

Psycho-education with refugee children

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Abstract

Screening studies have revealed that a large number of displaced refugees and their children have been exposed to many severe traumatic events and that many of them suffer from psychological sequelae. Despite this, only a few psychosocial and prophylactic programmes for refugee children have been developed, described, and systematically studied. This article presents the main studies in the field including an evaluation by the author of a psycho-educational programme run by the Danish Red Cross. Organizational and clinical implications are discussed.

Introduction

Every year thousands of children are displaced and become refugees, fleeing from war and atrocities, leaving behind destroyed homes, villages, family and friendship networks, the social fabric and culture of which they were a part. They have to start adapting to a new culture, a new language, and new educational challenges in a situation where their parents and families often are not able to support them efficiently because of their own worries and losses. Many refugee children have no one to turn to when they want to share their losses and misery. Many host countries take care of housing, food, medical treatment, and educational needs for the children, but the psychological problems associated with trauma are often not attended to. There is a growing awareness among professional mental health workers that an important task lies in relating to the psychological problems of refugee children. In the same way that local professionals are beginning to reflect on how to solve the task, a similar process, according to Ajduković,¹ is taking place in international, humanitarian organizations. Most of these organizations have a limited experience in developing and carrying out psychosocial remedial programmes, which is also evident from the very limited literature available within this area.

A literature search on PsycINFO from the period 1992-2001 only gave five references when using the search words "psycho-education" and "refugee". None of these five references had any relevance for the present article.

This article will address the following questions: In which situations are psychosocial programmes necessary for helping refugee children and their families? How can we ensure that they are effective? Which children and adults will profit most from them? The article will also outline the experiences of a psycho-educational project from the Danish Red Cross.

The problems of the children and their families

The quality of life of the refugee children and their resilience is connected with the distress their parents are exposed to, and with the parents' capacity to protect their children and mitigate the most damaging effects of the horrors they have lived through. This experience stems from the work of Freud and Burlingham² with English children during the Second World War, which showed that the parents' emotional reactions were a better predictor of symptom development in the children than the actual horrors the children had experienced.

Besides the parents' emotional reactions, the degree of destruction of the social system also plays an important role. This was proven by Galante and Foa,³ who studied 300 Italian school children after an earthquake, a type I trauma. They found that a psycho-educational programme resulted in reducing fears of earthquakes. They expected that the degree of destruction in the villages would prove to be connected to the children's subsequent neurotic or antisocial problems. This turned out not to be the case, but in return they concluded that the critical factor of the occurrence of pathology in the children was connected to how much time the local society needed to reorganize after the catastrophe.

After clinical experiences with refugees in need of treatment, Dahl, Hauff, Sveaass, and Lavik⁴ stated that of the many traumas which accompany the flight process, the loss trauma is the most important. There is no detailed definition of this trauma, but loss of network and image of oneself, loss of the continuous cultural self-affirmation, competence, social status, house, and home are mentioned. It must be assumed that the authors see "loss traumas" as the opposite of "danger traumas", when they subsequently discuss traumas caused by political persecution, imprisonment, maltreatment, and torture.

A study which involved the screening of the psychological and somatic state of 1,224 children and adolescents from Kosovo offered a unique opportunity to study empirically the above-mentioned assumption.⁵ The conclusion was that torture, living a period at the absolute subsistence level, and a long flight period (including the many dangers this involves) were very decisive for symptom development occurring immediately after the refugees have arrived safely in another country. In comparison, losses did not have the same importance at that point of time. That does not mean that losses will not dominate at a later time in the life of a refugee child or its parents, when some of the "danger traumas" recede into the background.

From a developmental psychological point of view, four conditions must be emphasized as being particularly relevant in order to limit the negative influence of war trauma in refugee children (cf. Cichetti, Toth, and Lynch⁶):

- a) The quality of the child's attachment to a parental figure is very important. Loss of attachment figures may lead to

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severe psychological disturbance and even to physiological damages similar to that which is seen in PTSD (cf. van der Kolk⁷). Secure attachment is a very strong resource in children, which would make new attempts of attachment more successful. Insecure attachment might make short term adaptation easier due to lower expectations, but at the same time be equivalent to interpersonal problems later on.

- b) Can the child's affects be regulated? Does the child have the opportunity for continuous talks about the feelings that arise, and are tensions, losses, and conflicts processed? Are feelings suppressed in misunderstood consideration, or are they acted out?
- c) To what extent is the individual child (and all the family members) allowed to choose friends, activities, and points of view? Loyalty to the culture that has been left is likely to be important for the feeling of continuity and having roots, but maintained in a rigid way it could at the same time be a hindrance to an adaptation to the new culture.
- d) As part of a normal development children choose to engage themselves, to invest in school and leisure activities, and through such activities achieve competence in skills and subjects. This process can be seen as a (long) intermediate phase, through which the child builds up sufficient resources to be able to leave the original core family for the benefit of a broader social network. Heavily strained families can see this process as a threat to the existence of the family, and underachievement in school and work competence can be a strategy for some children to solve such a dilemma.

