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MENTAL HEALTH ISSUES IN REFUGEE POPULATIONS: A REVIEW

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1. INTRODUCTION

As the situation grew worse, we moved away from our village into huts we had built in the mountains. But government soldiers saw this as a sign of our being friends with the rebels. One day they came to the area and, surrounding the huts, killed many people, including my mother-in-law. I myself escaped, along with my son, aunt and three brothers-in-law. But my wife was taken by the soldiers.[1]

My own house was burning as I ran from it, leaving all my possessions behind. All my family managed to get away, but we were separated in the confusion. Over the next few days we were gradually reunited, and we than began to travel towards the border. We took quiet routes by day, and hid in the bush at night. We met soldiers along the way - but we had little trouble with them - after a while we had nothing left to steal. About one month later we finally got to the border.[1]

In the camp I am not content. I have many worries. I can not clothe my family properly. I have no 'voice' in the situation we are in. I feel deeply about my home. I want to advise the government and rebels simply to stop so that we can go home in peace. I won't go, though, until there is real peace...if someone tried to pressure us to go we just couldn't...we'd say 'just shoot us here'.[1]

1.1 The context of refugee mental health

The growth in refugee numbers

Obtaining reliable data on numbers of refugees is undermined by a range of practical, political and definitional difficulties (Harrell-Bond et al. 1992, Kibreab 1991). Nonetheless, there is clear agreement that refugee displacement has become, globally, a phenomenon of major significance. Figures of the United Nations High Commissioner for Refugees (UNHCR) suggests growth in the global refugee population from 2.5 million in 1970, through 8.2 million in 1980, to 15 million in 1990 (de Girolamo 1990, Refugees 1989). Muecke (1992) cites a current estimate of refugees worldwide of 17 million. Harrell-Bond (1988) reports an estimate of 140 million people forcibly uprooted this century.

Distribution of refugees

The current crisis in the former Yugoslavia is estimated to have led to more than 2 million individuals fleeing their homes (Rutter and Sorensen 1992), and the potential for further large-scale movements in the area remains high. With the likely displacement of significant numbers of ethnic Russians from the Baltic region and other former states of the Soviet Union, Europe has become, again, a significant focus for refugee movements. Globally, however, the largest numbers of refugees are still believed to be found within the continents of Asia and Africa (Muecke 1992). De Girolamo (1990) cites estimates - broadly supported by Clinton-Davis and Fassil (1992) - of approaching 7 million refugees in Asia (hosted predominantly in Pakistan and Iran) and close on 5 million in Africa (predominantly across central and eastern regions).

Majority of refugees live in the poorer countries of the world

Whilst much has been written about refugees resettled into western, developed nations - and much may be learned from such analyses - such refugees must, therefore, be seen as atypical in global terms (Muecke 1992). Less than 17% of the world refugee population resides in the industrialized countries of Western Europe, the USA, Canada and Australia (Clinton-Davis and Fassil 1992). The experience of being a refugee is typically borne in amongst the poorest countries of the world (Muecke 1992, Rutter and Sorensen 1992).

1.2 The study of refugee mental health

The literature on refugee mental health generally reflects agendas established by the social concerns of developed nations with regard to specific refugee influxes. It is appropriate to consider some of these agendas in advance of formal review of the literature, as it clarifies the nature and purpose of most existing investigations.

Studies following World War II

The first coherent attempt at the study of the psychosocial impact of becoming a refugee was represented by a number of researches examining the psychiatric adjustment of refugees from central Europe following resettlement after World War II. This work was focused in the U.K. (Murphy 1955), Norway (Eitinger 1959, 1960, Eitinger and Grunfield 1966) and Australia (Krupinski and Stoller 1965, Krupinski 1967). These studies identified refugees as at significantly increased risk for psychotic illness compared to the native population, a phenomenon which did not appear to be reduced by length of stay in the country of resettlement (Eitinger and Grunfield 1966). Severity of war experiences was found to predict rates of psychiatric illness (Murphy 1955, Krupinski et al. 1973). In conception these studies were essentially epidemiological. Developed within a medical framework, their major emphasis was on the experience of being a refugee acting as a predisposing factor with regard to psychiatric breakdown. Despite the constraints of a medical framework of analysis, these studies generally displayed a high degree of empirical rigour (infrequently matched by later studies), and served to lay a valuable foundation for subsequent conceptualization.

Studies of Southeast Asian refugees in the period following the Vietnam War

Studies prompted by the flight of Southeast Asian refugees to the developed world (most notably, but not exclusively, to North America) - which comprise the next major corpus within the refugee psychosocial literature - were generally more clinically oriented (Kinzie et al. 1980, Tyhurst 1977, Westermeyer et al. 1983). This appears to reflect the reality of psychiatric services within western societies being presented with symptomology of a nature and extreme which they were ill-equipped to deal with (Kinzie et al. 1982b). Conceptual analysis was extended beyond the narrow psychiatric bounds of earlier studies, particularly in increasing acknowledgement of the role of culture in defining and shaping the experience of mental ill-health (Le 1980, cited in

structure is close to the forms of epidemiological construction proposed by such researchers as Rutter and Garmezy (see Garmezy and Rutter 1983, Rutter 1985), which identifies environmental *stressors* as potential risk factors for mental ill-health, and *protective* or *ameliorative* factors which may mitigate this risk. However, the function it may serve here is principally as a framework with respect to which observations, insights and findings from a variety of perspectives may be related to one another. As adopted here, such a framework makes no attempt to relate together specific stressors and particular presentations of mental ill-health (e.g. trauma and paranoia, or separation and depression). It is assumed that the latter are heavily determined by the cultural context of the stressor (Clinton-Davis and Fassil 1992, Eisenbruch 1992), which represents an additional plane of analysis to the generalized framework considered.

This form of structure also provides potential continuity of analysis regarding related phenomena, such as the experiences of the Jewish holocaust (Bettelheim 1979, Krystal 1968), general trauma (Bolin 1985, Eth and Pynoos 1985) and cultural adjustment (Berry 1980, Fisher & Cooper 1990). The opportunity of acknowledging the relevance of distinct literatures is particularly crucial given the general isolation of current analysis of the psychosocial impact of displacement from relevant theory in such disciplines as psychology and anthropology.

2. THE PHASES OF REFUGEE EXPERIENCE: STRESSORS AND THEIR PSYCHOSOCIAL IMPACT

The psychosocial consequences of displacement may be usefully considered with respect to distinct phases in the refugee experience, for each of which a range of characteristic stressors may be posited (Baker 1983, Ben-Porath 1991, Felsman et al. 1990). The pre-flight period is the first such definable phase, referring to experience in the home country in the time leading up to the decision to seek refuge. The period of flight is the experience of migration from the home country to the country of first asylum. The reception phase is then that period (which may extend into years of residence in refugee camps or similar settings) which elapses before an individual returns to his or her home country, settles formally within the country of first asylum, or resettles in some third country. These options represent the final resettlement phase of refugee experience. These phases provide a helpful framework for reviewing the literature on the impact of displacement on refugee mental health.

2.1 Pre-Flight

Economic hardship

Despite the widely acknowledged linkage between economic status and mental health, within the refugee literature itself remarkably little attention has been paid to the psychosocial impact of the economic deprivation which frequently characterises the pre-flight phase. In the period leading up to flight, many households will have experienced major hardships as the result of disruption of income-generating activity and/or shortage of food. Such hardships may relate to the more frequently recognised factors of political persecution or armed conflict, but they can also serve in their own right as major stressors threatening well-being. Athey and Ahearn (1991) note the

likelihood of cognitive and emotional impairment in refugee children as a result of economic deprivation, though the report which they cite of physical and mental delay in Korean children malnourished during the course of the war (Carlin and Sokoloff 1985) is one of the few empirical studies pertinent to this concern. A comprehensive study of a probability sample of Indochinese refugees in the USA (see Rumbaut 1991) which examined the relationship between present symptomology and reported motives for migration indicated escape from harsh living conditions (famine, poor economic conditions, inability to make a living etc.) as a significant predictor of psychological distress. Whilst this study demonstrates that retrospective data can illuminate aspects of pre-flight experience and its impact on mental health, a fuller understanding of the impact of such deprivation inevitably requires study within the home country of refugees prior to their flight. Ben-Porath (1991) and Felsman et al. (1990) both indicate the potential value of such data, but then suggest the impracticability of its collection. Such studies do present major methodological and logistical difficulties, but with many refugee situations involving large, protracted and, as a result, somewhat predictable migrations, gathering of pre-flight data in situ should not be an unattainable goal.

Social disruption

As might be argued for economic hardship, social disruption can be considered to impact refugee mental health pre-flight both directly (acting as a source of stress) and indirectly (reducing resources which may buffer the impact of stressful external events). Concern with the direct experience of persecution or violence can blind appreciation of the profound consequences that such factors as restricted mobility or school closure can have on community mental health. The psychological impact of such disruption of civil society has received little empirical attention in the refugee literature, despite numerous studies of the consequences of natural disasters having demonstrated the significant impact of social disruption on mental health (Gueri & Perez 1986, Lima 1992, Newman 1976). The fragmentation of families is the only factor to have been considered with any vigour in the context of refugees, and here primarily with respect again to the direct impact of military conflict (Ressler et al. 1988). In a study of a sample of 373 eastern European refugees resettled in Australia prior to 1955, Krupinski et al. (1973) found 43% had had a close relative die during the military occupation of their homelands. Rumbaut (1991) reports that approaching 50% of the US resettled Indochinese refugees sampled in his study had lost a family member in the immediate pre-flight period, with nearly 20% reporting imprisonment of a family member during the same period. McCallin (1992b) observed that 24% of a sample of 109 Mozambican refugee women had been separated from their children prior to their flight to Zambia. In Rumbaut's (1991) study, analysis established that family loss was a significant predictor of psychological distress in the resettlement environment. Such effects would clearly be anticipated, but have as yet seldom been unequivocally demonstrated - again partly reflecting methodological constraints on study in the pre-flight period. Further study of this phase in refugee experience is clearly warranted, however, with Ben-Porath (1991) signalling, for example, the potential influence on psychological adjustment of factors such as familial conflict over the decision to flee - a key issue with respect to which there is little meaningful data.

