VolkswagenStiftung

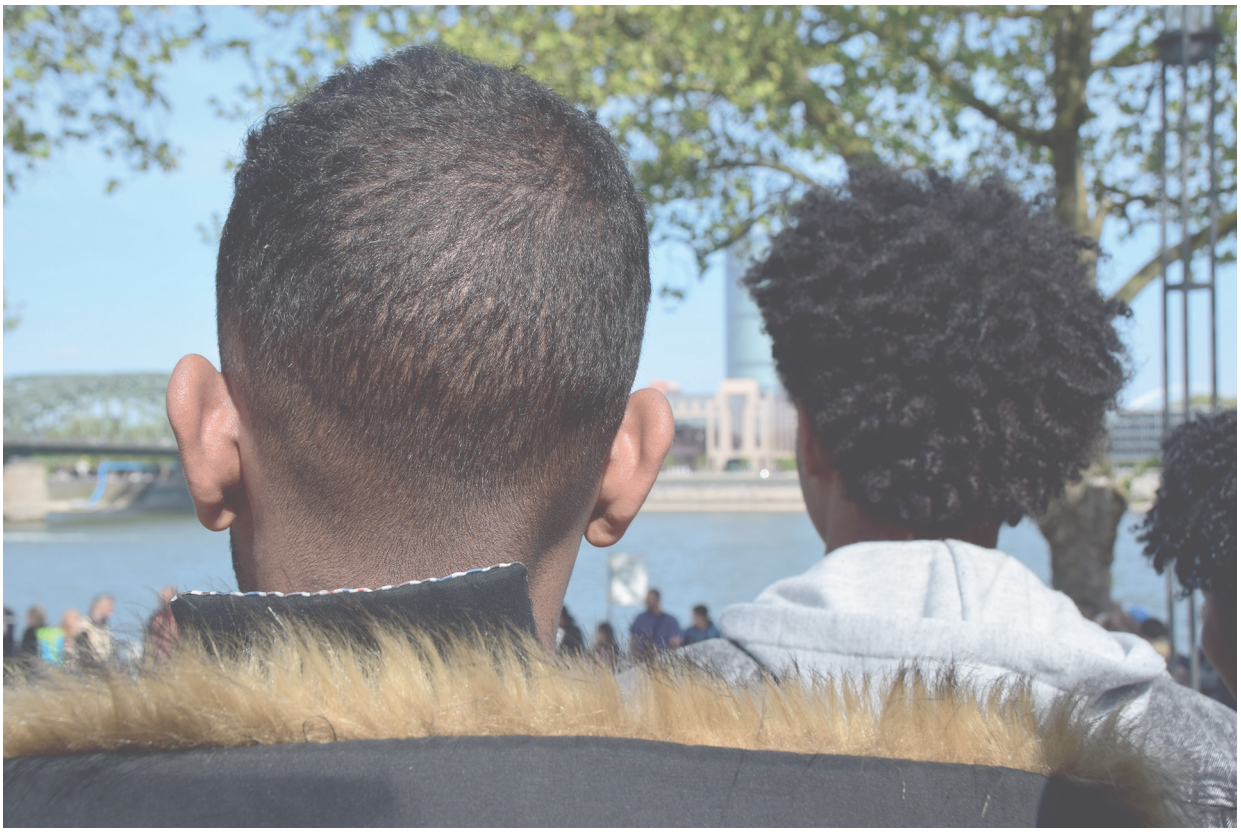
UNIVERSITÄT LEIPZIG
Medizinische Fakultät

CONFERENCE READER

Interdisciplinary Perspectives on Unaccompanied Minor Refugees

September 28–29, 2017
Conference Center of
Schloss Herrenhausen, Hannover

Edited by Susan Sierau, Yuriy Nesterko and Heide Glaesmer



Contents

Introduction

Because of disasters and armed conflicts constantly happening around the globe, people must leave their homes and become refugees. By the end of 2016, 65.6 million people were registered as forcibly displaced (UNHCR, 2016): 40.3 million were internally displaced people, 22.5 were refugees – all those who crossed the border of their home countries, and 2.8 million were asylum-seekers. In addition, 51% of the refugee populations in 2016 were children below the age of 18. Among them, unaccompanied minor refugees were the most dramatic growing group: In 2015, compared to 2014 with 34 300 and 2013 with 25 300 applications, 98 400 new asylum applications were registered submitted by unaccompanied or separated children and adolescents. The highest number among these new applications (47.8% of 75 000 applications in total) was registered in Germany.

Unaccompanied minor refugees belong to the refugees most in need of protection. Research has shown that unaccompanied minor refugees have often been subjected to discrimination and have frequently experienced difficult developmental or even traumatizing experiences before, during and after the flight. In this light, much more detailed research on the adjustment process of unaccompanied minor refugees is needed. There are great efforts to improve interdisciplinary collaboration and to establish effective prevention approaches to enhance different protective factors, as well as adapting intervention strategies to the needs of traumatized children, with special respect to unaccompanied minor refugees.

The symposium "Interdisciplinary Perspectives on Unaccompanied Minor Refugees" which took place on 28th and 29th of September 2017 in the conference centre of Schloss Herrenhausen (Hannover, Germany) presented the status quo of state-of-the-art research in this field. International researchers from the fields of psychology, psychiatry, history, political and law sciences as well as social work discussed current and future research foci and engaged in a vivid dialogue about practical implications of their studies. We are grateful to the Volkswagen Foundation for supporting this symposium and the pre-conference early career workshop financially and thus for allowing us to share our research in this international meeting.

The conference reader gives an overview about the program, some insights into the contributions of the speakers and the discussions during the conference.

Leipzig, March 2018 Yuriy Nesterko and Susan Sierau

Programme Overview

Thursday, 28th of September 2017

09:00 – 10:30 Pre-conference workshop I

Connecting young scientists with senior researchers

Young scientist participants:

PhD Student David Jäckle (Department of Medical Psychology and Medical Sociology, University of Leipzig, Germany):
Culture sensitive diagnostics – A brief introduction

PhD Student Malte Behrendt &
PhD Student Océane Uzureau (Faculty of Psychology and Educational Sciences, Department of Social Work and Social Pedagogy, Ghent University, Belgium):
Project "Childmove" – Unaccompanied refugee minors and how experiences before, during and after the flight impact their psychological well-being

10:30 – 11:00 Coffee break

11:00 – 12:30 Pre-conference workshop II

Connecting young scientists with senior researchers

Young scientist participants:

PhD Student Johanna Sill (Department of Clinical Psychology and Neuropsychology, University of Konstanz, Germany): *Psychological well-being and traumatic stress in unaccompanied refugee minors*

Dr. Sara Thommessen (Department of Psychology, City University London, UK):
Needs and experiences post-migration: Voices of unaccompanied refugee youth in England

PhD Student Michelle Alto (Mt. Hope Family Center, University of Rochester, USA): *Group interpersonal psychotherapy for unaccompanied refugee minors in the U.S. foster care system*

Senior researcher participants:

Prof. Dr. John W. Berry
Prof. Dr. Ilse Derluyn
Dr. Heide Glaesmer
Prof. Dr. Rolf Kleber
Prof. Dr. Ulrike Kluge
Prof. Dr. Sabine Lee
Prof. Dr. Eva Möhler
Dr. Brit Oppedal
Prof. Dr. Ruth Pat-Horenczyk

Prof. Dr. Paul L. Plener
Prof. Dr. Rita Rosner
Dr. Nando Sigona
Prof. Dr. Benedetto Vitiello

12:30 – 13:30 Lunch break

13:30 – 13:45 Welcome note

13:45 – 15:15 Keynote lecture I

Prof. Dr. Ilse Derluyn (Centre for the Social Study of Migration and Refugees, CESSMIR, Department of Social Work and Social Pedagogy, Ghent University, Belgium): *Suffering but strong? The psychosocial wellbeing of unaccompanied refugee youths in current political contexts*

15:15 – 15:45 Coffee break

15:45 – 17:15 Symposium 1: Trauma and resilience in unaccompanied minor refugees

Chair: Dr. Susan Sierau, University of Leipzig, Germany

Prof. Dr. Rolf Kleber (Arq Psychotrauma Foundation & Utrecht University, Netherlands): *Trauma and resilience in young refugees: Identifying adjustment strategies and long term consequences*

Prof. Dr. Hubertus Adam (Child and Adolescent Psychiatry Clinic, Eberswalde, Germany): *After the war – Trauma and reconciliation of child refugees*

Prof. Dr. Ruth Pat-Horenczyk (Paul Baerwald School of Social Work & Social Welfare, The Hebrew University Jerusalem, Israel): *Trauma and resilience after exposure to cumulative trauma: Guidelines for early interventions*

Prof. Dr. Eva Möhler (SHG-Kliniken Sonnenberg, Saarbrücken, Germany): *START: Stress-Traumasymptoms-Arousal-Regulation-Treatment with refugee minors*

Discussant: Prof. Dr. Benedetto Vitiello, University of Turin, Italy

17:15-18:45 Walk in the Royal Gardens of Herrenhausen

19:00 Conference dinner

Friday, 29th of September 2017

09:00 – 10:30 Keynote lecture II

Prof. Dr. John W. Berry (Department of Psychology, Queen's University, Kingston, Canada and National Research University, Higher School of Economics, Moscow, Russia): *Acculturation and adaptation: International perspectives*

10:30 – 11:00 Coffee break

11:00 – 12:30 Symposium 2: Belonging, acculturation and identity issues in unaccompanied minor refugees

Chair: Dr. Yuriy Nesterko, University of Leipzig, Germany

Prof. Dr. Paul L. Plener (Department of Child and Adolescents Psychiatry and Psychotherapy, University of Ulm, Germany): *Attitudes towards unaccompanied refugee minors in Germany*

Dr. Brit Oppedal (Department of Child Development, Norwegian Institute of Public Health, Oslo, Norway): *Dependent and self-reliant. The experiences of unaccompanied refugee minors in numbers and narratives*

Dr. Muireann Ní Raghallaigh (School of Social Policy, Social Work and Social Justice, University College Dublin, Ireland): *The provision of care and support to unaccompanied minors*

Discussant: Dr. Susan Sierau, University of Leipzig

12:30 – 13:30 Lunch break

13:30 – 15:00 Symposium 3: Interventions and clinical work in unaccompanied minor refugees

Chair: Dr. Heide Glaesmer, University of Leipzig, Germany

Dr. Abigail L. H. Kroening (Division of Developmental and Behavioral Pediatrics, Golisano Children's Hospital, University of Rochester, USA): *Advancing the care of refugee children with developmental delays or disabilities: An interdisciplinary approach spanning developmental-behavioral screening to specialty services*

Thorsten Sukale (Department of Child and Adolescents Psychiatry and Psychotherapy, University of Ulm, Germany): *Treatment needs – Providing Online Resource and Trauma Assessment (PORTA) for refugees*

Prof. Dr. Rita Rosner (Department of Psychology, Catholic University of Eichstätt-Ingolstadt, Germany): *Treatment of unaccompanied refugee minors with PTSD: Experiences and first results of the application of an evidence based intervention manual*

Discussant: Prof. Dr. Ulrike Kluge, Charité, University Medicine Berlin, Germany

15:00 – 15:30 Coffee break

15:30 – 17:00 Symposium 4: Legal issues, education and children's rights

Chair: Prof. Dr. Peter F. Titzmann, Leibniz University Hannover, Germany

Prof. Dr. Sabine Lee (Department of History, University of Birmingham, UK): *Children's rights and the best interest of the child*

Dr. Nando Sigona (School of Social Policy, University of Birmingham, UK): *Outsourcing the 'best interests' of unaccompanied asylum seeking minors in Britain*

Dr. Samantha Arnold (Economic and Social Research Institute, Trinity College Dublin, Ireland): *A children's rights approach to the refugee convention*

Discussant: Dr. Heide Glaesmer, University of Leipzig

17:00 – 18:30 Outcomes and open questions

Chair: Prof. Dr. Sabine Lee, University of Birmingham, UK

18:45 – 20:00 Light dinner

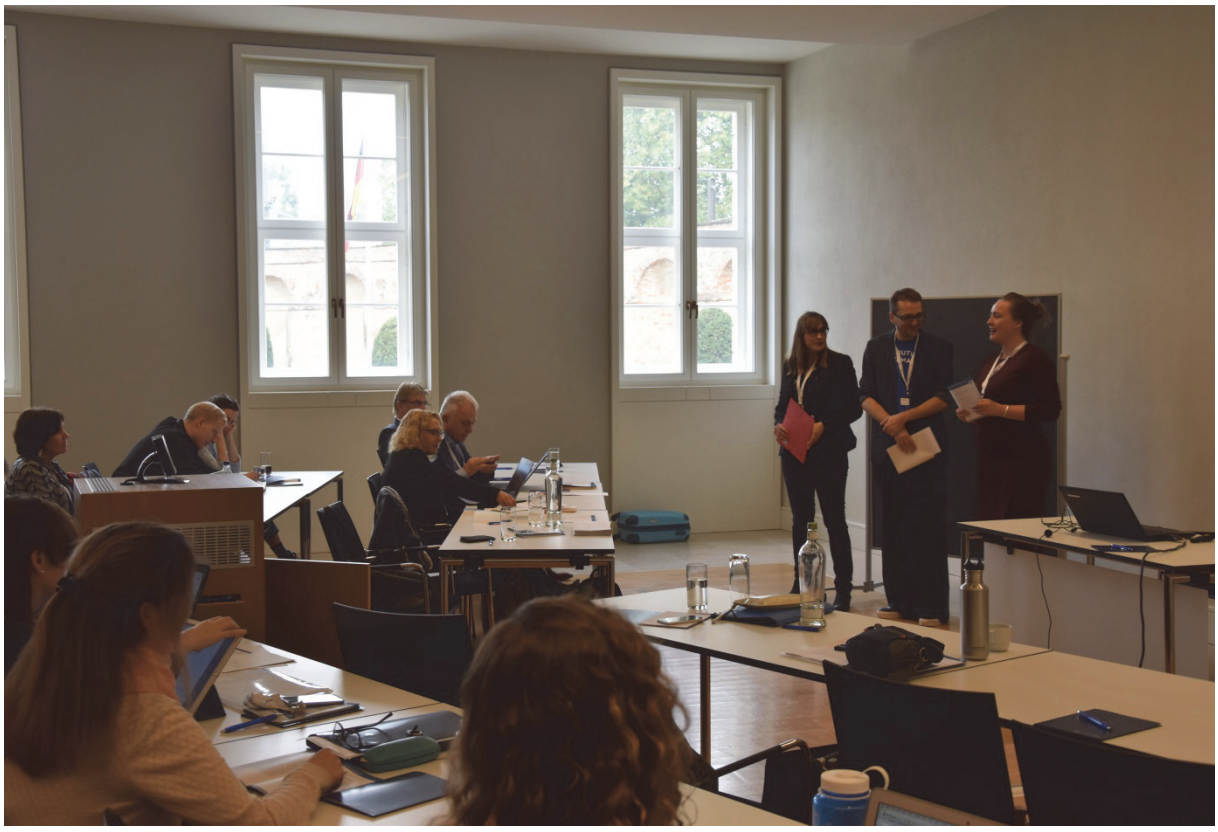


Photo: Welcome note held by the organizers Susan Sierau, Yuriy Nesterko and Heide Glaesmer

