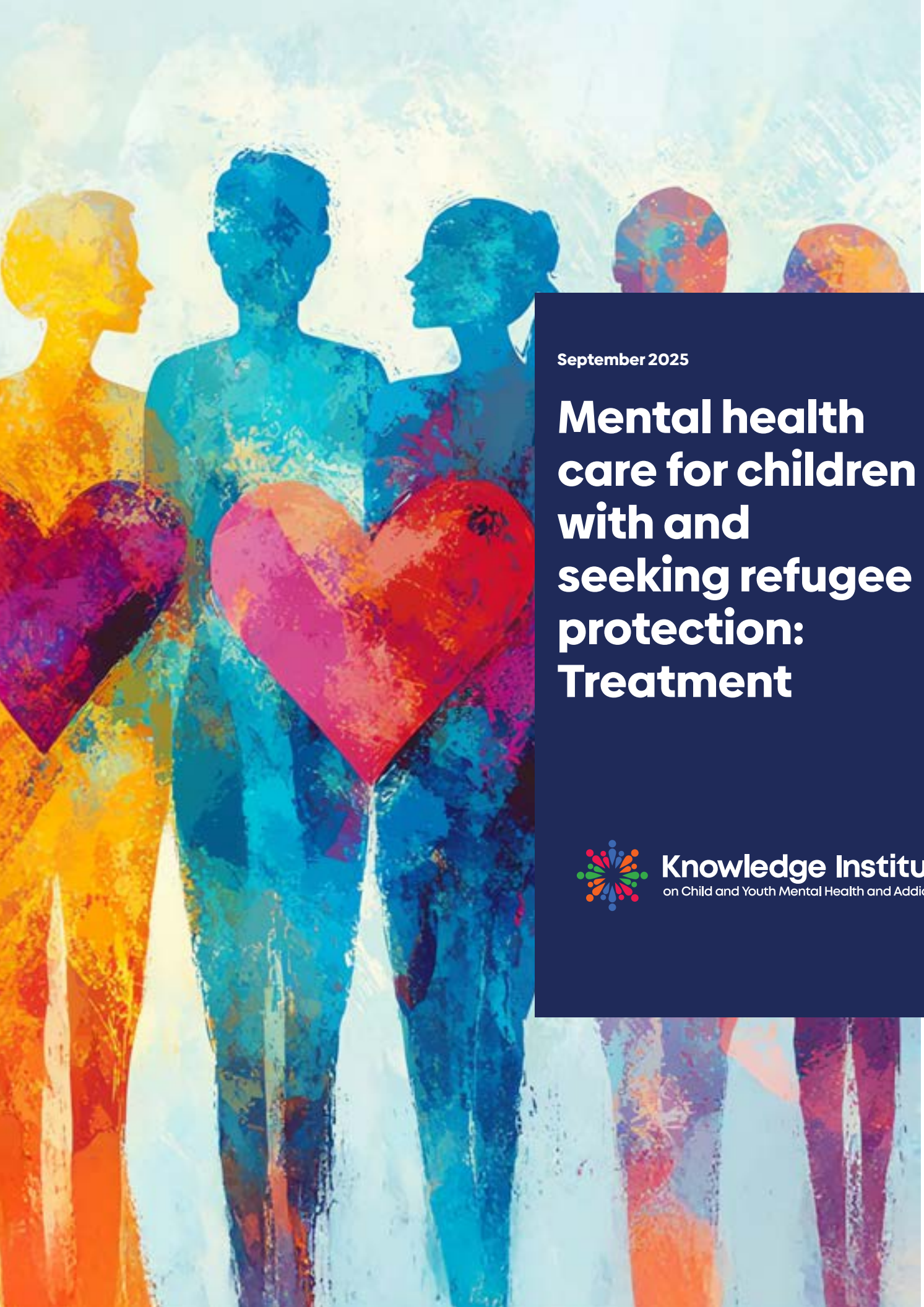

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Mental health care for children with and seeking refugee protection: Treatment

Knowledge Institute
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Table of Contents

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About this resource

Children with and seeking refugee protection have a high level of mental health needs, yet they are less likely to access and use mental health services. The resource series — Mental health care for children with and seeking refugee protection — provides evidence-informed guidance and key considerations to leaders and service providers, so they can responsively adapt the services that they provide and better support children with and seeking refugee protection to access the services they need. The resource series may also be helpful for others interested in learning more about the evidence behind mental health service delivery for children with and seeking refugee protection, such as young people, families, and partners from other sectors.

