# Child and Adolescent Refugees: Developmental Differences

*By Amanda Posner*

As they acculturate, refugee children face a distinct set of obstacles that are mediated by certain risk and protective factors. Their experiences differ, however, based on their developmental stage at the time of arrival in the host country. This article discusses the different effects of the refugee experience on the development of children and adolescents. It suggests that change is needed in current intervention programs and services. Such change should recognize and accommodate these differences in order to deliver more effective services.

More than half of the world's refugees are children (Fazel and Stein, 2002), and international migration has become a major social issue in the contemporary world. As these children go through the process of resettlement, there are several risk and protective factors that influence their ability to adjust successfully to their new culture. Children and adolescents experience resettlement, the process of permanently settling in a new country, differently, depending on where the individual is in his or her development. Adolescents and school-aged children face different developmental tasks. This is a seldom recognized fact, and successful interventions must pay more attention to such differences.

## THE REFUGEE EXPERIENCE

According to the United Nations High Commissioner for Refugees (UNHCR), on January 1, 2004, an estimated 17,093,361 people were classified as refugees or asylum seekers (UNHCR, 2004). The 1951 Convention relating to the Status of Refugees defined a refugee as a person who, "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside

the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country" (United Nations, 1954, art. 1, sec. A2). In the past decade, the refugee population has increased tenfold, and it is expected to continue to increase (Fazel and Stein, 2002). Child refugees witness horrific and traumatizing events, live in poor conditions, are forced to leave their countries and often their families, and are forced to assimilate to a new culture. Given the intense experiences of child refugees, it is not surprising that they are at significant risk of developing mental health issues (Fazel and Stein, 2002; National Child Traumatic Stress Network [NCTSN], 2003). The most common of such issues are posttraumatic stress disorder (PTSD) and depression (Richman, 1998; Papageorgiou et al., 2000; Fazel and Stein, 2002; NCTSN, 2003). The problems of the past are also highly significant in shaping the future. This is particularly true as refugee children attempt to successfully assimilate into their new cultures (Messer and Rasmussen, 1986).

## RISK AND PROTECTIVE FACTORS

Much of the literature regarding risk and protective factors in the acculturation of refugee children stresses the family as a key influence. Critical factors in identifying the children most at risk are the degree to which a family is intact, whether a parent has died, and whether the parent has been separated from the child (McCloskey and Southwick, 1996). Additionally, refugee children are at risk for mental health problems if one or both parents, especially the mother, suffers from depression or PTSD (McCloskey and Southwick, 1996; Fazel and Stein, 2002). Not surprisingly, the coping abilities of parents also strongly influence the mental health of their children. As Carmelina Barwick, Morton Beiser, and Gary Edwards (2002) state, "The family plays an important role in determining children's mental health. Refugee children sheltered from stress by parents who adopt a coping style of low dogmatism and low authoritarianism are particularly immune to psychological risks" (p. 42).

Individual risk factors include the number of traumatic events witnessed or experienced by a child, physical health problems from trauma or malnutrition, and PTSD leading to long-term vulnerability in stressful situations (Fazel and Stein, 2002). Some of the notable environmental risk factors are poverty, the number of transitions made by the child between different places, the amount of time taken from flight to resettlement, time spent in refugee camps, and the general cultural isolation that comes from fleeing one's homeland to take up residence in another country (Fazel and

Stein, 2002). Refugee children are clearly at significant risk of developing mental health problems. They suffer not only the effects of flight from a war zone but also the process of adjusting to a new culture (Fazel and Stein, 2002). These stressors affect the whole family; a child's success in overcoming these risks depends heavily upon the successful adjustment of his or her parents and other family members.