Contribution Outline

Pre-Conference Contributions

Culture sensitive diagnostics – A brief introduction

David Jäckle (Department of Medical Psychology and Medical Sociology, University of Leipzig)

With 65.6 million forcibly displaced people worldwide in 2016 (UNHCR, 2017), there is also a rising demand on health professionals working with this specific population. By 2016 18.6 million people, which is around one quarter of the German population, have a so-called "migration background". According to the German Federal Office for Statistics, this definition refers to people who themselves have a first-hand migration experience or who are member of a second generation (Bundesamt für Statistik, 2017). Also, by the end of 2016, the population of asylum seekers and officially recognized refugees in Germany added up to 1.3 million people (UNHCR, 2017). This population is a specific subgroup, which is mostly exposed to diverse stressful events in their home country and during the journey to the country of refuge and in the host country. As defined in the 1951 Geneva Refugee Convention, the term refugee refers to a person who is persecuted in their country of origin because of his or her race, religion, nationality, social group membership or political belief. The following will refer to the group of migrants, but can also be transferred to the subgroup of refugees.

The process of migration, in the case of migrants, is assumed to have an influence on health or general well-being and therefore on the personal need for medical or psychological care. Schenk (2007) postulates six migration-related factors that can influence health. First of all, the conditions and health-requirements of the country of origin (1), which can lead either to positive or negative influences depending on the possible treatment for the specific disorder. Then there is the act of migration itself (2), which is a demanding process at least for the first generation of migrants. Besides that, there are the social (3, i.e. socio-economic status) and legal (4, i.e. status of the asylum procedure) conditions of the host country as well as the ethnic affiliation (5), which again can be of positive (i.e. finding a place within a community) or negative (i.e. discrimination) influence. Lastly, there are specific barriers for migrants in entering the health care system (6) as opposed to locals, which will be explained in detail below.

Razum, Geiger, Zeeb and Ronellenfitsch (2004) assume that there are three reasons for possible differences in health care access and utilization between migrants and locals. On the one hand there are problems in communication on the side of the migrants and a lack of culture-sensitive information and skills on the side of the health care system. On the other hand the legal status of the migrant might prevent them from using the full range of health care services, the health care providers lack intercultural expertise, and moreover, there are not enough language and cultural interpreters available. Ultimately, the different cultural concepts of illness between migrant patients and native physicians go along with a specific understanding of medical and psychological symptoms, its reporting and the expectation on the treatment provided.

When it comes to psychological diagnostics, there is a challenge in understanding the specific lingual expression of symptoms, the so-called "idioms of distress" (Bhugra, 2005; Kraus, 2006). As an example, despite a correct translation, a statement or behavior that stands for a depressive symptom in one culture could mean a different thing in another culture. Moreover, the willingness to talk about certain problems can differ between people of different cultural backgrounds, which is assumed to result in a risk of misdiagnosis (Glaesmer, Brähler & von Lersner, 2012).

When using psychometric tests, these problems also account for difficulties in intercultural studies. It should be assured that the same construct is measured when using the same test in groups with different languages, which is referred to as measurement invariance. Although measurement invariance can be investigated using confirmatory factor analysis, only few instruments available in different languages provide such information. Examples for tests that already exist in different languages with psychometric, culture-sensitive evaluation are the ***PHQ-9*** (Kroenke, Spitzer & Williams, 2001) measuring depression, the ***HSCL-25*** (Derogatis et al., 1974) measuring depression and anxiety, the ***IES-R*** (Weiss & Marmar, 1997) and the ***HTQ*** (Mollica et al., 1992) measuring posttraumatic stress disorder, ***PHQ-15*** (Kroenke, Spitzer & Williams, 2002) measuring somatoform disorders, the ***SF-36*** Health Survey (Tarlov et al., 1989) measuring health-related quality of life. Moreover, with the release of the DSM-5 (APA, 2013) the ***Cultural-Formulation-Interview (CIF)*** according to DSM-5 was published, a 16 items clinical interview covering cultural differences in concepts of illness.

Psychological diagnostics are put to a challenge when it comes to measuring symptoms in groups with different cultural backgrounds. Psychometric tests that are most commonly used screening instruments should be investigated in matters of measurement invariance. When using them, the results should be interpreted only in combination with a culture-specific interview such as the Cultural-Formulation-Interview. Moreover, the consideration and understanding of different idioms of distress should be implemented in the psycho-diagnostic process. These findings can also be transferred to the group of minor and adult refugees, who should be treated with special attention due to their high risk of psychological distress and language barriers.

References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: APA.

Bhugra, D. (2005). Cultural identities and cultural congruency: a new model for evaluating mental distress in immigrants. *Acta Psychiatrica Scandinavia, 111,* 84–93.

Bundesamt für Statistik (2017, Jan. 15). *Persons with a migration background.* https://www.destatis.de/EN/FactsFigures/SocietyState/Population/MigrationIntegration/Methods/MigrationBackground.html

Derogatis, L.R., Lipman, R.S., Rickels, K., Uhlenhuth, E.H. & Covi, L. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioral Science, 19*(1), 1–15.

Glaesmer, H., Brähler, E., von Lersner, U. (2012). Kultursensible Diagnostik in Forschung und Praxis – Stand des Wissens und Entwicklungspotenziale. *Psychotherapeut, 57*, 22–28.

Kraus, M. (2006). Somatisierung im kulturellen Kontext. In E. Wohlfart & M. Zaumseil (Hrsg.), *Transkulturelle Psychiatrie – Interkulturelle Psychotherapie*. Berlin: Springer.

Kroenke, K., Spitzer, R.L. & Williams, J.B.W. (2001). The PHQ-9 – Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613.

Kroenke, K., Spitzer, R.L. & Williams, J.B. W. (2002). The PHQ-15: Validity of a new measure for evaluating the severity of somatic symptoms. *Psychosomatic Medicine, 64*, 258–266.

Mollica, R.F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S. & Lavelle, J. (1992). The Harvard Trauma Questionnaire: validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *Journal of Nervous and Mental Disease, 180*, 111–116.

Razum, O., Geiger, I., Zeeb, H. & Ronellenfitsch, U. (2004). Gesundheitsversorgung von Migranten. *Deutsches Ärzteblatt, 101,* 2882–2887.

Schenk, L. (2007). Migration und Gesundheit – Entwicklung eines Erklärungs- und Analysemodells für epidemiologische Studien. *International Journal of Public Health, 52*(2), 87–96.

Tarlov, A.R., Ware, J.E., Greenfield, S., Nelson, E.C., Perrin, E. & Zubkoff, M. (1989). The Medical Outcomes Study: an application of methods for monitoring the results of medical care. *Jama, 262* (7), 925–930.

UNHCR (2017, June 19). *Global Trends. Forced Displacement in 2016.* Retrieved from: http://www.unhcr.org/5943e8a34.pdf

Weiss, D.S. & Marmar, C.R. (1997). The Impact of Event Scale – Revised. In J.P. Wilson & T.M. Keanse (Eds.), *Assessing psychological trauma and PTSD* (pp. 399–411). New York: Guilford.

BIO:

David Jäckle is a psychologist and research assistant at the Department of Medical Psychology and Medical Sociology at the University of Leipzig, specialized in trauma and migration research with Dr. Heide Glaesmer. At present he is involved in the project "Mental distress in newly arriving refugees in Saxony". When working with populations with heterogeneous cultural backgrounds, he often finds himself confronted with the challenges and limitations of psychodiagnostics. Therefore his ambition is to explore culturally sensitive psychological methods that are more appropriate in providing an accurate picture of the individual client.

Project "Childmove" – Unaccompanied refugee minors and how experiences before, during and after the flight impact their psychological well-being

Océane Uzureau and **Malte Behrendt** (Ghent University, Department of Social Work and Social Pedagogy, Center for the Social Study of Migration and Refugees (CESSMIR))

Abstract

"Unaccompanied refugee minors" are children or youngsters who flee their home country without their parents or any adult legally responsible for them. Considering their young age and the absence of their primary caregiver, they are especially vulnerable to adverse experiences at different stages of their migratory journey. Research has mainly focused on pre-departure traumatic experiences and post migration experiences such as daily stressors migrants' children must cope with in the host society (Fazel, Reed, Panter-Brick & Stein, 2012; Miller & Rasmussen, 2010). However little is known on the various experiences unaccompanied minors face while being on the move.

In order to fill in this gap, the Child Move project, a research project funded by the European Research Council, aims at finding out how the flight experiences of unaccompanied refugee minors affect their psychological well-being with regard to experiences in their country of origin, experiences they have during their trajectory through Europe as well as experiences in the country of settlement. Using an integrative mixed-methods, cross-country and multi-sited approach, the research team will document the minors' peri-migration experiences across various transit countries like Libya, Greece and Italy, highlighting the importance of specific stressors like racism and detention. By implementing a longitudinal design, we will try to get a holistic picture of the minors' life situation and to investigate their psychological well-being throughout various stages of their trajectories. Choosing a follow-up approach will also help us to create knowledge about how evolutions in the minors' psychological well-being are mediated by different traumatic experiences and daily stressors. In this regard, the project will specifically investigate the psychological impact and role of housing, reception and care structures in Belgium and in Italy. Special attention will be given to the concept of daily stressors and how the measurement of these can be operationalized. Besides quantitative methods like self-report questionnaires and qualitative methods like in-depth interviews, innovative research methods like visual ethnography (Derluyn, Watters, Mels & Broekaert, 2012) will be applied in order to grasp all aspects of the minors' complex situation.

References

Derluyn, I., Watters, C., Mels, C. & Broekaert, E. (2012). 'We are All the Same, Coz Exist Only One Earth, Why the BORDER EXIST': Messages of Migrants on their Way. *Journal of Refugee Studies, 27*(1), 1–20.

Fazel, M., Reed, R.V., Panter-Brick, C. & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *Lancet, 379*(9812), 266–282.

Miller, K.E. & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine, 70,* 7–16.

BIO:

Océane Uzureau holds a Master degree in Migration Studies and is currently a PhD candidate in educational sciences at Ghent University. Member of the Child Move project research team, in her research project she will focus on flight experiences and integration pathways of unaccompanied minors arriving and crossing through Italy to continue their migratory journey through Europe. She has much research experience with unaccompanied minors in France, where she worked for the Observatory of the Migration of Minors (University of Poitiers – National Center of Scientific Research) promoting social inclusion of unaccompanied minors at the local level with local organizations and NGO's.

Malte Behrendt graduated in Clinical Psychology in 2015. During an internship with an NGO in Colombia he was able to gather first work and research experience with minors in situations of extreme violence and displacement. Following his graduation Malte started working in an emergency shelter for unaccompanied refugee minors in Berlin as a psychologist and social worker. Shortly thereafter he started the training as psychological psychotherapist at "Zentrum Überleben" – an NGO specialized in the treatment of victims of torture. Malte Behrendt is now working as a PhD student in the ERC-funded research project "Childmove" at Ghent University.

Psychological well-being and traumatic stress in unaccompanied refugee minors

Veronika Müller-Bamouh, Julia Morath, Maggie Schauer, Katalin Dohrmann, Dorothea Isele, Thomas Elbert and Martina Ruf-Leuschner (Universität Konstanz, Clinical Psychology and Clinical Neuropsychology)

Background: We investigated the mental health problems of unaccompanied refugee minors (URM) who seek asylum in Europe and assessed the exposure to adversity, with a focus on family and organized violence.

Methods: 56 unaccompanied refugees who came to Germany as minors were interviewed by trained clinical psychologists. They came from 20 different countries of origin and were between 13 and 21 years of age. Adverse and traumatic life experiences including domestic and organized violence were assessed using structured interviews. Furthermore, mental health problems including symptoms of PTSD, depression, somatization, as well as behavioral problems and appetitive aggression were investigated. Socio-demographic information including residence status and housing situation were assessed. 2 years after the first interview, 22 URM (aged 17 to 22 years) were re-investigated using structured interviews.

Results: Unaccompanied refugee minors reported a minimum of two traumatic events. More than two thirds of the respondents had experienced organized violence and 77% had lost at least one parent. 36% of the URM fulfilled the DSM-IV criteria for PTSD. The greater the exposure to organized violence, the greater was the severity of trauma-spectrum symptoms. Half of the participants presented moderate to severe depression symptoms. Self-reported violent acts correlated with the violence experienced within the family.

