon and Bryant (2002) have suggested that before cognitive restructuring can take place in treating PTSD among children and adolescents, basic emotional regulation skills need to be available. One cannot presume *a priori* that URM have a repertoire of emotional regulation skills or are emotional competent enough to be able to begin CBT treatment of traumatic stress reactions. Furthermore, it is clear that URM have been exposed to multiple stressors and continue to live in an unstable situation which can (and frequently does) exacerbate the already high distress levels (this dissertation).

There is a lack of empirical studies to support the use of (expressive) therapies such as play, sand, puppets/dolls, art, music, and psycho-motor (uses movement as a therapeutic tool for stimulating psychological and emotional functioning). However, there are documented accounts in the literature of the successful application of these therapies in alleviating psychological suffering among traumatized children and adolescents (see Boyd Webb, 2006 for a discussion). These alternative approaches might also be attractive (and ultimately effective) among URM from cultures in which “talking” about problems is not customary (Kohli & Mather, 2003). Perhaps flexibility and knowledge of many treatment methods on the part of the therapist (team) will allow for tailored-made treatments that are appropriate for strengthening the self-efficacy and mental health of individual URM.

The research findings concerning the biological changes which can take place after trauma should not be underestimated and suggest that trauma exposure can have long-lasting effects on all levels of brain activity which can influence the further (neuro)development of the individual (Yehuda & McFarlane 1997; Pynoos, et al., 1999; Perry & Azad, 1999; Perry, 2006; Heim, Meinschmidt, & Nemeroff, 2003; Charney, 2004). These findings imply that the whole developmental process of URM can be severely altered if no intervention takes place.

In the trauma literature, it has been documented that only a small minority of persons who have experienced traumatic events ever go on to develop psychiatric problems or have impaired functioning. (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Cuffe, Addy, Garrison, Waller, Jackson, McKeown, & Chilappagari, 1998). Some have explained the vulnerability to the development of PTSD through a relationship between attachment style and traumatic stress reactions; adult child abuse survivors who were insecurely attached developed more PTSD symptoms (e.g., Muller, Sicoli, & Lemieux, 2000). Muller and colleagues (2000) go further and suggest that individuals which have an insecure attachment or PTSD both have problems with the regulation of affect. However, there is a dearth of research substantiating this relationship among refugee children and adolescents (Punamaki, 2002). Furthermore, due to the fact that the attachment style, family structure (primary caregivers), and age when separated from parents of URM in the present study was unknown, it would only be speculative to report on how early attachment might have played a role in the development of chronic traumatic stress reactions among URM.

After experiencing adverse experiences, some people show positive personality changes (traumatic growth) or experience new meaning in life and/or develop new life goals (Linley & Joseph, 2004). Vulnerability or growth (resilience) can also occur among URM. Most of the URM have a strong survival instinct and reported working on age appropriate developmental goals. Their survival skills are probably one of the most important reasons that they made it to the Netherlands, while others did not. Many of these young people go to school, take part in all kinds of types of extra-curricular activities and are busy planning their futures. Nevertheless, experiencing so many (sequential) adverse events within a very vulnerable developmental period in their life, loss of family, limited cognitive development, limited emotional regulating skills, a limited social network, and great uncertainty surrounding their future can result in a fragile balance between their personal capabilities for resilience and overwhelming intense emotions that confront them daily. The high severity levels of psychological distress that have been found in this study among URM might in part be due to undeveloped intrinsic processes of URM being overwhelmed by unavoidable external hardship and stress.

