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**The Aftermath of War: Improving Psychosocial Measures to Address Trauma in Child
Refugees in the Schengen Zone**

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Spring 2018

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Abstract

With the large number of refugee children currently displaced due to war and conflict, there is a necessity to look into alleviating any resulting trauma so that these children don't face further social or health effects later in life. The study focuses on how to improve psychosocial care for child refugees in the Schengen zone suffering from war trauma. Through a combination of research done using existing literature and interviews with experts, there were three main findings on improving psychosocial support for this population. These include improving consolidation of psychosocial programs and focusing on education, having greater cultural awareness when working with children, and acknowledging the resilience of children when addressing trauma. These results call for changes in approaches to psychosocial care and the study encourages greater awareness in host populations. Further research on specific populations within this group would be beneficial.

Preface

Childhood, for many, is a time of simplicity and carefreeness. It is a period of life that is synonymous with riding bikes, building sandcastles and having sleepovers. However, this reality is but a distant dream for children who have been displaced from their hometowns, fleeing from the destruction that is war. It adds a certain burden to childhood, the mere thought of which staggers me. We may have come a long way in terms of technological development and globalization but our progress as a world is tainted by the extensive war and conflict that still ravage nations and shatter families. Many children are now without homes due to this violence and the subsequent hardships it brings. This research project started off as an effort for myself to understand their experiences and see

what could be done to ameliorate the situation. The knowledge gap and lack of focus on the mental health of refugee children was intriguing to me and I found myself wanting to learn more. Studying abroad in Geneva, Switzerland meant that a vast array of knowledge and expertise was now accessible to me and I could not pinpoint a better time for me to study this topic. Before they became refugees, these children had identities. They had hopes and dreams, a fact that is often forgotten. The global community now has an opportunity to prevent the formation of a lost generation, to support these children and allow them to have the life they deserve. This study is mere footstep in establishing why and how.

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Introduction

The number of people displaced due to persecution, conflict, violence or human rights violence is at a staggering 65.6 million according to the 2016 Global Trends Report from the United Nations High Commissioner for Refugees. Of these people, 22.5 million are refugees and 51% of refugees are made up of children younger than 18 years of age (Global Trends, 2016). The definition of refugee according to the UNHCR is as follows:

“A refugee is someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries.”

The effects of war can be seen in every part of life. In addition to threats to their lives and safety, presence of conflict zones limit civilians’ access to essential institutions such as hospitals, workplaces and schools (Lustig et al., 2014). While the immediate consequences of war such as physical harm and the resulting need for emergency aid are portrayed in the media, there is a lack of attention on the longer, less visible effects of the mental health of those who have been exposed to such violence (Betancourt et al., 2013). The World Health Organization (WHO) estimated that 10% of those exposed to traumatic events will exhibit behavior that negatively affects their daily functioning and another 10% will develop serious mental health consequences (World Health Report, 2001). For example, regular occurrences during war, such as bombings, can leave lasting effects on the mental health of those exposed (N. Drissi, personal communication, April 11, 2018). In the past few years,

there has been an increase in interest on the effects of war on the mental health of civilians (Carballo et al., 2004). Efforts of the United Nations International Children's Emergency Fund (UNICEF) as well as other intergovernmental and nonprofit organizations have contributed to this by drawing attention to war trauma (Mollica et al.). The effects of war, combined with the hardships endured during and after the process of migration, can often lead to trauma in refugees that cross borders in search of a better life (Ellis et al., 2008). Due to the unique nature of these stressors, it is important to support people in their reactions to these abnormal situations (Schinina, n.d).

Why Focus on Children

According to the United Nations Convention on the Rights of the Child, the term 'child' is defined as a person less than eighteen years of age unless stated otherwise by the national law of the country that the child resides in. Children are susceptible to different stressors than adults, resulting in a need for comprehensive knowledge on addressing traumatic experiences in children (Anagnostopoulos et al., 2016). Refugee children that have been exposed to war often experience insomnia, anxiety, depression, and anger and violence (Lustig et al., 2004). From a sample of 95 Bosnian children who had experienced war from the ages of 8-13, many of them recalled their traumatic experiences from war. After being evaluated through standard measures, researchers found a significant association between the number of traumatic war experiences and avoidance scores on the Impact of Event Scale (IES) measuring PTSD (Papageorgiou et al., 2000). Depressive, anxiety related and psychosomatic symptoms are among those that are reported most frequently by war-traumatized refugee children (Möhlen et al., 2005).