This resource – **Treatment** – is the third in a series of three. It describes key considerations for selecting and providing evidence-informed mental health treatment to meet the needs of children with and seeking refugee protection.

Check out the other resources in the Mental health care for children with and seeking refugee protection series.

- **Service delivery** provides an overview of foundational information to better understand the mental health needs of children with and seeking refugee protection, and key considerations for enhancing their access to and experiences of mental health care. It recommends additional resources, including services for children and families with and seeking refugee protection and training and guidance for mental health service providers.
- **Assessment** describes key considerations for conducting mental health assessments for children with and seeking refugee protection.

The resource series was created by conducting a rapid, non-systematic review of peer-reviewed and grey literature using various keywords and keyword combinations relating to children with and seeking refugee protection and mental health. We also incorporated relevant findings from consultations with experts in mental health services for children with and seeking refugee protection in Canada.

Children with and seeking refugee protection

In Canada, refugees are people who either have a well-founded fear of being persecuted in their country of origin because of their race, religion, nationality, political opinion, or membership in a particular social group (e.g., a group defined by gender or ethnicity), or who are at risk of torture, cruel, or unusual treatment or punishment (Government of Canada, 2001; Immigration and Refugee Board of Canada, 2021).

This resource focuses on children between the ages of seven and 17 because this is the age range of most of the research evidence on supporting the mental health of children with and seeking refugee protection (school-aged children). There is a lack of research on the mental health of children with and seeking refugee protection in early childhood, from birth to age six.

The term "children with and seeking refugee protection" emphasizes the right to protection and reflects how Canada's refugee system works. This term is rooted in the understanding that children with and seeking refugee protection have an active right to protection in Canada and the sector has an active role to play in helping ensure their protection (Schutte, 2023).

- **Children with refugee protection** have been determined to be refugees and have been granted protection.
- **Children seeking refugee protection** are in Canada or trying to enter Canada to seek safety because it is not safe for them in the country where they usually live. They may have asked the Canadian government to recognize them as refugees, but the Canadian government has not determined whether they are refugees.

Selecting and providing treatment

Narrative exposure therapy for children, trauma-focused cognitive behavioural therapy, and eye movement desensitization and reprocessing are evidence-based treatments, and research has shown that they can be effective for children with and seeking refugee protection (Velu et al., 2025). When available, develop and leverage partnerships with community representatives and practitioners who can support or provide culturally affirming care.

Narrative exposure therapy and narrative exposure therapy for children

Narrative exposure therapy (NET) is an evidence-based treatment for people who have post-traumatic stress disorder (PTSD) and experienced multiple potentially traumatic events. It was originally developed for adults living in refugee camps (Neuner et al., 2002, 2004) and is most frequently used with adults with and seeking refugee protection (American Psychological Association [APA], 2022a).

NET helps people to reinterpret and rewrite their life events into true but more life-enhancing narratives or stories (APA, 2022b). This is important because the story that people tell themselves about their life influences how they perceive their experiences and well-being. Framing one's life story only around traumatic experiences leads to distress (APA, 2022a). NET is based on the idea that people make meaning as the authors of their lives and can rewrite their life stories by learning to do three things (APA, 2022b).

- Deconstruct problems or events in their life story.
- See patterns in their ways of interpreting life events or problems.
- Reconstruct problems or events in a more helpful light.

Narrative exposure therapy for children (KIDNET) is an adaptation of NET for children ages eight and older whose mental health is affected by multiple and continuous exposure to traumatic stressors (Onyut et al., 2005; Schauer et al., 2017; Velu et al., 2022). It is commonly used for children experiencing trauma- and stressor-related disorders, including those with comorbid diagnoses (Fazel et al., 2020).

For practical guidance on using narrative exposure therapy with children and adolescents, see Schauer and colleague's (2017) handbook on narrative exposure therapy for children and adolescents (KIDNET).

There are three phases in KIDNET (Schauer et al., 2017).