Physical violence

I told them to run away with us....but they refused....and stayed and hid in a hole. It was two aunts and one of my uncles with his son and one brother of mine. They stabbed my brother here in the front....they killed my brother with a knife. And one of my brother's cousins....they opened the stomach and they put the intestines on the chest of my aunt. They cut the arms, the legs and they cut the head off.[2]

I see it like it is happening now. I see the images exactly like I saw the day the people were killed. And sometimes I become deaf because hearing sounds like guns and shooting my ears become closed. When I remember that....I used to cry sometimes....and I can't eat....sometimes I sleep without eating because of what I think I saw....I have never seen things like that.[2]

Whilst there is little data on the impact of economic deprivation and social disruption on the mental health of refugees, there are a considerable number of studies which have attempted to relate exposure to violent events to level of psychological distress (Beiser et al. 1989, Kinzie et al. 1990, Mollica et al. 1987). Whilst such events clearly do have a major impact on mental health outcomes, there is a tension that an overemphasis on discrete experiences of trauma can encourage an acutely individualised and decontextualised view of refugee experience (Muecke 1992). It is not in question that such events are highly salient in understanding the processes influencing the psychological adjustment of refugees, but there must be a concern to conceptualise such events within the full breadth of refugee experience. Individuals' 'trauma stories' repeatedly emerge in presentation of clinical case material and anthropological case study alike, with a clear implication that such narratives have a key role in refugees own understandings of their experience. Mollica (1989) indeed asserts:

> Each and every refugee patient has at least one traumatic experience that figures prominently as an essential aspect of his or her life history. It is not uncommon for a refugee patient to respond to the question, "when did your problem begin?" by stating, "On April 20, 1975, at 6 p.m., the Communist troops...." (p. 109).

This phenomenon asserts the key role of the "trauma story" in refugee self-understanding. But there is a danger that the vividness and drama of such events - which promotes their centrality in the attributions of distress made by refugees and mental health workers alike - can encourage inattention to other less tangible aspects of the refugee experience which may be equally powerful in influencing psychosocial status. In this vein Muecke (1992) relates the pre-existing focus on traumatic experiences to reductionist dangers in the widespread use of the diagnostic label Post-Traumatic Stress Disorder (PTSD):

> Whilst having PTSD as a diagnostic assist no doubt has empowered clinicians by giving them the sense that they know what they are dealing with clinically, the label has yet to lead to cure or even palliation of the profound distress with which many refugees live. The widespread utilisation of the PTSD diagnosis.....sanctions continuing neglect of refugee suffering, suffering that is

> associated not only with the experience of persecution and trauma, but with....stigma, isolation and rejection (p. 520).

It is important then, in this context, that trauma is appropriately understood in psychosocial, rather than discrete environmental, terms. As Dodge and Raundalen (1991) note, it is the subjective appraisal of an event as unintegrable within a person's basic assumptions about the world which render it traumatic, rather than the characteristics of the event per se.

The early classic study of war trauma by Freud and Burlingham (1943) firmly established the role of family support in individuals' interpretation of, and response to, violent events. Subsequent studies have not always been so thorough in identifying the social context of experienced trauma. Clinical case studies of traumatised refugees (which presently provide the bulk of data in this field, see Garcia-Peltoniemi 1987) are generally incapable of drawing out the function of such social factors, constrained as they are by a lack of a non-clinical comparison population who may have experienced similar events (Mollica et al. 1987).

Such reports have nonetheless served to highlight specific trauma-related symptomology (flashbacks, memory disturbance, panic, sleeplessness etc.) in a significant proportion of refugees. In a prospective study of admissions over a six-month period to their Indochinese Psychiatry Clinic, Mollica et al. (1987) reported 92% of Hmong/Laotian patients to be meeting PTSD diagnostic criteria. A meta-analysis of studies of the survivors of torture (Goldfeld et al. 1988) - whilst indicating wide variation across studies and contexts - indicated extreme levels of anxiety and insomnia persisting for considerable periods after such trauma.

It is population-based studies that are required to put these findings in perspective. Murphy (1955) studied rates of mental illness for refugees resettling in the UK after World War II, and demonstrated a positive correlation with the degree of persecution and trauma experienced during the war. Krupinski et al.'s (1973) study of post-war resettlement of Eastern European refugees in Australia also established a clear relationship between rates of psychiatric illness and the severity of war experiences, though this relationship was significantly modulated by the socio-cultural background of refugees. Garcia-Peltoniemi (1987) notes the difficulties in conducting similar studies with contemporary refugee influxes, but they clearly are vital. The context of the clinical work of Kinzie and associates in Oregon is clarified considerably, for example, by their non-clinical population study demonstrating that as many as 50% of the Cambodian refugees attending a Portland high school evidenced PTSD to DSM-III standards (Kinzie and Sack 1991).

Political oppression

Her husband left as usual for work but did not return home that night. Finally, she called his mother and sister to tell them she thought that he had been detained. As for herself, she said that she had been afraid yet did not cry. She began to worry about what would happen to her four children if she too were arrested. Toward midnight, the oldest child began to cry. The mother told her children, "Pack a suitcase. We have to go." She left the house alone to check whether someone was watching them.[3]

Whilst political oppression may manifest itself in terms of economic hardship, social disruption and/or physical violence, it is appropriate to acknowledge that lack of rights to assembly, freedom of expression etc. may have a direct psychological impact in addition (Zwi and Ugalde 1991). Powerlessness has a major influence on perceived well-being, and to the extent that it may produce an established pattern of attribution regarding self-esteem and personal potency, can clearly have a long-term influence on mental health (Gonsalves 1990). Punamaki's work with Palestinian women experiencing military occupation has demonstrated the clear - if complex - linkages between the experience of political oppression and mental health (Punamaki 1986, 1989). With displaced populations the relevance of such linkage has perhaps been acknowledged most clearly in work with refugees from Central America. Subsequent to an analysis of the emotional distress evidenced in a clinical sample of individuals displaced from El Salvador, Farias has argued that the analysis of refugee experience needs increasingly to 'take into account the dialectical relation between the socio-political processes of terror and intimidation, the social conditions of marginality and illegality, and the emotional responses of individuals' (Farias 1991, cited in Muecke 1992). The work of Punamaki (1986, 1989) provides a model - presently unemulated - of how such political factors may be integrated within an empirical analysis of psychological well-being.

2.2 Flight

Separation

Flight from one's homeland represents a major life event which - even if accomplished swiftly and in safety - is likely to prompt major emotional and cognitive turmoil, with concomitant risk of mental ill-health (Ager et al. 1991). Across samples of Cambodian refugees resettled within Australia and the USA, Eisenbruch (1990b) found anger regarding separation from homeland one of the strongest and most widespread responses. For those leaving family members behind in Cambodia separation had had a clearly tangible focus. Even those who did not experience family separation, however, commonly reported a sense of "unfinished business" in Cambodia and a wish to return. It is the strength of such reactions to separation from one's home society which has led Eisenbruch (1990a, 1990b, 1992) to propose recognition of the phenomenon of "cultural bereavement" as a discrete diagnostic condition of major prevalence and impact within refugee populations. For resettling refugees, further consequences of separation from one's homeland are considered in the context of readjustment to a new culture (section 2.4).

Passage

Ms A left Vietnam in a boat with 32 people, nine of whom were female. A few days after they set out to sea they were met by five pirate boats. All nine females were abducted. They were separated into three boats. Ms. A was raped for five consecutive nights. Each night she was raped by seven pirates. She attempted to commit suicide by jumping in to the sea, but she was grabbed by her hair and rescued. On the sixth day, the pirates abandoned her on a beach by a refugee camp.[4]

The emotional burden of flight is frequently further exacerbated by the experience of extreme danger (Ben-Porath, 1991). Women appear to be particularly vulnerable to sexual abuse during this phase (Forbes-Martin 1992 ;Goldfeld et al. 1988; Mollica et al. 1987). Empirical studies of refugee adaptation shortly after arrival in a country of first asylum (e.g. Felsman et al. 1990) have, however, generally not attempted to partial out the discrete psychological impact of passage from that of the pre-flight period. Given evidence of the extreme experiences of many refugees during passage to countries of first asylum - and their salience in individuals' personal accounts of flight (Mollica 1989) - this appears a major omission within the literature.

2.3 Reception

First arrival

A refugee arrives in Hong Kong numbed, disoriented, vulnerable, sometimes half alive - living a nightmare of Kafkaesque proportions. He is hanging by a thread to both external and internal life. He is immediately interviewed by immigration officials and later by UNHCR representatives, given a number and assigned to a camp....where a hut and bed number are designated. Bewildered and isolated in his confusion....the refugee's first inclination is to preserve what remains of his identity by burying it. faced by uniformed authority asking questions, giving him numbers, talking about camps, he feels sufficient reverberations of Vietnam....to immediately distrust camp officials and camp regulations.[5]

On arrival in the country of first asylum refugees are generally faced with some form of registration procedure. Establishment of status as a refugee may be crucial with regard to receipt of food assistance and other support. The experience of new arrivals at reception centres can frequently be harrowing (Harrell-Bond 1986). Refugees may go through an extensive period when they may have justifiable fear of being forced to return to their home to once again face war and/or persecution. Especially with large influxes of refugees - where treatment can be especially impersonal and threatening (see Mitchell and Slim 1990) - refugees may quickly assume roles of dependency and helplessness, with clear implications for psychological well-being. A greater awareness of the psychological needs of refugees at the point of registration is called for in a recent Medicin Sans Frontier manual:

> The pragmatic approach adopted should not make us lose sight of the fact that displaced people are above all individuals, and if it is necessary to give people identity numbers or to count them, particular attention must be paid in day to day contact to ensure that they feel they are being treated as people and not as numbers (Tollet et al. 1988).

Settlement

It is important to acknowledge that a significant proportion of the world's refugees do not reside in camps on arrival in the country of first asylum. Throughout Africa large numbers of refugees have 'self-settled' amongst the indigenous population (Kibreab 1991). This pattern seems especially prevalent where there are close kinship ties between the refugee group and the local population (see Ager et al. 1991). Studies of

'self-settled' refugees - who will frequently have avoided the registration process indicated above - are far fewer in number than those examining the experience of refugees in established camps. Such studies as have been conducted have indicated significant advantages to self-settlement, despite the fact that such refugees will generally receive less (or nothing) in the way of assistance from governmental and non-governmental agencies and may - in some contexts - appropriately fear action by the authorities with regard to their 'informal' status (Hansen 1990) . Compensations appear to include greater opportunity for income-generation (Ager et al. 1991, Zetter 1992), increased socialisation (Ager et al. 1991), and a greater sense of belonging and independence (Hansen 1990).