Ajduković⁸ studied how 58 refugee mothers, who were situated in an asylum centre in Croatia, experienced their children's psychosocial difficulties. During a period of six months, it was evident that the mothers spoke less with their children and became more nervous themselves. The children's most common difficulties were loss of appetite, anxiety at night, sleep problems, sweating, fear of being separated from their mothers, and general timidity. As time went by, the prevalence of reported distress symptoms decreased. There was a close association between the adaptation of the mothers, their contact with their children, and the frequency of problems with the children. Separation from the father was also a factor implying a higher problem rate with the children.

During and after a war, both parents are likely to be deeply influenced in a way that reduces their ability to be attentive to the psychological needs of their children. There are almost no studies of fathers who have been soldiers and return to their families in a war-ravaged country. One relevant study is done by Bucat, Frančičević, and Moro,⁹ who worked in a psychiatric clinic at the University Hospital in Rijeka in Croatia. They described how war veterans and (war)traumatized people normally obtain the support and help they need from their existing social network in order to establish a good adaptation. Still, it is their experience that between 10-15% develop some kind of PTSD, and that between 20 and 30% of the war veterans show adaptation difficulties and need psychiatric help. Apart from a reduction in PTSD symptoms resulting from the trauma processing, they emphasized, among other things, an increased self-acceptance and ability to talk about the trauma, which they see as respectively an affective and a behavioural adaptation.

A study conducted at the Center for Crisis Psychology in

Bergen¹⁰ showed that Bosnian refugee children had received little or no explanation or dialogue about what had happened during the war, during the evacuation, or the time after.

Ajduković¹¹ emphasizes that based on her experiences with refugee families in Croatia, the situation which is particularly distressing to a child is when the parents are overwhelmed by their own feelings, and are unable to satisfy the child's increasing emotional need. Many refugee mothers suffer from depression, anxiety, and various somatic problems, which sometimes may develop into a disease. The parent who has emotional or somatic problems often neglects the child's needs, while also displaying a low tolerance towards the child's behaviour, illustrated by increased irritability and a punishing attitude in the upbringing of the child.

Ajduković¹¹ mentions three maladaptive strategies used by the parents: a) underestimating the child's difficulties and misinterpreting its behaviour as disobedience or laziness, b) overprotective reactions and making the child the centre of the adult's life, and c) trying to solve their own problems through the child, for example by expecting the child to fulfill the dreams that the parents were unable to materialize. Refugee parents living under difficult conditions often suppress both their own and their children's emotional problems. The parents do not see the problems of the child, e.g. the loss of a family member or a home, because the parents are not capable of facing the loss themselves.

Systematic evaluation

Silove¹² stated that "in a number of Western countries specialized centres have been established to counsel and rehabilitate survivors of torture". "Unfortunately," he continues, "the initiatives that were planned to develop screening programs at arrival have not occurred mainly because of inadequate co-ordination between the immigration authorities and the organisations responsible for the psychological and mental treatment."

Wolters¹³ stresses that the long-term effects of traumatic events on the children are still inadequately understood. Wolters agrees with Udwin¹⁴ that "there are only few reports available about which treatment strategies are suitable for children suffering from post-traumatic stress reactions, and basically no systematic evaluations of methods are used today".

In a pilot study of 246 unaccompanied refugee children, of which 26% had received special care or treatment, Stæhr, Lindskov, and Carey¹⁵ concluded that "the results give rise to considerations of extending screening interviews with regard to traumatic experiences and psychological symptoms with a view to an early intervention in the pre-asylum phase. On this basis it was recommended to develop a structured questionnaire to use for screening in order to find vulnerable persons at an early stage and prevent them from developing more symptoms. Furthermore, such a tool can be used in developing differentiated psychosocial measurements and this implies that concrete measurements of implemented arrangements will be possible."

Williams¹⁶ was one of very few who at an early stage wrote an overview article about preventive intervention for young refugees. She showed that despite an increasing interest there hardly exists even one single programme primarily for intervention for refugee children. Almost a decade later the situation is just a little better, as today only a few descriptions of programmes exist and evaluations of these programmes are available. Williams strongly emphasized that to call a pro-

programme preventive does not necessarily mean that it will reduce the number of mental problems. Limited results can sometimes be used to justify the closing of a programme with a reference to the limited resources.

Stuvland¹⁷ advocates an environmental orientated trauma psychology that acknowledges the importance of individual experiences by focusing on the events that caused the post-traumatic reactions. Some therapists' resistance against looking at traumas at all, to perceiving PTSD as far too limited a perspective, or the widespread interest in the resistance of children can, according to Stuvland, be seen as an expression of ignorance. However, it can also often be seen as examples of counter-transference, protecting the therapists from the extremely painful feelings, which normally accompany intense traumatic experiences. The problem, Stuvland wrote, is not that too many adults talk too much with the children about their traumatic experiences, but that too many completely overlook or avoid talking directly to the children or listening to their stories.

