The Quebec Adolescent Refugee Project: Psychopathology and Family Variables in a Sample From 35 Nations.(Statistical Data Included)

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Objective: This study presents the results of a psychiatric epidemiological survey using a sample of adolescents from refugee families. Method: The sample included 203 adolescents, aged 13 to 19 years, coming from 35 countries. Psychopathology was assessed with the Diagnostic Interview Schedule for Children Version 2.25 and general functioning with the Children's Global Assessment Scale (CGAS). Results: The total rate of psychopathology excluding simple phobia was 21% compared with 11% in a province-wide survey of young adolescents. Overanxious disorder had a high prevalence of 13%. The rates of major depression and conduct disorders were also high, at 5% and 6%. The rate of 3% of attempted suicide was similar to the rate found in Montreal high schools. Girls had a higher rate of psychopathology than boys, with a gender ratio similar to the one found in the provincial survey. Father's long-term unemployment in the first year of settlement was associated with psychopathology for the whole sample, and family structure was associated with psychopathology for boys only. Conclusions: The high rate of psychopathology in this group confirmed results from other surveys with similar samples. On the other hand, the CGAS scores indicated that many of the adolescents with a diagnosis had good social adaptation.

Key Words: refugees, adolescents, psychiatric epidemiology, resettlement.

This research grew from concerns voiced by community groups across Canada regarding the mental health and adaptation of adolescents from refugee families (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988). This Task Force also raised some questions concerning the facilitation of adaptation of refugees in nonmetropolitan communities and the impact of the age of arrival in the new country. Canada has also received refugees from a large number of nations, and this context provided an opportunity to complete an epidemiological survey on a sample of refugees from 35 nations. The second part of this article examines the family variables associated with psychopathology on the assumption that conditions of life after arrival in a new country have more influence on mental health than those encountered before arrival (Beiser, 1987).

Some studies have reported a decrease in prevalence of various diagnoses with the length of stay. A study of a Southeast Asian sample in the western United States has shown that after a 6-year follow-up, there was still a high rate of posttraumatic stress disorder (PTSD) but a sharp decrease of depressive and anxiety states (Sack et al., 1993, 1994). In the earlier survey, more than two thirds of the sample had a diagnosis; PTSD, major depressive disorder, and generalized anxiety disorder were the most prevalent (Kinzie et al., 1986; Sack et al., 1986). In an Australian longitudinal study, the symptoms of Vietnamese refugee children decreased to the level of local children only 2 years after arrival, repeating the results of a Canadian study on Southeast Asian adults (Krupinsky and Burrows, 1986).

Most other studies of refugee adolescents were descriptive and relied on convenience samples using a single cultural group (Hicks et al., 1993). Two studies conducted on samples of adolescents and young adults, one with Southeast Asians from the United States (Muecke and Sassi, 1992) and the other with Chileans from Sweden (Hjern et al., 1991), found these groups to be at high risk for emotional distress compared with local samples. In the last study, conducted shortly after resettlement, persecuted children fared worse than spared children within the refugee population.

Concerning family variables, there has been no study on the effect of parental separation on the mental health of refugee children. Since the review of Emery (1982), it has been known that the family climate is a better predictor of children's mental health than the family's marital status. There has been a long debate with no definitive answer, however, about whether divorce has more negative effects on boys than on girls, and most studies were completed with white middle-class samples (Amato and Keith, 1991).

The lack of mastery of one of the official languages of the host country by the parents may have an indirect effect on the

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mental health of refugee children. It could produce more intergenerational value conflict, an issue already well documented (Rosenthal et al., 1988). On the other hand, mastering an official language of the host country, by increasing the parents' social integration, can be a protective factor for the children (Rumbaut, 1991).

To sum up, this study is centered around 4 questions:

1. What is the prevalence of psychopathology in adolescents from refugee families in Canada, a country with a liberal policy of entry? Do rates differ according to the cultural area of origin?

2. Is the age of arrival in Canada associated with psychopathology?

3. Are the rates of morbidity higher in a metropolitan than in a nonmetropolitan area?

4. What family variables are associated with psycho-pathology after arrival?

METHOD

Sampling

There is no available list of refugees in Canada. In the annual reports of Citizenship and Immigration Canada, refugees are distributed in 3 categories of similar size: government-sponsored, privately sponsored, and individual claimants. In addition to these categories, many persecuted persons have chosen to obtain citizenship through the normal process of immigration, often through a third country. Montreal has recently received many individual claimants from a wide range of countries, especially from Eastern Europe and sub-Saharan Africa. Accordingly, the population of refugees in Quebec is divided among many cultural groups with a low demographic density.