From a health perspective, untreated trauma can lead to a variety of health problems later in life as well. PTSD has been linked to a number of psychiatric disorders later in life (Papegeorgiou et al., 2000). Moreover, as researchers at the University of Zurich and ETH Zurich have recently found, trauma can be hereditary and traumatic experiences can affect behaviors disorders that are passed from generation to generation (Franklin et al., 2010). These findings emphasize the importance of treating trauma at a young age. Currently, there are not enough resources, both material and human, to address this growing issue. The epidemic is especially relevant in the Schengen zone. The Schengen area refers to zone of 26 different European nations that do not have “internal borders with other member nations” (Schengen Area Countries List, 2017). Countries in this zone are: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovaia, Slovenia, Spain, Sweden, Switzerland and Liechtenstein. Many countries in Europe have seen an influx in refugees recently and frontline countries, such as Italy and Greece, struggle to deal with the ongoing situation (H. Mattila, personal communication, April 17, 2018). The exposure to the Western health care system and change in culture and language can also affect the development of refugee children. Research and dialogue on identifying and addressing war trauma in children is imperative in order to ensure that it does not adversely affect the child’s future. Important guidelines have been created to address mental health and psychosocial support (MHPSS) in these populations but consolidated policy and efforts are still scarce. Such reports include those of the International Committee of the Red Cross (ICRC), the United Nations High Commissioner on Refugees (UNHCR), Médecins Sans Frontières (MSF) and the Inter-Agency Standing

Committee (IASC). According to the IASC, MHPSS is defined as “any type of local or outside support that aims to protect psychosocial well-being and/or prevent or treat mental disorder” (IASC 2007). There are many psychosocial programs available to address trauma in children but there is a lack of methodology and consistency on which aspects of these programs need focus and how they should be approached.

Objectives and Framework

The objective of this paper is to show the different effects of war-related stressors on child refugees and highlight measures to improve psychosocial programs for refugee children in the Schengen Zone who are affected by war trauma. The results section is categorized into three categories for each of the findings. The subsequent discussion categorizes stressors, identifies factors that affect the psychological wellbeing of refugee children and suggests solutions based off of the findings on various methods to alleviate trauma. The specific question motivating this project asks what measures can be taken in order to improve psychosocial programs for refugee children in the Schengen Zone who are affected by psychological trauma due to war. This information can be used to implement better mental health and psychosocial programs and increase public awareness on the experiences faced by child refugees.

Methods

For the purpose of this study, research was done primarily through interviews with experts such as psychologists, pediatricians, migration specialists and international program coordinators working in this domain. This information was amalgamated with consulting existing literature on the topic since both primary and secondary sources were essential to have a comprehensive framework on the topic. Interviewees were contacted

through mutual contacts, emails and phone calls. Respondents were found with the aim of gaining a variety of insights from different sectors working with refugee children, including medical, social, humanitarian and policy-related perspectives. Four interviews were done face-to-face while three were conducted through a telecommunications software known as Skype. The first of the face-to-face interviews was conducted with Dr. Ariel Eytan, a specialist in mental health and conflict. Dr. Eytan was scheduled to give a lecture on the topic to all the students of the School of International Training (SIT), but circumstances led to the cancellation of the lecture. Following that, the SIT program coordinators were able to schedule a few students to interview him separately. The interview took place at the Hospital Psychiatry De Belle-Idée in Geneva, Switzerland in the presence of one other student. The second interview was with Ms. Nezha Drissi, who is the president of an NGO named Althea Foundation and has worked with many refugees in Lebanon on techniques to alleviate trauma. This interview took place in Ms. Drissi's place of residence in Lausanne, Switzerland. The third interview was with Dr. Daniel Martinez, a pediatrician and medical advisor working at Médecins Sans Frontières (MSF). This interview took place at the MSF office in Geneva. The fourth and final face-to-face interview was with Dr. Heikki Mattila, a migration specialist who has worked with IOM. This interview took place in the Geneva office of SIT. The fifth interview was done over Skype with Dr. Laurent Chapuis of UNICEF. Dr. Chapuis was contacted through email after being given his contact information by another UNICEF specialist who was not able to provide an interview. The sixth interview was done over skype with Afif Beigi, a former refugee, in the presence of Ms. Drissi. Following the interview with Ms. Drissi, she had offered to contact Mr. Beigi and he was willing to provide an interview. The third Skype interview and final interview overall was

