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PROBLEMS OF ASIAN CHILDREN IN A REFUGEE CAMP.(U)
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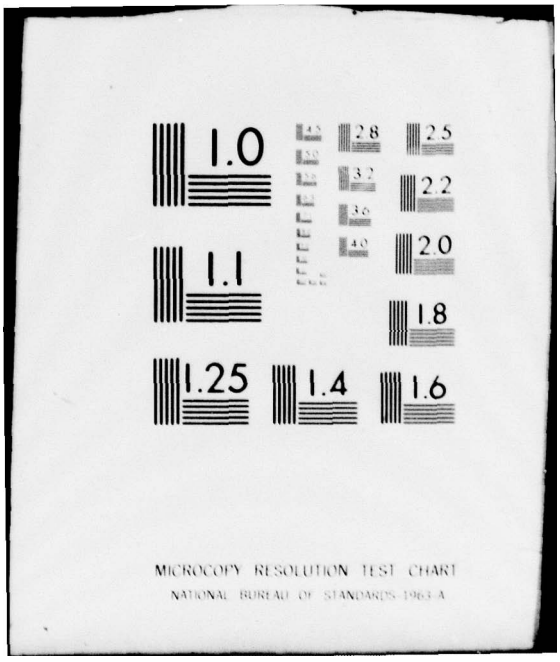
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PROBLEMS OF ASIAN CHILDREN IN A REFUGEE CAMP

LEVEL II

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J. G. LOONEY

REPORT NO. 76-28

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NAVAL MEDICAL RESEARCH AND DEVELOPMENT COMMAND
BETHESDA, MARYLAND

Abstract

The report documents the intervention carried out by two child psychiatrists in order to meet the mental health needs of Vietnamese children and their families in a large refugee camp. The strong support provided the children by the multigenerational Vietnamese families is illustrated. Children separated from their families demonstrated increased emotional vulnerability and foster placement of children without families presented a serious problem. The authors fear that our national commitment to these refugees may have ended when they left the confines of the refugee camp.

Revised version of paper presented at a Special Session, "New Americans: Southeast Asian Children and Their Families," held at the Annual Meeting of the American Psychiatric Association, Miami Beach, Florida, May 1976.

Problems of Asian Children in a Refugee Camp*

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and

John G. Looney, M.D.[2]

In April 1975 the Thieu Government of South Vietnam capitulated to the North Vietnamese, and masses of Southeast Asian people fled their country to begin new lives in American refugee camps. Sadly, being a refugee has been a common experience for man. There have been numerous accounts since antiquity of people fleeing their homelands after the collapse of the established social order. A United Nations Report (1) estimates that in a recent period, 1945 to 1969, 45 million persons have been denied residence in their homelands. During 1968 alone, 7 million people were considered international refugees (2).

Since World War II refugees have been studied by numerous authors who have noted their increased incidence of mental disorders (3-11). Psychological problems for refugees are increased when the period between immigration and definitive resettlement is protracted (9,12), or when the group cohesiveness is interrupted (13,14). The first several years following migration have been noted to be particularly stressful (6), with problems being accentuated when refugees are culturally and racially dissimilar to the indigenous population (15). Successful adaptation in the host country has, in some cases, been unconsciously sabotaged by failure to learn the new

language (2). Those isolated because of a language barrier have been noted to have increased insecurity and anxiety (16) comparable to the feelings of isolation and mistrust experienced by individuals with increasing deafness (14). Such feelings of isolation may be at least a partial cause of paranoid reactions so frequently noted in the literature on refugees (5,11,14,17-19). Other reasons suggested for the increased incidence of mental illness in refugees are: 1) decreased social status, 2) loss of individuality incurred by becoming part of a mass refugee group, and 3) the actual stress of the experience of flight (11).

Unfortunately, little systematic attention has been given to the effects of involuntary migration on youth. Thus, the focus of this paper will be on youth and will: 1) note the capability of Southeast Asian children to cope with stresses of migration when supported by their families, 2) note, by contrast, the vulnerability of children separated from families, 3) note, retrospectively, impediments to optimal handling of problems of high risk children without families, and 4) make suggestions about follow-up support for these children.