Moreover, our research suggests that mental health problems like PTSD and depression will not remit in URM across a two-year period when living in Germany, even when a secure residence status has been obtained.

Conclusion: Results indicate that unaccompanied refugees who immigrated to Germany frequently suffer from mental disorders. An early mental-health screening for URM and a better access to trauma-focused treatment seems mandatory to reduce the suffering and to integrate these adolescents in the society.

The substantial experience of adversity and violence may contribute to limited self-control and thus reduce the threshold for aggressive behavior. It is important to sensitize social workers and legal guardians for the problems of this group.

BIO:

Dr. Dipl.-Psych Veronika Müller-Bamouh is a researcher at the department of Clinical Psychology and Neuropsychology at the University of Konstanz. Since 2011 she also works at the Centre of Excellence for Psychotraumatology (CEP) at the University of Konstanz. This research centre collaborates with vivo (http://www.vivo.org/), a non-governmental organisation focussing on field research and the treatment of refugees in several countries who have suffered traumatic stress. Thus the competence centre combines research (University of Konstanz) and practical field experience (vivo). Dr. Müller-Bamouh's research focus is traumatic stress, aggression and mental health of Unaccompanied Minor Refugees. Aside from research and practical work she dedicates to trainings in the field of Trauma and Post-traumatic stress disorder.

Needs and experiences post-migration: Voices of unaccompanied refugee youth in England

Sara Amalie O'Toole Thommessen, Paula Corcoran and Brenda K. Todd (City, University of London, UK)

Background

According to the UN High Commissioner for Refugees (UNHCR), as a result of continuing conflicts, violence, persecution and human rights violations, the number of forcibly displaced individuals has increased in recent years, rising from 51.2 million in 2013 to 65.6 million in 2016 (UNHCR, 2015; 2016; 2017a; 2017b). Approximately 51% of refugees are under 18 years of age and many of these make long and hazardous journeys to asylum countries unaccompanied by adults and therefore with little protection. Unaccompanied refugee minors have been found to face severe adversity prior to their flight, during the journey as well as in post-migration environments (e.g. Fazel, Reed, Panter-Brick & Stein, 2012; Lustig et al., 2004). Compared to accompanied refugee children, they are at greater risk (Derluyn & Broekaert, 2007; Fazel et al., 2012; Sourander, 1998; Wiese & Burhorst, 2007) and have been found to experiences more psychiatric disorders (Wiese & Burhorst, 2007). In the asylum-countries, factors such as lengthy asylum processes, loss of culture, social status and social support, as well as discrimination, loneliness and isolation, continue to add to the needs, distress and disadvantage of these young people (e.g. Carswell, Blackburn & Parker, 2011; Fazel et al., 2012; Lacroix, 2006; Lie, 2002; Mawani, 2014; Silove, Sinnerbrink, Field, Manicavasagar & Steel, 1997).

Method

To supply efficient and humane support, we need to appreciate more fully the young refugees' experiences of entering an asylum country. Researchers, officials and educators must avoid making assumptions about experiences, cultural views and personal needs. With this in mind, we adapted an interview method based on personal construct theory, originally devised by George Kelly (1955). We aimed to avoid preconceptions and instead to strike directly at the viewpoints and meaning-making of the individuals involved, discovering what had best supported or hindered their immediate and long-term integration into their new society. Six young individuals, five men and one woman, aged between 18 and 28 years, who had arrived in England from Sub-Saharan Africa as unaccompanied minors took part. Their experiences of their social world were investigated through thematic analysis (Braun & Clarke, 2006; 2012) of interviews and Personal Construct assessments based on George Kelly's Personal Construct Theory. Additionally, participants took part in group sessions led by a therapist.

Findings

Findings based on interviews and group sessions emphasised social support as a means for hope, and highlighted gains from having close friendships and relationships that resembled family bonds. Social support was found to function as an escape from distress and isolation, and social vulnerability, and fear of rejection and issues related to trust and stigmatisation were emphasised. Despite the adversity and stress faced, the desire to move forward in life and to achieve personal goals was expressed.

Relationships that resemble family bonds and reduce despair by rebuilding trust and instilling optimism:

> *"I trust her as well. Yes, I've known her since I was 15, as a young refugee in the country, so she's been like a mother. Oh, she, she's done a lot. When you are new in the country, and you can't find your way – she kind of – that's why I call her like a mother – because she kind of showed me the way. And she tried to make it happen, you know. If it wasn't for people like her, maybe I wouldn't go to University, or maybe I was just going to forget about my dreams and forget about my goals and – cause I've been through a lot – that's why I call her like a mother."*

And friendships which offer an escape from distress:

> *"This friend is like, we do something together; do something – happy and whatever – he doesn't get angry or upset. He likes to play with young people, and to make them happy, you know, and to do something different with them and to try to help them. You can laugh, you can tickle him or whatever – it doesn't mind – he doesn't get angry or something like that. These two people are more about help; family, mum, dad, brother, sister... and this one is more like doing something, playing football or doing something – and it makes me remember when I was back home, and I would normally do something with my friends, like we would be riding bicycles or playing football or playing together or doing something together, you know... that was nice."*

Participants also reflected on their vulnerability to loss of relationships and fear of rejection:

> *"Now the relationship has reached a point that if I lose her then it might affect me, if I bring it back again maybe just to square one. Because now I would say I have no family here but they are my family now, right, so if I happen to lose them again - I lost my family once and I found another family again. So I cannot afford to lose this family again. If I happen to lose again this family for the second time then I don't know what my situation will be."*

Fears around discrimination, labelling and discussing refugee status were expressed:

> *"I even feel scared when I go for a job interview and I take my refugee passport to present. And I'm just thinking; the manager will already put me in another group."*

> *"It's like the theatre. While you are at the theatre, you know there is a real world outside, there is something else there, like a door at the back of the theatre: which is just normal for us. In the theatre, they just play a role, but at the back there is someone else as well, the real me. There is a real world. In the theatre I play something else, that's how I feel. I feel like an actor. I'm playing this movie but there is also a real me. People just see the actor, but there is also a real me."*

However, the young participants also showed resilience and optimism – hope versus despair:

> *"I want to be able to look after my family and look after myself and achieve my goals. I can live like anyone; I can do this or that. Yes, you can't automatically say that everything will be fine, but you will find a way of minimising it, you will find a solution for how to get rid of it. Find a way of living a better way. Because there will be a barrier between you and your monster, a big barrier. And there will be a point when your children grow up, that you can sit them down and explain yourself to them, it's another way of getting rid of it. You'll feel good about yourself, you will feel like you have achieved. Yes, you will feel like a man. Yes, you came from a long way, I was there and I thought I couldn't make it. But I made it."*

Conclusions and recommendations

This study illustrates the critical importance of providing access to appropriate social support and offering opportunities for meaningful relationships to develop. Our conclusions are that initiatives which seek to prevent discrimination, stigmatisation and isolation, and that aim to facilitate the development of social relationships, should be initiated and supported in the context of professional care systems and education. As well as therapeutic care, legal advice and guidance, there is need for support from adult mentors, membership of community groups and opportunities for education and work. Based on the participants' expressed need for social support in our study, it is evident that there is an important gap for asylum-countries to fill, particularly for young individuals who find themselves in a foreign country without their families.

Acknowledgement

We would like to thank the participants for sharing their stories, views and opinions, and their time.

The full paper can be found here:

Thommessen, S., Corcoran, P. & Todd, B. (2017). Voices rarely heard: personal construct assessments of Sub-Saharan unaccompanied asylum-seeking and refugee youth in England. *Children and Youth Services Review*, DOI: 10.1016/j.childyouth.2017.08.017

References

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology, *Qualitative Research in Psychology*, *3*, 77–101.

Braun, V. & Clarke, V. (2012). Thematic analysis. In H. Cooper, P.M. Camic, D.L. Long, A.T. Panter, D. Rindskopf & K.J. Sher (Eds.), *APA handbook of research methods in psychology,* Vol. 2: Research designs: Quantitative, qualitative, neuropsychological, and biological (pp. 57–71). Washington, DC, US: American Psychological Association.

Carswell, K., Blackburn, P. & Barker, C. (2011). The Relationship Between Trauma, Post-Migration Problems and the Psychological Well-being of Refugees and Asylum Seekers. *International Journal of Social Psychiatry*, *57*, 107–119.

Derluyn, I. & Broekaert, E. (2007). Different perspectives on emotional and behavioural problems in unaccompanied refugee children and adolescents. *Ethnicity & Health*, *12*, 141–162.

Fazel, M., Reed, R.V., Panter-Brick, C. & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *The Lancet*, *379*, 266–282.

Kelly, G.A. (1955, 1991). *The Psychology of Personal Constructs*. New York: Routledge.

Lacroix, M. (2006). Social Work with Asylum Seekers in Canada. *International Social Work*, *49*, 19–25.

Lie, B. (2002). A 3-year follow-up study of psychosocial functioning and general symptoms in settled refugees. *Acta Psychiatrica Scandinavia, 106,* 415–425.

Lustig, S.L., Kia-Keating, M., Knight, W.G., Geltman, P., Ellis, H., Kinzie, J.D. et al. (2004). Review of child and adolescent refugee mental health. *American Academy of Child and Adolescent Psychiatry*, *43*, 24–36.

Mawani, F.N. (2014). Social Determinants of Refugee Mental Health. In L. Simich & L. Andermann (Eds.), *Refuge and Resilience: Promoting Resilience and Mental Health among Resettled Refugees and Forced Migrants* (pp. 8–27). Springer: London.

Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V. & Steel, Z. (1997). Anxiety, Depression and PTSD in Asylum-seekers: Associations with Pre-migration Trauma and Post-migration Stressors. *British Journal of Psychiatry*, *170*, 351–357.

Sourander, A. (1998). Behaviour Problems and Traumatic Events of Unaccompanied Refugee Minors. *Child Abuse and Neglect*, *22*, 719–729.

UNHCR (2015). *Global Trends: Forced Displacement in 2014*. (accessed July 2017): http://www.unhcr.org/556725e69.html

UNHCR (2016). *Unaccompanied Minors and Separated Children: Young, Alone and Vulnerable* (accessed July 2017): http://www.unhcr.org/ceu/90-enwhat-we-docaring-for-the-vulnerableunaccompanied-minors-and-separated-children-html.html

UNHCR (2017a). *Global Trends: Forced Displacement in 2016*. (accessed July 2017): http://www.unhcr.org/statistics/unhcrstats/5943e8a34/global-trends-forced-displacement-2016.html

UNHRC (2017b). *The Central Mediterranean Route: Working on the alternatives to dangerous journey*. (accessed July 2017): http://www.unhcr.org/596f4c4a7.pdf

Wiese, E.B.P. & Burhorst, I. (2007). The mental health of asylum-seeking and refugee children and adolescents attending a clinic in the Netherlands. *Transcultural Psychiatry*, *44*, 596–613.

BIO:

Dr. Sara Amalie O'Toole Thommessen gained a first class honours degree in Psychology from City, University of London, an MSc in Psychology from the University of Copenhagen, Denmark, and her PhD from City, University of London. The PhD thesis, entitled *Exploring the experiences and needs of asylum-seeking and refugee individuals through qualitative and Personal Construct methods*, was defended in November 2016 and was supervised by Dr. Brenda Todd and Dr. Paula Corcoran. Sara is currently working with unaccompanied refugee youth in a therapeutic context in Copenhagen, Denmark.

Group interpersonal psychotherapy for unaccompanied refugee minors in the U.S. foster care system

Michelle Alto (Mt. Hope Family Center, University of Rochester, New York, USA)

Background

Refugee and asylum seekers face significant trauma and stress as they flee their country of origin (Lustig et al., 2004). Unaccompanied refugee minors (URM) and undocumented children (UC) are especially vulnerable to mental health-related challenges, because they make this journey as children and adolescents, without the protection and support of their parents or other caregivers. Local organizations in the United States distinguish between these groups of unaccompanied children as those who enter the country with legal refugee status (URM) or those who are apprehended at the US border and do not have refugee status (UC).

Organizations such as Catholic Family Center (CFC) in Rochester, New York, USA have developed programming for URM/UC youth that includes foster care placement, legal services, educational support, and mental health referrals. Although these youth have histories of significant trauma and CFC works to connect them with mental health services, CFC's program coordinator reports that many URM/UC youth do not pursue their referrals, or only attend a few sessions before dropping out of treatment. It is important to understand what barriers interfere with engagement in mental health treatment in order to make mental health care more accessible to this population.

Barriers to Care

A study by Majumder, O'Reilly, Karim and Vostanis (2015) assessed perceptions of mental health care by URM adolescents living in the United Kingdom and found that they held negative views of mental health care and did not trust services. To the best of our knowledge, the only study conducted on barriers to mental health service delivery to refugees conducted in the United States was done with adult refugees and not URM, and was conducted over two decades ago (Gong-Guy, Cravens & Patterson, 1991). Findings from this study suggested that to improve mental health services for refugees, providers would need to modify diagnostic assumptions and treatment approaches, be cautious about the use of interpreters, and consider consultation, prevention, and outreach in conjunction with mental health. According to advocacy lawyers working with UC in New York City, language, cost, and limited local services were also barriers to care (Baily, Henderson, Taub, Shea & Verdeli, 2014). It is important to determine whether these barriers can be generalized to URM/UC in Rochester, and to assess additional practical barriers that interfere with engagement.