Then one becomes aware of the ongoing psychological catastrophe: almost everybody is silent, even children, apart from some sore, persistent crying. People's faces wear a dazed, distant or constantly distressed look. People sit motionless, staring ahead, or with their faces covered, as if trying to hide within themselves. Children sit as close up to their mother or father as possible, they do not play. They do not smile or giggle shyly, but look at you with large, serious, anxious eyes.[6]

Well, we are refugees and have to put up with things. But we do need to know what our fate is to be. We need help to get out of the camp. I don't think we shall manage it soon. That is the worst of living here, you never know a thing. You must just hope to be told to go - but you never know a thing.[5]

For most refugees, however, camp life represents an extended period (Chan and Loveridge 1987, Muecke 1992) of their refugee experience. Studies of psychological distress within camp settings frequently confound the impacts of the camp environment and pre-refuge experience (Felsman et al. 1990). A study by Beiser et al. (1989) partially isolated the impact of camp experiences by comparison across three settings which varied in the harshness of their regime. Stressful camp conditions led to an increase in depressive symptoms, though the effect was transient - differences between those interned in the harsh and less harsh camps decreased on subsequent resettlement in Canada. A WHO mission to camps on the Thai-Cambodian border (de Girolamo et al. 1989) - whilst not attempting rigorous empirical analysis - linked observed increases in attempted suicide, domestic violence, apathy, hopelessness and depression to presenting camp conditions. A number of writers have noted how conditions within camps approximate the form of "total institution" identified by Goffman (1963) as encouraging authoritarianism in those with power and dependence in those without it. To the extent that camps facilitate an attitude of "learned helplessness" (Seligman 1975) amongst refugees, they may also significantly increase the likelihood of depression (Chan and Loveridge 1987). Whilst such propositions are supported by observations within camp settings (Ager et al. 1991, de Girolamo et al. 1989, Harrell-Bond, 1986, Urrutia 1987) there is a general lack of empirical data on which to base firm analytic conclusions. Given the relative permanence of these settings for a significant proportion of the world refugee population (Muecke 1992, Stein, 1986) such paucity of data is a major omission.

2.4 Resettlement

Culture conflict

Resettlement in the developed world involves significantly fewer than 20% of the world's refugees (Clinton-Davis & Fassil 1992). Given the political and social agendas of developed nations receiving refugees, however, this group has received considerably greater attention than the majority resettling in the developing world (either through repatriation to their homeland or settlement in a neighbouring state). Analysis in terms of the "social distance" involved in resettlement would question the generalisability of findings regarding resettlement within the developed world to the situation facing most refugees (Fisher & Cooper, 1990). The work of Lin (1986) with Southeast Asian refugees would support this contention, evidencing the greater problems of those resettling into western settings compared to those remaining within the region. Nonetheless, the considerable heterogeneity of cultures within developing nations ensures that settlement in a neighbouring state - or indeed displacement within one's home country - can also involve transition across a very significant social distance.

The model proposed by Berry (1991) with regard to the acculturation strategies available to refugee groups has won wide currency. The model essentially proposes that refugee and host country attitudes towards (i) refugees' cultural identity and (ii) their relationship with other groups, determines the mode of acculturation adopted by resettlers. Refugees valuing both will tend to pursue 'integration', for instance, whilst governmental policy encouraging only the latter would foster 'assimilation'. Whilst Berry notes some evidence that refugee health may be better in societies encouraging the pluralist, integration strategy rather than assimilation, the linkage between acculturation strategy and mental health outcome appears to be dependent upon a broad range of personal, social and political factors (Berry and Kim 1988). Krupinski et al. (1973) noted a significant relationship between intensity of refugees' social contacts and their psychiatric status, which was interestingly modulated by refugee country of origin. A prospective study of Hmong refugees resettled in the Minnesota area (Westermeyer et al. 1983) indicated that refugees sponsored by religious organisations with explicit assimilationist goals were more vulnerable to psychiatric difficulties. A number of other variables plausibly linked with the process of acculturation (including proximity of household to other Hmong households, change of residence since arriving in the United States, and access to an individual with knowledge of both Hmong and American societies) bore no apparent relationship to psychological adjustment (Westermeyer et al. 1983). A study by Nicassio and Pate (1984, cited in Ben-Porath 1991) of 1,638 Indochinese refugees resettled in the US noted more adjustment difficulties in refugees who were more advanced in age, who had less education and income, who were unemployed, and had resided in the United States for shorter periods of time. This latter finding reinforces the conclusions of Berry (1991), Garcia-Peltoniemi (1987) and Rumbaut (1991) with regard to the initial period of resettlement evidencing the greatest psychological distress. Nonetheless, for a significant minority of refugees being in an alien culture appears to present chronic adjustment difficulties (Eisenbruch 1990a). Further work is clearly needed to clarify the factors identifying those at greatest risk at different periods following initial resettlement.

Employment difficulties

Difficulties in gaining appropriate employment can provide an additional long-term stressor (Ben-Porath 1991). Without employment financial and personal pressures may be considerable (McSpadden 1987). Rumbaut's major study of Indochinese refugees (1991) found those not in the labour force to report significantly higher levels of psychological distress. Amongst US-resettled Hmong refugees, those in receipt of welfare payments were found by Westermeyer et al. (1983) to be significantly more likely to present with mental health problems. Those successful in gaining employment will typically experience substantial downward mobility (Garcia-Peltoniemi 1987, Krupinski et al. 1973, Stein, 1979), with consequential threats to self-esteem as well as standard of living (Ben-Porath 1991).

Intergenerational conflict

A Hmong family was referred from the emergency room after the mother had attempted suicide by swallowing pills. The family crisis was precipitated unknowingly by their eldest 14-year-old daughter, who had allowed a 14-year-old Hmong boy to carry her books home from school. When she introduced the boy to her mother at the door, her mother began weeping, tearing at her clothes, and later ingested pills. The mother had assumed that the girl had become sexually active and was trying to force a marriage on her parents (neither of which was the case).[7]

Differential rates and/or strategies of acculturation within families clearly create major stresses (Westermeyer 1991). Children typically acculturate faster than adults as a result of school socialisation. Women and the elderly - with a greater likelihood of isolation at home - may commonly adjust behaviour and expectations far more slowly, if at all (Krupinski et al. 1967; Westermeyer 1986). Intergenerational conflict is, in consequence, generally a phenomenon which is likely to *increase* rather than *decrease* over time from resettlement. Acute difficulties may arise after many years in the new setting, long after specific sponsorship supports have been withdrawn. Crises can occur precipitously and outside the expectation of the host community, as in the case (cited by Westermeyer 1991) of a Hmong father who hanged himself when his son - with money that the youth had himself earned - bought a car without first seeking his father's permission. Role reversals within families - children assuming adult roles as consequence of their relative facility with language and procedure within the host culture - can produce powerfully destructive dynamics within families. Schools - as a major agent of socialization of refugee youth into the mores of a host society (Ready 1991) - hold a key role in monitoring potential conflicts within families as a result of such acculturation.

The above discussion reflects the bias of the existing literature in focusing on resettlement which involves movement from the country of temporary asylum to some third country. Given trends within the global refugee population, however, adjustment required on repatriation - resettlement within one's country of origin - is likely to become an increasingly important issue. Whilst some of the stressors identified above will clearly apply to repatriating refugees, the unique problems faced on repatriation require urgent investigation.

3. AMELIORATIVE FACTORS

Irrespective of the theoretical stance that is taken with regard to the precise role of environmental factors in the aetiology of mental ill-health, the above account of the common stressors within refugee experience clearly establishes refugees as at major risk of psychological distress. The quality of existing data generally makes it hard to draw firm conclusions regarding the exact level of risk and the manner in which stressors may combine to increase this still further. Such analysis awaits the development of more sophisticated empirical studies (of the style and rigour of the work of Rumbaut, 1991, for instance). However, the reviewed literature does clearly establish that risk of mental ill-health is not related to exposure to stressors in a unilinear fashion, but may be modulated by a range of personal and social factors. Within the general literature on stress and coping such factors are usually referred to as "protective factors" (Rutter 1983), though their action is generally more ameliorative than strictly protective. In order to construct an analytic framework which may plausibly structure responses to global refugee needs, understanding of such ameliorative factors is crucial.

3.1 Family integration and attachment

The classic study of Freud and Burlingham (1943) provided a clear demonstration of the potency of familial attachment in combating the influence of trauma and disruption. Children exposed to the bombing of London generally remained psychologically well-adjusted if they stayed in the care of their mother (or a familiar substitute):

> 'London children....were on the whole much less upset by bombing than by evacuation to the country as a protection against it' (Freud and Burlingham 1943).

This emphasises the value of maintaining day-to-day routines in establishing resilience (Garbarino 1992). The increased potential for the positive modelling of coping behaviour within intact families may also be a crucial factor (Punamaki and Suleiman 1990). Ressler et al. (1988) summarise a number of studies regarding war-affected children and draw the firm conclusion that 'organised evacuation programs which have intentionally separated children from their families in order to protect them from potential psychological or physical harm have been judged to be historical mistakes'. The benefits of an integrated family as a 'buffer' to stress do not only hold for children. McCallin and Fozzard (McCallin and Fozzard 1990, McCallin 1992b) found those Mozambican refugee women living with their extended family to demonstrate significantly better psychological adjustment than others.

3.2 Social support

Social linkages outside the family have also been suggested as functioning to ameliorate the effects of psychological stressors (Ager, 1992, Davidson 1979). Nonetheless, Westermeyer et al. (1983), in their study of Hmong refugees resettling in Minnesota, found frequency of visits to other Hmong households to predict poorer, rather than improved, psychological adaptation. Rumbaut (1991) found number of reported friendships to bear no significant relationship with levels of psychological

distress. Punamaki (1987) reported social support to predict positive sentiments amongst Palestinian women, but not psychological outcome. Such studies should caution against a naive belief in the power of social linkage to protect individuals from exposure to stressors.

However, other studies have produced more positive findings. Shisana and Celetano (1985, cited in Punamaki-Gitai, 1990) found social support functioned as a protective factor in mitigating the impact of stress on depression amongst Namibian refugees. McCallin and Fozzard (1990) reported factors such as having friends live nearby and seeing family members as a source of support as predictive of better psychological adjustment amongst Mozambican refugees. McSpadden (1987) found the psychological well-being of Eritrean refugees resettling in the USA to be significantly better amongst volunteer-assisted refugees than refugees resettled through formal governmental agencies, and attributed much of this difference to the broader social networks commonly established with the former strategy.

The study of Southeast Asian refugees by Beiser et al. (1989), which also indicated a protective function of social support, provides some insight into potential causes of contradictory findings in this field. Analysing their data with respect to distinct phases of the experience of refugees, social linkage (defined as links with ethnic community and having an intact marriage) was found to moderate the impact of adjustment in the resettlement environment, but served no buffering function with respect to prior stresses in refugee camps. It makes some sense to propose that social support, by enhancing a sense of identity and belongingness (Beiser et al. 1989), protects against the stresses of sociocultural adjustment rather more potently than against the effects of trauma and deprivation.