conducted with Dr. Guglielmo Schinina, the International Organization for Migration's Head of Global Mental Health, Psychosocial Response and Intercultural Communication. The interviews of Dr. Martinez, Dr. Mattila and Ms. Drissi were all recorded with their consent. Notes were also taken on a computer during the interview. For each interview, questions were prepared ahead of time and asked during the process of interview. Questions had a wide range since each person's expertise was different. Based on the responses of the interviewees some questions were added, edited or omitted. Each interviewee was able to give a different perspective on the effects of war on the mental health of children and ways to improve how trauma is addressed. After the interviews, the data was coded thematically in order to identify recurring themes and ideas across all the interviews.

The literature consulted in this study was largely found through scholarly search engines or recommendations from the interviewees. Search engines such as PubMed, EBSCO and Google Scholar were used to find a variety of literature both scientific and gray. Websites of international organizations were integral in locating yearly reports and psychosocial guides. Dr. Chapuis and Dr. Martinez had also sent literary works to support this topic of research.

The limitations in methodology include a lack of response since some specialists were not able to meet due to geographic barriers or did not have any available time until after the deadline of the project. Due to ethical constraints and difficulty of location, it was not possible to conduct interviews with current child refugees on their experience. Ethical considerations were taken into account when interviewing professionals and using their names for the purpose of the study.

Results

On the topic of improving care for refugee children in the Schengen Zone who experience trauma from war, there were three major findings as to how to improve psychosocial support. The first was the need for structure and consolidation in the psychosocial programs being implemented, with a focus on education. The second is the importance of approaching psychosocial support with cultural competence and awareness. Finally, the third is accounting for the resilience of children when addressing trauma. Each finding will be separated into its own section.

Structuring Psychosocial Programs

From the interviews and consulted literature, it was found that, for the majority of children, psychosocial programs, not psychiatric help, were most beneficial. According to Chapuis, attending creative, informal activities for a certain period of time is enough to help



Figure 1.1 (IASC, 2007)

them recover from traumatic situations (L. Chapuis, personal communication, April 17, 2018). While this is true for the majority, it certainly does not negate the experiences of children who need

more serious, psychiatric assistance. Overall, psychosocial programs, especially those focusing on language and education are very important in normalizing the situation and

allowing the child to adjust (A. Eytan, personal communication, April 4, 2018; L. Chapuis, personal communication, April 17, 2018). An aspect of primary psychosocial care, opportunities for social inclusions and structured learning can reduce feelings of anger, frustration, isolation and helplessness (Nikolaidis et al., 2017). In Figure 1.1, these activities fall under the first two levels of the pyramid. Once basic survival needs are met, most children will resume normal functioning (L. Chapuis, personal communication, April 17, 2018). One thing that is particularly important for children is education. For children in Syria, in the case that the war started when they were six, it is quite possible that they have never been to school (N. Drissi, personal communication, April 11, 2018). In order to foster their development this is one of the first things that need to be focused on. However, there is a lack of structure in how these programs are implemented. Often, programs do not communicate with each other (G. Schinina, personal communication, April 23, 2018). This itself is a source of stress of children since there is a lack of connection between the psychosocial programs they encounter first and the care that they later receive. Having proper, uniform procedures for psychosocial support can streamline the process and provide children with the comprehensive support they need (G. Schinina, personal communication, April 23, 2018).

Improving Cultural Consideration

The next finding was that incorporating cultural aspects into psychosocial support can be very beneficial for children. Reactions to trauma can have many different manifestations and it is important to consider how diagnoses are made (A. Eytan, personal communication, April 4, 2018). This is especially important because, for example, a fifteen-year-old girl in Paris may demonstrate distress in a very different way than a young

Pakistani boy (L. Chapuis, personal communication, April 17, 2019). Even PTSD itself is a Western category and it is imperative to take cultural differences into account when looking at the presence of symptoms. Working with translation, adaptation and interpreting is also important. This is one of the big concerns in psychosocial efforts currently (G. Schinina, personal communication, April 23, 2018).