Treatment Approaches

One approach to overcoming mental health stigma is to provide therapy sessions in a group format. Group approaches are also promising for non-Western cultures in which people view themselves as part of a community more than as individuals. Group Interpersonal Psychotherapy (IPT-G; Wilfley, Mackenzie, Welch, Ayres & Weissman, 2000) is an evidence-based model that has been implemented with non-Western populations of adults and internally displaced adolescents in Uganda, and found to be effective in reducing symptoms of depression (Bolton, Bass, Verdeli, Clougherty & Ndogoni, 2003; Verdeli et al., 2008). This empirically supported, time-limited approach uses the group as an interpersonal setting to explore communication patterns and practice new communication and interpersonal problem-solving skills. Rather than

focusing on past trauma, IPT-G addresses how symptoms are related to current challenges in interpersonal relationships through work on four focus areas: grief, interpersonal disputes, role transitions, and interpersonal deficits. Having the opportunity to share feelings and experiences can reduce the sense of isolation that may challenge some URM/UC youth. The group format also supports the development of positive relationships, which is especially important for youth who may be having trouble assimilating and forming peer relationships, whose interpersonal behaviors may be affected by their mental health symptoms, or who may feel isolated and alone as a result of their traumatic history.

When IPT-G is implemented in non-Western countries, research teams first conduct a qualitative analysis of the needs and perceptions of mental health according to the local population to inform treatment adaptations (e.g. Verdeli et al., 2003). For example, modifications for the trial with internally displaced adolescents in Northern Uganda (Verdeli et al., 2008) included involving caregivers in treatment, accounting for the multiple roles held by adolescents in the camp, and taking time to establish trust among group members and group leaders. Other cross-cultural trials of empirically supported treatments developed in Western settings have gone through similar modification processes. For example, in a trial of trauma-focused cognitive behavioral therapy with children in Zambia, the intervention was modified to use non-stigmatizing language and more relatable metaphors (Murray et al., 2013).

Study Aims and Methods

The aim of the qualitative phase of this study is to identify barriers to mental health engagement for URM/UC youth, from the perspective of foster parents and service providers. Specifically, focus groups will explore the mental health needs of these youth, the cultural, logistical, and systems barriers to treatment, and how IPT-G can be adapted to meet the needs of this population. The qualitative phase of the study will include 2–4 focus groups, each consisting of 8–10 service providers and foster parents (separated by role) scheduled to take place in the winter of 2018.

This information will inform program implementation, including composition of therapy groups (e.g. gender, age, cultural background), practical considerations (e.g. location, scheduling, transportation), content delivery (e.g. including a recreational component), language requirements, and use of appropriate mental health terminology. This modified IPT-G program will then be tested in a pilot group, scheduled to take place in the spring of 2018, to assess its feasibility. Youth in the pilot group will be assessed at baseline and post-intervention for mental health symptoms, interpersonal functioning, and adaptive functioning.

Preliminary Results

Preliminary qualitative analyses have been conducted on 3 key informant interviews with service providers who have worked with URM/UC youth (100% female; 33% White, 33% African American, 33% Hispanic). Their provider roles included licensed psychologist, mental health counselor, and foster home finder. Interviews were audio recorded, transcribed verbatim, and analyzed using grounded theory and a socio-ecological framework. Preliminary findings regarding barriers and recommendations for treatment are presented in Table 1.

Table 1: Preliminary findings and recommendations for barriers to URM/UC mental health care

Socio-Ecological Level	Barriers	Recommendations
Public Policy	• Anti-immigrant/anti-refugee government policies	• Incorporate mental health within organizations that address policy concerns (e.g. securing documentation) • Educate URM/UC on limitations of public policy • Acknowledge effects of policy on mental health
Community	• Cultural differences between provider and youth • Language barriers • Diversity of URM/UC backgrounds makes it difficult to generalize treatment to all youth	• Incorporate culture into treatment (e.g. include a culture-focused session) • Incorporate language into treatment (e.g. use native words for emotions)
Organizational	• Uncoordinated services • Scheduling conflicts • Lack of transportation • Mistrust of authority	• Foster a coordinated system of care with existing organizations • Be flexible with scheduling (e.g. weekends, biweekly sessions) • Provide transportation or school-based treatment • Build in time for trust to develop
Interpersonal	• Lack of family encouragement of mental health treatment	• Provide psychoeducation to family • Engage family in treatment

Individual	• Negative perceptions of mental health treatment:
	  ○ Stigma
	  ○ Lack of understanding
	  ○ Negative previous experiences with mental health treatment
	• Discomfort with disclosure
		• Take a strengths-based, resilience-focused approach
		• Provide psychoeducation
		• Support youth choice and autonomy

Conclusions

Service providers' and foster parents' perspectives on URM/UC mental health, interpersonal relationships, and treatment barriers are essential to informing the development of an IPT-G program that best meets the needs of this unique population. By better understanding how to deliver mental health interventions in a culturally sensitive and practical way, we can more effectively provide support to youth in need and reduce significant barriers to care, resulting in a broader mental health impact. Project findings will guide further intervention development both in terms of content and delivery to optimize intervention effects and eventually support the development of sustainable, integrated programming that can support the long term mental health needs of URM/UC youth.

References

Baily, C.D.R., Henderson, S.W., Taub, A.R., Shea, G.O. & Verdeli, H. (2014). The Mental Health Needs of Unaccompanied Immigrant Children : Lawyers ' Role as a Conduit to Services. *Graduate Student Journal of Psychology*, *15*, 3–17.

Bolton, P., Bass, J., Verdeli, H., Clougherty, K.F. & Ndogoni, L. (2003). Group Interpersonal Psychotherapy for Depression in Rural Uganda. *Jama*, *289*(23), 3117–3124.

Gong-Guy, E., Cravens, R.B. & Patterson, T.E. (1991). Clinical issues in mental health service delivery to refugees. *American Psychologist*, *46*(6), 642–648.

Lustig, S.L., Kia-Keating, M., Knight, W.G., Geltman, P., Ellis, H., Kinzie, J.D. et al. (2004). Review of child and adolescent refugee mental health. *American Academy of Child and Adolescent Psychiatry*, *43*, 24–36.

Majumder, P., O'Reilly, M., Karim, K. & Vostanis, P. (2015). This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry*, *61*(2), 129–136.

Murray, L.K., Dorsey, S., Skavenski, S., Kasoma, M., Imasiku, M., Bolton, P. et al. (2013). Identification, modification, and implementation of an evidence-based psychotherapy for children in a low-income country: the use of TF-CBT in Zambia. *International Journal of Mental Health Systems*, *7*(1), 24.

Verdeli, H., Clougherty, K., Bolton, P., Speelman, L., Lincoln, N., Bass, J. et al. (2003). Adapting group interpersonal psychotherapy for a developing country: Experience in rural Uganda. *World Psychiatry*, *2*(2), 114–120.

Verdeli, H., Clougherty, K., Onyango, G., Lewandowski, E., Speelman, L., Betancourt, T.S. et al. (2008). Group Interpersonal Psychotherapy for Depressed Youth in IDP Camps in Northern Uganda: Adaptation and Training. *Child and Adolescent Psychiatric Clinics of North America*, *17*(3), 605–624.

Wilfley, D.E., Mackenzie, K.R., Welch, R., Ayres, V.E. & Weissman, M.M. (2000). *Interpersonal Psychotherapy for Group*. New York, NY: Basic Books.

BIO:

Michelle Alto is a fourth year doctoral student in clinical psychology at the University of Rochester in Rochester, NY. Her research at Mt. Hope Family Center with Dr. Sheree Toth focuses on the implementation of evidence-based trauma-focused interventions with low-income children and families who have experienced maltreatment. She hopes to extend this work by making culturally sensitive modifications to existing evidence-based interventions to make them more accessible to cross-cultural populations like unaccompanied refugee minors.

Keynote Lectures

A critical analysis of the creation of separated care structures for unaccompanied refugee minors

Ilse Derluyn (Centre for the Social Study of Migration and Refugees, CESSMIR, Department of Social Work and Social Pedagogy, Ghent University, Belgium)

1. Introduction

Unaccompanied refugee minors, children and adolescents who are migrating without their parents, legal guardian or previous caregiver, are a relatively 'new' group in migration history and policy in Western European countries. While young people have always migrated, also when being separated from their family, this group of unaccompanied refugee minors has only been 'discovered' or 'labeled' as a separate group by policy makers in European countries since the late 1980s. Their recognition as a group and the related right to receive a special protection because of their specific status as unaccompanied minors in the International Children's Rights Declaration of 1989 has clearly contributed to the proliferation of specific reception and care structures for this group of unaccompanied youth. In this article, we reflect on how the creation of and evolutions in the specific care structures for unaccompanied children and youths relate to their particular labeling, herein oscillating between, on the one hand, their label as 'vulnerable minors' and, on the other hand, the focus onto their 'maturity' and 'agency'. We hereby use the evolutions in the way the care and reception structures for unaccompanied minors are organized in one particular country of settlement, Belgium, and hereby critically reflect on the (political) arguments that have been put forward to justifying the choices made.

2. Age (minor)

The 1989 UN Convention on the Rights of the Child (CRC) (UN Doc A/Res/44/25, 1989), in its article 22 recognised unaccompanied refugee minors – as part of the larger group of refugee minors – as a specific group of minors, with specific needs, and therefore in need of and entitled to the right to specific and adapted protection and care. Yet the entire CRC is built around the specific group of 'minors' – defined as those under eighteen years of age, hereby consolidating the creation of a specific 'childhood period', separated from 'adulthood', an evolution which started in several Western European countries at the beginning of the 20th century (Dekker, Kruithof, Simon & Vanobbergen, 2012). As a social category, children started to obtain more and more a special position within society, "*charged with strong symbolic value, often portrayed as society's most vulnerable but also most valuable member*" (Eastmond & Ascher, 2011, p. 1186), leading up to the creation of specific care structures for 'vulnerable' children or those in need of special support.

The CRC is thus strongly built around that age-limit of eighteen years, which also through this convention became strongly institutionalized and as such created a strong and sometimes very strict division between 'children' (minors) (and children's rights) and 'adults'. This strong division is clearly reflected onto the group of unaccompanied refugee minors, in relation to their right to protection and care, protection and care that is significantly higher and stronger than the protection and care that are given to (very similar) young people older than 18 years of age.

As a result, governments of countries that receive (relatively) large groups of unaccompanied minors have put increasing efforts into distinguishing 'minors' (under-eighteens) from 'adults' (over-eighteens) within this group of unaccompanied youngsters, in order to keep the specific care and reception measures meant for underage unaccompanied refugees from being provided to adult young refugees who present themselves as minors. Many of the procedures that are nowadays used to determine the biological age of unaccompanied children have been widely contested in literature, in particular those procedures that are relying on medical age assessment testing, such as signs of puberty or X-ray scans of teeth, wrist, collarbone and/or knees (see e.g. Hjern, Brendler-Lindqvist & Norredam, 2012). Still, these methods keep on being used, whereby the 'body' (biological age) of the unaccompanied young people is used as the main (and sole) criterion to allocate care and protection rights, and as such to distinguish between those who deserve 'extra' (special) care and support and those who don't. Also, for unaccompanied youths themselves, this is difficult to understand, as it becomes apparent in interviews with unaccompanied young people who were age-assessed in Belgium over eighteen (Hjern, Ascher, Vervliet & Derluyn, forthcoming):

> *"I don't understand the big difference between minors and adults. Sometimes I think that if I would have been acknowledged as a minor, that I would have learned to speak Dutch more easily." (Afghan young man)*

> *"It has been astonishing for me that they make a distinction between minors and adults. One person is not the same as another person. One person can receive two kinds of treatments." (Afghan young man)*

Decisions regarding age and thus the particular category to which a young refugee belongs are thus taken on basis of 'what their bodies tell', instead of what they have to say: *"their bodies were made to speak to doctors and other professionals, for the bodies could give a more reliable and relevant accounting than the refugees' stories"* (Malkki, 1996, p. 384).

By using age as the main (sole) defining criterion for allocating certain rights, as a kind of 'strategic categorization' (Watters, 2012) for separating those 'deserving' 'extra' care and protection from the 'undeserving', a 'politics of exception' is created, whereby the immigration regime cares as a form of 'discretionary humanitarianism' and out of compassion for the 'most vulnerable' (children), but simultaneously frames the majority of refugees (adults) as less or undeserving and unwelcome (Fassin, 2012; Malkki, 1996; Ticktin, 2011).

3. Age (minor) + refugee / foreigner

3.1 Refugee / foreigner

Being recognized as a minor thus entitles you to special protection and care, yet for unaccompanied minors, this right is strongly intertwined with their status as asylum-seeker, refugee or foreigner[1]. In most European countries, all unaccompanied minors first apply for asylum and then can receive a refugee status (as defined under the 1951 Geneva Refugee Convention), a 'subsidiary protection status' (temporary status) or another temporary protection specifically designed for unaccompanied minors (EMN, 2015). In some contexts (e.g. Belgium), unaccompanied minors can immediately opt to apply for this specific procedure for unaccompanied

[1] With 'foreigner', we refer to so-called 'Third Country Nationals': nationals not belonging to a state that is part of the Schengen area (mainly European Union without the United Kingdom) as defined in the Schengen Borders Code (http://eur-lex.europa.eu/legal- content/EN/TXT/PDF/?uri=CELEX:32006R0562&from=EN).

minors, providing temporary and eventually also definitive residence documents (De Graeve, Vervliet & Derluyn, 2017).

In their residence status, their identity as asylum-applicant/refugee/foreigner is thus largely prevailing. Yet this is also reflected in the care and reception structures for this group of unaccompanied minors, since most European countries have created specific reception structures for this group of young people (EMN, 2015) that are mainly clearly separated from mainstream youth care services – thus based on their status as unaccompanied refugee[2] minor.

The prevalence of the residence status in the care structures created for unaccompanied minors was highly visible in the way the reception structures for this group were created in Belgium at the end of the 1990s: unaccompanied minors applying for asylum were cared for in specific reception structures under the authority of the federal (Belgian) agency (Fedasil) that is also responsible for the reception structures for adult asylum-applicants. On the other hand, those minors not applying for asylum but opting in for the specific procedure for unaccompanied minors were considered as not falling under the responsibility of the federal authority, so they were referred to specific, categorical care structures for unaccompanied minors within the regionalized mainstream youth care system. In the way the care structures for unaccompanied minors in Belgium were then created, it becomes clear that not the *needs* of the individual child were the determining factor to decide which type of care (s)he received, but instead the residence documents he had were the decisive factor.