Initial Consultation and Recommendations

In April 1975 the first refugees arrived in California and established temporary residence in a tent city hastily built and equipped for them in the stark hills of Camp Pendleton Marine Corps Base.[3] Although the Medical Corps of the Navy undertook the task of meeting the physical health needs of these refugees, civilian camp administrators initially failed to involve mental health professionals in any planning, consultation, or service delivery

Camp Pendleton Marine Corps Base. At the request of the Department of State,[3] the Marines had, almost overnight, erected and equipped this living facility for 20,000 people. The Medical Corps of the Navy undertook the similarly enormous task of meeting the physical health needs of these refugees. An unintentional oversight was the failure of civilian camp administrators initially to involve mental health professionals in any planning, consultation, or service delivery capacity. This oversight became apparent when a report appeared in the press quoting a Vietnamese religious leader predicting mass suicides among the refugees. It was at this point that a team of military mental health consultants[4] was asked to evaluate and make recommendations concerning the mental health status of the refugees at Camp Pendleton. One of the authors, Dr. Looney, a child psychiatrist, was among the four mental health professionals of this team.

The team spent a week talking with the Vietnamese and Cambodian people and paid particular attention to family structure and the status of the children. There was some initial difficulty comprehending Vietnamese linquistic expressions of emotional distress (25) even through an interpreter. Information was gathered from a large number of refugees, including their political leaders and physicians. Navy physicians, Marine Corps personnel, and a variety of volunteer workers were also interviewed. The team was unable, however, to establish a dialogue with the State Department officials at the top of the intra-camp administrative hierarchy, and as will be noted, this failure may have played a key role in the later development of problems.

Generally, the mental health status of refugees of all ages was good.

There was no evidence of impending mass suicide, little evidence of morbid grief states, and no observed or reported psychotic disorders.

The camp was teeming with youngsters; children and adolescents constituted 75% of the refugee group. The team was impressed by the Vietnamese youths' strong sense of family solidarity. Large multi-generation families, some with as many as 30 members, were the rule, and family members provided each other with strong emotional support. Teenagers, who were busy helping with the care of their younger siblings or aged relatives, expressed a sense of importance and usefulness. This sense of purpose seemed to help mitigate against the development of boredom and its sequelae -- antisocial behavior.

The consultation team observed a number of important positive findings related to these youths. First, the children appeared well-nourished and well-developed. With the exception of enteric parasites, there was no evidence of chronic disease or deficiency states. Secondly, younger children appeared in extremely good spirits; they were vivacious and outgoing, interacting freely with their American hosts. Laughter was heard everywhere. It was almost as if the children were on a camping expedition with their families. In addition, most of the children were straining to improve their communication skills by participating in Red Cross English classes. Even the preschoolers practiced saying, "Good Morning," "Hello," and "Goodbye." The teenagers also appeared in good spirits and expressed optimism about entering American society and showed keen interest in American music, hair styles, and teenage customs. The older adolescents were more optimistic about the new life ahead of them than were the younger adolescents who more acutely missed their friends in Vietnam.

Initially only a few problems were identified. Since the children did not have adequate footwear for cold days, their play was restricted to their tents. There were few toys and educational devices available, and there were few formally organized activities, such as day care centers, nurseries, schools, or athletic activities. Two adolescents who were without families were found. They stated their families had provided a way for them to escape to a "better life." Their parents had contracted with a refugee family to bring them to America. The boys presented a front of false bravado behind which lay fear and depression. They stated there were other teenagers in the camp in a similar predicament.

The consultation team made a series of recommendations regarding primary, secondary, and tertiary preventive measures, and it was generally felt that these measures decreased problems for the refugees. It is beyond the scope of this presentation to detail the many recommendations made. However, one important recommendation was made with regard to the children who were without families. Recognizing that these children were at high risk, the team emphasized the importance of maintaining them with their unofficial foster families. It was specifically suggested that these children be able to leave the camp and remain with these unofficial foster families unless their relatives could be found.