Accounting for Resilience

Lastly, it was found that it is incorrect to assume that all children may go through trauma (Lustig et al., 2004). This was a slightly unexpected result but a common theme among all the data that was used. Although stressing trauma may result in more action in the psychological realm, this may not always be true and can be demoralizing to an extent (Lustig et al., 2004). Assuming that these children are completely helpless is very disempowering (Meyer 2013). When implementing psychosocial programs, the resilience of children must be accounted for (D. Martinez, personal communication, April 13, 2018). If it is not, measures to help may become more destructive than helpful. When giving psychosocial care, this is an aspect that is often overlooked and should be given more consideration.

Discussion

To understand the importance of regularity, consolidation and cultural consideration in psychosocial efforts, first the effects of war on the mental health of children must be discussed. For refugees, there are three distinct stages of stressors. The first is the pre-migration phase when the children are still in the country of unrest. Second is the migratory phase and third is the resettlement phase. Each phase has different

stressors that implicate how psychosocial programs should be structured and implemented.

Pre-Migration

According to Eytan, a specific aspect of being in a country of war is that it is a chronic, not acute stress. The situation can last for weeks, months and sometimes years. The effects of intense violence, witness of death and torture and fear for one's own life can be very impacting (A. Eytan, personal communication, April 17, 2018; H. Mattila, personal communication, April 17, 2018). Specific noises and stimuli can trigger reactions. For example, refugees displayed stress sleeping near airports since the sounds reminded them of bombs and warfare in their home countries (N. Drissi, personal communication, April 11, 2018). As children especially thrive in stability, this is not a positive stressor and can increase the chance of internal or external dysfunction (D. Martinez, personal communication, April 13, 2018). Often children have limited access to get the care they need in their home countries due to a lack of psychologists and lack of reliability of institutions that have been affected by war (A. Eytan, personal communication, April 4, 2018). These countries may not have a focus on medical health and it is difficult since psychologists are not everywhere (D. Martinez, personal communication, April 13, 2018). This cultural difference reflects a lack in focus on mental health, which is more reason to have comprehensive programs to address these issues when refugees migrate.

During Migration

From a psychiatric point of view, migrating is also an ongoing stress. The journey itself can be incredibly taxing, both physically and mentally. While directly it may be less intense than that of war, questions about the future will be a constant cause of unrest.

According to Eytan, this ongoing stress is not removable so it is important to support those going through it (A. Eytan, personal communication, April 17, 2018). This physical journey from coast-to-coast itself can be a major source of trauma. Afif Beigi, who was a former child refugee, recalls the boat being very small, only two and half meters wide with 35 people in it during the first time he tried to cross the Mediterranean. There were women and children on this boat as well. Every attempt to cross the sea is referred to a “game” (A. Beigi, personal communication, April 20, 2018). Since this attempt was unsuccessful, Beigi did a second game and tried to cross again. Without anyone professional to drive the boat, the only direction they were given was to go straight ahead towards the light. They did not know how long the journey would take and to prevent being sent back the way they came, they had to break the boat upon arrival (A. Beigi, personal communication, April 20, 2018). These details of strenuous migration process are often unknown to the public and contribute to the unawareness of the public as to what migration for refugees truly entails.

TABLE 1: Prevalence of worrying signs noticed by shelter staff

	f (%) of cases (N=1065)*
Having nightmares and/or not being able to sleep	144 (19.7%)
Aggressive behavior against staff	136 (18.6%)
Unusual crying and screaming	83 (11.4%)
Self-harming behavior	81 (11.1%)
Sadness (e.g. not talking, not eating, etc.)	67 (9.2%)
Spending less time with friends	48 (6.6%)
Violence against staff	52 (7.1%)
Violence against other children	57 (7.8%)
Aggressive behavior	47 (6.4%)
Substance abuse (drugs)	42 (5.8%)
Anti-social (isolating themselves)	41 (5.6%)
Substance abuse (alcohol)	38 (5.2%)
Panic attacks and related symptoms	36 (4.9%)
Involvement in illegal activities (vandalism, commercial sexual exploitation)	34 (4.7%)
Disoriented behavior	20 (2.7%)
Suicide attempts	19 (2.6%)
Victim of bullying due to ethnic origin and/or religion	18 (2.5%)
Being a victim of violence by other children	16 (2.2%)
Being a victim of violence by adults	15 (2.1%)
Sexual assault or exploitation by adults	13 (1.8%)
Overt psychotic symptoms (paranoia, etc.)	11 (1.5%)
Victim of bullying due to sexual orientation	8 (1.1%)
Attack on people outside structure (other civilians)	8 (1.1%)
Bullying other children due to sexual orientation	6 (0.8%)
Bullying children due to ethnic origin and/or religion	5 (0.7%)
Sexual assault of other children	5 (0.7%)
Committing crimes	5 (0.7%)
Engaging in high risk sexual behavior	4 (0.5%)
Victim of bullying due to gender	3 (0.4%)
Recruitment of other children in illegal activities	3 (0.4%)

* More than one signs may concern the same UAC; this is why the total sum of the signs is higher (=1065) than the number of UAC (=730).