Treatment principles

Despite our limited knowledge of long-term effects of intervention, there is today among professionals a widespread consensus on the need to implement preventive interventions. Several in the field have stressed that before intervention begins, staff qualifications need upgrading. In a conference report from 1993 concerning "The emotional needs of refugee children and their families: Implications for professionals", James¹⁸ concluded that the lack of concern will be expensive for society in the long run. The conference recommended that all personnel groups should be trained in identifying the various problems caused by children's war experiences. More specifically, the conference recommended that a simple evaluation, for example in the form of a questionnaire, should be developed in order to ensure that the children receive the necessary help.

Pupavac¹⁹ drew attention to her experiences with trauma work for children and adolescents in the "Suncokret" project in Zagreb, where non-professional and para-professional helpers could be ignorant about the complexity or the possibilities available in trauma treatment. Consequently, an essential part of their project consisted of developing the resources of the staff through: 1) two-day introduction workshops, 2) systematic training and continuous supervision, and 3) programme specific workshops, e.g. for personnel working with a certain age group.

The main principles for the chosen treatment strategies will in many cases be: 1) group-oriented due to resource and therapeutic reasons, 2) trauma-focused and coping/resource oriented – in order to verbalize and share painful experiences in a future-oriented context, and 3) in cooperation with the family – in order to obtain an open dialogue and to secure the child more relevant support.

The pivotal process in psycho-education starts by supplying the children and the adults with relevant information, which enables them to understand and interpret their own reactions. By supplying them with a knowledge of various coping skills, the internal healing forces are stimulated and their expectations of once again getting better are increased.²⁰ Pfefferbaum²¹ emphasized in her review article that group treatment is ideal for teaching young people about trauma symptoms and, adjusted to their age, can explain to them about post-traumatic reactions, mechanisms, and courses. It can be supportive to the children who have difficulties telling

about their worries, or who think that their experience is so unique that they are unable to share their experiences with others who have been in a similar situation (cf. Yule and Williams²²). The group format offers an opportunity to remember and examine loss, to observe different coping strategies, to see others at different levels as regards to processing the traumas, and to experience the happiness that stems from helping others. The group treatment is also an efficient method when it comes to identifying children who need a more intensive treatment (cf. Gillis²³).

However, there are also disadvantages of using a group format. Not all children feel comfortable telling about their horrors in a group – in some cases a more detailed description of new, unknown, and violent horrors can reinforce the children's traumatization, and without adequate support in processing from the adults in the group some children may experience a worsening of their condition.

Children can also preventively begin to use coping strategies, which they have heard other children talking about, before they themselves have examined their own reactions. It is also important that the therapists can define limits for outlets of aggression which can create anxiety in others in the group and in some cases can necessitate individual therapy (cf. Gillis²³).

In an article about "Group Work with Distressed Children", Ajduković²⁴ put forward the following principles for structuring group work with refugee children:

- 1) The meetings should be held in the same room, and there must be space for the children to work, play, move freely, and sit in a circle.
- 2) The ideal group size is 8-10 children.
- 3) It is desirable that there is stable participation.
- 4) Children in the latency age (9-11 years) prefer group members to be of the same sex.
- 5) Each child should feel accepted and have a feeling of belonging to the group.
- 6) The group leader must create a feeling of trust and safety in the following ways:
 - the group starts and finishes on time and is consistently held at the same time
 - the leader along with the children defines the rules of acceptable behaviour for both the leader and the children
 - the leader ensures the personal safety of all concerned
 - the leader pays attention to every child's emotional state, without necessarily sharing these observations with the group, for the proper regulation and direction that the group should take.
- 7) It is advisable that there are two co-leaders in the group.
- 8) The phases in the group work should follow carefully selected teamwork activities for each group meeting.
- 9) One should pay attention to the goals for each planned exercise.

Measuring of the programme effect

Ajduković and Ajduković²⁵ mentioned the difficulties of estimating the effects of psychosocial support on refugee children and their families through a decrease in their distress symptoms. Ideally, a classical experimental design with control groups is demanded. However, such a research model might be unethical to heavily traumatized groups, if it results in someone very much in need receiving no or delayed treatment. It might also be difficult to establish treatment and

research which follows a standard protocol, as the entire society structure can be ruined and very few things might function as expected. If the treatment takes place in the host country, the future prospects of the individual might also be very different, depending on the degree of destruction of the local community, the total number of losses, the possibility of repatriation, asylum status, and the integration politics of the receiving country. All these aspects can hamper the research process as confounders.