Despite these obstacles, most refugee children adapt to their new countries and display amazing levels of resiliency (Barwick et al., 2002). There are multiple levels at which protective factors operate and enable children to overcome risks. At the individual level, protective factors involve a positive personality disposition, the preservation of self-esteem, and the assertion of personal autonomy (Barwick et al., 2002; Fazel and Stein, 2002). The warmth, cohesiveness, and absence of discord within the family environment can also be a protective influence. This is especially true if children have a secure relationship with a parent who can offer support and encouragement in times of stress (Barwick et al., 2002; Fazel and Stein, 2002). Another important protective factor is support from a like-ethnic community. Refugees who resettle in an area where there is an established community of the same ethnocultural background experience lower levels of distress and are able to receive support within familiar cultural contexts (Barwick et al., 2002). At the broadest level, the host culture provides the backdrop for the child's continued development. That society's openness to diversity and receptiveness to immigrants therefore influences the well-being of the child (Barwick et al., 2002). External societal agencies, such as schools, and individuals, such as counselors and social workers who reinforce a child's coping efforts, can also be important protective factors (Barwick et al., 2002; Fazel and Stein, 2002).

## DIFFERENCES BETWEEN CHILDREN AND ADOLESCENTS

The problems of the past are highly significant for the mental health of child and adolescent refugees, but those problems can also affect their ability to become part of the new host culture. Child refugees face different challenges than their adolescent counterparts because childhood involves different stages of development than adolescence. Thus, experience and significance of resettlement processes vary depending on where the individual is in his or her development. Whatever a person's age, it is clear that being a refugee and adjusting to a new culture can have significant effects on individual development.

### *Adolescent Development*

Apart from early infancy, adolescence is the period of most rapid growth and developmental change in the human life cycle (Loughry and Ager, 2001). Thus, given their developmental stage, adolescent refugees may have a more difficult time adjusting to their new cultures than younger children. As Lydia Kovacev and Rosalyn Shute (2004) observe, "For adolescents, these challenges may be especially great, as the non-normative experience of migration is superimposed upon a complex of normative changes such as puberty, a developing sense of identity, and the renegotiation of earlier parent-child relationships" (p. 259). Some of the normative developmental tasks in adolescence include forming a sense of group identity, establishing attitudes about and relationships with peers, and renegotiating relationships with parents or caregivers (Newman and Newman, 2003; Kovacev and Shute, 2004).

During adolescence, individuals face the new psychosocial tasks of allying with specific groups and becoming comfortable functioning as members of these groups (Newman and Newman, 2003). Throughout the process of seeking a group affiliation, adolescents question their identities, values, needs, and personal characteristics (Newman and Newman, 2003). As Barbara Newman and Philip Newman (2003) state, "Perceiving oneself as a competent member of a group or groups is fundamental to one's self-concept as well as to one's willingness to participate in and contribute to society" (p. 318). Especially salient for adolescent refugees are issues of ethnic group identity. For many, these issues have not been previously considered, but contact with others in a new country inevitably raises issues of ethnic identity and ethnic group differences (Kovacev and Shute, 2004). Young refugees negotiate multiple worlds, making attitudinal and behavioral changes to fit in with their new peers. While ethnic identity varies across groups, it does have a significant effect on development and individual identity formation, especially during adolescence (Newman and Newman, 2003).

The importance of peer interaction for healthy psychosocial development is also widely accepted. During adolescence, peer groups become more structured. The individual's relation to the group becomes more defined and more important (Newman and Newman, 2003). The peer group provides support, companionship, a sense of identity, and experience with the opposite sex (Kovacev and Shute, 2004). At this key point in the development of peer relationships, international migration processes can be especially disruptive. Adolescent refugees have experienced the total loss of their former peer support networks and must start over in a new culture (Kovacev and Shute, 2004).

Additionally, most of the peers available to them are from the host culture, and this creates difficulties related to language and other cultural barriers (Kovacev and Shute, 2004). Studies suggest that adolescent refugees have very strong personal investments in their classmates since positive regard from their peers is closely related to the ways they view themselves (NCTSN, 2003; Kovacev and Shute, 2004). Adolescents who do not form relationships with peers in the host culture are at a greater risk for emotional problems (Messer and Rasmussen, 1986), and one study finds that people who migrate during adolescence tend to have fewer friends as adults than those who migrate during childhood or adulthood (Kovacev and Shute, 2004). Lack of social integration can have implications for self-esteem and adjustment; it can also lead to lifelong difficulties in work, in the formation of intimate bonds, in anger management, and even in physical health (Newman and Newman, 2003).

