

28 have been exposed to war and its consequences, including violence, death,
29 torture, rape deprivation of basic needs, and separation from caretakers
30 (Boothby, 1994). Child and adolescent refugees often suffer from severe
31 psychological distress including depression, posttraumatic stress disorder,
32 and difficulty with identity and acculturation (Pernice, 1996; Sundquist &
33 Johansson, 1996).

34 Burma (Myanmar) has waged a decades-long war against its ethnic
35 minorities, and Thailand is the primary recipient of the refugees from this
36 war (South, 2007). Many of those entering Thailand from Burma are stateless
37 (without documentation of their nationality). The largest group of de facto
38 refugees fleeing into Thailand is the Shan, at least 300,000 of whom live in
39 Thailand (Grundy-Warr, 2002; Risser, Kher, & Htun, 2003; Suwanvanichkij,
40 2008). Very little is known about their health and psychological well-being
41 (Lang, 2002; Su & Muennig, 2005).

42

METHODS

43 Overview

44 The children were drawn from three Shan communities in Northern Thailand
45 which have been receiving basic public health and education services from
46 two small nongovernmental organizations, the Burmese Refugee Project and
47 Opportunity for Poor Children.

48 We administered the Strengths and Difficulties Questionnaire (SDQ) to
49 all 51 children between the ages of 11 and 16 in these communities with
50 institutional review board approval. We also conducted qualitative interviews
51 with one family member of 11 of the sampled households.

52 The SDQ is a widely used screening tool widely used and has been
53 validated amongst Thais and Southeast Asian refugees (Goodman, 1997). It
54 is a 25-item questionnaire divided into five subscales measuring emotional,
55 conduct, hyperactivity and inattention, peer relationship problems, and the
56 prosocial behavior of the individual (Goodman, 2000). We were given access
57 to the Thai normative data (Woerner, et al., 2007).

58 We also conducted 11 semistructured, open-ended interviews on a sam-
59 ple of adults to obtain a sense of the families' experiences in Burma and while
60 immigrating to Thailand.

61 We used Thai normative cutoffs to determine a "normal," "borderline,"
62 or "abnormal" score. Comparison to the Thai population ($n = 2,682$) and a
63 sociodemographically similar, matched subsample ($n = 357$) from Chiang Rai
64 (17) was conducted with two sample t tests with the Bonferonni correction
65 for multiple comparisons.

66

RESULTS

67 None of the parents interviewed were actively involved in firefights or ad-
 68 mitted to being rape, but all were forced to carry munitions at gunpoint or
 69 give a significant portion of their earnings to Burmese and/or Shan rebel
 70 soldiers. All migrated from the same village in Burma through challenging
 71 terrain.

72 Only 37% of the population had birth certificates, the remainder being
 73 stateless (Table 1). About 12% of the population spoke only Shan, just under
 74 one third were single or dual orphans, and 40% had a self-reported health
 75 of “good,” “fair,” or “poor.”

76 About 6% of the population had an abnormal total difficulty score
 77 and 25% had a borderline score (data not shown). There was no sig-
 78 nificant difference in any scores between Shan children born in Thai-
 79 land versus Burma or between those who preferred the Shan language to
 80 Thai.

81 About 70% of the Shan children showed borderline or abnormal
 82 peer functioning, significantly more than either comparator Thai popula-
 83 tion (Table 2). In addition, the conduct and hyperactivity scales showed
 84 a trend toward statistical significance. The Shan youth also showed a
 85 higher rate of conduct disorders when compared with a matched rural
 86 population.

TABLE 1 Baseline Characteristics of Shan Population (Continuous Variables Expressed as $M \pm SD$)

Characteristics	Males ($n = 25$)	Females ($n = 26$)
Age (years)	12.8 \pm 1.59	12.8 \pm 1.62
Height (cm)	147 \pm 12.8	144 \pm 7.3
Weight (kg)	38 \pm 10.5	36.9 \pm 7.3
Time in Thailand (years)	9.7 \pm 4.3	8.6 \pm 4.8
Years of Education (years)	4.8 \pm 2.2	3.7 \pm 2.1
Born in Thailand	48%	39%
Birth certificate	45%	31%
Visa/work permit	29%	35%
Speak only Shan*	21%	4%
Preferred language Shan*	37%	9%
Health status		
0 (<i>poor</i>)	0%	4%
1 (<i>fair</i>)	0%	0%
2 (<i>good</i>)	30%	44%
3 (<i>very good</i>)	44%	44%
4 (<i>excellent</i>)	8%	8%
< 2 (<i>parents</i>)	25%	36%

* $p < .05$ for comparisons between males and females.

TABLE 2 The Difference in Mean SDQ Scores and Two Sample *T*-Test Comparison Between Shan Population and Thai Norms, and Norms Derived From a Subsample Of Sociodemographically Similar Youth from a Similar Rural Province (Chiang Rai)

SDQ subscale	Difference of <i>M</i>	<i>p</i> value
Thailand norms		
Emotional	0.0	1.0
Conduct	-0.35	0.09
Hyperactivity	0.56	0.04
Peer	-0.64	0.004*
Prosocial	0.21	0.21
Total difficulties	-0.37	0.57
Chiang Rai subsample norms		
Emotional	-0.29	0.3
Conduct	-0.58	0.008*
Hyperactivity	0.13	0.65
Peer	-0.90	0.001*
Prosocial	0.41	0.19
Total difficulties	-1.57	0.02

Note. SDQ = Strengths and Difficulties Questionnaire.

**p*-value remains significant after correcting for multiple comparisons within the sample or subsample category.

87

CONCLUSION

88 This study highlights the level of social difficulty amongst the Shan youth.
 89 Many of the children have lost at least one parent and some cannot adequately speak the Thai language, a critically needed skill. Nevertheless, in
 90 many of the SDQ domains, the Shan children scored similarly to their Thai
 91 contemporaries. Thus, their total difficulties scores are similar to those of
 92 Thai youth.
 93 Thai youth.

94 This study was subject to a number of important limitations. First, the
 95 community we studied may represent a “best case scenario” as they likely
 96 did not suffer as severe hardship as some other Shan children in Thailand,
 97 and they are being served by NGOs that provide basic education and health
 98 services. Second, This study was powered to detect a difference of $> .5$ at
 99 a $\beta = .8$ but not powered to detect small differences (traditionally defined
 100 as a 1 difference in means). Low power is unlikely to explain a difference in
 101 the total difficulties score; however, it may mask differences in the conduct
 102 and hyperactivity subscales.

103 In this study, we find reason for both hope and alarm. Hope, in that dif-
 104 ficulties with peer interactions may be easier to repair than other domains of
 105 the SDQ, and because the children surveyed are generally well-functioning.
 106 Alarm, because this particular community is relatively well positioned for suc-
 107 cess within Thailand, but it nevertheless reveals some signs of poor physical
 108 and mental health among its youth.

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