The Problem of Children without Families

Four months after the arrival of the first refugees at Camp Pendleton, over 20,000 Vietnamese had been placed with American sponsors. Small families and those containing members with valuable occupational skills were the

first to leave. Refugees with large families had the greatest difficulty finding sponsors. Heads of large families came forward and stated that some children who had been with them since leaving Vietnam were not related to them. They felt that by decreasing the size of their family their chances of finding a sponsor would be increased. These families were allowed to extrude these unrelated children, and, thus, an increasing pool of children without families became apparent. It was estimated that there were 500 of these children in camp.

These children without parents were divided into categories according to the degree of affiliation they had with some family within the camp. Children who entered the camp without any relatives or friends were cause for the greatest concern. These "unaccompanied children" who ranged in age from 18 months to 18 years had the greatest need for social and psychological supportive care. Within this group there were four boys for every girl, and the children's backgrounds varied from illiterate servant status to the most privileged class. Initially many of these children were reunited when parents or relatives were located in other camps. However, as time went on, it became evident that a good number of these children had no relatives outside of Vietnam. These high risk children were assigned to a special facility run by Red Cross workers, missionaries, and a Boy Scout leader who were to provide care until placement could be made or relatives located.

Dr. Looney, in his continuing role as consultant in child psychiatry, and the Chief Pediatrician[5] evaluated the status of these children and found many of them to be significantly depressed. Somatic complaints were the most

prevalent expression of distress. In addition, sleep disturbances, tantrums, violent antisocial behavior, and marked withdrawal were apparent. The children's pessimism was also manifested by their refusal to learn English. Being thrust together caused these children to potentiate each other's sadness and hopelessness.

Noting the resemblance of the unaccompanied children's facility to a psychiatric ward, the evaluating physicians recommended the employment of a team of skilled mental health professionals from several disciplines to be headed by a child psychiatrist. Although the State Department camp administrators showed interest in the recommendations, no implementation of such a plan was made until after two serious incidents had occurred: One in which a 14-year-old boy had lacerated his wrists and another in which a girl had had a psychotic episode. The urgency of the recommendation then became apparent, and one of the authors, Dr. Harding, a child psychiatrist on active duty with the Navy, was asked to assume full-time responsibility for the facility. From the beginning the camp administrators showed mixed feelings about having a mental health professional involved,and he was asked not to wear the military identification badge which designated him as a psychiatrist. It was made quite clear that the existence of the children's emotional problems was not to be brought to the attention of the press.

Two clinical vignettes are presented to give insight into the types of children who were included in this group.

A Transient Psychosis

R was a 14-year-old boy who, among the group, appeared the most

disturbed. He was distant and emotionally uninvolved with the other children and the staff. He was seen posturing and staring, and he appeared to be having auditory hallucinations. On one occasion he attacked a staff member with scissors without provocation. In addition to the ministrations of the staff, an older Vietnamese boy, the most mature of the group, spent additional time with him and he succeeded in making emotional contact with R. Gradually, R was brought into the group activities. This child, who had been seriously considered for hospitalization, became pleasant and affectively appropriate. His withdrawal ceased and for the remainder of his time at Camp Pendleton, and after placement, he had no recurrances of psychotic behavior.

The Manipulator

B was a bright and appealing 13-year-old boy whose parents had not made it out of Vietnam. He had obviously learned to fend for himself in Vietnam for as he moved across the Pacific he charmed stewardesses and other Americans. He soon devised a successful plan for getting rich quickly. His plan was to write to previous contacts and state that he had no shoes and little food. Then, when a letter with $10 to $20 would return, he would write again and say that the letter had never reached him. Back would come another $10 or $20 as well as, perhaps, a letter from a Congressman querying camp administrators about this child's deprivation.

Beneath his veneer of shrewdness was a depressed child in great need of approval. Once when seriously depressed he made a "tombstone" and placed it on the foot of his bed. While others read his epitaph, he lay quietly on his bed with arms crossed upon his chest. The tombstone read:

> Overcame hardship and arrived in California. Very tired of life and wanted to die. Who will build for me a monument after I die? Who will bury me? And who will say, 'I love you'? It should be remembered I loved girls best. I would like chicken and hamburgers to be served at the service in remembrance of me. This will help my soul come to heaven soon. I always remember my friends and family. Died

August 1975.

The current status of this child is unknown.