To which extent is information based on different data sources reliable? Different studies have shown that the degree of consensus among e.g. children and parents depends on the type of problem. Consequently, there is much more agreement when it comes to manifested behaviour, less consensus with depressive symptoms, and least consensus with anxiety.^{26,27} Parents are not necessarily the best informants because they will often have a strong desire for their children to be free of serious problems. Teachers and health staff will often be directed by different perspectives ("silence in the classroom to be able to teach"; "does this suffering need to be treated?"), which can make the comprehensive understanding of the individual child more difficult. Countertransference and lack of relevant education can also partly explain the limitations of some staff groups when it comes to obtaining knowledge of traumatization. Children can also be limited in their capacity to report emotional conditions and assess their general state.

Ajduković and Buško²⁸ described a school based intervention programme for Croatian children in a war-ravaged area. After developing work material and exercises in a pilot project, a 20-week project for 1,200 pupils was started, in which the teachers – supported whenever possible by a school psychologist or another colleague – for 2 hours per week focused on the children's emotional experiences, their resources, and their ethnic attitudes. Prior to the project the teachers had participated in a five-day training programme, and they received supervision twice a week. During the period there was a significant decrease in the symptom level of the children who participated in the programme. There was also a significant increase in the children's self-esteem, just as the children's attitudes to ethical conflict solving changed in a positive way. The study also showed that there were essential differences depending on locality.²⁸

Ispanovic-Radojkovic, Davis, Mincic, Tenjovic, and Wolf²⁹ studied the effect of common youth club activities for 128 young refugees in Belgrade. The aim of the club activities was to activate the person's coping competence and avoid activating the weak and vulnerable sides of the personality. The participation in the club activities took place over a year and was then compared with a control group. They found a substantial decrease in social withdrawal and an increase in self-esteem for both genders. The boys had a decrease in the occurrence of depression and the girls a decrease in the prevalence of social problems.

However, there was a small, but not significant, increase in the Impact of Event scores for those who attended the youth club. Ispanovic-Radojkovic et al.²⁹ explained this result as the young people subjectively feeling better and having a higher self-esteem, at the same time as their traumatization level was unchanged or had even increased with the intervention. Participation in the club activities may possibly have strengthened the youngsters by enabling them to start confronting themselves with the as yet suppressed, painful memories in an attempt to integrate them. Whether club

activities are sufficient to secure the psychological health of the adolescents in the long run or whether some of them at a later point need therapeutic intervention cannot be answered through this study.

The Danish Kosovo Refugee Psycho-educational Project

As a part of the Danish Red Cross' psychosocial work for the Kosovo refugees, the preventive work started with the development of a research instrument and an examination of the need for treatment. An action plan in the form of a psycho-educative programme was planned and implemented, and the result of the efforts was recorded and analyzed. This dialectic work form can be described as action research ad modum Kurt Lewin.³⁰ In order to maintain the acquired experiences, to develop the programme, and to assess the strengths and weaknesses with special reference to future programmes, it was important to carry out a systematic evaluation which: 1) included all the participants in the field, 2) built on a multivariat principle (i.e. several different methods complementing each other), and 3) examined the programme both from a process and a product perspective (including the feedback of the participants based on the presented results). The systematic approach was considered very important. Descriptive studies can be inspiring and informative, but they have difficulties procuring knowledge which can be generalized to comply with other groups of children or to other studies due to the idiosyncratic methods used to decide symptoms and effect (cf. Lonigan, Shannon, Finch, Daugherty, and Taylor³¹).

On the basis of a screening study³² showing that approximately 70% of the children and 20% of the adults suffered from PTSD, the Danish Red Cross implemented a psycho-education programme³³ which included 490 children and their parents accommodated in asylum centres in Denmark. For the youngsters (7-18 years) the programme consisted of three two-hour sessions and two parental meetings. The programme reached between 83% and 93% of the children. In total there were 43 groups, of which 11 were aimed at parents with small children in the age group 3-6 years. Psychologists ran the 32 groups for the youngsters, who were divided into age groups. Furthermore, interpreters, health nurses, and pedagogues participated. The average size of each group was 12 children. A natural control group was established due to the fact that another organization than the Danish Red Cross accommodated part of the refugees and did not run a psycho-educational programme.

The overall aim of the programme, i.e. reaching a large number of children and parents at a relatively early stage, was accomplished. Many parents stated that they would have liked a similar offer. This information may be an incentive to expand this part of similar programmes in the future.

The participation in the psycho-educative programme had the effect that the level of intrusive memories and the level of hypervigilance decreased significantly (the IES total score went down by two points), as did self-satisfaction.³⁴ The direct focusing on the war traumas apparently resulted in a better direct contact with intrusive memories and hypervigilance, and the tendency to be on guard all the time. The improved contact with the vulnerable parts was probably the reason for the decrease in satisfaction with oneself. In many cases the programme caused an opening to strong emotions, but it did not last long enough to ensure an even greater reduction in the traumatization level.