Large-scale referral of URM to mental healthcare facilities would only seem to be partly satisfactory in answering the question how to provide adequate mental healthcare services to a specific culturally diverse traumatized population. Rather, it is perhaps more realistic to provide large-scale care at a low-threshold level in the direct environment of URM. In this discussion, it has been suggested that a stable, secure and supporting environment could relieve some of the distress URM experience and provide a secure base from where they can further grow. However, as already outlined, treating the chronic traumatic stress reactions of URM is complex. To be able to facilitate long-term psychosocial adaptation among URM, it is first imperative that the caregivers of URM provide a secure and stable environment. Secondly, caregivers will need to be able to teach URM social skills, emotional regulation techniques and promote self-reflection and relaxation to learn to manage their traumatic stress reactions in their lives. Only after these skills have been acquired, can complex interventions such as mastering intrusive thoughts and memories and cognitive re-structuring be offered through caregivers/professional caregivers that have been trained to provide such specific care. At this moment, this approach seems the most far-reaching and appropriate form of psychosocial care for this population for the following reasons:

1. The mental healthcare which is offered to URM in this way will be more accessible and reach more children and adolescents. Accessible care must be appropriate to the needs and experiences of URM (Hodes, 2001; Kohli & Mather, 2003),
2. In the direct living environment of URM, it is possible to enlarge the “emotional and physical availability” of the caregiver for the URM. This availability is essential for creating a secure and stable environment (Schofield & Brown, 1999). Also this availability forms a protective barrier against adverse events (Howe, Brandon, Hinings, & Schofield, 1999, 275),

3. If a secure and stable environment has been created in which URM feel comforted and supported, more complex interventions can be conducted by caregivers (Howe et al., 1999, p. 279-291),

4. In this form of mental healthcare, the caregivers of URM can be trained by mental health professionals and receive periodic supervision from professionals to teach them how they can instruct URM to manage their (chronic) traumatic stress reactions. Using this approach, the experience and knowledge of the mental health professionals would be disseminated on a wide-scale reaching the entire population.

Clinical Implications

URM in the Netherlands who experience severe psychiatric problems and are temporarily impaired in their daily functioning will, of course, still need to be able to rely on the regular professional mental healthcare services for assistance. However, several adaptations in the current referral system, such as adequate diagnostic assessments and early identification (screening) for psychological distress or maladaptive behaviours are greatly needed to assist guardians in making more accurate and effective referrals. Moreover, developing “evidence-based” treatment methods in the Dutch mental healthcare services will lead to effective interventions that can treat URM in a more appropriate and efficient manner. A similar call to therapists “..to develop and evaluate innovative treatments designed to address more complex symptom presentations (of PTSD).. (and) ...interventions that intentionally target subpopulations of traumatized individuals who have thus far been underrepresented in PTSD efficacy research” has been recently published in a review article of PTSD treatment efficacy (Spinazzola, Blaustein, and Van der Kolk, 2005)

Unfortunately, there have been many URM that have not received adequate supervision by pedagogically competent residential staff or effective interventions to timely treat their high severity levels. These young people could (still) arrive on the doorstep of a mental healthcare institution for a variety of reasons. A couple reasons are; they have not learned how to come to terms with their great losses, psychological distress, traumatic stress reactions and/or and have not been able to form their own identity, a crucial development task of adolescence. Persons who suffer from long-term effects of traumatic stress reactions and have never gotten sufficient help can experience being overwhelmed and become submerged in feelings of helplessness, hopelessness, shame, guilt, feeling estranged from others, becoming withdrawn from social relations and mistrusting others (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005; Perry, 2006). Daily social functioning can be seriously disturbed. In the case of former URM, they may have become parents themselves. The pregnancy might have taken place under severely stressful conditions, social isolation and little or no medical care. These conditions can have an adverse effect on the development of both mother and (un)born child (Belsky & Vondra, 1989; Lewis, 1992). Moreover, there can be an accumulation of problems due to the unprocessed loss experiences of URM which leads to inappropriate emotional regulation and in turn can lead to disorganized attachment in their own children (Allen, Hauser, & Borman-Spurell, 1996).