This way of allocating care and support contrasts largely with the needs-based approaches that are always argued for when allocating services to people with particular care and support needs (e.g. youth care, people with disabilities,…), and also clearly contrasts with what the Child Rights Convention has put forward in its article 22. This of course evokes the question why this choice has been made to create specific reception systems for unaccompanied (asylum-seeking) minors, separated from other care structures such as mainstream youth care services, and how this choice is justified. The policy arguments here generally point to two 'characteristics' of this group of young people, on the one hand their presupposed 'maturity', and on the other their 'specific (special) needs'. We will further elaborate on both aspects in the next paragraphs.

3.2 Maturity

As a first argument to create specific reception and care structures for unaccompanied minors, separated and different from mainstream care structures for native-born young people, policy makers have pointed to the 'maturity' of unaccompanied children, indicating that they are 'more mature' than 'native' peers of their age. At first, it is sometimes argued that young unaccompanied refugees are more mature because they have already lived for a long time on their own, during the flight and migration trajectory, and even before they left their home country. The latter element is clearly deconstructed in research findings, where it has been shown that most unaccompanied minors lived together with their closest family members up until the moment they left home (or even afterwards) (see e.g. Derluyn, Mels & Broekaert, 2009). Secondly, they are also considered as being more mature because it is argued that in the countries of origin these minors originate from, they would be generally considered 'older' (in

[2] We prefer to use the overall term 'refugee', hereby referring to the entire group of unaccompanied children and youth, so not only to those who applied for refugee status under the Geneva Convention or were recognized as such. The perceived forced character of their migration decision for most of them, and the fact that often others were involved in this decision-making process are the main reasons for this particular choice (for a more elaborated explanation: see Derluyn & Broekaert, 2008).

terms of responsibilities, tasks, expectations) compared to peers from the same age in 'western' countries. While child development is undoubtedly context- and culturedependent (see e.g. De Haene & Derluyn, 2015), there is little 'overall' evidence to support this argument for all unaccompanied children and youth, in particular not given these minors' heterogeneous backgrounds, in terms of both countries of origin and past educational and socioeconomic living contexts.

Given this 'independent living' they are 'used to' and their 'maturity' compared to their host country peers, it is then argued by policy makers that these youngsters cannot adjust any more to a close follow-up and/or intensive care structures, thus needing to stay in services with less intensive support. In the Belgian reception system for unaccompanied minors (as also in many other European countries), this view is, amongst other aspects, reflected in the differences in 'quality of care' between the specific care structures for (asylum-seeking) unaccompanied minors and mainstream youth care services (including the categorical centres for unaccompanied minors): in terms of, amongst other aspects, the number of staff in relation to the number of minors in a certain shelter, the educational level of the staff members, the number of children living together in one group and the overall infrastructure of the reception centre, standards are generally much lower in the specific reception systems for asylum-seeking unaccompanied minors compared to the ones in mainstream youth care.

3.3 Specific needs

A second argument that is often raised when defending specific systems for unaccompanied youth separated from mainstream (youth) care services is that this group has specific needs that cannot be met appropriately in these mainstream care structures, such as their lack of knowledge of the host country's language, systems and habits (e.g. education, health care, food), their specific legal situations in terms of residence documents and related procedures, or specific problems that might emerge in their support trajectory that are related to their migration process, such as their involvement in human smuggling or trafficking networks.

While, undoubtedly, this group of children and young people does have specific care needs that are often very different from those in other groups of young people in need of support, the interesting element here is that these separated care and reception structures seem to consider unaccompanied children as one very homogenous group, with all of them establishing more or less the same needs. Indeed, seen from the legal definition, they are indeed quite easily to identify as a homogenous group (Derluyn & Broekaert, 2008), and all of them have left their home country through a migration process, yet when looking more closely, we can easily see that these children and adolescents are very different in terms of countries of origin, age, gender, migration motives, projects and expectations, in educational and socio-economic backgrounds, experiences before and during the flight, coping strategies, ways of expressing emotional distress, etcetera. Again, this way of creating care and support systems does not start from a needs-based perspective, but entirely departs from their legal/juridical situation as refugee/foreigner to organize their care in a one-size-fits-all-system.

4. Age (minor) + refugee / foreigner + 'vulnerable'

4.1 Vulnerability

Despite the focus on their 'maturity', we have overall strong empirical evidence that unaccompanied minors do run a much higher risk of developing mental health problems compared to those fleeing with their parents (see e.g. Bean, Derluyn, Eurelings-Bontekoe, Broekaert & Spinoven, 2007; Derluyn et al., 2009; Fazel, Reed, Panter-Brick & Stein, 2012). The separation from their parents and related lack of parental support, combined with their increased risk to experiencing difficult events before and during the migration trajectory are two main determining factors here. Yet interestingly, more and more studies have documented how the daily stressors the minors are confronted with in their living situation in the host country largely impact unaccompanied minors' emotional wellbeing (see e.g. Montgomery, 2010; Vervliet et al., 2014b). These studies clearly illustrate how the current reception and care structures evoke important stressors: large-scale reception centres create, for example, lack of privacy, experiences of violence and abuse, limited possibilities for interaction with the staff and deep feelings of being bored (see e.g. Keygnaert, Vettenburg & De Temmerman, 2012; Vervliet et al., 2014a).

4.2 Structures for 'vulnerable unaccompanied minors'

Confronted with these huge emotional needs, with the perceived inappropriateness of current reception structures for certain (groups of) unaccompanied children and an increasing number of unaccompanied minors in 2015, the Belgian government – in line with many other European governments – has created specific care and reception facilities and trajectories for so-called 'vulnerable unaccompanied minors'. More specifically, unaccompanied minors under the age of fourteen, girls and youngsters showing important psychological or medical problems, are now, after a short stay of a couple of days in the first phase of the observation and orientation centre, directly referred[3] to specific, categorical centres for unaccompanied minors within the mainstream youth care structures or to foster care families specifically selected to care for unaccompanied children. Both these centres and the foster care families follow the structures and rules of the regional (Flemish) youth care, including the norms on staffing, infrastructure, support, number of children living in a group, etc., again institutionalising an important difference in the 'quality of care' for the unaccompanied children hosted here compared to those cared for in the specific structures for unaccompanied minors under the Belgian asylum authorities (Fedasil).

Two important reflections need to be put forward here: first, the 'identification' of those in need of these 'extra' services with 'higher' quality and more intensive support is based on certain 'objective characteristics', in particular age, gender and disability. Again, a needs-based approach – de facto a 'subjective' approach, based on an assessment of the individual client and his context – to allocate services is not used as the main reference frame, contrasting the main approach of other groups in need of care and support, such as children born and/or raised in Belgium (Ní Raghallaigh & Thorton, 2017). So-called 'objective' characteristics of the

[3] While this type of intensive care methods within mainstream youth care structures (such as residential centres or foster care) can only be allocated to children after an intensive assessment by an external governmental agency (the so-called 'Intersectoral Gateway'), these specific residential centres and foster care places for 'vulnerable' unaccompanied minors are now made 'directly accessible', without the need to have the permission of this governmental agency. All other youth care services are, as has been always the case, still accessible for unaccompanied minors, yet still only after this assessment procedure and approval by the 'Intersectoral Gateway'.

'body' (i.e. gender, age, disability) are now the deciding factors, which is again a 'medicalization' of the minors' body, and again, 'objective characteristics' are used to access certain services and rights (cf. the distinction between minors and adults), and not the minor's story and needs.

Secondly, the introduction of 'vulnerable' unaccompanied minors within this overall group of unaccompanied minors seems to suggest that those not classified as 'vulnerable' are indeed not vulnerable, and thus not 'deserving' particular types of intensive care and support. While previously the group of unaccompanied minors as a whole was – based upon their age as decisive criterion – approached as a 'vulnerable' group in need of extra support and care (in contrast to adult asylumapplicants), we now observe a new 'strategic categorization' (Watters, 2012) introducing new categories *within* this overall group of unaccompanied children, new categories of 'deserving' and less or 'undeserving' unaccompanied minors, whereby the needs and rights of the latter category (i.e. adolescent boys, not surprisingly the biggest group within the group of unaccompanied minors) become increasingly questioned.

5. A pedagogical paradox: children (age) or refugees (foreigner)?

While being a 'child' (your age) makes you 'vulnerable' (or a 'victim') and entitles you to particular rights of extra care and support, as agreed upon with the (almost) worldwide ratification of the CRC, being a 'refugee' (partially) makes you 'strong' or 'mature', certainly when you are able to 'make it' from your country of origin up to a far-away located 'western' country[4], and when, as such, you demonstrate considerable 'agency' (Watters, 2012). This focus on 'maturity' (instead of 'vulnerability') and on the related 'strengths' of the children involved is put forward more and more as an official legitimation to allocate 'different' (read: less) support and care for these young refugees compared to native-born peers in similar difficult living situations. As such, a political choice to allocate less services on the basis of a combination of nationality (so-called 'third country nationals') and migration trajectory (recent arrived youngsters) is 'psychologised', through its framing in terms of maturity.

Exceptions to this generalized approach of all unaccompanied minors as being (more) mature (than 'our' youngsters) (hereby also ignoring their heterogeneous backgrounds and diverse needs) are framed in terms of 'vulnerability'. Yet the category of 'vulnerable unaccompanied minors' is also more and more restricted: while initially all unaccompanied minors, on basis of their age and if assessed underage, were considered vulnerable, nowadays almost only younger and female unaccompanied minors (the smallest groups in the total population of unaccompanied minors!) are still considered as (extra) vulnerable unaccompanied minors.

To conclude, care policies for unaccompanied minors have become strongly framed within a migration management perspective, as 'new regimes of control' (Garrett, 2015), whereby governments increasingly reduce the 'influx' of unaccompanied minors, as illustrated in the (increased) use of age assessment procedures, and whereby governments also try to reduce

[4] This changing way of labeling 'refugees', as a result of the increasing number of refugees in European countries in 2015, also became apparent in the remarkable introduction of a new category of the 'economic refugee' by several policy makers, hereby mainly referring to Syrian refugees who after their initial refuge to Turkey decide to travel further (i.e., to Europe) and apply for asylum in another (Western European) country. Their decision to continue their migration trajectory out of Turkey to Europe is then framed as if finding 'safety' (in terms of no war-related violence any more) is not their (only) migration motive, but they (also) migrate out of 'economic reasons' (to create a better living). This then raises questions about their right to receive asylum under the Geneva Convention in the European country of settlement and the hereto related support measures and social welfare benefits.

the costs of care and reception structures for this group through reducing the quality of the services provided and restricting more intensive (and thus more expensive) services to small subgroups. The expressed anxiety to create 'pull factors' for migrants/refugees is also echoed as possible argument here (Ni Raghallaigh & Thornton, 2017), although with little scientific support. This migration management perspective also 'objectifies' young refugees through reducing them to certain 'objective characteristics' (age, gender, nationality, documents) instead of starting from their personal histories and needs, instead of taking the CRC's main guiding principle of the 'best interest of the child' as point of reference. As such, more and more unaccompanied minors are defined as 'undeserving' and 'unwelcome', or are even portrayed as 'perpetrators' through pointing to, for example, their 'illegal' border crossings, the use of smugglers or their 'lies' about the asylum story and/or age, with growing impact onto the care and support services they are provided with or considered to be deserving of.

References

Bean, T., Derluyn, I., Eurelings-Bontekoe, E., Broekaert, E. & Spinhoven, P. (2007). Comparing psychological distress, traumatic stress reactions and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *Journal of Nervous & Mental Disease, 195*(4), 288–297.

De Graeve, K., Vervliet, M. & Derluyn, I. (2017). Between Immigration Control and Child Protection: Unaccompanied Minors in Belgium. *Social Work & Society, 15,* 1.

De Haene, L. & Derluyn, I. (2015). Ontwikkeling en opvoeding in culturele context: betekeniswereld, migratie en maatschappelijke positie. In G. Bosmans, I. Noens, P. Bijttebier & L. Claes (Eds.), *Diagnostiek bij kinderen, jongeren en gezinnen. Deel II: Ontwikkeling in context* (pp. 145–168). Leuven/Den Haag: Acco.

Dekker, J.H., Kruithof, B., Simon, F. & Vanobbergen, B. (2012). Discoveries of childhood in history: an introduction. *Paedagogica Historica, 48*, 1–9.

Derluyn, I. & Broekaert, E. (2008). Unaccompanied refugee children and adolescent: the glaring contrast between a legal and a psychological perspective. *International Journal of Law and Psychiatry, 31*, 319–330.

Derluyn, I., Mels, C. & Broekaert, E. (2009). Mental health problems in separated refugee adolescents. *Journal of Adolescent Health, 44*(3), 291–297.

Eastmond, M. & Ascher, H. (2011). In the Best Interest of the Child? The Politics of Vulnerability and Negotiations for Asylum in Sweden. *Journal of Ethnic and Migration Studies, 37,* 1185–1200.

EMN (2015). *Policies, practices and data on unaccompanied minors in the EU Member States and Norway. European Migration Network Synthesis Report for the EMN Focussed Study 2014.* European Migration Network.

Fassin, D. (2012). *Humanitarian Reason, a moral history of the present.* University of California Press.

Fazel, M., Reed, R.V., Panter-Brick, C. & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: Risk and protective factors. *Lancet, 379,* 266–282.

Garrett, M. (2015). Constraining and confining ethnic minorities: Impoverishment and the logics of control in neoliberal Ireland. *Patterns of Prejudice, 49,* 414–434.

Hjern, A., Brendler-Lindqvist, M. & Norredam, M. (2012). Age assessment of young asylum seekers. *Acta Paediatrica, 101,* 4–7.