Besides the measured outcome, the parents and the different staff groups have mentioned a number of examples of not only the children's improved functioning, greater happiness, and concern for others, but also of a larger degree of contact with anger and mourning. A typical parental statement was: "The children sleep better, they have fewer nightmares. We now know more about what to do when we can feel that they are going through a hard time." A typical staff statement (from a pedagogue): "Sometimes we have a certain eye contact due to the fact that we have shared something very important."

The staff as a whole has had a common assignment of an intense nature. This has influenced the team spirit in a positive direction. The knowledge of the other participants has increased. A common understanding has arisen that to a larger extent it has become acceptable to talk about the intense traumas, which otherwise had a tendency to be avoided. Even though the organizational cooperation across the professional groupings all in all has worked well, there is no reason to think that a certain staff formula is the only right one. One might consider limiting the number of staff present in the group so that the children would not have to relate to so many adults at once; on the other side, the value of the improved cooperation and the increased knowledge of the children must be considered. A very strong desire has been to receive supervision. A more extensive introduction and continuous staff supervision would also be in line with the recommendations a number of international studies have put forward (cf. above).

The critique of the use of the IES questionnaire has been substantial. One main point was that it has taken valued time from the therapeutic work. Another main point was that the youngest children had great difficulties in understanding it. Consequently, one should be careful when trying to compare the results, especially those regarding the youngest children, with other similar situations. Dyregrov, Gupta, Gjestad, and Mukanoheli³⁵ applied IES-R in a study of 1,830 Rwanda children, ranging from 8-19 years of age, almost one year after the genocide. The average values for the sub-scales Invasion and Avoidance were 2.4 times and 1.6 times higher for the Kosovo children than for the Rwanda children.

As opposed to Dyregrov et al.³⁵ we found a strong positive association between the sub-scales of Avoidance and Hyper-vigilance, and a high positive association between Invasion and Avoidance at the arrival 7 months later. The latter result can be interpreted as an expression of avoidance being a factor that develops relatively independently some time after the traumatizing event (cf. Creamer, Burgess, and Pattison³⁶). Compared to Ispanovic-Radojkovic et al.²⁹ our results were quite diametrical: they had an increase in the degree of traumatization (measured by IES) and a rise in self-esteem. This difference might be due to the different foci of the two projects: to address trauma and coping in a direct way vs. strengthening coping resources via play and competence activities and avoiding to address traumas. But other variables as age, cultural differences, etc. may also play a role in explaining the differences.

The present report builds on a number of the above-mentioned treatment principles. The psycho-educative programme has only been one element in the total package of psycho-social initiatives, which the Danish Red Cross supplied to the refugee group. It is also important to remember that each psychologist and programme group has adapted to the children and situation in question. The programme has taken

place in an interdisciplinary cooperation run by the health nurses. It has demanded an extensive work effort regarding planning and organization. The screening element is hardly mentioned in the feedback from the professional groups, whereas almost everybody describes the outcome, the process, and the difficulties of the programme. This may reflect the fact that the energy has been used to create and implement the programme.

The asylum work of the Danish Red Cross and of other large humanitarian organizations seems to change from exclusively emergency tasks to taking care of refugees and asylum seekers for long periods of time. This change makes demands on the entire organization, its management, and the individual employees. If psychological intervention in the future becomes a part of a standard programme, it requires new staff skills, new closer forms of cooperation, a more intense focus on the individual client, better communication, and passing on of the acquired information to a third party (e.g. GPs, social services, etc.). The significant workload and the great enthusiasm which has been put into implementing the psycho-educative programme seems to show that the particular organization is progressing in this process.

It may seem ambitious to try to measure the effect of a short-term programme because six hours may seem like a drop in the ocean compared to the many horrors the children and their parents have been through. When the outcome of the Danish Red Cross' psycho-educative programme for Kosovo-refugees was added up, the impression was quite positive. Psychologists and health nurses described the results as important; the interpreters who were culturally and linguistically closer to the refugees were, just as the parents, very positive. The pedagogues were the only group who was less sure of the outcome; however, this could also reflect the less central placing of this staff group in the programme. From the children's report it appeared that there was a small, but significant decrease in the traumatization symptoms. This decrease must be due to the programme as the degree of traumatization ascended in the control group. However, as mentioned before we also see other effects, including a decrease in the self-satisfaction, which may be interpreted as an effect of the programme: The traumatic memories were opened up, but there was not enough time to help the children reorganize their experiences.

Recommendations

This final section builds on the experiences in Elklit,³⁷ who made an external evaluation of the project based on interviews of all the staff groups and parental focus groups, plus feedback from the participants in two large evaluation conferences:

- 1) Screening tools should be developed and improved – if possible as an international cooperation – so they are ready to be used in a number of languages.
- 2) Assessment questionnaires should to be completed in such a way that:
 - a) they do not take time from the other activities in the programme.
 - b) they are placed in another context outside the programme.
 - c) special research instruments for children 10 years and younger should be developed.
- 3) General plans should be made with instructions for preparation, implementation, and evaluation of new pro-

grammes. Apart from the acquired experiences mentioned above it is suggested to use the experience that Ajduković³⁸ has described. It is also suggested to include the kind of activities and exercises which Ajduković and Buško²⁸ have described.