Identity problems are also a possible consequence of living in years of uncertainty. In the uncertain situation in which URM (have) had to live, they could not properly form their identity and how they wanted to live and/or plan their life. They simply did not (do not) know where they would be living and under what conditions. For URM who are allowed to integrate in the Dutch society, the question also remains when they will ever be considered as a “real” Dutch citizen, postponing the formation of their identity as a Dutch citizen. Previous research has shown that when someone does not feel that they are accepted into the host culture that they can develop depressive symptoms (Phinney, Locher, & Murphy, 1990). Mental healthcare professionals should be aware of the specific mental health needs of former URM.

In conclusion, using a “stepped care¹” approach where intensive mental healthcare is offered if a pedagogically, stable, and secure residential environment is not adequate in

¹ according to the principles of the stepped care-program, the recipient of care, in the first place, receives the most effective, non-intrusive, economic and shortest form of treatment which fits the nature and the seriousness of the problem. If the minimum intervention has had an insufficient effect, more intensive intervention it then applied (www. Trimbo.nl, 2004).

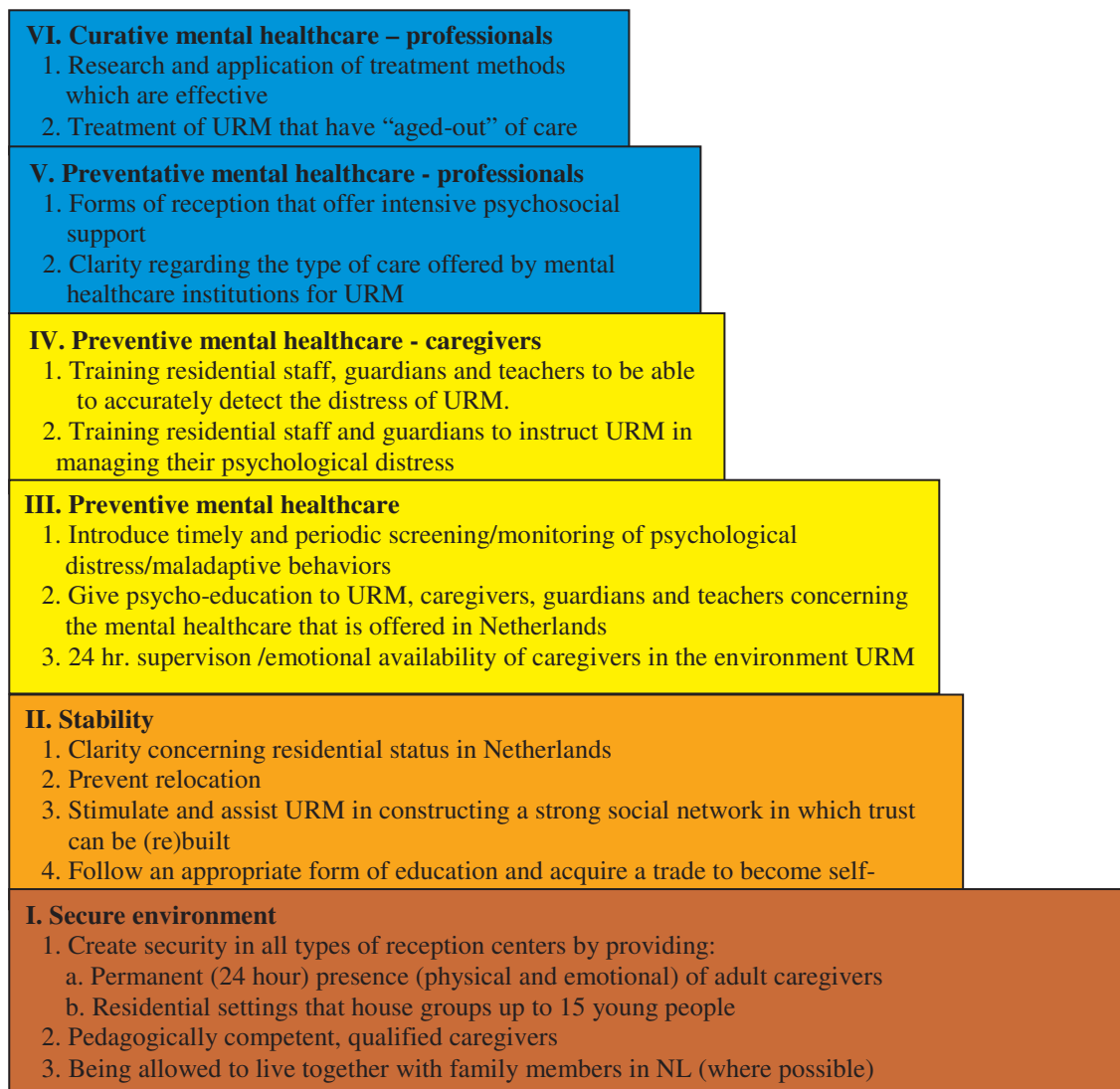
alleviating the psychological distress of URM, adequately addresses the *nature* of the psychological problems of URM and the *need for* specialized mental healthcare when severe compromises have taken place in the daily functioning and adaptation of URM.