Figure 1.2 (Nikolaidis et al., 2017)

children (UAC), this immediate network is unavailable. It is a huge stress, especially when followed by growing up in a foreign environment. Parents not only protect the child but also set limits that contribute to a child's department (A. Eytan, personal communication, April 17, 2018). In a study done on unaccompanied children in Greece, key signs of trauma were identified, as shown in Figure 1.2.

It is also important to discuss the impact children's separation from their parents. Unaccompanied minors are among the most vulnerable populations of refugees. In one study, separation from their immediate family was associated with post-traumatic stress disorder in the child (Fazal et al., 2011). The typical protective network of children includes family, relationships and institutions (D. Martinez, personal communication, April 13, 2018). Children are safer if they have a protective network surrounding

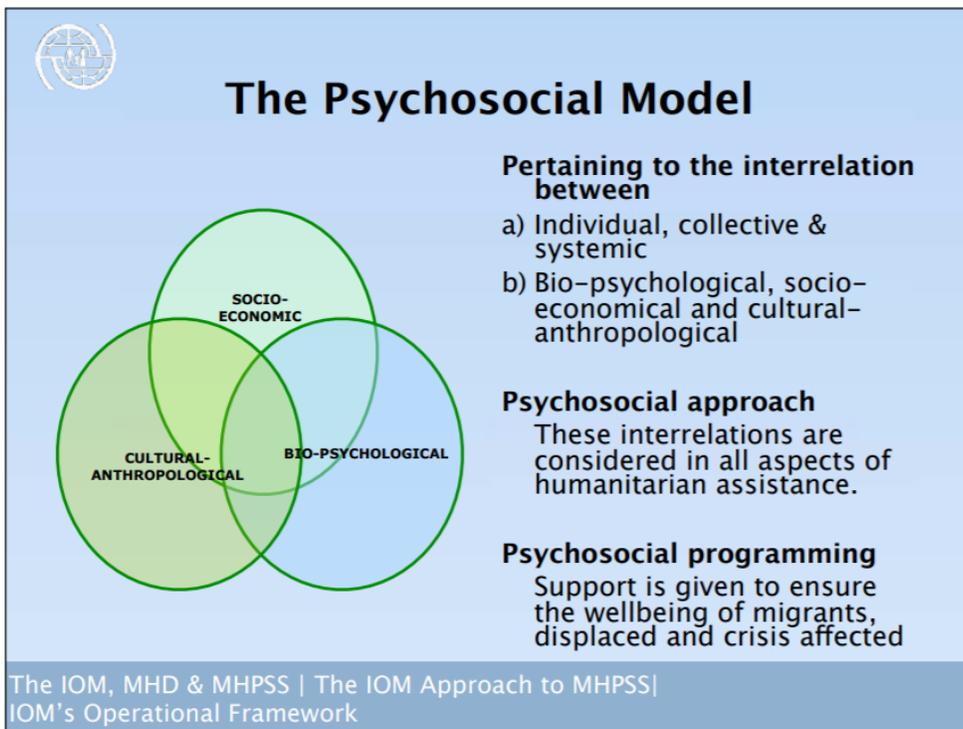
them and for unaccompanied refugee

This report came to the conclusion that UACs were at greater risk of facing MHPSS related challenges. Addressing these issues at an early stage is of utmost importance to prevent more serious problems (Nikolaidis et al., 2017). More than psychiatrists, these children need counselors or someone there to help them navigate the situation since they do not have significant others to depend on (G. Schinina, personal communication, April 23, 2018). Psychosocial support that is properly done is can help mitigate these effects. While psychiatry is only one part of this, education and language play a much larger role which is why psychosocial programs need to have a certain continuity and focus on these topics.