3.3 Religious affiliation/political ideology

Confrontations with the occupation soldiers, loss of friends and other hardships have made me more conscious about the Palestinian issue and world problems, and through that, I think, I have become deeply aware of life around me. I see clearly its motley character, painfulness and also its beauty. I realise that my function in this world is to change it, and my sense of the necessity to participate in my people's struggle gives me strength and a feeling of importance.[8]

The common proposal that religious affiliation can serve as a protective factor with regard to experienced stressors has won some empirical support (McCallin and Fozzard 1990, Pines 1989, cited in Garbarino 1992). Whilst such affiliation may be seen to represent another source of social support, its primary effect may rather be concerned with the provision of a form of ideology with respect to which psychological coping mechanisms may be structured (Garbarino 1992, Urrutia 1987). Based on anthropological study with refugees on the Thai-Kampuchea border, Reynell (1989) notes confidence in Prince Sihanouck and the resistance movement as predictive of apparent psychological health, and suggests this as an issue worthy of further detailed study. Regarding her work in the Occupied Territories, Punamaki notes evidence that 'psychological processes of healing....drew strength from political and ideological commitment' (1987). Cambodian youths resettled within the USA and Australia reported traditional religious beliefs and ritual as powerful resources in

combating painful memories of the past (Eisenbruch 1990b). Kanaaneh and Netland (1992) found symptoms of anxiety and withdrawal to correlate negatively with the degree to which individuals expressed nationalistic identity. Further evidence that ideology may mitigate the influence of stressful events comes from the work of Dawes and de Villiers (1987) in South Africa and Protacio-Marcelino (1989) in the Phillipines. Such a proposal is also coherent with observations from other fields, notably regarding the role of ideological commitment in preserving psychological intactness within the setting of the Nazi concentration camps (Bettelheim 1979, Krystal 1968).

3.4 Coping style

The literature on stress and coping suggests that individuals adopt a variety of cognitive strategies as a means of dealing with stress, some of which generally prove rather more adaptive than others (Lazarus and Folkman 1984). The strategy of denial is typically considered maladaptive to the extent that it encourages passivity, whilst appraising a problem as within one's locus of control will facilitate constructive problem-solving. The work of Seligman suggests that individuals who perceive negative events as outside their personal control are at considerably higher risk of developing depressive symptomology on experiencing life stresses than individuals with a more "optimistic" appraisal style (1975).

In the refugee context, no studies have pursued analysis of such issues with any real rigour. However, work from Northern Ireland (Cairns and Wilson 1984) , Lebanon (Bryce et al. 1989) and the Occupied Territories (Punamaki-Gitai 1990) suggests that the conception of what constitutes adaptive coping needs to be adjusted and extended with regard to situations of persistent and overwhelming stress. Punamaki-Gitai (1990), for instance, notes that it was those exposed to the most extreme violence and conflict (rather than those who lived under the threat of this) who adopted the more active and purposive coping strategies, such as engagement in political activity and confrontation with occupying forces. However, those who adopted such strategies actually reported higher levels of psychological symptoms and anxiety than those adopting a more passive coping style. In general, therefore, whilst the use of active, problem-solving strategies by refugees might appropriately be encouraged (Ager 1993), their effectiveness in circumstances of extreme stress - and in some cases cultural appropriateness - may be questionable. Given such findings - and the centrality of the concept of coping within general formulations of psychosocial well-being - the protection afforded by differing forms of coping style (including collective rather than individual strategies, Punamaki, 1986) clearly requires further investigation.

4. IMPLICATIONS FOR POLICY AND PROGRAMMES

Having reviewed the major stressors within the experience of refugees, their impact, and factors which may in some circumstances ameliorate their influence, it is appropriate to address the implications for mental health policy and programmes for refugees.

4.1 Prevention

The major thrust with regard to refugee mental health must be preventative. A preventative approach is marked by an attempt to anticipate risk and put in place actions considered likely to reduce the likelihood of the onset of difficulties, rather than respond to needs only when such difficulties have clearly arisen (Williams 1991a). Preventative approaches seem the only sustainable means of addressing such needs, demonstrated as they are predominantly within the developing world (Ager 1990; Williams 1991b). Likely refugee movements - reflecting political or environmental events - may frequently be predicted some way in advance, allowing anticipatory, preventive strategies. Many of the events within refugee experience which serve as stressors are potentially - if not in actuality - within the control of governmental and non-governmental agencies.

Removal of stressors

Prevention is necessarily a political activity (Williams 1991b). It is clearly not inappropriate to signal that a reduction in global political conflicts and the establishment of resilient economies within the developing world would have a major impact on global mental health by reducing forced migration. The costs of war and famine must be weighed in resultant psychosocial distress, not purely in terms of economic interest and raw physical morbidity. The dissemination of accurate data regarding the impact on mental health of displacement is a necessary - though clearly not sufficient - condition for putting the psychosocial needs of refugees on the world political agenda.

Lessening potency of stressors

Whilst circumstances leading up to flight commonly result from the deliberate and hostile acts of political groups within the country of origin, many subsequent stressors within refugee experience are within the clear control of states and/or agencies purporting to be sympathetic to the needs of refugees. In some circumstances refugee assistance is offered with clear ambivalence (e.g. the Thai reception of Vietnamese refugees discussed by Beiser et al. 1989), and resultant refugee experience may be seen to be purposefully harsh. Even where governments and agencies appear genuine in offering assistance, however, they are commonly grossly insensitive to aspects of their policies which negatively impact refugees. It has been suggested that this may reflect a process of denial, as if acknowledging the psychological needs of refugees would prove overwhelming - either personally or in resource-terms (de Waal 1988, Harrell-Bond 1986). Other analyses acknowledge that actions of governments and international agencies inevitably work to serve their own interests, and that these commonly conflict with the real needs of refugees (Reynell 1989). The form of refugee assistance offered by international agencies, for example, seems frequently more coherent with agency needs and expectations than the expressed concerns of refugees (Zetter 1992).

Whatever the cause of this situation, there are a vast numbers of areas where reception, assistance and resettlement programmes could reflect greater sensitivity to the potential impact of stressors on refugee mental health. Greater participation by

refugees in decision-making, for example, not only commends itself on the basis of improving the quality and reliability of decisions made (Ager 1992, Gedalof 1991), but indirectly encourages a sense of personal control in refugees likely to foster positive mental health. Improved communication (including a greater deference to the expressed needs of refugees) and better advanced planning by sponsoring organisations would potentially eliminate many of the conflicts and adjustments faced by resettling refugees in their early months in a new country (McSpadden 1987, Westermeyer et al. 1983). Facilitating better access of children to schooling - particularly within camp environments - would serve to minimise disruption to cognitive and intellectual development and, equally important, maintain a key social routine and means of socialisation (Tolfree 1991).

Bolstering ameliorative factors

Given the nature and extent of refugees' mental health needs, any formal programmes to assist in this area should clearly consider building upon existing mechanisms which may foster coping and adjustment. Programmes can, therefore, seek to directly bolster the operation of the ameliorative factors noted previously. Family renunciation programmes (Ressler et al. 1988, Richman 1993) can thus be seen to encourage the healing processes associated with family integration and attachment. Acknowledging the value of social networks in mitigating against alienation and isolation, the establishment of Mutual Assistance Agencies amongst Indochinese refugees in the United States potentially serve a valuable mental health promotive function (Abhay 1992) and commend replication (as in proposed programmes with refugee groupings in Slovenia, Flaker 1992). Refugee assistance programmes can deter passivity and foster active coping by allowing refugees to take greater responsibility and initiative in their own affairs (Harrell-Bond 1986; James 1992, Zetter 1992).

Findings in support of the value of ideology in promoting mental health provide perhaps the greatest challenge to agencies wishing to facilitate a preventative approach. In refugee camps and resettlement zones alike, governments and agencies may fear encouraging ideological zeal potentially at variance with their own. This appears to be true with regard to both religious (Westermeyer et al. 1983; Wilson 1992a) and political (Beiser et al. 1989) ideology. Yet refugees' understanding of their experience within some narrative framework appears to be a key issue influencing refugee adjustment. The benefits of a supportive, co-ethnic social network may, indeed, primarily stem from the negotiation and definition of meaning afforded by access to a community with a shared cultural and linguistic framework (Mead 1934). Coping with trauma, loss and acculturative stress all require adjustments in the way a refugee views the world, or in other terms, reconstruction of an individual's narrative framework. Ideological commitment provides some form of "grand-narrative" with respect to which such individual narratives may be constructed. Programmes which foster such commitment - acknowledging factors (such as fear and guilt regarding flight) which will inhibit refugees' more public expressions of ideology (Kinzie and Fleck, 1987) - may be seen to be facilitating a key process in refugee adjustment.

Whilst the forgoing analysis suggests that such activities may serve to ameliorate the consequences of stressors, it is vital that any such strategies are rigorously evaluated, to allow such conceptions to be challenged and refined. The field of refugee mental

health has generally lacked commitment to the testing and refinement of models in this manner. In particular, there is need to refine understanding of those circumstances where social support is and is not an effective ameliorative factor (see discussion in 3.2 previously) and of the most appropriate forms of coping strategy in specified circumstances (see discussion of 3.4).

4.2 Treatment

Psychiatric services generally distinguish between prevention and treatment with regard to whether clients are considered at risk for, or are actually suffering from, a specified disorder (Williams 1991a). Within the field of refugee mental health, to the extent that diagnostic labels such as Post-Traumatic Stress Disorder have been criticised as distorting and decontextualizing refugee experience (Muecke 1992) and offering little in the way of guidance for classification or treatment (Richman 1993), such clear distinctions will frequently be problematic. With fieldwork programmes targeted at specific groups, such as war-traumatized refugee children, the aims and scope of provision typically span both preventive and therapeutic action (Tolfree 1991; Williamson 1992).