To care for the unaccompanied children a professional staff was assembled which included an experienced psychiatric nurse and specialists in children's recreational and occupational therapy, as well as an adequate number of dedicated child care workers. In addition, Vietnamese couples worked each shift, providing culturally familiar parental surrogates.

Gradually a supportive milieu evolved. Daily community meetings facilitated the children's ability to express their concerns. Recreational activities provided channeled physical outlets. Occupational activities helped to increase the children's sense of worth. Educational periods stressed practical skills such as how to use a city bus system or contact the police. Somatic complaints became almost nonexistent. Occasionally one of the children would say, "Doctor, me sick." and then burst out laughing in a parody of his previous state of distress.

Major problems developed regarding placement of the children. Previously the authors had made specific recommendations, suggesting that whenever possible the children should be placed with Vietnamese foster families and that group homes run by Vietnamese and supervised by mental health professionals should also be considered. It was also suggested that if neither of these resources were available, placement should be considered with Americans who had had cross-cultural experience and who would respect the child's cultural and religious background. The camp administrators, while

agreeing with these recommendations, stated that Vietnamese couples were not eligible for licensing as foster parents because of state restrictions. Arranging for group homes was made difficult because Congress had made no provision for continued funding after the initial crisis period. It was difficult to find American families with cross-cultural experience. Therefore, the authors were told the only option was placement with American foster parents through routine placement procedures.

The authors' suggestions for placement were essentially negated because a contract for placement of the children had already been established between the camp administrators and the Welfare Department of a California city. The welfare workers were encouraged by the administrators to carry out placements as rapidly as possible. The workers, not having had the experience of seeing the children's previously distressed states, viewed them as capable of rapid placement. The authors, on the other hand, felt that if placement with American families was the only option, it should be done in deliberate steps of gradual cultural integration. Despite the authors' efforts, it was made clear that the ultimate decisions about placement would be made by the administrators, and that a premium would be placed on speed.

Dr. Harding's task became that of helping the children adjust to the reality of the impending placements. The children's regressions and painful recurrances of earlier feelings of loss and isolation had to be attended. It was important to facilitate their expression of fears and fantasies of what would come and to minimize distortions about what they would face.

Placement Follow-Up

Despite the fact that symptoms demonstrated by several of the children

after their placement suggested that psychiatric evaluation and treatment might have been needed, the city's Welfare Department resisted efforts of interested psychiatrists in the community to be helpful. In addition, the foster parents were instructed not to utilize mental health professionals except those social workers within the Welfare Department. Fortunately, many of the children from the Center placed in American foster homes have done reasonably well. Placing the children in one city allowed them to maintain contact with friends they had made earlier. At first they appeared to cling to these attachments and failed to invest themselves in their new families. The girls, especially, clung to each other and frequently made telephone calls plotting how to get back together. In three cases, the foster parents were so threatened by these strong attachments that they rejected the children. Two girls had problems of a serious nature. One has been in five foster homes, has manifested severe withdrawal, learned little English, and has failed in school. The second girl made two suicidal gestures. However, after receiving counseling from a Vietnamese social worker and after being removed from an American home and placed with Asian-American foster parents, she has stabilized. Overall, the boys have shown a more satisfactory adjustment than have the girls. Unlike many of the girls they did not feel the need to maintain close contacts with the other children, and, thus, have been more successful in establishing friendships with American children. The fact that some of these boys came to America with the avowed purpose of seeking a better life may possibly explain their more aggressive attempts to integrate.

In Retrospect

In looking back at their experience, the authors were impressed with the adaptability of Vietnamese children who had families, but were also alarmed by the fact that the unaccompanied children's profound vulnerability was never really appreciated.