The recommendations that have been listed throughout this entire discussion form guiding principles for the protection and promotion of the mental health of URM. The recommendations are summarized in a visual “stepped care” model below. In this model, the intensity of the care corresponds with the level of severity of psychological distress and needs of URM. The model begins under on and ends at the top of the page.

To reduce the psychosocial distress of URM there are no fast and easy solutions at hand. As is often said by the organization War Child, “you can take a child out of war, but how do you take war out of a child?” From the results of this study, it is apparent that structural adaptations in the reception of URM, the early detection of psychological distress through monitoring of symptoms, and developing effective treatment methods which can be disseminated in the residential settings of URM should promote an atmosphere in which the levels of psychological distress among URM can be reduced/managed and their mental healthcare needs can be fulfilled.

Visual summary of a Stepped Care Approach to Protect and Promote the Mental Health of URM

Figure 1.



Future research directions

1. To be able to carry out more complex studies, it is crucial that psychological instruments that assess many levels of psychological and cognitive functioning be translated and validated for culturally diverse adolescents. This process is expensive and time-consuming, but is essential to be able to obtain reliable and valid results in future research projects.
2. In this dissertation, the significant adults in the lives of URM are not always able/capable of accurately assessing the mental healthcare needs of URM. Introducing an early and periodic screening protocol for URM through a research project, could have a positive impact on the adults' ability to timely perceive the psychological distress of URM.
3. Furthermore, the “stepped care” approach has been recommended in this dissertation to be able to structure the mental healthcare services for URM. If this method is applied, it is important that the approach is examined by means of a research project to determine if it is more efficient and effective than the mental healthcare that is currently being provided.
4. A priority for future research in the field of the mental healthcare which concerns URM is the adaptation/development of treatment methods or interventions which are effective in alleviating the psychosocial distress of URM. It is imperative to their well being that clinicians undertake research studies in which the effectiveness of their treatments can be evaluated. In doing so, referrer's of URM can be informed and be kept up-to-date with the types of treatments that mental healthcare professional utilize and encourage URM to take part in effective treatments.
5. There has been little research done in the countries of origin of URM residing in the Netherlands. To enhance our understanding of the effects of immigration and separation from parents on the mental health of URM, a comparison study should take place between orphans and adolescents with parents still living in the country(s) of origin and URM from the same country(s) residing in the Netherlands.
6. There is a lack of information regarding the daily lives of URM from the moment they arrive until they are repatriated or integrate into Dutch society. Qualitative ethnographic research would allow for a better understanding of how individual URM deal with life in a host country and better show the way they handle the positive experiences and adversity in their lives.
7. Conducting a multi-disciplinary longitudinal study which spans at least one developmental stage would be of great worth in determining psychiatric diagnoses among URM, educational performances, social functioning, (re)integration into society and adaptation skills. Such information would give in-depth insight into how we are able to strengthen the individual psychological development of an URM to promote resilience and limit vulnerability.