Community work

With refugee groups resettled within the industrialised world, community work interventions have been the most commonly reported (de Monchy 1991, Faust and Lipson 1992, Rosario 1992). Such programmes typically represent a blend of preventative and curative actions, commonly featuring three major elements: (i) facilitation of group contact, discussion and the sharing of experiences, (ii) practical assistance for refugees in such areas as childcare and income-generation, and (iii) provision of more intensive, individual assistance (usually by referral) for those in appropriate need. Group discussion may usefully function to assist development of a shared narrative of refugee experience in the manner commended above, though for refugees whose native culture does not encourage speaking openly about personal problems and feelings extensive personal revelation may be acutely threatening (Kinzie and Fleck 1987). Even when open sharing of experience is not a major feature, groups are likely to bring benefits at the level of increased socialisation and provision of a supportive environment (Kinzie and Fleck 1987). The community work model has increasingly been adopted by programmes in countries of first asylum, adapted as necessary by the constraints and resources of implementation in refugee camps, primary health care clinics etc. (Fozzard and Tembo 1992). WHO and UNHCR have recently collaborated on the production of a refugee mental health manual for use in such settings (WHO/UNHCR 1992). This aims to 'assist relief workers, community workers, PHC workers... in the recognition of people with high levels of stress...and help with respect to common mental disorders' and features sections on helping victims of torture and also of rape. However, the manual has not presently undergone field testing, and there is therefore - as yet - no data regarding its efficacy. There is, indeed, a general lack of empirical evaluation of community work interventions of this type, despite the obvious need for such data in the formative development of programmes (Tortorici 1992). For instance, whilst many have commended this form of training for community workers as the most effective and culturally appropriate means of responding to refugees' psychosocial needs (de Girolamo 1990, Muncy 1992), others

have questioned such workers likely capacity to cope with the complex issues that may be raised in the course of their activities (Tolfree 1991).

Traditional healing

Acknowledging the cultural salience of traditional healing practices for many refugee groups, refugee mental health workers are now frequently encouraged to collaborate with the work of traditional healers (Eisenbruch 1992, Hiegel 1984). Whilst cultural sensitivity is to be applauded, reconciliation of Western and many traditional approaches to health is not without conceptual difficulty (Wilkinson 1991). It is frequently managed by a symbolic "reading" of traditional practices (noting their social function within traditional societies), whilst retaining a very decontextualized view of western medicine (its social function within western society unacknowledged). The previously noted draft mental health manual produced by WHO and UNHCR explicitly defines the acceptability of traditional practices with regard to their coherence with western medical thinking:

> 'magical cures usually do no harm and can help patients, and there are no medical reasons for opposing them'

and

> 'they may say that their problem is caused by witchcraft or by the anger of spirits....this way of looking at [the]... problem will not help' (1992).

Given the potential resource of traditional medicine as a means of fostering refugees' psychosocial adjustment, there would be value in establishing a more conceptually coherent framework for collaboration with traditional healers. The psychoanthropological work of Eisenbruch (1990a, 1991, 1992) appears a valuable move in this direction to the extent that it provides a sensitive conceptualization of indigenous cultural views of healing, which yet remains accessible to western, more positivistic forms of analysis.

Pharmacotherapy

Drug treatments for mental ill-health in refugees have received little attention in the literature, although their utility within broader psychosocial interventions has been supported by some clinicians (Faust and Lipson 1992, van der Veer 1992, Westermeyer 1991). The joint WHO/UNHCR (1992) manual on refugee mental health, also commends the value of medication in specified circumstances. However, given the reported tendency amongst many refugee groups to "somatize" emotional problems (Clinton-Davis and Fassil 1992), particular caution should be exercised to avoid use of biological modes of treatment reinforcing unhelpful attributions regarding the nature and cause of distress (Westermeyer 1991).

Individual psychotherapy

For the vast majority of the world's refugees individual therapy is not a viable treatment option. A review of the approaches that have been used with refugees resettling into industrialised nations with a predominantly "individuocentric" approach to mental health can nonetheless highlight processes of healing which may be

capitalised upon within more socially-focused provision. There is little clear consensus regarding the efficacy of particular treatment strategies, however. The appropriateness of the 'ventilation' of emotions and thoughts regarding experienced trauma - a keystone of established therapeutic approaches to traumatization - has, for example, been called into question in work with refugees (Mollica 1989). Such a strategy may clash with individuals' cultural beliefs and practices (Mozambican refugees commonly describe *forgetting* as their normative means of coping with past difficulties).[9] Further, there is evidence that, following severe experiences, such discussion of the past may intensify rather than reduce existing symptoms (Kinzie et al. 1984). Punamaki (1992, cited in Richman 1993) reports a Palestinian mother as saying:

> 'if I would sit down and start to think of my feelings, I could break down....you, the Europeans can enjoy the luxury of analysing your feelings. We simply have to endure'.

"Working through the experience of trauma" remains, however, a key component of the psychodynamic therapy for victims of torture commended by Bustos (1992). Silove (1992) advises that the key therapeutic task is to 'help the patient compartmentalise and examine in tolerable doses elements of the trauma experience', hinting at a means of facilitating a degree of ventilation without overwhelming the individual. This clearly demands considerable clinical sensitivity. In an analogous fashion, behavioural treatments of trauma frequently involve a controlled exposure to recollections of traumatic events (Egli et al. 1991). Silove's mention of the need for 'compartmentalisation' of the trauma experience raises again the issue of the value and function for individuals of developing an explaining and defining narrative. Facilitating self-understanding of this nature is not only a goal of more psychodynamic therapies (van der Veer 1992). Cognitive therapies (Egli et al. 1991) examine individuals' attributions and judgements about themselves and their circumstances, with the aim of establishing coherent and self-maintaining cognitive schema, which may be viewed as forms of personal narrative.

4.3 Targeting Provision

Whilst all refugees - by virtue of the stressors to which they are subject - are at clear risk of mental ill-health, three groups have consistently been identified as being particularly vulnerable: women, children and the elderly (Williams 1991a). The special needs of refugee women are generally related to their lack of power in relations with men; women are at greater risk of experiencing certain forms of violence (e.g. rape), have poorer access to assistance resources in camp and related settings, and are more likely - by virtue of non-access to employment - to remain dependent and isolated following resettlement (Ager et al. 1991, Ferris 1992, Forbes-Martin 1992, Westermeyer 1986). The special needs of refugee children are principally related to stressors impacting at a foundational stage in individuals' development, and thereby threatening long-term psychological adaptation (Ager 1992). Unaccompanied children - orphaned or otherwise separated from family during flight - are a particularly vulnerable group (Ressler et al. 1988), for whom fostering and family-reunification programmes potentially play a key protective role (Tolfree 1991). Programmes targeted at refugee children (Ahearn and Athey 1991, McCallin and Fozzard 1992, Tolfree 1991) generally represent a major "growth area" in refugee assistance projects.

The needs of elderly refugees have been considered with considerably less vigour. A study by Godfrey and Kalache (1989) examining the needs of older adults displaced by the Sudanese war is an isolated attempt within the developing world to clarify the vulnerabilities of a group threatened by loss of social status, physical disability and diminished capacity for productive activity (Ratnavale 1983). For refugees resettled in the developing world, age has been identified as a risk factor for psychological difficulties, especially depression (Beiser et al. 1989, Hitch 1983). Loss of productive role has been indicated as of importance here, as have the increased tensions that may develop within families over time as a result of differential rates of acculturation (Spitzer 1984, cited in Beiser at al. 1989).

Harrell-Bond (1986) notes the need for refugee communities to be adaptive to circumstance if they are to be responsive to the needs of vulnerable groupings. Having acknowledged that specifiable groups may have particular needs, the development of specific programmes targeted at each group may often be less effective as a strategy than a broader community-focused approach, which aims to generally facilitate mechanisms of social support and community integration.

4.4 Behavioural health

Whilst the major focus of this review has explicitly been upon mental health, it is appropriate to acknowledge that refugee populations may be particularly vulnerable, in addition, to behavioural health problems such as alcoholism, drug abuse and delinquency (Diyanath 1991, Kinzie and Sack 1991, Ready 1991). It is coherent with the conception of such problems reflecting adjustment difficulties that they are most frequently cited either with regard to prolonged periods within refugee camps or following resettlement within an alien culture.

In refugee camp settings

Within camp settings adult males may be at particular risk of coming to view alcohol or drugs as a temporary means of escape from personal anguish, uncertainty and/or boredom (Urrutia 1987). Reports from within camp settings frequently support this view (de Girolamo et al. 1989, Harrell-Bond 1986). The loss of productive role typically enforced upon men within refugee camp settings can create both incentive and opportunity for such activities (Ager et al. 1991). Reynell (1989), however, also notes high levels of alcohol consumption amongst Cambodian women whose husbands have taken mistresses within the camp, making them vulnerable to both extreme poverty and social humiliation. Globally, there is little firm empirical data on such phenomena. Given the difficulties of not only measuring, but also interpreting (in appropriate cultural terms), the level of use of drugs and alcohol in such settings, this essentially remains an area of suspected rather than proven concern.

In countries of resettlement

Within resettlement environments, evidence is now increasingly emerging of the risk of male adolescent refugees' engagement in anti-social behaviour and substance abuse. Kinzie and Sack (1991), for example, observe a growing trend in their work with

Cambodian refugees in Oregon of teenage refugees - resettled in the USA for some considerable time - developing such behaviour. Reviewing several case studies, they note that such individuals typically experienced considerable disruption in early attachment relationships with caregivers during the Pol Pot era. Despite subsequent stability post-resettlement in the USA, lack of security and adaptive restraint at such a crucial period is proposed to have predisposed these individuals towards antisocial behaviour. Westermeyer (1991) notes the difficulties that teenage refugees may more generally have in identifying appropriate role-models for culturally appropriate pro-social behaviour. Those resettled in isolation from ethnically-similar peers, and those resettled in areas with high rates of delinquency, will face major - if distinct - challenges in identifying patterns of behaviour acceptable to both family and the broader society. Ready's (1991) account of work with Hispanic immigrants and refugees in Washington, DC. provides a graphic illustration of the sorts of pressures prevailing on teenagers who face simultaneously the transition to adulthood and acculturation within a new society.

[Drugs are] the worst. But at the time you live through it, they don't seem too bad....I mean it's fun....but you have to realise that you can not live like that. If that were life, the whole world would be screwed up. But when the world is screwed up for you already anyway, it looks pretty good. [10]

To the extent that drug use is a common feature of youth behaviour within a particular society, substance abuse by teenage refugees resettling there may be considered as a natural component of the process of acculturation. Westermeyer (1991) suggests, however, that substance abuse amongst refugees resettling in the USA is at a level which indicates especial adjustment difficulties for this group. Youths may be particularly vulnerable to substance dependence and a career in dealing drugs if their social role in the culture of resettlement is narrowly prescribed by social isolation, poor academic attainment and/or unemployment. Such social determination of substance abuse is supported by research which indicates the prevalence of such behaviour amongst refugees shortly after resettlement to be generally low (Morgan et al. 1984).

