

Refugee children's mental health and development - A public health problem in Europe

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Abstract

Knowledge about refugee children's mental health has developed considerably during the last 30 years. From believing that children's reactions largely depend on their parents, it has become clear that children are influenced both by their own experiences, by the reactions of their caregivers and by the social environment in which they live. While psychological problems are frequent in children close to arrival in exile, follow-up studies have shown that the magnitude of the problems is reduced over time. Aspects of social life as well as stressful events in exile seem to be of paramount importance for children's ability to recover from early traumatization. Prolonged asylum procedures, temporary residence permits, delayed family reunifications, many school-moves and xenophobic attitudes is counteracting healthy development. The results of research on refugee children and youth indicate the existence of a large public health problem which calls for policy change and political action.

Introduction

The scientific knowledge of how children react to various forms of traumatic experiences has developed considerably during the last 40 years. Until about 1980, only a few studies of children's reactions to various forms of traumatic events existed (Benedek,

1985) and these consisted primarily of collections of clinical case descriptions. The diagnosis, post-traumatic stress disorder (PTSD), was included in DSM-III in 1980; however, no diagnostic criteria for traumas in children were reported before the publication of DSM-III-R in 1987. In the early 1980s, Leonore Terr described the reactions in a group of children who had been kidnapped and buried alive in a school bus (Terr, 1981 & 1983). She documented how normal children reacted to their experience with a number of psychological symptoms; however, her observations were not immediately acknowledged by health professionals. In a review from 1985 (Garmazy & Rutter, 1985), it was further concluded, based on previous studies, that although some children could react with emotional difficulties to immediate and serious events, the reactions were short-term in most of the cases. At this early stage of the research within the field, the children's reactions were viewed, first and foremost, as being dependent on their parents' reactions; if their parents remained calm, the children would not react to serious events. Simultaneously, clinical documentation from working with referred children suggested that traumas could lead to serious cognitive and emotional disturbances and possibly lead to a permanently disturbed personality development, unless the experiences were treated with, for instance, therapy (Eth

& Pynoss, 1985).

My research on trauma in refugee children was initiated in the end of the 1980s at the Rehabilitation- and Research Centre for Torture Victims (RCT) in Copenhagen, where I worked as a clinical psychologist. Mainly through the clinical work, the importance of the family environment for traumatized children became obvious. The individual trauma perspective, focusing on the links between specific traumatic experiences and resulting psychopathology, was then complemented with a systemic-constructionist perspective with its focus on meaning-making processes and the socially constructed ‘realities’ in relation to which the families understand their lives and organise their experiences. Later, both through clinical experience and research findings, the importance of the wider social network for the children’s mental health and development became more apparent, and I became interested in the ecological perspective where people’s reactions are studied and understood in relation to the various contexts within which their lives are embedded, and where the focus for research and intervention is the relations between various factors contributing to psychopathology as well as to resilience. When I started my research, very little was known about the magnitude of the problems within unselected populations of refugee children. From my early clinical studies of the mental health consequences of torture and organised violence for children, I therefore expanded my research to non-clinical populations of asylum-seeking and refugee children to be able to identify and understand risk and protective factors and processes in the children’s social ecology. Over the course of my early work in the field, I found that it is through the interplay of quantitative and qualitative research methodologies that we are provided with the most thorough understanding of central

themes on which to base our interventions. Thus, modern epidemiology seemed relevant for this purpose, in combination with qualitative methods.

Taking the child’s perspective

I have learned early on the consequences of any given experience for a child depend both on the way in which the child understands the event and the meaning he/she attaches to it. Children often experience things different from adults. Fatimah is one of the children whose parents participated in my research early in the 1990s:

Fatimah was 4 years old when she arrived in Denmark with her mom and dad. They had escaped war and her father had been in jail shortly before they were able to escape. When they arrived to the refugee camp in Denmark, the father was questioned by the police and afterwards separated from his family and placed in the camp’s prison, while Fatima and her mother were placed in the family unit of the same camp. The mother next day told me that Fatimah in her homeland had experienced how her father was picked up by soldiers and later was returned to the family beaten up and in very bad shape. Now Fatimah cries, clings to her mother, and insists that her father will never come back. The parents had told her that when they came to Denmark, they would be free, and no one would take her father away again. Fatimah thinks that her father is starving and when she hears the shooting from the nearby military camp, she shouts in distress, “now they shoot my father”. She does not believe it when told that nothing would happen to her father in the prison here.

Fatimah’s father was never in danger in the prison in Denmark, but Fatima did not believe that. Her experience told her that being

put to prison had devastating results, and she had to experience otherwise before she would believe it.