- 4) Furthermore, it is suggested that the programme activities should be related to developmental psychology (cf. Cicchetti et al.⁶), which is mentioned above. A core concept could be the "identity", which is the comprehensive concept of the psychosocial intervention project for school refugee children which the Victoria Foundation in Melbourne carries out.³⁹⁻⁴¹ The use of different models may open up to new experiences.
- 5) Future programmes should involve resource persons among the refugees.
- 6) Compulsory supervision should be implemented for all staff groups working with refugees.
- 7) The responsibility of the centre leaders of coordinating activities should be clarified, so the programme can run without any internal organizational obstacles.
- 8) The responsible organization should hire or select psychologists who can professionally run the psycho-educative programmes, in order to have a stock of stable and experienced people available, who have a knowledge about clinical, developmental, and social psychology.

References

1. Ajduković D. Empowering children: psychosocial assistance under difficult circumstances. Zagreb: Society for Psychological Assistance, 1999.
2. Freud A, Burlingham D. War and children. New York: Ernest Willard, 1943.
3. Galante R, Foa D. An epidemiological study of psychic trauma and treatment effectiveness for children after a natural disaster. *Journal of the American Academy of Child Psychiatry* 1986;25:357-63.
4. Dahl C-I, Hauff E, Sveaass N, Lavik NJ. Klinisk erfaring med behandlingstrengende flyktninger. *Tidsskrift for Den norske Lægeforening* 1989;109:1871-4.
5. Abdalla K, Elkliit A. A nation-wide screening survey of refugee children from Kosovo. *Torture* 2001;11:45-9.
6. Cicchetti D, Toth SL, Lynch M. The developmental sequelae of child maltreatment: implications for war-related trauma. In: Leavitt LA, Fox NA, editors. *The psychological effects of war and violence on children*. New Jersey: Hillsdale, 1993.
7. van der Kolk BA. The separation cry and the trauma response: developmental issues in the psychobiology of attachment and separation. In: van der Kolk BA, editor. *Psychological trauma*. Washington DC: American Psychiatric Press, 1987:31-62.
8. Ajduković M. Mothers' perception of their relationship with their children during displacement: a six month follow-up. *Child Abuse Review* 1996;5:34-49.
9. Bucat N, Frančisković T, Moro L. What to measure when evaluating the outcomes of the trauma treatment. In: Ajduković D, editor. *Trauma recovery training: lessons learned*. Zagreb: Society for Psychological Assistance, 1997:395-404.
10. Dyregrov K, Raundalen M. Hvordan kommuniseres hjemvendingsproblemet i den bosniske familie? Fokus på barn og unges rolle. Rapport fra Nordiske komparative studier om mottak av flyktninger i et tilbakevendingsperspektiv. Bergen: Center for krisepsykologi, 1997.
11. Ajduković M. Family as a support system to children. In: Ajduković D, editor. *Empowering children: psychosocial assistance under difficult circumstances*. Zagreb: Society for Psychological Assistance, 1999.
12. Silove D. Prevention of psychosocial disability in victims of persecution and social chaos. In: Raphael B, Burrows GD, editors. *Handbook of studies on preventive psychiatry*. London: Elsevier, 1995:343-57.
13. Wolters WHG. Extremely shocking events: counseling the parents. In: Ajduković D, editor. *Trauma recovery training: lessons learned*. Zagreb: Society for Psychological Assistance, 1997:289-302.
14. Udwin O. Annotation: children's reactions to traumatic events. *Journal of child psychology and psychiatry and allied disciplines* 1993;34(2):115-127.
15. Stæhr M, Lindskov T, Carey RB. Uledsagede flygtningebørn med særlige omsorgs- og behandlingsbehov i Danmark. *Nordisk Psykologi* 2000;52(1):3-18.
16. Williams CL. Toward the development of preventive interventions for youth traumatized by war and refugee flight. In: Ahearn FL, Athey JL, editors. *Refugee children: theory, research, and services*. The Johns Hopkins University Press, 1991.
17. Stuvland R. Trauma projects and the future. In: Ajduković D, editor. *Trauma recovery training: lessons learned*. Zagreb: Society for Psychological Assistance, 1997:39-48.
18. James E. The emotional needs of refugee children and their families: implications for professionals. *Medicine and war* 1993;9:339-43.
19. Pupavac V. Trauma recovery training: "Suncokret" experiences. In: Ajduković D, editor. *Trauma recovery training: lessons learned*. Zagreb: Society for Psychological Assistance, 1997:335-344.
20. Dyregrov A. Teaching trauma intervention: lessons learned. In: Ajduković D, editor. *Trauma recovery training: lessons learned*. Zagreb: Society for Psychological Assistance, 1997:49-72.
21. Pfefferbaum B. Posttraumatic stress disorder in children: a review of the past 10 years. *Journal of American Child Adolescence Psychiatry* 1997;36:1503-11.
22. Yule W, Williams RM. Post-traumatic stress reactions in children. *Journal of traumatic stress* 1999;3(2):279-95.
23. Gillis HM. Individual and small-group psychotherapy for children involved in trauma and disaster. In: Saylor CF, editor. *Children and disasters*. New York: Plenum Press, 1993:165-86.
24. Ajduković M. Group work with distressed children. In: Ajduković D, editor. *Empowering children: psychosocial assistance under difficult circumstances*. Zagreb: Society for Psychological Assistance, 1999:103-116.
25. Ajduković M, Ajduković D. Impact of displacement on the psychological well-being of refugee children. *International Review of Psychiatry* 1998;10:186-95.
26. Loeber R, Green SM, Lahey BB, Stouthamer-Loeber M. Optimal informants on child disruptive behavior. *Development and Psychopathology* 1989;1:317-37.
27. Hodges K. Structured interviews for assessing children. *Journal of Child Psychology and Psychiatry* 1993;34:49-68.
28. Ajduković M, Buško V. Trauma healing and peaceful problem solving. Zagreb: Croatian Ministry of Education and Sports, UNICEF, CARE & McMaster University Project. [no date].
29. Ispanovic-Radojkovic V, Davis H, Mincic T, Tenjovic L, Wolf B. Traumatic war experiences and adolescence and healing. Poster presented at ESTSS 6th European Conference on Traumatic Stress, Istanbul, 1999.
30. Shaw M, Constanzo PR. *Theories of social psychology*. New York: McGraw-Hill Book Company, 1970:115-35.
31. Lonigan CJ, Shannon MP, Finch AJ, Daugherty TK, Taylor CM. Children's reactions to a natural disaster: symptom severity and degree of exposure. *Advances in Behavioral Research and Therapy* 1991;13:135-54.
32. Stæhr MA. Screening af traumatiserede Kosovo-flygtninge. (Unpublished).
33. Lindskov T, Abdalla K. Intern evalueringsrapport om psykoedukationsprogrammet: forebyggelse af alvorlige psykiske belastningsreaktioner hos børn og unge fra Kosovo. Copenhagen: Dansk Røde Kors, 2000.
34. Stæhr M, Elkliit A. Psykoedukation: en effektundersøgelse af et program for flygtningebørn. Dansk Røde Kors & Psykologisk Institut, Aarhus Universitet, 2000. (Unpublished).
35. Dyregrov A, Gupta L, Gjestad R, Mukanoheli E. Trauma exposure and psychological reactions to genocide among Rwandan children. *Journal of Traumatic Stress* 2000;13:3-22.
36. Creamer M, Burgess P, Pattison P. Reaction to trauma: a cognitive processing model. *Journal of Abnormal Psychology* 1992;101:452-9.
37. Elkliit A. Psykoedukation: 5 aktørgruppers evaluering af et pro-