High school lists were used to build the sample. In Quebec, attendance is compulsory until the age of 16. Adolescents from refugee families are older, on average, when they graduate from grade 11 either because they have missed school during or before exile (Sack et al., 1986) or because of the transition year needed to learn French. Because of the delay in obtaining permission from school authorities, we used names provided by ethnic cultural organizations; these accounted for the first 10% of the sample. The families were contacted by the organizations for ethical reasons. These results were not different from those of the rest of the sample.

We used school registration lists from the beginning of the academic year, which included dropouts of the current year. The lists provided the father's country of birth, and we contacted all students from countries where there had been a civil war recently.

The students were reached by telephone after being sent a letter describing the purpose and nature of the project. The call confirmed that the parents had obtained refugee status or had entered the country mainly for political reasons. All students meeting this criterion were included in the final sample.

The sample covered 3 Montreal schools in 3 separate districts as well as 2 public suburban Catholic school commissions, Ste-Croix and Longueil. In the nonmetropolitan area, the sample included the cities of Trois-Rivieres, Sherbrooke, and Quebec. The minimal period of residence for inclusion was set at 3 years.

We used 465 names from the original lists to construct a sample of 321, leaving 144 names not meeting the selection criteria. A total of 210 interviews was completed, 161 in Montreal and 49 in the nonmetropolitan region. The refusal rate was 34% (111/321) and was evenly distributed in and out of Montreal and among the various ethnic communities. The main reasons for refusal were lack of time, lack of interest, and absence of parental permission. Seven interviews of the 210 completed were excluded because the family did not meet the criteria of refugee, contrary to the preliminary information obtained by telephone.

The final sample included 98 boys and 105 girls. The mean age was 15.7, and 91% were between the age of 14 and 19 years. The average number of children in the family was 3.1, about twice the Quebec provincial average. Thirty-five

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countries of origin were represented. El Salvador (32), Cambodia (25), Laos (18), Iran (17), and Vietnam (16) and the regions of Southeast Asia (59) and Central America (54) had the highest number.

All adolescents except 2 were single. Twenty percent lived with a nonnuclear member of the family at home, mainly a grandparent or an aunt, and usually not on a permanent basis. Only 7% were born in Canada, and more than 70% arrived after the age of 6.

The level of education was higher for fathers than for mothers, with 55% and 40%, respectively, having reached a postsecondary education. There was a high rate of professional downward mobility among fathers. The percentage in the category of management/professional fell from 37% in the country of origin to 11% in Canada. The rate of nonemployment among fathers, which included a few retired and handicapped men, was 37%. The rate of unemployment was around 11% in the province during that period and was probably much lower in families with adolescents. Another important characteristic was the high percentage of mothers (58%) and fathers (48%) unable to communicate easily in either French or English. Two thirds of the families were intact, one quarter was headed by a single parent, and the remaining were reconstituted. Death or disappearance of the father accounted for 35% of single-parent families. In 10 other single-parent households, the biological father had never lived with the mother. Finally, 4 fathers of intact families were working abroad.

Instruments

Diagnostic Interview Schedule for Children Version 2.25. The French translation of the Diagnostic Interview Schedule for Children Version 2.25 (DISC-2.25) was used to assess DSM-III-R diagnoses during the previous 12 months. This instrument had been validated on the French child and adolescent population for the Quebec Child Mental Health Survey (QCMHS) (Breton et al., 1995). It has been tested in different versions and shown to have good validity and reliability (Schwab-Stone et al., 1993; Shaffer et al., 1993). This survey was conducted on a random community sample covering the province of Quebec, and we used the 13- to 14-year age group for comparison (Breton et al., 1999). The following diagnoses were included: simple phobia (SPh), overanxious disorder (OAD), generalized anxiety disorder, major depressive disorder (MDD), dysthymia (DYS), and conduct disorder (CD). Additional probing to each positive answer helped to confirm the presence of a symptom, because rates of symptoms tend to be inflated in some Latino groups (Angel and Guarnaccia, 1989). We did not assess PTSD as a majority of this sample had not been directly exposed to war violence.