1. Assessment and psychoeducation.
2. Lifeline exercise, where the child and therapist map the child's individual life history onto a timeline called a "lifeline".
3. Narrative exposure, where the child narrates their life story using the lifeline with the support of the therapist.

Evidence about KIDNET for this population

Seven studies have researched and evaluated the effects of KIDNET in treating children with and seeking refugee protection between the ages of eight and 17 (Velu et al., 2022), including four randomized controlled trials (Catani et al., 2009; Ertl et al., 2011; Peltonen & Kangaslampi, 2019; Ruf et al., 2010). All studies identified clinically significant improvements in functioning and PTSD symptoms after KIDNET (Catani et al., 2009; Ertl et al., 2011; Onyut et al., 2005; Peltonen & Kangaslampi, 2019; Ruf et al., 2010; Said & King, 2020; Schauer et al., 2004). Although some children reported that the process of reliving their experiences through KIDNET was challenging, they found the experience helpful and had low dropout rates, indicating a level of acceptability of the treatment for this population (Fazel et al., 2020; Said & King, 2020). No negative effects were observed, including no clinically significant worsening of symptoms (Ertl et al., 2011). Most children maintained treatment outcomes at 12-month follow-up (Ruf et al., 2010).

Adaptations

KIDNET has wide applicability (Fazel et al., 2020). It can be used with children and young people affected by different potentially traumatic events, with co-morbid diagnoses, and in different settings, including settings of ongoing difficulties and active danger (Fazel et al., 2020; Schauer et al., 2017). It can be combined with other treatments and adapted to individual children (Schauer et al., 2017). However, some components of KIDNET need to be kept the same (Schauer et al., 2017). Adaptations must use all three phases: assessment and psychoeducation, lifeline exercise, and narrative exposure (Schauer et al., 2017).

- NET for forensic offender rehabilitation (FORNET) is an official adaptation of NET that can be used with children associated with armed forces or armed groups (Fazel et al., 2020; Hecker et al., 2015; Koebach et al., 2021).[1]
- KIDNET can be adapted for those who are survivors of sexual abuse, those with autism spectrum disorder, and those who are unsure about treatment, but these are not official adaptations (Fazel et al., 2020; Schauer et al., 2017).

Trauma-informed cognitive behavioural therapy

For practical guidance on using trauma-informed cognitive behavioural therapy with children, see Kliethermes and colleagues (2017) and Cohen and colleagues (2017).

Trauma-focused cognitive behavioural therapy (TF-CBT) is a manualized treatment that was originally developed for children and adolescents who had experienced sexual abuse (Cohen et al., 2017; Uphoff et al., 2020). It is for children and young people ages three to 18 who have experienced trauma and are demonstrating trauma-related difficulties (Cohen et al., 2017; Kliethermes et al., 2017).

Evidence about TF-CBT for this population

Many studies have reported the effectiveness of TF-CBT to reduce trauma-related mental health difficulties in children from a range of cultural and ethnic backgrounds (Chipalo, 2021; Cohen et al., 2017). Among children with and seeking refugee protection, four studies found evidence that TF-CBT is effective with this population. Three of the studies were conducted in Germany and one in the United States, with participants originating from more than 21 countries (Chipalo, 2021).

- The studies reported significant improvements in PTSD symptoms as well as a significant reduction in PTSD cases after treatment (Schottelkorb et al., 2012; Unterhitzenberger et al., 2015, 2019).
- There was also evidence of depressive symptoms and behaviour problems decreasing and physical health problems improving significantly after TF-CBT (Unterhitzenberger et al., 2019).

1 "A child associated with an armed force or armed group refers to any person below 18 years of age who is or who has been recruited or used by an armed force or armed group in any capacity, including but not limited to children used as fighters, cooks, porters, messengers, spies, or for sexual purposes. It does not only refer to a child who has taken a direct part in hostilities" (UNICEF, 2007, p. 7).

- Improvements tended to be sustained at follow-up among most children, but there was some evidence to suggest that improvements from TF-CBT may not be sustained among children seeking refugee protection whose refugee claims are rejected (Unterhitzenberger et al., 2019).

Unaccompanied minors are children who are under the age of 18, not accompanied by a parent or legal guardian when they entered Canada, and do not have a parent or legal guardian in Canada (Immigration, Refugees and Citizenship Canada, 2023).