Whilst alcoholism and drug-abuse is a concern amongst refugee youth, clinical impression - if not hard data - suggests that it may also be a major issue amongst the adult refuge population in resettlement countries. Westermeyer (1991) proposes that growth in alcoholism and opium addiction amongst Southeast Asian refugees in the USA has been a major contributory factor in the upturn in child abuse and neglect within refugee communities.

5. CONCLUSIONS

Whilst recent years have clearly seen a burgeoning of the literature on refugee mental health, the foregoing analysis indicates that the conceptual analysis of mental health issues presently afforded by this literature generally remains fundamental and generalized in nature. Whilst research has established a number of factors which may predict psychological adjustment difficulties, and also those which may serve to ameliorate them, the complex manner in which such influences may interact is poorly understood. In order for such understandings to develop, it is important that more research within a rigorous, empirical tradition is conducted. Too much of present work

remains at an anecdotal and impressionistic level. Further, such researches need to be integrated with developing theoretical analyses in such fields as developmental psychopathology and psychological anthropology (Schwartz et al. 1992). Present analysis is peculiarly divorced from relevant discourses within related fields of study.

Within the context of these general observations, there are specific issues which warrant particular attention in subsequent work in the field.

5.1 Experience in country of origin

Whilst the relevance of pre-flight experiences to subsequent mental health status is widely acknowledged, study of this phase in refugee experience has been severely limited. Whilst there clearly are major practical constraints on such work taking place within the country of origin of major refugee population movements, recent studies within Mozambique (Wilson 1992a, 1992b) documenting the social and political factors determining refugee behaviour during the course of the civil war have demonstrated the potential explanatory power of such fieldwork. Retrospective analysis of pre-flight experience is less powerful, but may still provide valuable insights. The studies of Rumbaut (1991) and Westermeyer et al. (1983), which related Southeast Asian refugees pre-migration experiences to post-resettlement adjustment, are exemplars of the form of study required in far greater number.

5.2 Refugee Experience and Mental Health in the Developing World

The bulk of studies reviewed here have related to a distinct minority of refugees - those resettling in the industrialized world. A coherent picture of mental health issues in refugee populations will only emerge when this imbalance has been redressed. There is an acute need for study of the psychological distress amongst those displaced *within* the developing world. Whilst such study presents considerable methodological challenges, embryonic tools for such analysis are now appearing across the anthropological, psychological and psychiatric literatures (Dodge and Raundalen 1991, Eisenbruch 1990a, Hansen and McSpadden in press, Kinzie and Sack 1991, Roe 1986, Stuvland and Djapic 1993).

If subsequent studies in the developing world confirm the extent of psychological distress resulting from forced migration indicated by early work in this field, a major prioritization of such research by funding bodies and assistance agencies is clearly warranted. Appropriate commitment is also required from the research community itself, as the required approaches will necessarily involve extensive periods of fieldwork in areas of major social disturbance; the existing literature too often demonstrates the weakness and superficiality of research based on brief and decontextualized analysis of the experience of refugees in the developing world.

5.3 Narrative as a Unifying Concept in Assessment, Prevention and Treatment

Broadly construed, the concept of a personal "narrative" has emerged at many points in the preceding review. Narrative accounts - which have been used extensively to complement the text of this paper - comprise a verbal structure with respect to which the personal meanings given to experience are articulated. Whilst they do serve to give

graphic illustration of the experience of refugees, more fundamentally they afford insight into the psychological processes brought to bear on such experience. Narrative accounts commonly have a dominant role in refugees' presentation of their difficulties (Mollica 1989), may serve as a form of protective and enabling rhetoric (Punamaki 1987), can act to reinforce a shared cultural identity (Berry 1991), and form a common language with respect to which a range of psychotherapeutic approaches may be related (Bustos 1992, Egli et al. 1991, Silove 1992, van der Veer 1992). To the extent that narrative provides a conceptual vocabulary potentially accessible to anthropologists, psychologists, psychiatrists and, most importantly, refugees themselves, further research using this framework may prove particularly valuable. Such analysis may also valuably serve to ensure that the voice of refugees takes a central place in the analysis of the psychological impacts of refugee experience.

5.4 Utility of PTSD as a Diagnostic Label

The PTSD diagnosis is highly prevalent in writings regarding refugee mental health (Kinzie et al. 1984, Westermeyer 1991), and is frequently used even in circumstances where analysis is explicitly social rather than medical in conception (e.g. Faust and Lipson 1992). It has become a key conceptual device in attempts to understand the psychological experience of refugees. It has a face validity in terms of massive trauma proving unintegrable within existing psychological structures, and thus inducing adjustment difficulties. In terms of symptom presentation, it appears to have adequate construct validity (Kinzie et al. 1984, Kinzie 1991).

Nonetheless, there are a number of workers in the field who have expressed disquiet regarding the label. Muecke's (1992) views that its use 'sanctions continuing neglect of refugee suffering' were noted earlier. Essentially, the concern is that medicalization of social problems deflects attention from national and international responsibility for addressing their true cause. The symptoms of PTSD are not - in these terms - a disorder of the individual, but a natural and lawful response of that individual to an intolerable environment. Attention needs to be directed to the environment, not to the individual.

In reality, one is not forced to choose between these two alternatives. One can acknowledge the social determinants of mental ill-health, whilst still attempting to assist individuals whose psychological adjustment has been influenced by past and present traumatic stress. The critique of PTSD seems particularly useful, however, to the extent that it prompts a broader awareness of the psychological and social problems faced by refugees and, as noted by Muecke (1992), the value of studying resilience and coping rather than merely disorder.

5.5 Evaluation of Programme Effectiveness

Presently the driving force behind developments in the field of refugee mental health remains concern, rather than reasoned extrapolation from rigorous empirical study. The preceding analysis clearly calls for a more general preventative approach to the mental health needs of refugees: focusing on minimising stressors and bolstering ameliorative factors within refugee experience rather than discrete psychosocial interventions. Whichever approach is taken, however, understanding in this field will

only advance with rigorous evaluation. At present, refugee mental health programmes rarely feature an effective evaluative component. Indeed, many programmes appear marked by a severe defensiveness regarding evaluation and scrutiny (Wilson 1992a). Such defensiveness is not only obstructive to the development of relevant knowledge. It is also obstructive of the partnership required between governments, agencies, researchers and refugees themselves if refugee mental health issues are to be productively addressed.

Reference Notes

1. Statements of Mozambican refugees interviewed during the course of the UNHCR-funded study reported in Ager et al. (1991).

2. Statements of Mozambican children reported in Dodge and Raundalen (1991).

3. Statement of Chilean woman reported in Gonsalves (1990).

4. Quotation from US State Department report (Cheung, 1984) cited in Mollica et al. (1987).

5. Reported in Chan and Loveridge (1987).

6. Quotation from Jareg (1987).

7. Clinical report in Westermeyer (1991).

8. Statement of Palestinian woman reported in Punamaki (1990).

9. Fieldwork observations in Ntcheu and Mangochi (1990) and Mwanza (1992), Malawi.

10. Reported in Ready (1991).

References

ABHAY, K. (1992) Leadership and management: a comparative study of MAAs. Refugee Participation Network, 13, 9-11.

AGER, A. (1990) The importance of sustainability in the design of culturally appropriate programmes of early intervention. International Disability Studies, 12, 89-92.

AGER, A. (1992) Recruiting indigenous resources: the role of social support in provision for vulnerable refugee children. Refugee Participation Network, 12, 7-9.

AGER, A. (1993) Psychosocial coping strategies in Mozambican refugees. Presentation to the III European Congress of Psychology, Tampere, Finland, July 1993.

AGER, A., AGER, W. & LONG, L. (1991) A Case Study of Refugee Women in Malawi: A report for the United Nations High Commissioner for Refugees. Zomba: Centre for Social Research.

AHEARN, F.L. & ATHEY, J. (1991) Refugee Children: Theory, Research, and Services. Maryland: John Hopkins University Press.

ATHEY, J. & AHEARN, F.L. (1991) The mental health of refugee children: an overview. In Refugee Children: Theory, Research, and Services (eds F.L. Ahearn and J.L. Athey), pp. 3-19. Maryland: John Hopkins University Press.

BAKER, R. (1983) Refugees: an overview of an international problem. In The Psychological Problems of Refugees (ed. R. Baker), pp. 1-10. London: British Refugee Council.

BARTLE, P. & SEGERSTROM, E. (1992) A community focused approach to training: Afghan refugee children in Pakistan. In The Psychosocial Well-Being of Refugee Children (ed. M. McCallin), pp. 262-270. Geneva: International Catholic Child Bureau.

BEISER, M., TURNER, R.J. AND GANESAN, S. (1989) Catastrophic stress and factors affecting its consequences among Southeast Asian refugees. Social Science and Medicine, 28, 183-195.

BEN-PORATH, Y. (1991) The psycho-social adjustment. In Mental Health Services for Refugees, Refugee Mental Health Program, US Dept. of Health and Human Services, pp. 1-23. Maryland: NIMH.

BERRY, J.W. (1980) Social and cultural change. In Handbook of Cross-Cultural Psychology Vol. 5 (eds. H.C. Triandis and R. Brislin), pp. 211-279. Boston: Allyn and Bacon.

BERRY, J.W. (1991) Refugee adaptation in settlement countries: an overview with an emphasis on primary prevention. In Refugee Children: Theory, Research, and Services (eds F.L. Ahearn and J.L. Athey), pp. 20-38. Maryland: John Hopkins University Press.

BERRY, J.W. & KIM, U. (1988) Acculturation and mental health. In Health and Cross-Cultural Psychology: Towards Applications (eds P. Dasen, J.W. Berry, and N. Sartorius), pp. 207-236. London: Sage.

BETTELHEIM, B. (1979) Surviving and Other Essays. New York: Alfred A. Knopf.

BOLIN, R. (1985) Disaster characteristics and psychosocial impacts. In Disasters and Mental Health (ed. B.J. Sowder). Washington, DC: US Government Printing Office.

BRYCE, J.W., WALKER, N., GHORAYEB, F. & KANJ, M. (1989) Life experiences, response styles and mental health among mothers and children in Beirut, Lebanon. Social Science and Medicine, 28, 685-695.

BUSTOS, E. (1992) Psychodynamic approaches in the treatment of torture survivors. In Torture and its Consequences: Current Treatment Approaches (ed M. Basoglu), pp. 333-347.

CAIRNS, E. & WILSON, R. (1984) The impact of political violence on mild psychiatric morbidity in Northern Ireland. British Journal of Psychiatry, 145, 631-635.