Children's Global Assessment Scale. The Children's Global Assessment Scale (CGAS) was used to assess the lowest level of functioning during the past year (Shaffer et al., 1983). The score was based on information collected with 3 semistructured interviews - the Life Events and Difficulties Schedule (LEDS) (Brown and Harris, 1978), the Childhood Experience of Care and Abuse (CECA) interview (Bifulco et al., 1994; Bifulco and Moran, 1998), the Self-Evaluation and Social Support Schedule (SESS) (Brown et al., 1990) - and the section on antisocial behavior of the DISC-2.25. The LEDS investigates actual difficulties with family, school, and peers; the CECA provides a good description of family functioning; and the SESS assesses perception of social and family functioning. There was also some information in this material on the quality of coping. A score was first attributed jointly by the main author and a research assistant, and this score was later confirmed or corrected by a consensus group including 4 interviewers with training in clinical psychology. No independent reliability study was done.

Family Variables. The number of family living arrangements and changes of residence of more than 3 months were computed for each respondent.

[TABULAR DATA FOR TABLE 1 OMITTED]

The father's work status was assessed at the time of the interview, and we also asked whether there was a period of unemployment of more than 6 months during the first year of settlement. The mother's unemployment status was not investigated because half were not in the labor force and not looking for work. Three categories were used to compare professional level before and after exile according to the nature of the tasks performed and the level of decision-making.

A parent was judged fluent in French or English if able to converse in either of the 2 languages.

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The nature of contain with members of the extended family included 3 categories: face-to-face contact; nonvisual contact, either through mail or by telephone; and absence of contact. Mother's isolation was assessed with 2 indicators, the number of conversations of at least 15 minutes outside home in a week and the number of visits received at home.

Procedure

All 7 interviewers were fluent in French and English, and some spoke either Spanish, German, Arabic, or Kinyarwanda. Any other language besides French was used mostly to verify information. A majority of the interviews in Montreal took place at the university and either at home or in a community center. The complete interview lasted from 2 to 4 hours, and a small incentive of $15.00 Cdn was offered. A consent form described the informants' rights and the confidentiality procedure. All interviewers except one, a doctoral candidate in qualitative sociology, had training in clinical psychology. Support and counseling were offered to informants in need of help.

Statistical Measures

The [[Chi].sup.2] test with the Yates correction was used with dichotomous variables, and the 2-tailed Student t test with continuous variables.

RESULTS

We present 2 estimates of the total prevalence, 1 including and 1 excluding SPh (Table 1). The female rate of SPh was much higher in this sample (27.6%) than in the QCMHS (18.9%) or than the rate of 2% obtained with the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) in the United States [TABULAR DATA FOR TABLE 2 OMITTED] (Lewinsohn et al., 1993). A decision was made to drop this diagnosis from further comparisons because of its positive CGAS score (Table 2) and findings from other research (Bird et al., 1988; Costello et al., 1993). Our concern was that the inclusion of SPh would decrease the association with the risk factors and make the identification of preventive targets more difficult.

The refugee sample obtained a total rate of psychopathology 1.8 times higher than the 13- to 14-year age group of the QCMHS study when SPh was excluded. The fact that the refugee sample was older was not a significant factor because rates were similar in the 3 age groups in that sample.

Unipolar depression (MDD+DYS) and CD rates were twice as high in the refugee group than in the QCMHS group. OAD, relatively low in the QCMHS group, rose to 12.8% in the refugee group, accounting for a large part of the difference in the total rates. One of 4 refugee girls had a diagnosis of SPh, 1.5 times the rate of the female QCMHS group. The number of suicide attempts over the previous 12 months was 7 in the refugee group.

Girls had a higher prevalence than boys for all diagnoses except CD. The difference was only significant, however, for OAD and SPh. The girl-boy ratio of 1.75 in the refugee group was slightly greater than that of 1.58 in the QCMHS group. The CGAS scores did not reflect the gender discrepancy in the diagnoses. More boys (16.3%) than girls (12.4%) had a CGAS score of less than 61.

With the exception of the Middle East group, which had a lower rate of psychopathology (16.4%), the other regional rates were similar, ranging from 23. 1% for Southeast Asia to 26.7% for South America. El Salvador and Cambodia, the 2 countries with the highest number of informants, had a rate of 25% and 28%, respectively, which was in the high range but not much above average. The exclusion of SPh mainly decreased the Southeast Asian and South American rates and produced no change for Eastern Europe.