Adaptations

TF-CBT can be adapted generally for children with and seeking refugee protection and more specifically for those who are unaccompanied minors with few modifications (Unterhitzenberger et al., 2015, 2021).

For more information on adapting TF-CBT for children with and seeking refugee protection, including those who are unaccompanied and separated minors, see the following resources.

- A systematic review on the effectiveness of TF-CBT in reducing trauma symptoms among children with or seeking refugee protection (Chipalo, 2021).
- A case series on TF-CBT with unaccompanied children with and seeking refugee protection (Unterhitzenberger et al., 2015).
- Therapists' feedback on implementing TF-CBT with unaccompanied children with and seeking refugee protection (Unterhitzenberger et al., 2019).
- A pilot study on providing TF-CBT to unaccompanied children seeking refugee protection who have uncertain legal residence status (Unterhitzenberger et al., 2019).

Eye movement desensitization and reprocessing

Eye movement desensitization and reprocessing (EMDR) is an evidence-based treatment for trauma and PTSD (APA, 2025). It is based on the idea that people experience symptoms because their traumatic memories have not been adequately processed (APA, 2025). EMDR therapy aims to change how the memory is stored in the brain. During treatment, a client focuses on the traumatic memory while simultaneously experiencing left-right stimulation, for example, from moving their eyes left to right (APA, 2025).

For practical guidance on EMDR, see Shapiro (2017).

Evidence about EMDR for this population

Six studies have examined the effects of EMDR for children with and seeking refugee protection (Velu et al., 2025). All studies found reductions in posttraumatic stress symptoms after treatment (Banoğlu & Korkmazlar, 2022; Kuiper & Uriakhel, 2020; Lempertz et al., 2020; Oras et al., 2004; Perilli et al., 2019; Wadaa et al., 2010). Most children maintained treatment outcomes at three-month follow-up (Kuiper & Uriakhel, 2020; Lempertz et al., 2020).

Treatment approaches

Children with and seeking refugee protection often have complex needs, and so several approaches may need to be used together to comprehensively address their needs, strengths, and circumstances (Song & Ventevogel, 2020).

- Culturally responsive approaches, which tailor interventions to cultural identities.
- Developmental approaches, which tailor interventions to developmental stages.
- Family-focused approaches, which focus on the interrelationship between mental health, behaviours and family functioning.
- Gender-responsive approaches, which respond to differences based on sex and gender.
- Needs-based approaches, which identify specific needs and characteristics and tailor interventions to these needs.
- Trauma-informed approaches, which are sensitive to traumatic experiences and responsive to their effects.
- Strengths-based approaches, which build on strengths and assets developed in multiple contexts and environments.

When selecting an approach to use with children and families with and seeking refugee protection, it is particularly important to be sensitive to the aspects of their identity for which they may have previously been persecuted (such as race; religion; nationality; political opinion; membership of a particular social group, such as a group defined by gender or family structure). For example, a gender-responsive approach may be particularly appropriate for someone who has been persecuted based on their gender identity (United Nations Refugee Agency [UNHCR], 2022a/b).

Culturally responsive approaches

Culturally responsive approaches should be used to ensure that treatment is appropriate for the children's and families' cultural backgrounds (Ventevogel & de Jong, 2020). It is important to recognize that children and families with and seeking refugee protection have a vast range of cultural backgrounds and may perceive mental health differently depending on their cultures (Bhugra et al., 2021; Chipalo, 2021).

When determining what elements of a mental health treatment program should be culturally adapted for children with and seeking refugee protection, the Ecological Validity Model (Bernal & Sáez-Santiago, 2006) can be a useful framework (Wright et al., 2020). The model has eight dimensions delineating the program content that should be modified: language, persons, metaphor, content, concepts, goals, methods, and context.

Check out A guide to culturally adapting mental health and addictions programs to learn how the Ecological Validity Model can help you adapt programs for different cultural groups.