CARLIN, J.E. & SOKOLOFF, B.Z. (1985) Mental health treatment issues for Southeast Asian refugee children. In Southeast Asian Mental Health: Treatment, Prevention, Services, Training, and Research (ed T.K. Owan), pp. 91-112. US Department of Health and Human Services. Maryland: NIMH.

CHAN, K. B. & LOVERIDGE, D. (1987) Refugees 'in transit': Vietnamese in a refugee camp in Hong Kong. International Migration Review, 21, 745-759.

CLINTON-DAVIS, L. & FASSIL, Y. (1992) Health and social problems of refugees. Social Science and Medicine, 35, 507-513.

DAVIDSON, S. (1979) Massive psychic traumatization and social support. Journal of Psychosomatic Research, 23, 395-402.

DAWES, A. & DE VILLIERS, C. (1987) Preparing children and their parents for prison: the Wynberg seven. In Mental Health in Transition (ed D. Hanson), pp. 77-94. Cape Town: OASSSA.

DE GIROLAMO, G. (1990) Mental health and psychological problems among refugees: an international overview. Presentation to the 2nd European Conference on Traumatic Stress, Noordwijkerhout, Netherlands, September 1990.

DE GIROLAMO, G., DIEKSTRA, R. & WILLIAMS, C. (1989) Report of a visit to border encampments on the Kampuchea-Thailand border. Geneva: World Health Organisation: MNH/PSF/90.1.

DE MONCHY, M.L. (1991) Recovery and rebuilding: the challenge for refugee children and service providers. In Refugee Children: Theory, Research, and Services (eds F.L. Ahearn and J.L. Athey), pp. 163-180. Maryland: John Hopkins University Press.

DE WAAL, A. (1988) 'The sanity factory': expatriate behaviour on African relief programmes. Oxford: Refugee Studies Programme Network Paper 2b, May 1988.

DIYANATH, S. (1991) Substance abuse and alcholism problems amon refugees - an international perspective. Paper presented at the First International Conference on the Mental Health and Wellbeing of Refugees and Displaced Persons, Karolinska Institute, Stockholm, October 1991.

DODGE, C.P. & RAUNDALEN, M. (1991) Reaching Children in War: Sudan, Uganda and Mozambique. Bergen: Sigma Forlag/Scandinavian Institute of African Studies.

EGLI, E.A., SHIOTA, N.K., BEN-PORATH, Y.S. & BUTCHER, J.N. (1991) Psychological interventions. In Mental Health Services for Refugees, US Dept. of Health and Human Services, pp. 157-188. Maryland: NIMH.

EISENBRUCH, M. (1990a) The Cultural Bereavement Interview: a new clinical research approach for refugees. Psychiatric Clinics of North America, 13, 715-737.

EISENBRUCH, M. (1990b) Cultural bereavement and homesickness. In On the Move: The Psychology of Change and Transition (eds. S. Fisher and C.L. Cooper), pp. 191-205. Chichester: Wiley.

EISENBRUCH, M. (1991) A study of the Cambodian mind. Paper presented at the 1991 World Congress, World Federation for Mental Health, Mexico City, August 1991.

EISENBRUCH, M. (1992) Toward a culturally sensitive DSM: cultural bereavement in Cambodian refugees and the traditional healer as taxonomist. The Journal of Nervous and Mental Disease, 180, 8-10.

EITINGER, L. (1959) The incidence of mental disease among refugees in Norway. Journal of Mental Science, 105, 326-38.

EITINGER, L. (1960) The symptomology of mental illness among refugees in Norway. Journal of Mental Science, 106, 947-966.

EITINGER, L. & GRUNFELD, B. (1966) Psychosis among refugees in Norway. Acta Psychiatrica Scandinavia, 42, 315-328.

ETH, S. & PYNOOS, R.S. (1985) Post-Traumatic Stress Disorder in Children. Washington, DC: American Psychiatric Press.

FAUST, S.C. & LIPSON, J.G. (1992) Refugee health care: problems and solutions. Paper presented at the Annual Meetings of the American Anthropological Association, San Francisco, December 1992.

FELSMAN, J.K., LEONG, F.T.L., JOHNSON, M.C. AND FELSMAN, I.C. (1990) Estimates of psychological distress among Vietnamese refugees: adolescents, unaccompanied minors and young adults. In Social Science and Medicine, 31, 1251-1256.

FERRIS, E. (1992) Refugee women and family life. In The Psychological Well-Being of Refugee Children: Research, Practice and Policy Issues (ed M. McCallin), pp. 90-105. Geneva: International Catholic Child Bureau.

FISHER, S. & COOPER, C.L. (1990) On the Move: The Psychology of Change and Transition. Chichester: Wiley.

FLAKER, G. (1992) Project: Network for Refugees. Ljubljana: Association of Preventive and Voluntary Work.

FORBES-MARTIN, S. (1992) Women Refugees. London: Zed Books.

FOZZARD, S. & TEMBO, L. (1992) Promoting a caring environment for the children: a community based model for intervention. In The Psychological Well-Being of Refugee Children: Research, Practice and Policy Issues (ed M. McCallin), pp. 130-147. Geneva: International Catholic Child Bureau.

FREUD, A. & BURLINGHAM, D.T. (1943) War and Children. New York: Ernst Willard.

GARBARINO, J. (1992) Developmental consequences of living in dangerous and unstable environments: the situation of refugee children. In The Psychological Well-Being of Refugee Children: Research, Practice and Policy Issues (ed M. McCallin), pp. 1-23. Geneva: International Catholic Child Bureau.

GARCIA-PELTONIEMI, R.E. (1987) Psychopathology in Refugees. Prepared for the National Institute of Mental Health's Refugee Assistance Program - Mental Health Technical Assistance Center of the University of Minnesota.

GARMEZY, N. & RUTTER, M. (1983) Stress, Coping and Development in Children. New York: McGraw-Hill.

GEDALOF, E. (1991) Refugee participation. In Refugee Children in Malawi: a study of the implementation of the UNHCR guidelines on refugee children (ed D. Tolfree), pp. 129-131. Geneva: International Save the Children Alliance.

GODFREY, N. & KALACHE, A. (1989) Health needs of older adults displaced to Sudan by war and famine: questioning current targetting practices in health relief. Social Science and Medicine, 28, 707-713.

GOFFMAN, I. (1961) Asylums. Chicago: Aldine.

GOLDFELD, A.E., MOLLICA, R.F., PESAVENTO, B.H. & FARAONE, S.V. (1988) The physical and psychological sequelae of torture. The Journal of the American Medical Association, 259, 2725-2729.

GONZALVES, C.J. (1990) The psychological effects of political repression on Chilean exiles in the U.S. American Journal of Orthopsychiatry, 60, 143-153.

GUERI, M. & PEREZ, A.L. (1986) Medical aspects of the "El Ruiz" avalanche disaster, Columbia. Disasters, 10, 150-157.

HANSEN, A. (1990) Long-term consequences of two African refugee settlement strategies. Paper presented at the Annual Meeting of the Society for Applied Anthropology (USA), York, England, March 1990.

HANSEN, A. & McSPADDEN, L.A. (in press) Self-Anchoring Scale, or Ladder of Life: a method used with divers refugee populations. Journal of Refugee Studies.

HARRELL-BOND, B.E. (1986) Imposing Aid: Emergency Assistance to Refugees. Oxford: OUP.

HARRELL-BOND, B.E. (1988) The sociology of involuntary migration. Current Sociology, 36, 1-6.

HARRELL-BOND, B.E., VOUTIRA, E. & LEOPOLD, M. (1992) Counting the refugees: gifts, givers, patrons, clients. Journal of Refugee Studies.

HIEGEL, J.P. (1984) Collaboration with traditional healers: experience in refugees' mental care. International Journal of Mental Health, 12, 30-43.

HITCH, P. (1983) The mental health of refugees: a review of research. In The Psychological Problems of Refugees (ed. R. Baker), pp. 42-49. London: British Refugee Council.

INTERNATIONAL CATHOLIC CHILD BUREAU (1987) Report of the proceddings of a planing meeting to discuss the design of training programmes iin mental health issues for non-professional staff in refugee camps, and intervention programmes for refugee children to alleviate the effects of the refugee experience. Geneva: ICCB.

JAMES, W. (1992) Managing food aid: returnees' strategies for allocating relief. Refugee Participation Network, 13, 3-6.

JAREG, E. (1987) Psychosocial factors in relief work during famine and rehabilitation. Oslo: Redd Barna.

KANAANEH, M. & NETLAND, M. (1992) Children and Political Violence. Jerusalem: Early Childhood Resource Centre.

KIBREAB, G. (1991) The State of the Art Review of Refugee Studies in Africa, Uppsala Papers in Economic History, Research Report 26, Uppsala.

KINZIE, J.D., BOEHNLEIN, J.K., LEUNG, P.K., MOORE, L.J., RILEY, C. & SMITH, D. (1990) The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees. American Journal of Psychiatry, 147, 913-917.

KINZIE, J.D. & FLECK, J. (1987) Psychotherapy with severely traumatized refugees. American Journal of Psychotherapy, XLI, 82-94.

KINZIE, J.D., FREDRICKSON, R.B., BEN, R., FLECK, J., & KARLS, W. (1984) Post-traumatic stress disorder among survivors of Cambodian concentration camps. American Journal of Psychiatry, 141, 645-650.

KINZIE, J.D., MANSON, S.M., DO, T.V., NGUYEN, T.T., BUI, A. & THAN, N.P. (1982) Development and validation of a Vietnamese-language depression rating scale. American Journal of Psychiatry, 137, 1276-1281.

KINZIE, J.D. & SACK, W. (1991) Severely traumatized Cambodian children: research findings and clinical implications. In Refugee Children: Theory, Research, and Services (eds F.L. Ahearn and J.L. Athey), pp. 92-105. Maryland: John Hopkins University Press.

KINZIE, J.D., TRAN, K., BRECKENRIDGE, A. & BLOOM, J. (1980) An Indochinese refugee psychiatric clinic: Culturally accepted treatment approaches. American Journal of Psychiatry, 137, 1429-1432.

KRUPINSKI, J. (1967) Sociological aspects of mental ill-health in migrants. Social Science and Medicine, 1, 267-281.

KRUPINSKI, J. & STOLLER, A. (1965) Incidence of mental disorders in Victoria, according to country of birth. Medical Journal of Australia, 2, 265-269.

KRUPINSKI, J., STOLLER, A., & WALLACE, L. (1973) Psychiatric disorders in East European refugees now in Australia. Social Science and Medicine, 7, 31-49.

KRYSTAL, H. (1968) Massive Psychic Trauma. New York: International Universities Press.