The relationship between adolescents and their parents also undergoes a change during resettlement. Because parents and adolescents acculturate at different rates, conflicts over various aspects of the new culture are likely to arise (Messer and Rasmussen, 1986; NCTSN 2003). Some behavioral problems may be acceptable and even expected in the host culture but are met with disapproval at home (Messer and Rasmussen, 1986). Studies have shown that adolescents who have school-based relationships with peers from their host culture are at a higher risk for conflict with their parents (Messer and Rasmussen, 1986; Kovacev and Shute, 2004). In many families, parents' own struggles with acculturation prevent them from providing support or supervision to their adolescent children (NCTSN, 2003). This can lead adolescents to become overly susceptible to negative peer influences, such as substance abuse and gang involvement (NCTSN, 2003).

In addition to these emotional development issues, adolescents experience much physical maturation as they go through puberty. This can cause confusion in adolescent refugees, because many cultures do not recognize adolescence as a separate developmental stage (Messer and Rasmussen, 1986). Some refugees may feel that their life cycles are out of sync—that they have become adults too soon or not soon enough. Additionally, refugee adolescents must deal with these physical changes while negotiating two different cultures. Each culture may have different views about physical changes and their meanings, and expectations for behavior may change to reflect physical maturation (Messer and Rasmussen, 1986).

### *Childhood Development*

During the middle childhood stage of development, from 6 years until the

onset of puberty (usually 11 or 12), children are learning the fundamental skills required for success within their culture (Davies, 2004). In general, the following developmental advances are made during this stage: improved self-regulation, internalization of the self, advances in moral development, increased ability to substitute thinking and words for impulsive action, and increasing peer orientation (Davies, 2004). As they gain confidence in their abilities, children in this stage are able to develop a more realistic view of their potential contributions to the larger community (Newman and Newman, 2003; Davies, 2004). The age at which a child becomes a refugee has a large effect on how the child deals with associated experiences of trauma, loss, and exile. Younger children who experience the disruption of early attachment relationships are more susceptible to developing oppositional traits than children who have had roughly 8 years of normal life prior to these experiences (Hamilton et al., 2004). It has been noted that refugee flight generally disrupts childhood development in two ways; flight breaks the continuity of the socialization process and prevents the child from progressing normally in the acquisition of information and skills (Hamilton et al., 2004).

Skill learning during middle childhood is embedded within social and cultural contexts. As Newman and Newman (2003) discuss, "Children's beliefs and attitudes about which skills are important, what they should expect of themselves, what others expect of them, and what kinds of competing demands should influence their dedication to skill development all contribute to the levels of performance they are likely to achieve" (p. 267). Thus, adapting and developing new skills within a new social and cultural context are primary tasks for the child refugee. When children reach school age, they have developed more cognitive, emotional, and behavioral resources for handling traumatic situations than they previously possessed, and are often able to externalize the causes and consequences of events, rather than fully internalizing them (Papageorgiou et al. 2000). While the developmental tasks of middle childhood are clearly important, children who become refugees during this time seem to be better equipped to overcome developmental barriers than their older and younger counterparts. However, childhood development among child refugees is adversely affected by the accumulation of risk factors (Loughry and Ager, 2001).

As previously discussed, many risk factors are associated with the refugee and resettlement process. As the number of risk factors increases, it also becomes increasingly likely that a child will experience lasting effects from his or her experiences as a refugee (Loughry and Ager, 2001). These factors, such as the stresses of acculturation and dealing with past traumatic experiences,

affect development.