- gram til forebyggelse af alvorlige psykiske skader hos børn og unge fra Kosovo. [Psycho-education: the evaluation of a prophylactic programme for Kosovo refugee children from five different groups of participants]. Psykologisk Pædagogisk Rådgivning. (Unpublished).
38. Ajduković D. Psychosocial assistance to children. In: Ajduković D. Empowering children: psychosocial assistance under difficult

circumstances. Zagreb: Society for Psychological Assistance, 1999:13-20.

39. Robinson K. Personal communication (20 March, 2000).
40. Tucci M. Personal communication (20 March, 2000).
41. Richman N. In the midst of the whirlwind: a manual for helping refugee children. Stoke on Trent: Trentham Books, 1998.

Selected list of publications

received in the IRCT International Documentation Centre

Mourir au Kivu: du génocide Tutsi aux massacres dans l'Est du Congo-RDC / Bulambo Katambu, Ambroise L'Harmattan, 20010000. - 179 p.: ill.

The medical profession and human rights: handbook for a changing agenda / British Medical Association. - London: Zed Books; British Medical Association, 20010000. - xxxiii, 561 p.

The mental health consequences of torture / Gerrity, Ellen (ed.); Keane, Terence M. (ed.); Tuma, Farris (ed.). - New York: Kluwer Academic, 20010000. - xxiii, 375 p. - Plenum Series on Stress and Coping.

A study on victims of torture in refugee community and local / migrants in and around Delhi (NOIDA) / The Shubhodaya Center for Rehabilitation of Victims of Torture and Violence (SCRVTV); Society for Social Research Art and Culture (SOSRAC). - New Delhi: Society for Social Research Art and Culture (SOSRAC), 20010000. - 57 p.