Early research has shown that families who come to Denmark or other European countries as refugees often have a past marked by violence, deprivation, insecurity, and anxious waiting (Montgomery, 1998). The parents have chosen to flee from areas of war or other forms of organised violence out of a desire and hope to create a better future for themselves and their children in another country. Where they end up is often a coincidence. Every family member has their own story and need to be heard and understood.

The trauma of refugee children

Studies of children's psychological reactions to war, other organised violence, and being a refugee, became more frequent during the late 80s and 90s and documented a high prevalence of psychological symptoms (for an overview see e.g. Lustig et al., 2004). Children who arrive alone, without their parents, or who are separated from their parents, are at greater risk for developing psychological problems and need particular attention.

An important discovery was that conceptualizing trauma reactions in children in terms of PTSD is not sufficient. Epidemiological studies, among them my own (Montgomery, 1998 & 2001), showed that children's reactions to traumatic experiences are not necessarily PTSD specific, but can be much more varied. The children often react with some form of anxiety, they may appear sad and upset, suffer from sleep disorders, have difficulties with concentration, and become restless and aggressive. How serious the reactions are depends, among other things, on the parents' condition and how quickly and effectively the family is helped to a safer life in exile.

Research from the early 90s (see Montgomery, 1998) also documented that refugee children often have had their own traumatic experiences of, for example, war, imprisonment, persecution, and flight. At the same time, they may have lost or been separated from significant caregivers for a longer period of time if, for example, the father has been at war or in prison, or if one or more family members have died. Many children have lived in a refugee camp under difficult circumstances before or during the escape, they have experienced shootings, sought protection against bombing, have witnessed killings and assaults against their family or others, and have had to leave their homes and belongings, often in a hurry (Baro, 2006; Montgomery, 1998). Only a few of the children in my own research had themselves been subjected to torture, whereas 30% of the parents had been imprisoned and tortured (Montgomery & Foldspang, 1994) so that more than half of the children were living in a torture surviving family (Montgomery, 1998). However, other studies have documented a high number of tortured children particularly among unaccompanied refugee children, child soldiers, children living in extreme poverty, and abandoned children (Alayrian, 2009).

Although early studies suggested that both the traumatic experience and factors related to the family or the exile situation could be associated with the children's psychological problems, few studies in the early 90s utilized a multivariate statistical method when analysing the associations between traumatic life circumstances and psychological problems among refugee children. More such studies were published during the following years. A conclusion in my own research from the 90s was that having lived during prolonged conditions of organised violence rather than experiencing specific events, was asso-

ciated with anxiety at arrival, however, later it appeared that also the cumulative trauma (number of types of traumatic events experienced by the child or the family) as well as living with a parent, who had been tortured, had a profound effect on the children's reactions shortly after arrival.

Intergenerational transmission of trauma

'Intergenerational transmission of trauma' is a concept that has been used to describe the phenomenon of children reacting to their parents' traumatization with trauma-related symptoms. The children do not necessarily have traumatic experience themselves; however, the trauma is passed on and communicated to the children through their parents' reactions and the impact of these reactions on the parents' ability to be actively present and attentive to their children's needs.

The importance of intrafamily support and the interrelationship between children's and parents' situations and reactions have been documented in both my own and other research up through the 90s and 2000s (Arakelyan & Ager, 2021; Dalgaard, Thøgersen & Riber, 2020; Bryant et al, 2018; Montgomery, 2011). Three potential and mutually interlinked pathways were suggested for this relationship: post-traumatic disruptions in parental attention to the child because of the parents' own problems; family violence or neglect secondary to organised violence; and aspects of trauma-focused family communication.

We know from clinical experience that parents who are traumatized following exposure to torture or organised violence can have difficulties in living up to their children's demands for empathy, sensitivity, and presence. Secure attachment and children's trust in their parents' ability to protect them against danger are important prerequisites for healthy development. Studies have pointed to the role

of refugee trauma in disrupting attachment security in both children and adults as well as to the protective role of safe attachment representations in reversing the impact of traumatic events in children (Haene, 2009). Furthermore, the transgenerational transmission of trauma has been found associated with overall family functioning, and particularly with a pile-up of stressors within the family such as serious physical illness, financial problems, worries about the extended family in the country of origin, worries about residence permits/citizenship, having a disabled child, or the family's housing situation (Dalgaard & Montgomery, 2017).