Asymmetric acculturation, which occurs when children acculturate faster than their parents, forces children to negotiate access to services on behalf of their parents (NCTSN, 2003). This is especially common as parents and children learn the host culture's language. This causes stress to children and disrupts the family order as roles are reversed and parental authority is weakened (Barwick et al., 2002; Davies, 2004; Leavey et al., 2004). Evidence suggests that children are harmed by being placed in this position because they acquire more power while losing parental guidance (NCTSN, 2003). Barwick and associates (2002) also mention that children who arrive in the host country during middle childhood are more likely to adopt the new culture's values and attitudes, causing intergenerational culture clashes that can threaten family stability. The stress of acculturation and the processing of past experiences of trauma lead to the most common mental health problems in school-aged children: PTSD and depression (Messer and Rasmussen, 1986). The overwhelming differences in language, culture, school structure, parent-child relationships, and family values can cause a child refugee to sink into hopelessness and helplessness; the child may also act out with aggressive or disruptive behavior (Messer and Rasmussen, 1986; Fazel and Stein, 2002). Symptoms of PTSD and depression are often long lasting. Many studies of refugee children find that these symptoms persist in the months and years after the child has resettled (Papageorgiou et al., 2000; Leavey et al., 2004). Trauma disrupts a child's cognitive functioning and children who have experienced trauma in the past return to these disruptive states when faced with threatening situations, limiting their access to higher-order reasoning and problem-solving skills (Newman and Newman, 2003). If left untreated, the disruption caused by these experiences can hinder a child's ability to develop the tools that help modulate strong impulses, such as empathy, self-control, and problem-solving skills (Newman and Newman, 2003).

## IMPLICATIONS

Children and adolescents are active agents in their own development. Actions to ensure their appropriate involvement in decisions that affect them can support their development of resiliency, efficacy, and self-worth (Loughry and Ager, 2001). Yet simply working with the child or adolescent alone is not enough; these issues must be addressed within the context of the family. A supportive and understanding family and a healthy relationship between parents and children can mitigate many of the negative effects of the resettlement

process. As Matthew Hodes (2002) mentions, "Given children's dependency and involvement with families and other adults, interventions targeting family and the community will necessarily reduce the risk factors for childhood psychiatric disorder and distress" (p. 204). Additionally, families need extra support in building and maintaining healthy parent-child relationships as roles and cultural norms are challenged. Intervention strategies that recognize this may be more successful.

As previously noted, children going through the refugee resettlement process understand the experience differently than their adolescent counterparts, and the experience has a different impact on the development of children. In order for interventions to be successful, practitioners need to be aware of these differences and design interventions and programs that are sensitive to specific developmental needs. Adolescent refugees have a special set of needs, vulnerabilities, and capacities that are rarely addressed in children's programs. Because of the developmental processes associated with adolescence, adolescents are particularly at risk and need specific protective measures that are geared toward their experiences. These measures must also recognize the importance of being accepted by a peer group. Such experiences are all too commonly ignored when social service providers plan and implement programs for adolescent refugees (Loughry and Ager, 2001). For school-aged children, schools can play a key role in successful resettlement, and a teacher who takes an interest in the child can have a lasting positive effect on his or her social and emotional development (Fazel and Stein, 2002). While this is still true for adolescents, more important are relationships with peers and acceptance into groups. Given this information, programs for adolescent refugees could include components that would help participants learn to initiate and maintain relationships, both within their own communities and in their host communities. Adolescent programs should also provide healthy and culturally appropriate ways to deal with anger and conflict.

## CONCLUSION

The experience of being a refugee and resettling in a new culture creates many challenges. There are several risk and protective factors that influence the effects of this experience on children and adolescents. Additionally, the experience affects the individual development of children and adolescents very differently. To better serve refugees and aid their healthy development, agencies need to make sure that they do not group children and adolescents together in treatment efforts. The problems and adjustment issues of child

refugees should be acknowledged as separate and unique from those of their adolescent counterparts. As these differences are noted and integrated into service delivery, programs should see an increase in successful outcomes. With the number of refugees growing every year, this is an issue that is likely to receive mounting attention. ■

## REFERENCES

Barwick, Carmelina, Morton Beiser, and Gary Edwards (2002). Refugee children and their families: Exploring mental health risks and protective factors. In Fern J. Cramer Azima and Natalie Grizenko (Eds.), *Immigrant and refugee children and their families: Clinical, research and, training issues* (pp. 37-63). Madison, CT: International Universities Press.