Hjern, A., Ascher, H., Vervliet, M. & Derluyn, I. (forthcoming). Age assessment of young asylum seekers – science or deterrence? *Elgar Research Handbook on Migration and Childhood.*

Keygnaert, I., Vettenburg, N. & De Temmerman, M. (2012). Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. *Culture, Health & Sexuality, 14,* 505–520.

Malkki, L. (1996). Speechless Emissaries. Refugees, Humanitarianism, and Dehistoricization. *Cultural Anthropology, 11*, 377–404.

Montgomery, E. (2010). Trauma and resilience in young refugees: A 9-year follow-up study. *Development & Psychopathology, 22, 477–*489.

Ní Raghallaigh, M. & Thornton, L. (2017). Vulnerable childhood, vulnerable adulthood: Direct provision as aftercare for aged-out separated children seeking asylum in Ireland. *Critical Social Policy, 37,* 386–404.

Ticktin, M.I. (2011). *Casualties of care: Immigration and the politics of humanitarianism in France.* Berkeley: University of California Press.

Vervliet, M., De Mol, J., Broekaert E. & Derluyn, I. (2014a). "That I live, that's because of her." Intersectionality as framework for unaccompanied refugee mothers' experiences. *British Journal of Social Work, 44*(7), 2023–2041.

Vervliet, M., Lammertyn, J., Broekaert, E. & Derluyn, I. (2014b). Longitudinal Follow-Up of the Mental Health of Unaccompanied Refugee Minors. *European Journal of Child and Adolescent Psychiatry, 23*(5), 337–346.

Watters, C. (2012). Forced migrants: from the politics of displacement to a moral economy of reception. In S.J. Gold & S.J. Nawyn (Eds.), *International Handbook of Migration Studies*. London: Routledge.

BIO:

Prof. Ilse Derluyn obtained her PhD in Educational Sciences at Ghent University (Belgium) and is currently affiliated as Associate Professor to the Department of Social Work and Social Pedagogy of Ghent University, where she teaches courses in migration and refugee studies. Ilse's main research topics concern the psychosocial wellbeing of unaccompanied refugee minors, migrant and refugee children, war-affected children, victims of trafficking and child soldiers. She is also actively involved in supporting refugees and practitioners working with refugees and migrants, in policy research and policy-influence.

Ilse has published over 50 international publications and has recently obtained an ERC Starting Grant on the topic of unaccompanied refugee minors. Prof. Derluyn heads the Centre for the Social Study of Migration and Refugees (CESSMIR) of Ghent University, and is co-director of the interuniversity Centre for Children in Vulnerable Situations (CCVS).

Acculturation and adaptation: International perspectives

John W. Berry (Queen's University, Kingston, Canada and National Research University, Higher School of Economics, Moscow, Russia)

Acculturation is the process of cultural and psychological change following contact between two or more cultural groups and their individual members. It takes place in all groups and all individuals in contact. Although one group is usually dominant over the others, successful outcomes require mutual accommodation among all groups and individuals living together in the diverse society. Most acculturation takes place in culturally-diverse societies that have emerged following colonization and immigration.

At the cultural level, there are three phenomena that need to be examined: 1. cultural features of the groups prior to their contact; 2. the nature of their intercultural relationships; 3. the cultural changes following their contact. At the psychological level, there are also three phenomena: 1. behavioural changes (in daily repertoire, identity); 2. stress reactions to the challenges being faced (acculturative stress); 3. adaptations (psychological, sociocultural, and intercultural).

The goals of acculturation research are to: 1. understand the various phenomena of acculturation and adaptation; 2. examine *how* individuals and groups acculturate; 3. examine *how well* individuals and groups adapt; 4. search for relationships between *how* and *how well,* in order to discover if there is a *best practice;* and 5. apply these findings to the betterment and wellbeing of immigrant and ethnocultural individuals and groups. These same goals apply equally to all members of the larger societies. Without an understanding of how they are also impacted by intercultural contact and the resultant acculturation, there can be no improvement in the wellbeing for ethnocultural groups, when their social, economic and political environments remain negative. Nor can there be benefits for members of the larger society without mutual acceptance and adaptation.

Of particular importance is the need to understand the *how* question. Groups and individuals in acculturating groups hold differing views about *how* to relate to each other and how to change. It is now well established that acculturation takes place in many ways, and has highly variable outcomes.These views about how to engage the acculturation process involve two underlying issues: 1. Maintenance of heritage cultural and identity in order to sustain cultural communities; 2. Intercultural contact and participation with other groups in the life of the national society.

Their intersection produces four *acculturation strategies* used by groups in contact. From the point of view of non-dominant individuals and groups these are: 1. *Integration,* when individuals seek to maintain their heritage culture and also seek to participate in the larger society; 2. *Assimilation*, when individuals give up their heritage culture and become engaged mainly with the larger society; 3. *Separation*, when individuals maintain their heritage culture, and seek to avoid engagement with the larger society; and 4. *Marginalisation*, when individuals give up their heritage culture, and at the same time do not engage in the life of the larger society.

With respect to the 'how well' question, there are three forms of adaptation to acculturation: 1. Psychological adaptation is characterised by 'feeling well' about oneself. Such psychological health is usually considered to be a prerequisite for a successful life. It is assessed by lack of psychological problems (anxiety, depression, psychosomatic symptoms), and the presence of self-esteem and wellbeing; 2. Sociocultural adaptation refers to the degree to which individuals are competent in carrying out their daily lives in their new social and cultural con-

texts (e.g. in school, at work, in social engagements). It is characterised by 'doing well' in life achievements. It is assessed by success at school or work, lack of behaviour problems (e.g. truancy, petty theft, drug use), and competence in daily activities; 3. Intercultural adaptation refers the degree to which individuals and groups adapt to each other, either positively or negatively. Intercultural adaptation includes: *attitudes* towards specific groups (which may become more positive, or less positive, or not change at all); *prejudice and tolerance* (which may increase or decrease); *multicultural ideology* (i.e., the acceptance of the value of diversity and equity in society*)* may or may not develop; and *discrimination* (which may become prevalent or be reduced).

The most important issue in acculturation is whether there are systematic relationships between the *how* and *how well* findings. This is because relationships between answers to these two questions may allow for the promotion of ways of acculturating that lead to greater wellbeing for all those who are living interculturally.

Evidence from research with immigrant youth and adults who are settled in many societies reveals that there is indeed a 'best practice' for achieving wellbeing: those who engage both their heritage cultures and identities, as well as participate in the daily life of the larger society, have higher levels of wellbeing that those who engage with only one or the other, or with neither culture. That is, integration and multiculturalism appear to be the best policies, strategies and practices for overall wellbeing.

BIO:

John W. Berry (PhD, University of Edinburgh) is Professor Emeritus of Psychology at Queen's University, Canada, and Research Professor, National Research University Higher School of Economics, Moscow, Russia. He received Honorary Doctorates from the University of Athens, and Université de Geneve (in 2001). He has published over 30 books in the areas of cross-cultural, intercultural, social and cognitive psychology with various colleagues. These include Cross-Cultural Psychology: *Research and Applications* (3rd edition, Cambridge University Press, 2011); *Handbook of Acculturation Psychology* (2nd edition, Cambridge University Press, 2016); *Families Across Cultures* (Cambridge University Press, 2006), *Immigrant Youth in Cultural Transition* (LEA, 2006), *Mutual Intercultural Relations* (Cambridge, 2017) and *Ecology, Culture and Human Development* (Sage, 2017). He is a Fellow of the Canadian Psychological Association, the Netherlands Institute for Advanced Study, the International Association for Cross-Cultural Psychology, and the International Academy for Intercultural Research. He received the Hebb Award for Contributions to Psychology as a Science in 1999, and the Award for Contributions to the Advancement of International Psychology in 2012 (from CPA), the Interamerican Psychology Prize from the Sociedad Interamericana de Psicologia (in 2001), and the Lifetime Contribution Award from IAIR (in 2005). His main research interests are in the role of ecology and culture in human development and in acculturation and intercultural relations, with an emphasis on applications to immigration, multiculturalism, educational and health policy.

Symposium 1:
Trauma and resilience in unaccompanied minor refugees

Trauma and resilience in unaccompanied minor refugees: Considerations and findings

Rolf Kleber (Utrecht University / Arq Psychotrauma Expert Group)

1. Introduction

Unaccompanied refugee minors were confronted with war, terror or disaster in their countries. Forced by atrocious circumstances, they had to escape their homeland and to migrate to other often unfamiliar countries or even continents. During their flight they were separated from both parents and other relatives, and at the time of their asylum application in a new country these children and youngsters were not being cared for by an adult. Globally there appear to be at least 300 000 refugee children fleeing hardship and oppression without adults. At least 170 000 of these minors have applied for asylum in Europe (Abouzeid, 2017).

Nowadays between 200 000 and 250 000 refugees (with an official status) live in The Netherlands. Most of them have the Dutch nationality. In 2015, 58 880 asylum seekers came to The Netherlands. In 2016, 18 171 asylum seekers (mostly from Syria, Albania and Eritrea) arrived. Nearly three quarter of them received asylum. In the beginning of this century The Netherlands received the largest number of unaccompanied minors seeking asylum (URMs; hereafter also referred to as refugee minors) in Europe, followed by the United Kingdom and Austria (UNHCR, 2004). In 21 European countries, 63 500 unaccompanied minors applied for asylum during 2000–2003, most of them originating from war-torn countries. Of all asylum seeking refugee minors that recently (2017) migrated to the Netherlands, 52% came from Eritrea, often after a long journey characterized by terror, despair and hunger.

2. Trauma as a flourishing area

The term trauma has become very popular and very influential in the past years. The term is frequently used, not only in scientific and clinical publications, but also in newspapers, television programs and common parlance. The concept of trauma refers to a confrontation with death, serious injury, or threat to the physical integrity of a person or of others. Trauma denotes the experience of accidents, violent crimes, disasters, abuse, and war. All these experiences are characterized by an overwhelming sense of powerlessness and an extreme disruption of basic assumptions of life (see Kleber & Brom, 2003). The continuity of the life of the individual is broken.

The concept of trauma is an attractive concept. It refers to both spectacular and shocking events that receive huge attention, such as acts of terrorism and large-scale calamities. Something really dramatic happens that could happen to anyone: the cause appears to be clear and the responsibility appears to lay elsewhere. One could argue that traumatic experiences show us the limits of our abilities to master our lives and that they defy our efforts to control the circumstances.

The concept of trauma is also a dangerous concept. It is often used too easily and too quickly. Not every stressful event is a traumatic experience and not every person confronted with war, disaster or terror is traumatized. Above all, overstretching the concept may create the risk of medicalization of regular difficulties of the afflicted people and ignoring the self-reliance and the adaptive skills of them (Brom & Kleber, 2009).

3. Posttraumatic stress disorder and resilience

The scientific and clinical literature on the after-effects of trauma is strongly dominated by a psychopathological perspective. Most discourses on trauma are discourses on posttraumatic stress disorder (PTSD). The diagnosis of PTSD is directly linked to experiencing or witnessing a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape or other violent personal assault. PTSD consists of symptoms of re-experiencing the traumatic event such as intrusive memories, distressing dreams, flashbacks or distress or physiological reactions upon exposure to cues of the trauma. Also, symptoms of avoidance of the reminders of the trauma, alterations in memories or mood associated with the trauma, as well as clear alterations in physiological arousal and reactivity belong to PTSD (APA, 2013).

The concept of PTSD applies well to the difficulties of young refugees. After all, they were confronted with profound experiences of powerlessness and disruption. However, it should not be forgotten that young refugees can also face other psychological problems, such as depression, manifestations of aggression, acculturation stress, loneliness and addiction. It is also disputed in recent scientific and clinical literature whether the construct of Complex PTSD (proposed in ICD-11) does not suit them better. After all, they were exposed to prolonged and persistent traumatic experiences. Complex PTSD is characterized by the core symptoms of PTSD (re-experiencing, avoidance/numbing and hyperarousal) in conjunction with a range of disturbances in self-regulatory capacities: affect problems (such as heightened emotional reactivity), a disturbed sense of self (such as beliefs about himself/herself as diminished, defeated or worthless) and persistent difficulties in sustaining relationships (such as difficulties in feeling close to others). However, the concept of Complex PTSD is not without criticisms (ter Heide, Mooren & Kleber, 2016).

Yet not everyone suffers from PTSD or another disorder after a disaster, a war experience or a violent offense. As a matter of fact, the majority of people affected by these extreme events do not develop psychopathology at all, as has been shown in several epidemiological studies, depending of the type of event and the instruments used. In a systematic review of interview-based psychiatric surveys of unselected refugee populations resettled in western countries, prevalence rates of 35% and 12% were found for posttraumatic stress disorder and major depression in adolescent/young adult refugees. Among adult refugees living in Western reception countries, the estimated prevalence of PTSD was about 9% (Fazel, Wheeler & Danish, 2005). In systematic analysis (Steel et al., 2009) prevalence rates of PTSD and depression were identified from 181 surveys comprising 81 866 refugees and other conflict-affected persons from 40 countries exposed to humanitarian emergencies. Rates of reported PTSD and depression showed large inter-survey variability. The weighted prevalence estimates derived from methodologically robust surveys provided rates between 13% and 25% for PTSD. The risk of PTSD among refugees was increased by experiencing torture and sexual violence, having a higher age, being a woman and going through a long stay in different asylum seekers centres.

The fact that most people exposed to serious life events do not develop disorders like PTSD does not mean that they will not suffer with complaints and difficulties. Most people will experience posttraumatic stress reactions (intrusions, nightmares, numbness, etc.) to some extent. Findings from large epidemiological studies of disaster victims (Grievink et al., 2007) make this clear. However, the intensity and frequency of these responses do not reach the level of disorder. These people are able to find a new equilibrium. Therefore, restoration also implies resiliency.