Post-Migration

Once refugees reach the new country, there is an additional set of stressors that come into play. The idea of no future and no education can be very distressing to a child (N. Drissi, personal communication, April 11, 2018). Drissi recalled one child refugee she worked with saying “I’m fifteen, I’m not going to school, what’s the meaning of life then? I’m not doing anything.” This is directly connects to the first result of the study establishing the importance of education as one of the main focuses. Structure is also important in normalizing the situation for children and starting formal schooling or having structured classes and activities can help with that (A. Eytan, personal communication, April 17, 2018). To allow children to adapt to their new environments, getting them back on an educational track is very important (H. Mattila, personal communication, April 17, 2018). Educational support systems should be implemented as soon as possible, according to Schinina. When children are resettled and the situation normalizes, the idea is to integrate as many children as possible (L. Chapuis, personal communication, April 17, 2018).

The reception of refugees when they arrive can also affect their mental state and lead to more trauma. They are deposited in a completely new culture with new rules and regulations and this can be a confusing process for a child. In some cases, the bureaucratic process of being allowed to stay or not can be more traumatizing itself than the aspects of war or migration (G. Schinina, personal communication, April 23, 2018). This includes processes such as determining the age of a child (H. Mattila, personal communication, April 17, 2018). Children in restrictive facilities have a higher chance of suffering from adverse mental health effects (Fazal et al., 2011). Additionally, detention centers are a major source for contention. There is a strong advocacy push against detention, especially in the case of children. In Greece, the facilities are not up to standard and they host twice or thrice the amount of people they were meant to hold (L. Chapuis, personal communication, April 17, 2018). It is most often in Southern European countries, like Greece and Italy, that



detention centers are used (H. Mattila, personal communication, April 17, 2018). This type of reception can add to the trauma or create trauma that was not there before. Beigi

Figure 1.3 (Schinina, nd.)

described his experience being in a detention center as similar to a prison. He and other detainees were treated like criminals. These types of experiences contribute to trauma as well and should not be used, especially with young people. Sometimes treatment in these situations can be counterproductive because they do not need treatment, but rather freedom (G. Schinina, personal communication, April 23, 2018).

As can be seen through the myriad of effects war displacement and subsequent migration can have on children, it is important to create psychosocial programs that account for these factors. Figure 1.3 highlights the main components of the psychosocial model and shows how the intersection is needed for success. The first step is to provide basic needs and basic security. There is a current lack of knowledge in treatment and available care especially since there are few child psychologists (G. Schinina, personal communication, April 23, 2018). After this comes family and community support. If the children's parents are there, it is important to engage them in the programs as well. Debriefing children on the situation, involving their caretakers and versions of cognitive-behavioral therapy can be beneficial for children who are dealing with trauma (Papageorgiou et al., 2000). For children, their experiences often depend on the parent. Their neurons are very active so a lot of their emotions mirror others in their environment (G. Schinina, personal communication, April 23, 2018). Education and creating a structure for the children in this hazy situation is beneficial for their development. On the same topic of structure, psychosocial support should be structured as well. There are many organizations such as the IOM, UNHCR and MSF offering such support and collaborative guidelines and frameworks can improve this process. In an UNHCR review of MHPSS, recommendations were made to operationalize models and have higher clarity regarding

the duties of those working in this sector (Meyer, 2013). In terms of policy as well, there must be coordination to improve the situation (H. Mattila, personal communication, April 17, 2018). The discussion now moves to the importance of establishing cultural competence in all levels of psychosocial support discussed in this past section.

The Role of Culture and Language

As discussed in the previous section, when children migrate from one country to another they encounter very new experiences. As a result, children can have acculturative stress which is stress that stems from adapting to a new culture (Earnest, 2005). This leads into discussion of the second finding of the results, improving cultural competence. When treating children for trauma, cultural considerations must be taken into account for a variety of reasons. According to Chapuis, in Europe especially, the importance of language is underestimated and it is necessary to invest in levels to overcome these cultural barriers.

Overall, mental health terms, disorders and classifying systems are often westernized (A. Eytan, personal communication, April 17, 2018). Post-traumatic stress disorder (PTSD) for instance is a term devised by the Western academic field (A. Eytan, personal communication, April 17, 2018). Even in the presentation of symptoms, cultural differences must be accounted for. According to Eytan, one of the main questions is how to make the diagnoses. Possible methods include using psychometric tools, standardized or semi-standardized interviews to gain an understanding of the child's mental state. Clinical research on cultural variations in symptoms and diagnoses is important to better understand this topic (Lustig et al., 2004).