Davies, Douglas (2004). *Child development: A practitioner's guide* (2nd ed.). New York: Guilford.

Fazel, Mina, and Alan Stein (2002). The mental health of refugee children. *Archives of Disease in Childhood, 87* (5): 366-70.

Hamilton, Richard, Angelika Anderson, Kaaren Frater-Mathieson, Shawn Loewen, and Dennis W. Moore (2004). *Interventions for refugee children in New Zealand schools: Models, methods, and best practice* (Report). Wellington: New Zealand Ministry of Education. Retrieved on March 30, 2005 from http://www.minedu.govt.nz/index.cfm?layout=document&documentid=6042&indexid=1108&indexparentid=2107#P5_0.

Hodes, Matthew (2002). Three key issues for young refugees' mental health. *Transcultural Psychiatry, 39* (2): 196-213.

Kovacev, Lydia, and Rosalyn Shute (2004). Acculturation and social support in relation to psychosocial adjustment of adolescent refugees resettled in Australia. *International Journal of Behavioral Development, 28* (3): 259-67.

Leavey, Gerard, Kathryn Hollins, Michael King, Jacqueline Barnes, Christopher Papadopoulos, and Kate Grayson (2004). Psychological disorder amongst refugee and migrant school children in London. *Social Psychiatry and Psychiatric Epidemiology, 39* (3): 191-95.

Loughry, Maryanne, and Alastair Ager (Eds.). (2001). *Refugee experience—psychosocial training module* (Rev. ed.). Oxford: Oxford University, Refugee Studies Centre. Retrieved on March 7, 2005 from http://earlybird.qeh.ox.ac.uk/rfgexp/start.htm.

McCloskey, Laura, and Karen Southwick (1996). Psychosocial problems in refugee children exposed to war. *Pediatrics, 97* (3): 394-97.

Messer, Michael, and Norman H. Rasmussen (1986). Southeast Asian children in America: The impact of change. *Pediatrics, 78* (2): 323-29.

National Child Traumatic Stress Network (NCTSN), Refugee Trauma Task Force (2003). *Review of child and adolescent refugee mental health* (White paper). Boston, MA: National Child Traumatic Stress Network.

Newman, Barbara, and Philip R. Newman (2003). *Development through life: A psychosocial approach* (8th ed.). Belmont, CA: Thompson Learning.

Papageorgiou, V., A. Frangou-Garunovic, R. Iordanidou, W. Yule, P. Smith, and P. Vostanis (2000). War trauma and psychopathology in Bosnian refugee children. *European Child and Adolescent Psychiatry, 9* (2): 84-90.

Richman, Naomi (1998). *In the midst of the whirlwind: A manual for helping refugee children.* Stoke-on-Trent, UK: Trentham.

United Nations High Commissioner for Refugees (2004). *2003 global refugee trends: Overview of refugee populations, new arrivals, durable solution, asylum seekers and other persons of concern to UNHCR.* Geneva: United Nations High Commissioner for Refugees, Division of Operational Support. Retrieved on March 30, 2005 from http://www.unhcr.ch/cgi-bin/texis/vtx/statistics/opendoc.pdf?tbl=STATISTICS&id=40d015fb4.

United Nations, Treaty Series (1954, April 22). Australia, Belgium, Denmark, Federal Republic of Germany, Luxembourg, et al.: Convention Relating to the Status of Refugees. *Treaties and International Agreements Registered or Filed or Reported with the Secretariat of the United Nations, vol. 189*, no. 2545, pp. 137-220.

## ABOUT THE AUTHOR

AMANDA POSNER, currently in her first year, is pursuing a dual degree with the School of Social Service Administration and the Harris School of Public Policy Studies. She comes from the West Coast, with a stop-over in New York, where she received a B.A. in anthropology and sociology from Vassar College. Her interests are still forming, but include education policy, community development, and the desire to work with children and adolescents.