There were impediments to the optimal management of the psychological problems of the refugees, especially management of the problems of the high risk children. As mentioned, the failure to involve mental health professionals in the initial planning for the needs of the refugees was an original oversight. Therefore, from the beginning the civilian camp administrators and the mental health workers had difficulty establishing an effective working relationship. The fact that psychiatric consultation was requested only when it was feared that problems were already out of control only made matters worse. In a crisis situation so closely covered by the news media the administrators stated they wanted to avoid having the presence of mental health workers observed. The authors inferred by this that the administrators believed mental health problems would be seen as resulting from managerial inefficiency. In addition, the camp administrators and physicians, including the psychiatrists, had different orientations toward solving problems with the refugees. The administrators placed the highest premium on speed of placement. The physicians, on the other hand, stressed their concern about the quality of placement and about the need for continuing care after placement. Physicians, including the authors, became frustrated working in a system in which the ultimate authority for basic health care decisions rested with administrative directors. Perhaps, some of these problems could have

been minimized had the psychiatric consultation team been able initially to establish a dialogue with the camp administration. When a dialogue finally did take place it had been forced by the emergence of serious problems for which there were no adequate answers.

In reviewing problems of the unaccompanied children, it seemed clear that most of them should never have been severed from the unofficial foster families with whom they had been residing, and the families might have been given some incentive for taking the children out of the camp when they left. No serious attempts were made to solve the legal impediments to this placement procedure. These families might have been provided special follow-up support until optimal placement was decided. The establishment of a contract with a city Department of Welfare for rapid placement of these children with American foster families may have been, in the authors' opinions, a move in which administrative expediency outweighed concern for the youngsters' ultimate welfare. The fact that the Welfare Department personnel have subsequently minimized or denied the existence of some of the children's psychological problems remains an issue of major concern.

Conclusion

Nearly 100,000 Vietnamese children are in the process of becoming new Americans. The authors, after their experience at Camp Pendleton, were asked to become members of the Vietnamese Children's Resettlement Advisory Group,[6] a group of concerned mental health professionals who have sent to the Department of Health, Education, and Welfare, as well as to key Congressmen, specific recommendations for facilitating the integration of these

young people into our society.

Regarding the status of the unaccompanied children, it has been recommended that: (1) when appropriate these children be returned to their parents in Vietnam; (2) the legal status of these youngsters be clarified to make easier permanent adoptive placement if they cannot be returned to Vietnam; (3) continuing monetary support for long-term care be provided since these children will continue to be at high risk for psychiatric problems; and (4) the welfare of these children be overseen by a Federal agency.

At present no action has been taken at the Federal level to provide for any ongoing support for these Southeast Asian youngsters. The authors fear that our national commitment to them may have ended once they left the confines of the refugee camp.

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Footnotes

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[1]Dr. Harding is a Lieutenant Commander, Medical Corps, U.S. Naval Reserve, on active duty as a Staff Child Psychiatrist at the Naval Regional Medical Center, San Diego, California.

[2]Dr. Looney is a Lieutenant Commander, Medical Corps, U.S. Naval Reserve, on active duty as Head, Health Care Systems Branch, Naval Health Research Center, San Diego, California, and he is also a Clinical Assistant Professor of Psychiatry, University of California, San Diego.

[3]The resettlement of Southeast Asian refugees in America was supervised by a consortium of Federal (Department of State, Department of Health, Education, and Welfare, and Immigration and Naturalization Service), civilian, and military agencies. This consortium was called the Inter-Agency Task Force. The Department of State was the agency with ultimate authority within the Task Force. Thus, even though the refugee camp was within a military base, State Department administrators made final decisions.

[4]The Medical Director of the Refugee Unit at Camp Pendleton, California, requested the consultation team from the Naval Health Research Center, San Diego. The team was lead by Captain Richard H. Rahe, MC, USNR, a psychiatrist with expertise in the area of stress and illness vulnerability. The other members of the team were: Lieutenant Commander Looney; Captain

Hamilton I. McCubbin, MSC, USAR, a sociologist; and Lieutenant Commander Harold A. Ward, MC, USNR, a psychiatrist with expertise in public health administration.

[5]Lieutenant Commander Michael Sexton, Medical Corps, U.S. Naval Reserve, now on active duty as a Staff Pediatrician at the Naval Regional Medical Center, San Diego, was Chief of Pediatrics at the refugee camp while it was in operation.

[6]The Vietnamese Children's Resettlement Advisory Group is chaired by Dr. Edward Zigler, Professor of Psychology and Head, Psychology Section, Child Study Center, Yale University. This Group is supported by the Department of Health, Education, and Welfare and serves in an advisory capacity to that Agency concerning refugee children.

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20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

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