Unfortunately, resilience and self-reliance of people still receive less attention in the field of traumatic stress studies. The term resilience has been widely used in recent years. It is frequently used in everyday language, rightly or wrongly, in relation to a variety of circumstances,

topics and correlations. Fundamentally, it refers to a person's ability to adapt successfully to acute stress, trauma or chronic forms of adversity (e.g. Masten, 2014). However, there are various understandings of resilience. Resilience is treated as a quality, a personal trait, a process and an outcome. While, for example, some researchers conceive of resilience as a multiple determined developmental process that is not fixed, others use measures of trait resilience, which favour the assumption that resilience is a personality attribute. Investigation of resilience can lead to useful avenues for intervention (Luthar & Cicchetti, 2000). The concept offers a different perspective on risk and protection. Focusing on what makes individuals strong rather that what makes them weak may aid in understanding what helps them to maintain their mental health.

4. Research on young refugees

The Dutch researcher Marieke Sleijpen examined trauma and resilience of young refugees in a range of studies using various methods. In one of her studies (Sleijpen, Boeije, Mooren & Kleber, 2017) she presented the results of semi-structured interviews about the needs, experiences and strategies in dealing with negative experiences of young refugees living in the Netherlands. The findings revealed that young refugees in the Netherlands were affected by memories of traumatic experiences in their country of origin or during the flight, but at the time of the interview, current stressors, especially for young people without a residence permit, played a more significant role in determining their psychological well-being. In general, the participants in this study used the following four strategies to deal with traumatic experiences and current stressors: (1) acting autonomously, (2) performing at school, (3) perceiving support from peers and parents, and (4) participating in the new society. These strategies helped the young refugees to strengthen their sense of power and control, they gave them some distraction, and they supported or sustained their spirit within the family unit and the new society. Having to wait a long time for a residence permit and being older negatively influenced the participants' resilience strategies.

In another study, Sleijpen and colleagues (submitted) focused on the question whether resilience moderated the relationship between exposure to potentially traumatic events (PTEs) in adolescent refugees and their Dutch peers. The findings confirmed that adolescent refugees living in asylum seeker centres (ASCs) in the Netherlands were emotionally challenged. Most have experienced many PTEs, resulting in high overall posttraumatic stress disorder symptom severity. Additionally, no evidence was found that (individual) resilience reduced the negative effect of exposure to war, violence and migration on the adolescent refugees' emotional wellbeing. This contrasted with the protective effects of (individual) resilience in Dutch (non-refugee) adolescents who had experienced at least one PTE. These findings show that not all groups benefit similarly from (individual) resilience. In particular, (individual) resilience appears to protect non-refugee adolescents from some negative effects of exposure to PTEs but may not be sufficient to protect young refugees from the negative effects of all of the negative circumstances.

In yet another study, the genetic makeup of individuals has also been linked to resilience. There was a significant relationship between a particularly interesting polymorphism (corticotropin-releasing hormone receptor 1 (CRHR1) [rs878886] on the one hand and (individual) resilience and 'satisfaction with the life' of adolescent refugees and Dutch (non-refugee) adolescents (e.g. Sleijpen, Heitland, Mooren & Kleber, 2017).

Through a multifaceted research tool, this collection of studies showed that adolescent refugees and asylum seekers are faced with the memories of several potentially traumatic experiences and are burdened by daily stressors as a result of their position in the new country. As a

result, they reported a high level of re-experiences, avoidances, sleep problems and cognitive disturbances, but also a high level of (individual) resilience and even growth (Sleijpen, Haagen, Mooren & Kleber, 2016). The results also show that the resilience of young refugees can be strengthened on many levels. Resilience in young refugees must be approached from a 'multiple-level-of-analysis' perspective that includes psychological, biological, cultural and contextual processes.

5. Late effects

Traumatic experiences can have long-lasting consequences. It is often thought that the complaints and difficulties of especially young refugees decrease when they have found an existence in the new country. The memories would gradually disappear into the background. But at the same time it is also assumed that the relative peace and stability in the new country will enable the persons affected by violence and war to reflect on all that they have experienced.

Smid and colleagues (Smid, Lensvelt-Mulders, Knipscheer, Gersons & Kleber, 2011) examined the phenomenon of delayed-onset PTSD among unaccompanied refugee minors who had participated in a large and longitudinal population study (Bean, Derluyn, Eurelings-Bontekoe, Broekaert & Spinhoven, 2007) and found high prevalence rates of screening positive for PTSD equalling about 40% at both 1 (T1) and 2 (T2) years following resettlement. Certain factors were thought to increase these levels of posttraumatic stress symptoms in refugee minors, such as experiencing violent death of a family member, being completely unaccompanied, and severity of the exposure. Twenty-eight percent of all detected probable PTSD cases across the two assessments resulted from late-onset PTSD during the 2nd year following resettlement. Late-onset PTSD was associated with older age, low education, and the number of reported stressful life events at the first assessment. Path analysis revealed many similarities between the PTSD-T1 and late-onset PTSD groups. Specifically, the same variables that predicted PTSS severity at T2 in the PTSD-T1 group also accounted for a considerable proportion of the variance of these symptoms in late-onset PTSD. However, in the group with late-onset PTSD, in contrast to the PTSD-T1 group, the effects of traumatic event exposure on PTSD severity were fully mediated by depression and anxiety, suggesting that late-onset PTSD may be secondary to increases in depression and anxiety.

In this context it is significant to focus on a study of child survivors from World War II. They have experienced rather similar circumstances as unaccompanied refugee minors. These children survived internment in the Japanese camps in the former colony of the Dutch Indies (now Indonesia) during the period 1942–1945 (and afterwards), where they were sometimes separated from their parents. Most of them were forced to migrate to The Netherlands in the 1940s and 1950s. A large community-based sample of war survivors was studied by Mooren and Kleber (2013) and compared with a reference group from the Dutch population as well as with clinical groups. Long-term sequelae of the Japanese persecution in the Dutch East Indies in child survivors were studied by analysing sets of standardized questionnaires of 939 persons. Instruments dealt with posttraumatic responses, general health, and dissociation.

Compared with age-matched controls that lived through the German occupation in the Netherlands during World War II, the child survivors from the former Dutch Indies reported both more trauma-related experiences and mental health disturbances in later life. In about a quarter of a community sample of these child survivors from the former Dutch East Indies, serious adjustment problems were present. It is striking that after more than fifty year later, a considerable group of survivors still suffered from difficulties related to this war. In particular, the number of violent events during the war, among which especially internment in a camp,

contributed to the variation among groups, in support of the significance of these disruptive experiences at older age.

These results underline the long-term significance of traumatic experiences. Decades after World War II there are still many war survivors struggling with the aftermath. The attention in this study was focused on the group of people who experienced the war as a child, more than half a century later. That makes it relevant for the refugee minors who have migrated to Europe in recent years.

6. Implications

Unaccompanied refugee minors struggle with the memories of several traumatic experiences. They report high levels of re-experiences, avoidances and sleep problems. And on top of that, the long waiting period for a possible residence status is a major source of tension among young asylum seekers, as well as the necessity to adapt to the demands of the new society. The uncertain future perspective puts a lot of pressure on the quality of life of these young people. Therefore, it is comprehensible that the consequences of traumatic experiences among young refugees are approached from a psychopathological framework.

Nevertheless, in order to understand their behaviour and to properly understand their needs, the perspective of 'resilience' is also important. There is also personal growth, and these young people exhibit a high level of (individual) flexibility, as found in the studies of Sleijpen and colleagues. In general, the research on resilience in children and adolescents affected by armed conflict in low- and middle-income countries supports the notion that resilience is determined by a complex interaction between developmental, gender, and context-dependent variables (Tol, Song & Jordans, 2013).

Screening for trauma and migration related morbidity among refugee minors is warranted and should take place on multiple occasions. Mental health professionals should undertake efforts to increase stakeholders' awareness of the psychological symptoms of the minors. Early detection by health practitioners, immigration officers, child protection services, and legal guardians dealing with refugee minors can thus be stimulated. Mental health professionals should structurally be involved early in the asylum procedure of refugee minors, for instance, by providing education to the minors about how to cope with their situation and the complicating symptoms. Education to the minors should include information about the psychological risks associated with traumatic experiences and migration demands as well as available evidence-based treatments.

References

Abouzeid, R. (2017). Young, alone, and stranded. *National Geographic, 232*(6), 118–125.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington: APA.

Bean, T., Derluyn, I., Eurelings-Bontekoe, E., Broekaert, E. & Spinhoven, P. (2007). Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *Journal of Nervous and Mentals Disease, 195*, 288–297.

Brom, D. & Kleber, R.J. (2009). Resilience as the capacity for processing traumatic experiences. In D. Brom, R. Path-Horenczyk & J.D. Ford (Eds.), *Treating traumatized children: Risk, resilience and recovery* (pp.133–149). New York: Routledge.

Fazel, M., Wheeler, J. & Danesh, J. (2005). Prevalence of serious mental disorder in 7,000 refugees resettled in Western countries: A systematic review. *The Lancet,* 365(9467), 1309–1314.

Grievink, L., Velden, P.G. van der, Stellato, R.K., Dusseldorp, A., Gersons, B.P.R., Kleber, R.J. & Lebret, E. (2007). A longitudinal comparative study of the physical and mental health problems of affected residents of the firework disaster Enschede, the Netherlands. *Public Health, 121,* 367–374.

ter Heide, F.J.J., Mooren, T.M. & Kleber, R.J. (2016). Complex PTSD and phased treatment in refugees: A debate piece. *European Journal of Psychotraumatology*, *7*, 28687.

Kleber, R.J. & Brom, D. in collaboration with Defares, P.B. (2003). *Coping with trauma: Theory, prevention and treatment*. Amsterdam/Berwyn, Pennsylvania: Swets & Zeitlinger International.

Luthar, S.S. & Cicchetti, D. (2000). The construct of resilience: Implications for interventions and social policies. *Development and Psychopathology, 12*(4), 857–885.

Masten, A.S. (2014). Global perspectives on resilience in children and youth. *Child Development, 85*(1), 6–20.

Mooren G.T.M. & Kleber, R.J. (2013). The significance of experiences of war and migration in older age: Long-term consequences in child survivors from the Dutch East Indies. *International Psychogeriatrics*, *25*, 1783–1791.

Sleijpen, M., Aa, N. van der, Mooren, G.T.M. & Kleber, R.J. (submitted). Does resilience matter? The moderating role of individual resilience in refugee and Dutch adolescents after trauma.

Sleijpen, M., Boeije, H.R., Mooren T. & Kleber, R.J. (2017). Lives on Hold: A qualitative study of young refugees' resilience strategies. *Childhood, 24,* 348–365.

Sleijpen, M., Haagen, J.F.G., Mooren T. & Kleber, R.J. (2016). Growing from experience: An exploratory study of posttraumatic growth in adolescent refugees. *European Journal of Psychotraumatology*, *7*, 28698.

Sleijpen, M., Heitland, I., Mooren T. & Kleber, R.J. (2017). Resilience in refugee and Dutch adolescents: Genetic variability in the corticotropin releasing hormone receptor 1. *Personality and Individual Differences*, *111,* 211–214.

Smid, G.E., Lensvelt-Mulders, G.J.L.M., Knipscheer, J.W., Gersons, B.P.R. & Kleber, R.J. (2011). Late-onset PTSD in unaccompanied refugee minors: Exploring the predictive utility of depression and anxiety symptoms. *Journal of Clinical Child and Adolescent Psychology, 40*, 742–755.

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R.A. & Van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA, 302*, 537–549.

Tol, W.A., Song, S. & Jordans, M.J.D. (2013). Annual Research Review: Resilience and mental health in children and adolescents living in areas of armed conflict – a systematic review of findings in low- and middle-income countries. *Journal of Child Psychology and Psychiatry, 54*, 445–460.

UNHCR (2004). *2003 Global refugee trends: Overview of refugee populations, new arrivals, durable solutions, asylum-seekers and other persons of concern to UNHCR*. Geneva: UNHCR, Population Data Unit.

BIO:

Rolf J. Kleber, Ph.D. is Emeritus Professor of Psychotraumatology, Utrecht University as well as Past Director Research of Arq Psychotrauma Foundation. He was lecturer at the University of California, Irvine (USA) and held academic positions at several Dutch universities. Prof. Kleber has conducted and supervised research projects on posttraumatic stress disorder treatment outcome, work related trauma and intervention programs, late sequelae of war stress, psychosocial consequences of disasters, health issues of refugees, and cross-cultural aspects of mental health. He is also a consultant in mental health care after major life events and emergencies in The Netherlands and abroad. Prof. Kleber has published various articles and books on stress, coping with trauma and cross-cultural psychology.

"In between" – Adolescent refugees in exile

Hubertus Adam (Child and Adolescent Psychiatry Clinic, Eberswalde, Germany)

1. Background Information and Definitions

In Europe and especially in Germany, migration and flight causing psychological strains are well known: after World War II tens of million of expellees, refugees and migrants came to West Germany; in fact, in 1950 they accounted for 20 % of the West German population (Hettlage-Varjas & Hettlage, 1984). In the decade from 1990 to 2000, again two million children lost their lives in armed conflicts, six million were injured or mutilated for life, one million were orphaned, and 12 million lost their homes (Deutsches Komittee für UNICEF, 2001). Today, still, war and persecution continue to cause great suffering for children and families worldwide and as a result nearly 900 000 refugees arrived in Germany – nearly as much as in 1995.

By our definition, a migrant child is a child whose biography is characterised by a – in many cases lifelong – process somewhere between the poles of voluntary migration and forced flight and which, depending on the child's stage of development may vary. If the child and/or one of his parents have lived through war, civil war or other kinds of "organised violence" (van Geuns, 1987) and the child has had to leave his homeland on the basis of one of these occurrences or was born in exile, we call it a refugee child.