LIN, K.M. (1986) Psychopathology and social disruption in refugees. In Refugee Mental Health in Resettlement Countries (eds C.L. Williams and J. Westermeyer), pp. 61-73. Washington: Hemisphere.

LIMA, B.R. (1992) Psychosocial consequences of natural disasters: implications for informing action with refugee communities. In The Psychological Well-Being of Refugee Children: Research, Practice and Policy Issues (ed M. McCallin), pp. 46-67. Geneva: International Catholic Child Bureau.

McCALLIN, M. (1992a) The Psychological Well-Being of Refugee Children: Research, Practice and Policy Issues. Geneva: International Catholic Child Bureau.

McCALLIN, M. (1992b) The impact of current and traumatic stressors on the psychological well-being of refugee communities. In The Psychological Well-Being of Refugee Children: Research, Practice and Policy Issues (ed M. McCallin), pp. 68-89. Geneva: International Catholic Child Bureau.

McCALLIN, M. & FOZZARD, S. (1990) The impact of traumatic events on the psychological well-being of Mozambican refugee women and children. Geneva: International Catholic Child Bureau.

McSPADDEN, L.A. (1987) Ethiopian refugee resettlement in the western United States: social context and psychological well-being. International Migration Review, 21, 796-819.

MEAD, G.H. (1934) Mind, Self and Society. Chicago: University of Chicago Press.

MINISTRY OF EDUCATION, MOCAMBIQUE (1990) Helping Children in Difficult Circumstances: A Teacher's Manual. London: Save the Children Fund.

MITCHELL, J. & SLIM, H. (1990) Registration in Emergencies. Oxfam Practical Health Guide No. 6. Oxford: Oxfam.

MOLLICA, R.F., WYSHAK, G., & LAVELLE, J. (1987) The psychosocial impact of war trauma and torture on Southeast Asian refugees. American Journal of Psychiatry, 144, 1567-1572.

MOLLICA, R.F. (1989) Developing effective mental health policies and services for traumatised refugee patients. In Crossing Cultures in Mental Health (eds. D.R. Koslow and E.P. Salett), pp. 101-115.

MORGAN, M.C., WINGARD, D.L. & FELICE, M.E. (1984) Subcultural differences in alcohol use among youth. Journal of Adolescent Health Care, 5, 191-195.

MUECKE, M.A. (1992) New paradigms for refugee health problems. Social Science and Medicine, 35, 515-523.

MUNCY, S. (1992) Vietnamese paraprofessionals in child welfare. In The Psychological Well-Being of Refugee Children: Research, Practice and Policy Issues (ed M. McCallin), pp. 215-225. Geneva: International Catholic Child Bureau.

MURPHY, H.B.M. (1955) Refugee psychoses in Great Britain: admissions to mental hospitals. In Flight and Resettlement (ed H.B.M. Murphy), pp.173-194. Paris: UNESCO.

NEWMAN, C.J. (1976) Children of disaster: clinical observations at Buffalo Creek. American Journal of Psychiatry, 133, 306-312.

ORLEY, J. & SARTORIUS, N. (1991) Psychiatric disorders among refugees: epidemiological and clinical considerations. Paper presented at the First International Conference on the Mental Health and Wellbeing of Refugees and Displaced Persons, Karolinska Institute, Stockholm, October 1991.

PALME, L. (1991) Adults responding to children in times of war. Address to the seminar of the NGO Committee on UNICEF, April 1991, New York.

PROCACIO-MARCELINO, E. (1989) Children of political detainees in the Phillipines: sources of stress and coping patterns. International Journal of Mental Health, 18, 71-86.

PUNAMAKI, R-L. (1986) Stress among Palestinian women under military occupation: women's appraisal of stressors, their coping modes, and their mental health. International Journal of Psychology, 21, 445-462.

PUNAMAKI, R-L. (1987) Psychological stress of Palestinian mothers and their children in conditions of political violence. The Quarterly Newsletter of the Laboratory of Comparative Human Cognition, 9, 116-119.

PUNAMAKI, R-L. (1989) Factors affecting the mental health of Palestinian children exposed to political violence. International Journal of Mental Health, 18, 63-79.

PUNAMAKI-GITAI, R-L. (1990) Political violence and psychological responses: a study of Palestinian women, children and ex-prisoners. Tampere Peace Research Institute Research Reports No. 41, Tampere, Finland.

PUNAMAKI, R-L. & SULEIMAN, R. (1989) Predictors and effectiveness of coping with political violence among Palestinian children. British Journal of Social Psychology, 29, 67-77.

RATNAVALE, D.N. (1983) The mental health needs of refugees and other victims of disaster. The American Journal of Social Psychiatry, III, 3, 39-46.

READY, T. (1991) School and the passage of refugee youth from adolescence to adulthood. In The Psychological Well-Being of Refugee Children: Research, Practice and Policy Issues (ed M. McCallin), pp. 181-200. Geneva: International Catholic Child Bureau.

REFUGEES (1989) Towards 1990: refugees around the world, 17, 12.

RESSLER, E.M., BOOTHBY, N. & STEINBOCK, D.J. (1988) Unaccompanied Children. New York: Oxford University Press.

RICHMAN, N. (1993) Annotation: children in situations of political violence. Journal of Child Psychology and Psychiatry, in press.

ROE, M.D. (1986) Personality development among refugee children in Central America: drawings of self and family as windows. Paper presented at the Annual Conference of the Minnesota Association for the Education of Young Children, October 1986.

ROSARIO, A.G. (1992) Psychosocial risk factors among Central Americans and their implications for social work intervention. In The Psychological Well-Being of Refugee Children: Research, Practice and Policy Issues (ed M. McCallin), pp. 117-129. Geneva: International Catholic Child Bureau.

RUMBAUT, R.G. (1991) The agony of exile: a study of the migration and adaptation of Indochinese refugee adults and children. In Refugee Children: Theory, Research,

and Services (eds F.L. Ahearn and J.L. Athey), pp. 53-91. Maryland: John Hopkins University Press.

RUTTER, J. & SORENSEN, T. (1992) Refugees and the New Europe. London: British Refugee Council/Danish Refugee Council.

RUTTER, M. (1983) Stress, coping, and development: some issues and some questions. In Stress, Coping and Development in Children (eds N. Garmezy & M. Rutter), pp. 1-41. New York: McGraw-Hill.

RUTTER, M. (1985) Resilience in the face of adversity: protective factors and resistance to psychiatric disorder. British Journal of Psychiatry, 147, 598-611.

SCHWARTZ, T.D., WHITE, G.M. & LUTZ, C.A. (1992) New Directions in Psychological Anthropology. Cambridge: CUP.

SELIGMAN, M.E.P. (1975) Helplessness: On Depression, Development, and Death. San Francisco: Freeman.

SILOVE, D. (1992) Psychotherapy and trauma. Current Opinion in Psychiatry, 5, 370-374.

SIMMONDS, S. VAUGHAN, P. & GUNN, S.W. (1983) Refugee Community Health Care. Oxford: OUP.

STEIN, B.N. (1979) Occupational adjustment of refugees: the Vietnamese in the United States. International Migration Review, 13, 25-45.

STEIN, B.N. (1986) The experience of being a refugee: insights from the research literature. In Refugee Mental Health in Resettlement Countries (eds C.L. Williams & J. Westermeyer), pp. 5-23. Washington, DC: Hemisphere.

STUVLAND, R. & DJAPIC, R. (1993) The psychological effects of war on children in Sarajevo: draft paper. UNICEF Sarajevo.

TOLFREE, D. (1991) Refugee Children in Malawi: a study of the implementation of the UNHCR guidelines on refugee children. Geneva: International Save the Children Alliance.

TORTORICI, J.M. (1992) Community mental health in three developing countries: Nicaragua, El Salvador, South Africa: Lessons learned. In The Psychological Well-Being of Refugee Children: Research, Practice and Policy Issues (ed M. McCallin), pp. 148-168. Geneva: International Catholic Child Bureau.

TYHURST, L. (1977) Psychosocial first aid for refugees: an essay in social psychiatry. Mental Health and Society, 4, 319-343.

URRUTIA, G. (1987) Mental health of encamped refugees: Guatemalan refugees in Mexican camps, 1978-1984. Bulletin of the Menninger Clinic, 51, 170-185.

UNICEF (1990) Children on the Front Line: the impact of apartheid, destabilisation and warfare on children in Southern Africa. New York: UNICEF.

UNHCR (1989(UNHCR Work Plan Concerning Refugee Children. IOM/24/89-FOM/27/89. Geneva: UNHCR.

US COMMITTEE FOR REFUGEES (1990) 1989 World refugee statistics. In World Refugee Survey, 1989. Washington D.C.: American Council for Nationalities Service.

VAN DER VEER, G. (1992) Counselling and Therapy with Refugees. Wiley: Chichester.

WESTERMEYER, J. (1986) Migration and psychopathology. In Refugee Mental Health in Resettlement Countries (eds C.L. Williams and J. Westermeyer), pp. 39-59. Washington: Hemisphere.

WESTERMEYER, J. (1991) Psychiatric services for refugee children. In Refugee Children: Theory, Research, and Services (eds F.L. Ahearn and J.L. Athey), pp. 127-162. Maryland: John Hopkins University Press.

WESTERMEYER, J., VANG, T.F. & NEIDER, J. (1983) Refugees who do and do not seek psychiatric care: an analysis of premigratory and postmigratory characteristics. The Journal of Nervous and Mental Disease, 171, 86-91.

WILKINSON, M. (1991) A Mental Health Handbook for Malawi. Malawi: Ministry of Health.

WILLIAMS, C.L. (1991a) Primary prevention and the need for a public health approach. In Mental Health Services for Refugees, US Dept. of Health and Human Services, pp. 205-217. Maryland: NIMH.

WILLIAMS, C.L. (1991b) Toward the development of preventive interventions for youth traumatized by war and refugee flight. In Refugee Children: Theory, Research, and Services (eds F.L. Ahearn and J.L. Athey), pp. 201-217. Maryland: John Hopkins University Press.

WILLIAMSON, J. (1992) An evaluation of the trauma programme at Ukwimi Refugee Setllement. Report prepared for the International Catholic Child Bureau. Virginia: Christian Children's Fund.

WILSON, K. B. (1992a) Internally displaced, refugees and returnees from and in Mozambique. SIDA Studies on Emergencies and Disaster Relief, Report No. 1. Oxford: Refugee Studies Programme.

WILSON, K.B. (1992b) Cults of violence and counter-violence in Mozambique. Journal of Southern African Studies, 18, 527-582.