Parental trauma has been proposed as a central risk factor for family related violence in refugee families (Timshel, Montgomery & Dalgaard, 2017). In a systematic review (Montgomery, Just-Østergaard & Jervelund, 2019), parents who had been exposed to traumatic events, especially parents who had been diagnosed with PTSD, were found to be at risk of perpetrating child abuse, particularly when the family was living in otherwise stressful life circumstances (e.g. war, poverty, exile). Bryant et al (2018) found PTSD in refugee parents to be associated with harsh parenting styles, leading to adverse effects on their children's mental health.

Communication between family members about traumatic experiences can foster resilience and serve a buffering role during critical times in the life of a child, but the quality of the communication depends on the way the family is experiencing its life story and situation as refugees. In a qualitative study, communication in the family was conceptualised in relation to 'stories told' and 'stories lived' (Montgomery, 2004). When the 'stories told' were in contradiction to the 'stories lived', a situation of ambiguity and uncertainty arose; for instance, this could be the case when the

parents insisted on their children not knowing anything about imprisonment and torture, and on it not being spoken about (the story told), at the same time as the father, in his desperation, at times would talk about details from his experienced torture in the presence of the children (the story lived). The meaning-providing contexts for making sense of the family history of violence and exile could be more coherent, less coherent, or contradictory which might directly result in a strengthened relationship or confusion, powerlessness, and action paralysis. One conclusion from this qualitative research was that information about parents' experiences of imprisonment and torture is not in itself helpful in relation to the children's ability to cope with their traumatic past. The ability to create meaning of the family's history depended more on the manner in which the parents and the children communicate with each other about the events than on what is actually communicated to the children – the relationship between children and parents thus seems to be the most important factor.

An interesting finding from my own follow-up study was an association between the parents' health and the observed difference between parents' ratings of their children's health and the children's self-ratings: When the father suffered from a somatic disease, both parents tended to underestimate their children's symptoms, while parents in families in which the father suffered from psychological problems tended to overestimate their children's problems (Montgomery, 2008b). Somatic illness in the parents can reduce their attention towards their offspring's problems because of difficulties in coping with the challenges of daily life. On the other hand, parents who are anxious or nervous can tend to worry more about their children's future in exile. This can have great clinical importance when refugee children and youth are referred for

examination and treatment as well as for understanding research on refugee children with only one informant (often a parent).

Long-term consequences of trauma

Do the psychological problems in refugee children persist over time? Not necessarily, but to understand the long-term trajectory of psychological problems, follow-up studies are necessary. However, such studies are rare, and most of them have a relatively small population (below 100) and the follow-up period is, in many cases, limited to a 1-3 year time period. A few studies that have included more than two observations suggest that many years can pass before a high initial symptom level is reduced, e.g. after 6 years or more (Hjern & Angel, 2000; Sack et al, 1999; Sack et al, 1993).

Studies with a longer follow-up period – among them my own research conducted 8-9 years after the baseline (Montgomery, 2008a) – have shown that the magnitude of the psychological problems is considerably reduced over time. Most refugee children and youth integrate well into the society, go to school, get work, learn the language, and find local friends. But although the high prevalence of psychological problems at arrival was considerably reduced over time, I found that it was still higher 8-9 years after arrival than what was found in populations of youth without a refugee background. While the children's traumatic background at arrival only to a limited extent seemed to determine their long-term mental health, the amount of life stressors in exile, including the experience of discrimination (Montgomery & Foldspang, 2008), was found to be of prime importance in my follow-up study.

To further understand the relative impact of previous traumatic experience and exile-related stress on psychological problems in exile,

at arrival and follow-up, I compared children with no psychological problems at both arrival and follow-up (the spared), with children who had problems at arrival, but not at follow-up (the adapted) and children with problems at both points in time (the traumatised) (Montgomery, 2010). The number in types of traumatic experiences before arrival in Denmark distinguished the spared from the traumatized, while the number in types of stressful life conditions in exile distinguished the adapted from the traumatized. Thus, stressful life conditions in exile exerted impact on the children's ability to adapt following initial problems at arrival rather than previous traumatic experience-related violence. This study stresses the importance of environmental factors for children and young people's ability to adapt in a healthy way after traumatic experiences related to war and other organised violence. Refugee children with traumatic experiences prior to arrival are vulnerable, but the long-term effects of these experiences depends on further exposure to individual, family, or society-related risk factors. This does not, however, mean that the traumatic experiences are without significance in the long run, but rather that the traumatic experiences from the home country are thrust into the background as other factors get a more direct influence on the child or youth's mental health. An overall conclusion is that refugee children can show a remarkable resilience; however, being resilient does not imply immunity to negative life events.