Cultural Implications of Trauma

The intersection between trauma and culture is one that has to be analyzed in order to provide the best support to child refugees coming in from different cultures. According to Drissi, who works with refugee children in Lebanon and Switzerland, there can be a bit of stigma. Her knowledge of the Arabic language helped reduce some of the stigma and made refugees more comfortable. When helping them address trauma, it is important for workers to not say they are doctors or that they are there to treat trauma. Sometimes they do not like the word trauma and Drissi instead uses terms like “inner peace method (N. Drissi, personal communication, April 11, 2018). Drissi works with different mind and body techniques to help refugees get rid of PTSD. The method focuses on selecting one event in particular and working on it. Drissi uses Neuro-Linguistic Programming (NLP) and focuses on how the mind records the traumatic event. In this method, Drissi dismantles the story and disconnects the story from the emotions of the subconscious mind. She recounted an experience working with a boy who was reluctant to go through this process with the rest of his family and worked with him alone instead (N. Drissi, personal communication, April 11, 2018). Often, cultural expectations of boys and girls also play a role in whether they seek out treatment or not so people who work with these populations must be aware of this and reach out to children who may not want to openly participate.

Language Restrictions

The language barrier can be a huge issue as well. Although there may interesting, comprehensive programs, children who do not know the language will not be able to benefit from these (G. Schinina, personal communication, April 23, 2018). Often times, translation, adaptation and working with an interpreter to give psychosocial support can

make this process more difficult (A. Eytan, personal communication, April 17, 2018). Especially if the interpreter is not a professional and instead is a family member of one of the kids, that can also make the children more hesitant to share their experiences (Schinina). Parents sometimes translate what they think is important rather than the full message and this can be counterproductive as well. It is important that psychosocial programs are administered by those who have training and expertise. Even basic training may not always be enough though. Current training goes over the basic crash course necessities, such as practices like not shaking hands or asking certain questions. However, it is not wise to stigmatize a culture like that (G. Schinina, personal communication, April 23, 2018). Understanding a culture goes beyond these basic measures and more integration is needed to truly be culturally aware when implementing psychosocial programs. A skill that is necessary is that of both understanding and addressing these cultural differences. According to Schinina, there are currently two models on this topic. In the first model, there is a professional who cannot understand the language so they include a third person in the discussion who can understand the language and culture. This is known as cultural mediation. The second model has a professional who does not understand the language and includes a third person in the discussion who is solely the interpreter. The professional still does the mediating. While the first model is the more common one, Schinina believes the second model is easier to manage and more beneficial. Overall, doctors, social workers, nurses and psychologists should all have cultural elements incorporated in their training (G. Schinina, personal communication, April 23, 2018).

Language Instruction

According to early childhood development experts, it is beneficial for them to access education in their own language. After this initial step, they can start acquiring the new language. In Greece, UNICEF is working on a program that uses mobile phones to help children teach themselves the national language in the situation that other method of instruction is not possible (A. Eytan, personal communication, April 17, 2018). Learning the host language is associated with reduced probability of having depressive symptoms (High Income). On the topic of cultural adaptation, children usually have good capacities (A. Eytan, personal communication, April 17, 2018). However, the child might face conflict between the culture of the host country versus the culture of his or her parents. There have also been situations where symptoms affect second, third or fourth generation children. These are things that psychosocial workers should be aware of as well when working with these children. It is demoralizing to assume that all children go through trauma and it is important to not make them feel like victims (Lustig et al., 2004).

The Resilience of Children

With the establishment of proper psychosocial care and effective cultural integration, there is another important component to addressing trauma that is often forgotten. This is the existing resilience of children. Many professionals still continue to be surprised at how strong and resilient children are (L. Chapuis, personal communication, April 17, 2018). Exposure to a traumatic event does not directly mean trauma (D. Martinez, personal communication, April 13, 2018). Because of this, most of the resources should be invested towards normalizing the situation. This doesn't include only psychosocial intervention but also making sure that children are in safe living situations. These types of mainstream general interventions are the most useful. In the media there is often a

connotation of helplessness in their portrayal of refugees. This negative idea does not account for the strength that is displayed in these adverse situations. While images provoking pity and sadness are powerful tools in driving donations, they create an aura surrounding refugees that is dispiriting. Children display resilience in many situations, this can especially be seen in resettlement and cultural acclimation (A. Eytan, personal communication, April 17, 2018). According to Martinez, resilience can be thought of as the capacity of an object to be deformed from its original state and still come back. At the mental level, children have a lot of adaptability (D. Martinez, personal communication, April 13, 2018). Using this adaptability is an important factor of psychosocial support.