Here are some examples of strategies for adapting the persons dimensions and methods in the Ecological Validity Model for children with and seeking refugee protection. To adapt persons, be sensitive and respectful when talking about race, religion, nationality, political opinions, gender, and HIV status because they may have been persecuted for these reasons (Immigration and Refugee Board of Canada, 2021). When adapting methods, it may be relevant to integrate culture-specific grief rituals (Unterhitzenberger et al., 2021) or change the treatment location to the child's school. Research suggests that some children with and seeking refugee protection prefer to access mental health services at school over their homes, hospitals, and community-based settings because they think of schools as safe places (Fazel et al., 2016). Develop and leverage partnerships with community representatives and organizations to support the provision of culturally affirming care and, where available and relevant, facilitate children's connections to these partners.

Family-focused approaches

Consider using family-focused approaches, which focus on the interrelationship between the child's mental health and the family's wellbeing.

- Provide resources and supports to the child to foster their mental health within their family system.
- Offer resources and supports to the family to enable them to support their child's mental health and wellbeing.
- Directly provide mental health services to family members or make suggestions of services that may be relevant to family members.
- Keep in mind that some children with and seeking refugee protection are separated from their family members during their journeys and may go for years without contact with their loved ones or never be reunited again (UNHCR, 2023). They may face uncertainty about whether they will be reunited with their family and how their family members are doing (Liddell et al., 2022). For children who have been separated from their family members, it can be relevant to address the following.
    - Distress from being separated from their family members (Hvidtfeldt et al., 2022; Miller et al., 2018).
    - Fears for family still in harm's way (Miller et al., 2018).
    - Feelings of powerlessness to assist their family (Miller et al., 2018).
    - Cultural disruptions (Miller et al., 2018).
    - Feeling guilty for being safe while their family may be in danger (Hvidtfeldt et al., 2022).
    - Feeling that they should not seek social support from family members because they do not want to burden family members living in danger or uncertainty with their difficulties (Miller et al., 2018).
- For children whose families have been reunited, it can be relevant to explore and address the following.
    - How their roles, relationships, and family dynamics changed.
    - How long they were separated.
    - How the separation affected the mental health of all family members. For example, research shows that fathers with and seeking refugee protection who are separated from their children are twice as likely to develop a mental health disorder than fathers who have been reunited with their children (Hvidtfeldt et al., 2022).

Gender-responsive approaches

Consider whether gender-responsive approaches, which respond to differences in children based on their sex and gender, are relevant. These approaches may be particularly relevant for children who became refugees because they were experiencing persecution due to their gender, the gender that others perceive them of holding as an identity, or their sexual orientation (UNHCR, 2022a/b). Gender-responsive approaches may also be relevant for children who experienced sexual and gender-based violence.

- Affirm their gender identities (Mulé, 2022; Vindevogel & Verelst, 2020).
- Orient them towards additional sources of support that could explicitly affirm their identities and help them to feel socially accepted (Mulé, 2022; Vindevogel & Verelst, 2020).

Needs-based approaches

Use needs-based approaches to identify and address children's specific needs, including those whose basic survival needs (such as food, water, shelter, clothing, warmth, and sleep) are not met, and those experiencing complex needs (physical health, housing, education, legal) and disparities in the social determinants of health in Canada. Where relevant, use integrated approaches to service provision to address these needs.

Trauma-informed approaches

Use trauma-informed approaches with children with and seeking refugee protection who have experienced trauma. Evidence-based treatments for this group – NET, TF-CBT, and EMDR – are trauma-informed approaches (Wilker et al., 2020).

Sweeney and colleagues (2018) provide practical guidance on using trauma-informed approaches in mental health services.

Strengths-based approaches

Use a strengths-based, resiliency-oriented approach to highlight the strengths that children share about themselves and the groups to which they belong (Hobfoll et al., 2014; Vindevogel & Verelst, 2020). Affirm their identities, strengths, agency, motivation, and sense of mastery. Maintain a holistic view of children and avoid viewing them based only on their refugee protection status or background (Vindevogel & Verelst, 2020).

KIDNET uses a strengths-based approach. During KIDNET, it is important for the child to remember and relive memories of positive experiences, moments of mastery, and important supportive relationships in their lifeline (Schauer et al., 2017).

Share back to clients the narrative that they share about their survival story. Their survival story is how they make sense of their experiences and find meaning in their suffering (Posselt et al., 2019). It can also support them to reestablish a coherent sense of self (Vindevogel & Verelst, 2020).

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