The relative importance of traumatic experiences and exile-related factors changed over time which, among other things, was found in a follow-up study of refugee children in Sweden fleeing from Chile and the Middle East: while previous traumatic experiences was found to be the most important predictor at arrival in Sweden, family-related stress was found to be a significant predictor

as well at the follow-up study after 18 months of residence in Sweden, and 6-7 years later, current family-oriented stress was found to be the most important predictor for the children's psychological problems (Hjern et al, 2000).

Studies point to the following factors as especially important for the long-term psychological reaction of children and youth: *Aspects of social life* (including schools, friends and parents' education and behavior), and *Stressful events in exile* (including discrimination).

The negative factors relate, to a large extent, to the difficulties associated with trying to integrate into the society. Networks of friends, supporting institutions and groups, such as schools, can be deciding factors for how well refugees will be able to cope with life in the new society.

Thus, whether or not traumatic experiences have long-term consequences for the child's development and mental health depends to a large extent on what happens to the child after arrival in the country of exile. (Re)establishing a supportive social ecology around the child and his/her family is of prime importance for the healthy adaptation and development. Community interventions should attempt to establish a secure, predictable, coherent, and stable life context within which positive experiences can enhance healthy development. One aspect of such interventions could be to actively combat discrimination and negative attitudes towards refugees within, for instance, the school setting. Another intervention would be to support refugee parents in understanding and dealing with their children's reactions. Teachers and prosocial peers can play an important role by providing compensatory or additional support when parents are too traumatized themselves to help their children. Some children will need extra support and professional treatment due to their traumatic experiences, their social life circum-

stances, and family relations. Interventions aimed at enhancing protective factors and reducing risk factors within the various life contexts of the child will have a positive influence on the child and might prevent psychopathology in the long run.

The changing paradigm on refugees in Europe

The United Nations Convention on the Rights of the Child is a legally-binding international agreement setting out the civil, political, economic, social, and cultural rights of every child. It was adopted in 1989 and the Nordic countries were among the first in the world to ratify it. Four general principles are set out: nondiscrimination; the best interests of the child; the right to life, survival and development; and the right to be heard. Asylum-seeking and refugee children are specifically mentioned and the convention states the rights of such children to receive appropriate protection and humanitarian assistance (Jørgensen, Leth & Montgomery, 2011).

During the last 20-30 years, we have witnessed a considerable change in the way refugees are perceived and talked about in Western countries. From primarily perceiving refugees as human beings in need of protection, the main discourse now seems to be how to protect Europe from the influx of new refugees and the general trend in Europe has been towards more and more restrictive migration policies (Gauffin, 2020). Studies have documented how the post 9/11 'War on Terror' has had a negative effect on Muslim children and youth in the West, and how parental identity formation among Muslim parents living in the West is highly influenced by the negative portrayals of Islam within mass media (Dalgaard, 2016).

This changing paradigm has had a profound influence on the rights of asylum-seek-

ing and refugee children, and has in several ways prevented the existing knowledge about the need of such children from being put into practice. The social and political environment in a country often has a greater impact on what is done, than what is known to be in the best interest of the child. We know for example that prolonged asylum procedures, temporary residence permits, delayed family reunifications, various school-moves, and xenophobic attitudes is counteracting healthy development, but that doesn't stop such praxis.

The way forward

Understanding refugee trauma in general, and in children in particular, is a relatively new field. What has been clearly demonstrated in research and clinical practice during the last 30-40 years, however, is the need to think much broader than in terms of individual psychopathology (Arakelyan & Ager, 2021). To capture the complexities involved, psychological trauma in refugee children and adolescents must be studied and understood in the context of a range of risk and protective processes involved in the pre-, peri- and post-flight life conditions of the child or the young person. Programs to enhance refugee children's mental health should always involve the family, considering that not only the nuclear family in exile, but also the extended family in the country of origin, can have a profound influence on the children. Treatment for traumatized refugee families should be made easily and early available and both parents and children should be targeted. Furthermore, initiatives aiming at reducing stress arising from the environments in which the potentially traumatized families live should be taken early on, e.g., in the form of financial or material support, educational activities for adults and children, and establishing emotional support groups.

Finally, in a time with growing anti-refugee rhetoric, xenophobia and restrictions of refugees' rights to apply for asylum and family reunification, mental health researchers and practitioners need to apply their knowledge in social action and advocacy for refugees working together with researchers and practitioners from other fields.

The results of research on refugee children and youth indicate the existence of a large public health problem which calls for policy change and political action. A critical review of procedures and practices regarding the reception and treatment of refugee families is necessary and mental health professionals need to play their part, e.g. by letting their voices be heard when refugees are treated in manners that counteract healthy development. It's a huge loss for both the young refugees and for the community, if refugee youth are allowed to grow up with a feeling of alienation.

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