There are still ways to help them with their experiences, but it is important to be careful with the approach. There are multiple measures that can be taken to refrain from making children feel as if they are helpless and need help. One method described by Drissi was to give the children dolls and whatever exercises she had for the children, they would in turn do with the dolls. This was interactive and did not make them feel like patients. Agency is incredibly important in treating trauma (G. Schinina, personal communication, April 23, 2018). There are readymade treatments available but those do not take into account what the children really need. This can result in organizations offering services that are not considerate of children's needs and hence is a non-productive method of giving care.

European Attitudes

Having good psychosocial programs that address culture and resilience are very important when looking at the mental health of refugee children. However, beyond this, the political scheme surrounding the refugee movement also plays an important role in the

implementation of these programs. The European Society for Child and Adolescent Psychiatry published a position statement on mental health of child and adolescent refugees. A topic discussed in this statement is the hostility towards foreigners and refugees that can contribute to trauma. European attitudes towards them play a great role in determining the burden of trauma in a refugee in the Schengen zone (Anagnostopoulos et al., 2016). For children especially, it is important to have a welcoming attitude towards them. Mattila, an expert in migration policy, further elaborated on this issue. Current attitudes in Europe are neither for nor against refugees. In many countries, there are those who rally against immigration to gain easy support but the majority of people are more moderate (H. Mattila, personal communication, April 17, 2018). According to the Dublin treaty, refugee children fall under the responsibility of the first country they step foot in and are often sent back to those countries. Frontline countries such as Spain, Greece and Italy take most of the burden and those countries now demand burden sharing because of the recent influx (H. Mattila, personal communication, April 17, 2018). The politicization of the issue makes it harder for policies to be passed and this results in a negative and unwelcoming environment for many refugees. ESCAP's position statement calls on a Europeans to have an "empathic and mentalizing attitude" to foster efficient integration. To address this, first there must be better awareness of refugee experiences and backgrounds. While this is a long process, with educational programs and accurate media coverage it is possible to improve the situation and affect people's attitudes.

Conclusion

Overall, there are multiple measures that can improve the psychosocial approach to treating war trauma in child refugees in the Schengen zone. First is to have a consolidated

structure and specific focus on education when it comes to implementing these programs. Lack of linear connections between psychosocial approaches can be confusing and counterproductive for children. Additionally, as multiple sources have expressed, education is one of the most important parts of normalizing children in this situation. Giving them structure and preparing them for the new life is important in reducing the trauma and allowing them to have a fresh start. Second, cultural implications must be taken into account in any psychosocial programs. The differences in culture regarding trauma can play a role in how children respond to treatment and accounting for this as well as the language barrier will improve how this issue is addressed. Third, the resilience of children must also be acknowledged. The word trauma has serious connotations and there is a concern in the academic world that this approach makes refugees seem helpless. Children are very adaptable and making sure they feel comfortable and giving them agency is an important aspect of improving psychosocial care. In addition to this, the politicization of this issue makes it imperative to improve awareness and knowledge about refugees so that these children will be able to come into a welcoming environment.

Limitations of this study include time and geographic barriers. The time constraint made longitudinal studies not possible and geographic constraints mean that research could not be carried out in a refugee camp. There were also ethical constraints, due to which current child refugees could not be interviewed.

There are many future directions that can be taken with this topic. While considerable amount of attention has been devoted to refugee populations, this is not the case for internally displaced populations (IDPs). There are now more internally displaced people than refugees and more research needs to be done on their access to health

services. There is also a knowledge gap on unaccompanied children that go missing during the process of migration. These children are often targets for trafficking groups and there should be more efforts put into their protection. These could be health related actions or more inclined towards policy. Additionally, more longitudinal research needs to be done on specific methods of psychosocial approach, such as music therapy or art therapy. While there is a general consensus that these approaches are beneficial to students, there is not enough conclusive, qualitative research to establish their importance. Further research on specific methods to alleviate trauma can provide a solid framework for organizations to address trauma using these methods. This topic is one that is very large and relevant so there are many options for further study.

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