Victims, perpetrators or actors?: gender, armed conflict and political violence / Moser, Caroline O. N. (ed.); Clark, Fiona C. (ed.). - London: Zed Books, 20010000. - xi, 243 p.

States of denial: knowing about atrocities and suffering / Cohen, Stanley. - Cambridge: Polity Press, 20010000. - xvi, 344 p.

The International Convention on the Elimination of All Forms of Racial Discrimination: a guide for NGOs / Tanaka, Atsuko; Nagamine, Yoshinobu. - London: Minority Rights Group; International Movement Against All Forms of Discrimination and Racism, 20010000. - 48 p. - Available from World Wide Web: <http://www.imadr.org/pub/pub.html>.

União Europeia relatório anual sobre os direitos humanos / European Union. The Council = Conselho da União Europeia. - Luxemburg: Serviço das Publicações Oficiais das Comunidades Europeias, 20010000. - 132 p. - Also available in English and Greek.

From the golden country to the promised land / Lingam, Jeanie. - In: Transitions; Autumn 2001, issue 9. - Fairfield: Service for the Treatment and Rehabilitation of Torture and Trauma Survivors; STARTTS, 20010000. - p. 33-35.

Finding your voice / Tegg, Allan. - In: Transitions; Autumn 2001, issue 9. - Fairfield: Service for the Treatment and Rehabilitation of Torture and Trauma Survivors; STARTTS, 20010000. - p. 30-32.

The health of temporary protection visa holders / Smith, Mitchell. - In: Transitions; Autumn 2001, issue 9. - Fairfield: Service for the Treatment and Rehabilitation of Torture and Trauma Survivors; STARTTS, 20010000. - p. 28-29.

Refugee women: the authentic heroines / Mehraby, Nooria. - In: Transitions; Autumn 2001, issue 9. - Fairfield: Service for

the Treatment and Rehabilitation of Torture and Trauma Survivors; STARTTS, 20010000. - p. 18-22. - Available from World Wide Web.

La vita non è sogno: aspects of the second generation rehabilitation / Boneva, Anny; Dimitrov, Emil; Yankova, Emilia; Genchev, Evgeni; Dimitrova, Mimoza; Ogoiski, Petko; Makarinov, Sergei; Makarinova, Vesselka. - Sofia: Assistance Centre for Torture Survivors; ACET, 20010000. - 86 p.: ill. - Also available in Bulgarian.

Zhivotut ne e sun: aspekti na rekhabilitatsiata na vtoroto pokolenie [T] = Aspects of the second generation rehabilitation [t] / Boneva, Anny; Dimitrov, Emil; Yankova, Emilia; Genchev, Evgeni; Dimitrova, Mimoza; Ogoiski, Petko; Makarinov, Sergei; Makarinova, Vesselka. - Sofia: Assistance Centre for Torture Survivors; ACET, 20010000. - 88 p.: ill. - Also available in English.

Handbook of cultural psychiatry / Tseng, Wen-Shing. - San Diego, London: Academic Press, 20010000. - xix, 855 p.: ill.

Human rights in development: yearbook 1999-2000: the millennium edition / Stokke, Hugo (ed.); Tostensen, Arnen (ed.). - Hague and Oslo: Kluwer Law Int. and Nordic Human Rights Publ., 20010000. - 260 p.

Behandlingsprocesser: psykoterapi med torterade flyktingar / Lindgren, Lena; Movschenson, Paul. - Stockholm: Röda Korsets Center för torterade flyktingar i Stockholm; Stockholm Universitet. Pedagogiska institutionen, 20010000. - 59 p.

Evidence of torture: a study of Pakistani torture survivors coming to the UK / Salinsky, Mary. - London: Medical Foundation for the Care of Victims of Torture, 20010000. - 104 p.

Torture as tort: comparative perspectives on the development of transnational human rights litigation / Scott, Craig (ed.). - Oxford: Hart, 20010000. - xliii, 731 p.

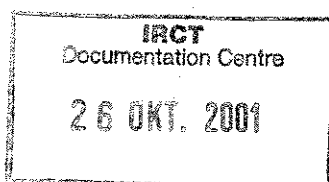
Los derechos humanos en el estado de Oaxaca: segundo informe / Red oaxaquena de derechos humanos. - Oaxaca [Mexico]: Red oaxaquena de derechos humanos, 20010100. - 86 p.: ill. - Los derechos humanos en el estado de Oaxaca / Red oaxaquena de derechos humanos; no. 2.

Protectors or pretenders?: government human rights commissions in Africa / Human Rights Watch. - New York: HRW, 20010100. - xvii, 407 p.: ill.

Brain function in a patient with torture related post-traumatic stress disorder before and after fluoxetine treatment: a positron emission tomography provocation study / Fernandez, Manuel; Pissioti, Anna; Frans, Örjan; Knorrning, Lars von; Fischer, Håkan; Fredrikson, Mats. - In: Neuroscience letters, no. 297. - 20010102. - p. 101-104.

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