The CGAS scores were similarly distributed among the regions. The Middle East group had a high percentage of 88% in the "well adapted" category, and only 6 percentage points separated the other 3 groups. Moreover, psychopathology was not associated with residence in a camp during exile.

With regard to the second question, there was no difference between the metropolitan and the nonmetropolitan area in the total rate of diagnoses or in the CGAS scores. The nonmetropolitan area was favored by the exclusion of SPh

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because it included a higher proportion of girls from Southeast Asia.

As for the third question, the age of arrival in Canada was not associated with psychopathology. In fact, those who had arrived after their sixth birthday had a slightly lower rate than those who had arrived before.

The fourth question is related to the post-exile family variables (Table 3). The girls' mental health was not associated with post-exile family structure. Parental separation was, however, associated with the boys' mental health. The rate of psychopathology for boys was 5 times lower if living with both biological parents than if living in other family arrangements. Boys with a diagnosis also experienced a significantly greater number of changes of family structures than boys without a diagnosis (t = 4.32, df = 96, p [less than] .001). The number of residences since birth was also significantly greater for boys with a diagnosis than for boys without (t = 3.46, df = 96, p [less than] .001).

None of the indicators related to parental socioeconomic status, such as education, unemployment, and downward professional mobility, was associated with adolescent psychopathology. The presence of a period of unemployment of more than 6 months during the first year in Canada was associated with adolescent psychopathology ([[Chi].sup.2] [1, N = 119] = 6.87, p [greater than] .01), but the father's actual work status was not. The unemployment variable was significant for both sexes.

TABLE 3

Twelve-Month Rate of Psychopathology and Family Structure

	Girls		Boys	
Family Structure	**%**	**Cases/N**	**%**	**Cases/N**
Two parents	**29**	**16/55**	**4**	**2/47(**)**
Single	**29**	**5/17**	**17**	**4/23**
Reconstituted	**14**	**1/7**	**40**	**4/10**

**** p [less than] .01.**

The indicators of parental social integration were not associated with psychopathology. Neither the absence of membership in a cultural organization nor the lack of mastery of a host culture language led to greater psychopathology in the children. Children from families with no kin contacts had more psychopathology, but the size of this group was small. Only 1 of the 2 measures of mother's isolation, the number of home visits, was associated with psychopathology.

In summary, the 2 main variables associated with a psychiatric diagnosis were parent marital status, but only for boys, and a period of 6-month unemployment for the father during the first year of arrival. Indicators of parental social integration had no contribution except for one measure of mother's social isolation.

DISCUSSION

The high prevalence of psychopathology in this adolescent sample from refugee families confirmed other reports of high rates (Kinzie et al., 1986; Muecke and Sassi, 1992; Sack et al., 1986) but failed to show that symptomatology would reach the level of the children of the host culture 2 years after arrival (Krupinsky and Burrows, 1986).

SPh and OAD were the diagnoses with the largest difference with the Quebec survey. More than a quarter of the girls in the refugee sample had SPh. The rate found in the United States with the K-SADS was only 2% (Lewinsohn et al., 1993). This large discrepancy may indicate a need for more investigation of the validity of this diagnosis (Bird et al., 1988; Costello et al., 1993). That SPh was mainly prevalent among Southeast Asian girls may indicate that SPh could be associated with PTSD.

The rate of suicide attempts of 3% was similar to that found in Quebec with a sample of Montreal adolescents, but lower than the rates found in multicultural schools in this study (Tousignant et al., 1993).

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The prevalence of CD among boys was 9%. Few of these adolescents mentioned belonging to organized gangs, and their crimes were usually committed alone or with 1 or 2 friends. The interviews showed a lack of parental control, especially in single-parent families. The worst cases had a comorbidity with depression and presence of a suicide attempt or serious suicidal ideation. At least 2 had been previously arrested but none had been sentenced or had received treatment.

Family income was higher in the QCMHS study than in this study, but the QCMHS survey did not find family income below the poverty line to be a significant factor associated with psychopathology. A recent Canadian national survey also found that poor new immigrant children reported no more symptoms than nonpoor Canadian-born children (Beiser et al., 1998).

More than 60% of adolescents with a diagnosis, with the exception of SPh, had a score of 70 or below on the CGAS, reflecting moderate to high impairment. Overall, those with CD, MDD, or DYS were socially impaired. Those with OAD had better social functioning. In another study, a group of Cambodian students with PTSD were also doing well in school (Sack et al., 1995).

