PTSD and depression in refugee children
Associations with pre-migration trauma and post-migration stress

Abstract This paper describes the effect of pre-migration and post-migration experiences on the mental health of a sample of 40 refugee children aged 8–16 who lived in London with at least one parent or a refugee relative. Children’s post-traumatic stress disorder (PTSD) and depression symptoms were assessed with standardised self-report measures (Impact of Event Scale and Depression Self-Rating Scale for Children, respectively). Information regarding past and present experiences were gathered during an interview with parents. There was a significant correlation between the number of pre-migration traumas experienced by the families and the children’s PTSD scores. There was also a significant correlation between the families’ number of post-migration stresses and children’s depression scores. Higher PTSD scores were significantly associated with the pre-migration experience of violent death of family members and the post-migration experience of an insecure asylum status. Higher depression scores were significantly associated with insecure asylum status and severe financial difficulties. The clinical implications of these findings are discussed.

Key words pre-migration experiences – post-migration experiences – PTSD – depression

Introduction

In the context of the European Union, Germany dealt with the highest number of asylum applications during the years 1990–2000. Almost two million applications were received during that period, accounting for nearly half of the total asylum applications in Europe. With nearly 500,000 applications during the same 10-year period, the United Kingdom came second, followed by the Netherlands with over 350,000 applications.

Research carried out in a number of different countries has singled out mental health issues as causing special concern in adult refugees, leading to an extensive body of literature. Clinic-based research has revealed rates of depressive disorders amongst refugees ranging from 4% to 89% and of post-traumatic stress disorder (PTSD) of 50% and higher [9, 22]. Population-based studies, especially in North America, found rates of depression amongst refugees of 15–80% [2, 12] and a prevalence of PTSD ranging from 3.5% to 86% [2, 5]. The large differences in prevalence are likely to reflect variations in sample characteristics and the measures used.

A large body of literature also exists on the effect of war and political violence on children. These studies indicate that, like adults, children develop considerable mental health problems as a result of their experiences. Severe war trauma has been shown to be associated with psychiatric disorders like PTSD and depression and has been found to predict psychiatric disorders in later life [8, 9]. Reports on the prevalence of PTSD have varied considerably. Almost all subjects (94%) amongst a group of internally displaced Bosnian children fulfilled criteria for PTSD (4). Similar findings were reported for...
Sudanese children who had found refuge in neighbouring Uganda [10]. PTSD prevalence rates of 40–50 % were reported in children who had experienced war in Cambodia and former Yugoslavia and who had emigrated to the United States [8, 13, 23]. Rates of PTSD varying from 11.5 % to 28 % were found in child refugees from Tibet and Bosnia [16, 23]. Several studies have reported a prevalence of depression similar to or somewhat lower than that of PTSD [11, 16, 23].

Sack et al. [13] have argued that, while earlier war trauma is associated with PTSD, depression is strongly correlated with stressful events after relocation. Children who have PTSD symptoms due to pre-migration experiences are said to be more vulnerable to the development of depressive symptoms in the post-migration period. Research on adults carried out in Australia has suggested that the mental health of individuals already traumatised by pre-migration experiences may be exacerbated by post-migration stresses [17–19]. Post-migration factors said to put PTSD sufferers at risk of continued and increased psychological distress included delays in processing refugee applications, obstacles to employment, language problems, racial discrimination and loneliness.

The identification of specific experiences associated with PTSD and depression could predict mental health problems in refugee children and, thus, contribute to more effective mental health services. The purpose of this paper is to examine possible relationships between children’s past trauma and ongoing stress and symptoms of depression and PTSD.

Subjects and methods

Subjects

The subjects were 40 refugee children aged between 8 and 16 living in London for no more than 5 years, who participated in a pilot study investigating reasons for referral or non-referral to child mental health services. The study was commissioned by a local mental health trust requiring a detailed report containing both quantitative and qualitative data. The sample was designed to consist of a group of children (N = 30) who had been referred to a mental health service in South London and a group of non-referred children (N = 30). In order to allow for self-reports, subjects had to be aged between 8 and 16, so that they could be expected to be able to read either in English or in their own language. Children born in Britain of refugee parents were excluded. The small sample was dictated by the size of the grant allowing a time-span of 14 months. In order to provide time for analysis and report writing, the data collection took place over a period of 11 months and was carried out by two full-time researchers.

Referred children and their families were recruited with the help of a Child and Adolescent Mental Health Service (CAMHS) and a newly established mental health project for refugee children. Efforts to enlist the help of other local CAMHS within the short time available were unsuccessful. The cooperating CAMHS identified refugee children who had attended their services in the past 2 years and who were in the right age group. This proved to be a slow process since only patients’ country of origin was recorded, not their refugee status. Out of a total of 17 children identified as refugees, six children who no longer attended CAMHS had moved away from their last known address and could not be traced, two were excluded by the clinicians and two further families declined to participate. Clinicians at the child refugee project provided the study with six children, while they excluded another five new patients who were considered too traumatised to participate. The majority of clinicians involved chose to introduce the study to the families themselves before passing contact details to the researchers. This meant waiting for the families to attend the clinic and waiting for the clinicians to remember to mention the study. Due to this recruitment system and the short time in which the study took place, the target of 30 referred children was not met and a total of 13 families were included.

Non-referred children were recruited with the cooperation of five local voluntary organisations providing support and practical help to refugees. One organisation dealt with refugees from Colombia, while the remaining four organisations provided support to any refugee requiring their services. Three of the centres approached families on our behalf, but no record was kept of the number of families who refused to participate. The remaining two centres invited the researchers to come to gatherings or special sessions and approach the families present. Although a sufficient number of families was available, the short time span meant that 27 children were included in this group.

Procedure

An interview with parents was conducted in order to obtain information about families’ experiences before and after relocation in Britain. Parents and children were also asked to complete questionnaires measuring their mental states. These questionnaires were translated into several languages. All parents approached for cooperation were initially sent a letter introducing the study in their own language. This was followed by a telephone call to make the appointment. Since the researchers were not familiar with the parents’ degree of fluency in the English language, all consenting parents were offered the assistance of an interpreter. A minority of parents (25 %) declined this offer. The interpreters were booked...