The reason for the high rate of OAD in this sample may be its possible association with PTSD. Children, however, do not usually experience as many violent incidents as their mothers, at least among those coming from Central America (McCloskey et al., 1995). But OAD in the children may be related to the level of parental anxiety consequent to their war experiences. Qualitative and anthropological research is needed to determine whether OAD items are correctly understood by all informants.

The differences between cultural regions were minimal. The high rates of psychopathology from Latin America and Southeast Asia make sense when considering the political events shared by both groups. In the Eastern European group, most of the families were Polish and had fled the persecution of the Solidarity movement. The high alcoholism rate of 50% among fathers likely contributed to making the children vulnerable.

The adolescents who arrived in Canada after their sixth birthday did not show more psychopathology than those who had come before or those born in Canada. This subgroup included many families from Southeast Asia, and a previous study had also found a high rate of chronic psychopathology in a Southeast Asia sample (Sack et al., 1994).

There was no advantage in residing in a nonmetropolitan area. There were significantly more girls than boys outside of Montreal, but correcting for gender decreased the prevalence in the nonmetropolitan area by only 1%. There were also more intact families outside of Montreal. The opinion of the second author from Rwanda, with extensive periods of residence in the 2 areas, was that adolescents faced less racist attitudes outside of Montreal but in counterpart were subjected to greater pressure to conform to their own cultural group.

The fourth question dealt with the postexile family variables. The effect of single parenthood was observed for boys only. We propose that single mothers in refugee families have more difficulty in asserting authority on male adolescents because they come from traditional cultures. Our interviews provided numerous examples of how the single mothers' authority is undermined when their sons socialize in school and with their peers. This process may also date back to the refugee camps, where anomic conditions sometimes prevailed. Another explanation is the conflict with a mother's boyfriend.

A more than 6-month period of unemployment for the father during the first year of immigration to Canada was associated to actual psychopathology in both sexes. This long period of inactivity comes during a period when the parents are more exhausted and more anxious about their capacity to integrate (Murphy, 1955). Any chronic and severe adversity during this time can shatter the parental self-confidence and have long-term consequences on the family climate. This result supports the idea that the early settlement period is critical for the future adaptation of the whole family. Likewise, a prospective study in Hawaii showed that father's unemployment during childhood was predictive of behavioral problems at age 18 (Werner and Smith, 1982).

We could not demonstrate an effect of the father's downward mobility. But there were too few fathers maintaining a high or moderately high status for a comparison group.

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Limitations

One limitation of the study is the rate of refusals of approximately one third. There is a hint that adolescents with less interest in the study had fewer personal problems, as previously observed in another study (Tousignant et al., 1993). Because we used schools roles at registration, we reached dropouts of the current year but not those who had left school after reaching age 16, a bias which can decrease the rate of psychopathology. On the other hand, Canada refused few applicants for refugee status from 1980 and 1990 and families were likely to be less vulnerable than in other host countries with more stringent rules.

There was no other source of information than the adolescent report. On the other hand, the CGAS score did not rely on the adolescents' perception but on a consensus group of 6 persons.

The gender effect of the father's absence should not be generalized to other cultural minorities and immigrant groups. We need to know whether the vulnerability factor for boys is the absence or the death of the father or the presence of another father figure in the family.

Clinical Implications

Adolescents from refugee families should be the focus of more clinical attention in school. The LEDS asked about mental health consultation over the previous 2 years, and no more than 3 informants had received psychological help. There is also a need to understand both at a clinical and at a cultural level why SPh and OAD have such a high prevalence.

The rate of CD cases among this refugee sample is a source of concern for clinicians, considering that 85% had a score of 60 or below on the CGAS. Given the negative long-term prognosis of CD, it would be worthwhile to focus preventive efforts around this issue.

The results also indicate the importance of the first year of settlement. There should be a special effort from community mental health practitioners and community groups to reach out to families with difficulties during that period.

Conclusion

We believe that the mental health of adolescents from refugee families is an important issue to be tackled by community groups, school authorities, and the families themselves. This issue has been brought to the attention of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1989), and we have found that there is some basis for this concern.

On the other hand, there is no need for alarm at present. Many of the mental health problems identified are far from being severe cases needing expensive, long-term treatment. The social impairment was often minimal as illustrated in the cases of SPh and OAD, and the costs to society in terms of academic achievement and future adaptation to the labor market may not be high.

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