2. Developmental Aspects

Developmental tasks are related to the demands and expectations of a certain culture of a certain age (van der Veer, 1998). Fulfilling these tasks forms a basic condition for a healthy development of adolescents and young adults. Organised violence can disturb fulfilling these tasks and can lead to severe and long-lasting psychopathology.

The following developmental tasks can be distinguished:

- Separation from parents and family, continuing life with internalised images.
- Strive for autonomy and independence, learning to be alone.
- Development of self-image and identity, multiplied by different cultures.
- Dealing with ambivalence, doubts and uncertainties.
- Cognitive growth, understanding the context and vicissitudes of life.
- Emotional differentiation, social-sexual growth, integration of aggressive and sexual impulses.
- Learning day-to-day living abilities: housing, financing, structuring.
- Future orientation: education, choice of profession, destination.
- Reshaping relationships and friendship, learning to love.
- Moral development, knowing and recognising the difference between good and bad.
- Orientation in a new cultural system.

3. Transcultural Aspects

Migration and flight itself can be seen as a potentially traumatic event, a disruptive process, different from the traumatisation by war and violence. It refers to loss of social structures, cultural values and loss of identity (Eisenbruch, 1991). But migration and flight can also be considered a challenge, as they offer the possibility for growth and psychological rebirth (Akhtar, 1995). Grinberg and Grinberg (1989) describe psychological growth in terms of integration,

reorganisation and consolidation of identity. It implicates a search for what is lost, but at the same time looking for what is left and can be saved. Therefore, in our opinion diagnosis and therapy of child and adolescent psychiatrists and psychotherapist should not only focus on ICD or DSM categories like PTSD but on cultural specifics as Di Nicola described in 1997:

- Openness and curiosity. This does not mean adopting a neutral or unbiased attitude or substituting one's own values for a xenophile attitude. What it does mean is incorporating cultural information in therapeutical work.
- The willingness to question and analyse one's own biases also means distancing oneself from the surrounding cultural norms without denying one's own cultural and ethical foundation.
- This means the willingness to keep questioning whether the symptoms or behaviour observed are the same or, in fact, differ from the usual.

4. Burdening and Coping: the Past

As early as the 1940s, reports on the psychological traumatisation of children through war, flight and persecution were published (e.g. Freud, 1949), followed by an increasing number of publications dealing with the various impacts of disasters (man-made as well as natural) on children and adolescents (e.g. Bloch, Silber & Perry, 1956; Eth & Pynoos, 1985; Garmezy & Rutter, 1985; Jensen & Shaw, 1993; Terr, 1991).

Many studies showed that long-lasting fear and uncertainty, the experience of shell attacks and bombing, witnessing maltreatment, rape, killing or even mass murder, to say nothing of the strains of flight and expulsion, put the developing child under severe stress and, at times, even provoked massive mental harm (e.g. Arroyo & Eth, 1985; Kinzie, Sack, Angell, Manson & Rath, 1986; Kuterovac, Dyregrov & Stuvland, 1994; Macksoud & Aber, 1996; Saigh, 1991). Bosnian children e.g. showed high degrees of PTSD symptoms, particularly those directly involved in war activity (Smith, Perrin, Yule, Hacam & Stuvland, 2002). Similar symptoms were confirmed in Bosnian children living in exile in Greece. Roughly half of the Bosnian refugee children had a definite tendency towards depressive behaviour, over 25 per cent increased anxiety and more than one-fourth suffered from post-traumatic disturbances (Papageorgiou et al., 2000). A Swedish research group (Hjern & Angel, 2000), which studied 63 refugee children from the Middle East, discovered that seven years after arriving in Sweden and having had their first medical check-up, 20 per cent of the children still displayed behavioural problems according to their teachers.

Perrin, Smith and Yule (2000), for example, report intrusive thoughts as to the traumatic experience in severely traumatised children, especially in calm situations and before falling asleep. The intrusions in children and adolescents differ according to their age and stage of development but, with growing maturity of the youths, they approach those observed in adults. The clusters of symptoms "avoidance" and "hypervigilance" were also found repeatedly in children and adolescents (Arroyo & Eth, 1985; Kinzie et al., 1986; Saigh, 1991). Contrary to expectation, we found in our own study of child soldiers in Uganda (Bayer, Klasen & Adam, 2007) no significantly positive association between traumatic experiences and PTSD symptoms and no association between particular kinds of exposure and measures of PTSD symptoms. But we found in studies of children in Kosovo just after the war (Adam, Österreicher, Asshauer & Riedesser, 2004) and in refugee children at school in Hamburg (Adam & Klasen, 2011) clinically relevant symptoms of PTSD. These children affected by war and violence had significantly less openness to reconciliation and significantly more feelings of revenge than those with fewer symptoms. Hence, posttraumatic stress might hinder the children's ability to deal with and

overcome emotions of hate and revenge. Likewise, the children with PTSD symptoms might regard acts of retaliation as an appropriate way to recover personal integrity and to overcome their traumatic experiences. Therefore, posttraumatic stress might be an important factor influencing post conflict situations and may contribute to the cycles of violence found in war-torn regions and in exile. Regarding the measurement of mental health of children afflicted by war, Bronstein and Montgomery (2011) investigated mental health in non-clinical samples of asylum seeking and refugee children residing in OECD countries. A total of twenty-two studies were identified of 4 807 retrieved citations, covering 3 003 children from over 40 countries. The problem they focused on was that studies varied in definition and measurement of problems, which included levels of post-traumatic stress disorder from 19 to 54%, depression from 3 to 30%, and varying degrees of emotional and behavioural problems. Hence the meaningfulness of statements regarding mental health is limited. Significant factors influencing levels of distress appear to include demographic variables, cumulative traumatic pre-migration experiences, and post-migration stressors.

5. Treatment Issues

External protection and the stability of parental care are essential in dealing with cumulative and ongoing stress. Developmental threats result from the unavailability of a caretaker or parent, the disruption of a normal, functioning family and a sudden change in environment as a result of evacuation or flight.

During the assessment one can focus on the following aspects to assess whether these children and adolescents will develop problems after experiencing organised violence:

- The history of migration, flight, acculturation, the history of strains as well as the reactions and psychopathology (beyond DSM and ICD), before and after traumatic events.
- The developmental strength and coping mechanisms such as an internal locus of control, positive self-esteem, social skills, stabile relationships, ability to use available support.
- The availability of parental support and care, and the continuity and safety of a caring family and supportive society.
- The cooperation with kinder garden e.g. school and other care takers, teaching psychodevelopmental aspects of as well as offering supervision if needed (Adam & Bistritzky, 2016).
- The ability for and the openness to reconciliation and feelings of revenge on the person or group refugee children or adolescents consider their enemy.

The patient and his or her family or the people closest to the patient are advised and informed of the need to talk about the psychosocial consequences of fleeing. Clarification that symptoms are not the result of an illness but of social circumstances and the experiencing of extreme stress which could lead to a disorder in the subjective well-being of virtually any human being who had gone through similar experiences. It is crucial that the distinction between normal stress reactions and pathological reactions be consulted and explained and the normal psychotherapeutic approach clarified in how it differs from traditional healing methods. Information about consultation with parents on early childhood perception of stress situations and the transgenerational transmission of interpretational and coping patterns as well as mental traumatisation should be given. It is necessary to show the way to immediate and accessible help for the creation of a helping and supportive environment. Also, a quick structuring of everyday life and creation of "normalcy" are essential. Hence, we support the need to fulfil the obligation under the United Nations Convention on the Rights of the Child to promote psychological

recovery for war-affected children. Strengthen these children on the one hand and avoidance of wishes of revenges will overtake thinking, feeling and acting of war affected children and adolescents – this might be one step to a peaceful society.

References

Adam, H. & Bistritzky, H. (2016). *Seelische Probleme von geflüchteten Kindern und Jugendlichen. Wie Schule und Kinderpsychiatrie kooperieren können.* Berlin: Cornelsen Verlag.

Adam, H. & Klasen, F. (2011). Trauma und Versöhnung, Versöhnungsbereitschaft bei traumatisierten Flüchtlingskindern. *Trauma und Gewalt, 5*(4), 356–369.

Adam, H., Österreicher, J., Asshauer, M. & Riedesser, P. (2004). Flüchtlingskinder – Individuelles Trauma, Versöhnungsprozess und soziale Rekonstruktion. *Zeitschrift für Psychotraumatologie und Psychologische Medizin, 4,* 75–86.

Akhtar, S. (1995). A third individuation: immigration, identity and the psychoanalytic process. *Journal of the American Psychoanalytical Association, 43,* 1051–1084.

Arroyo, W. & Eth, S. (1985). Children traumatized by central American warfare. In S. Eth & R.S. Pynoos (Eds.), *Post-traumatic stress disorder in children* (pp. 103–117). Washington, DC: American Psychiatric Press.

Bayer, C.P., Klasen, F. & Adam, H. (2007). Association of trauma and PTSD symptoms with openness to reconciliation and feelings of revenge among former Ugandan and Congolese child soldiers. *Journal of the American Medical Association, 298*(5), 555–559.

Bloch, D., Silber, E. & Perry, S. (1956). Some factors in the emotional reaction of children to disaster. *American Journal of Psychiatry, 113,* 416–422.

Bronstein, I. & Montgomery, P. (2011). Psychological distress in refugee children: A systematic review. *Clinical Child and Family Psychology Review, 14,* 44–56.

Deutsches Komitee für UNICEF (Hrsg.) (2001). *Zur Situation der Kinder in der Welt.* Frankfurt am Main: Fischer.

Di Nicola, V. (1997). *A Stranger in the Family: Culture, Families, and Therapy.* New York, London: W.W. Norton & Company.

Eisenbruch, M. (1991). From posttraumatic stress disorder to cultural bereavement: diagnosis of Southeast Asian refugees. *Social Science & Medicine, 33,* 673–680.

Eth, S. & Pynoos, R. (Eds.) (1985). *Posttraumatic Stress Disorder in Children.* Washington, DC: American Psychiatric Press.

Freud, A. (1949). Kriegskinder. *Die Schriften der Anna Freud,* Bd. 2 (S. 496–561). München: Kindler.

Garmezy, N. & Rutter, M. (1985). Acute reaction to stress. In M. Rutter & L. Hersov (Eds.), *Child and adolescent psychiatry: modern approaches* (2nd ed.). (pp. 152–176). London: Blackwell Scientific Publications.

Grinberg, L. & Grinberg, R. (1989). *Psychoanalytic Perspectives on Migration and Exile.* New Haven: Yale University Press.

Hettlage-Varjas, A. & Hettlage, R. (1984). Kulturelle Zwischenwelten. Fremdarbeiter – Eine Ethnie? *Schweizerische Zeitschrift für Soziologie, 10*(2), 357–403.

Hjern, A. & Angel, B. (2000). Organized violence and mental health of refugee children in exile: a six-year follow-up. *Acta Paediatrica, 89*(6), 722–727.

Jensen, P. & Shaw, J. (1993). Children as victims of war: Current knowledge and future research needs. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 697–708.

Kinzie, J.D., Sack, W.H., Angell, R.H., Manson, S. & Rath, B. (1986). The psychiatric effects of massive trauma on Cambodian children: I. The children. *Journal of the American Academy of Child and Adolescent Psychiatry, 25,* 370–376.

Kuterovac, G., Dyregrov, A. & Stuvland, R. (1994). Children in war: a silent majority under stress. *British Journal of Medical Psychology, 67,* 363–375.

Macksoud, M.S. & Aber, J.L. (1996). The war experiences and psychosocial development of children in Lebanon. *Child Development, 67,* 70–88.

Papageorgiou, V., Frangou-Garunovic, A., Iordanidou, R., Yule, W., Smith, P. & Vostanis, P. (2000). War trauma and psychopathology in Bosnian refugee children. *European Child and Adolescent Psychiatry, 9,* 84–90.

Perrin, S., Smith, P. & Yule, W. (2000). Practitioner review: The assessment and treatment of post-traumatic stress disorder in children and adolescents. *Journal of Child Psychology and Psychiatry, 41*(3), 277–289.

Saigh, P.A. (1991). The development of post-traumatic stress disorder following four different types of traumatization. *Behaviour Research and Therapy, 29,* 213–216.

Smith, P., Perrin, S., Yule, W., Hacam, B. & Stuvland, R. (2002). War exposure among children from Bosnia-Hercegovina: Psychological adjustment in a community sample. *Journal of Traumatic Stress, 15*(2), 147–156.

Terr, L.C. (1991). Childhood traumas: an outline and overview. *American Journal of Psychiatry, 148,* 10–20.

van Geuns, H. (1987). The concept of organized violence. In Ministry of Welfare, Health and Cultural Affairs (Ed.), *Health Hazards of organized violence* (pp. 7–10) Rijswijk: Ministry of Welfare, Health, and Cultural Affairs.

van der Veer, G. (1998). *Counseling and Therapy with Refugees. Psychological problems of victims of war, torture and repression.* New York: John Wiley & Sons.

BIO:

Prof. Dr. Hubertus Adam, born 1959, is child and adolescent psychiatrist and psychotherapist as well as analytic family therapist and head of the Child and Adolescent Psychiatry Clinic in Eberswalde near Berlin since 2007. He got experience in treatment of child refugees and refugee families during his time at the University Clinic in Hamburg as well as currently in Eberswalde, a region close to Berlin with an increasing number of refugee children seeking psychiatric care. He developed and headed projects for children afflicted by war and organized violence (treatment and education of local psychologist) in Kosovo, South Africa, Mozambique, Uganda and Damascus. He published several publications on this topic.

Trauma and resilience after exposure to cumulative trauma: Guidelines for early interventions

Ruth Pat-Horenczyk (School of Social Work and Social Welfare, The Hebrew University of Jerusalem)

This presentation will focus on the Israeli experience with trauma, posttraumatic distress, survival mode and resilience. Despite the different contexts, I will try to highlighted relevant experience that can be useful for the development of services for unaccompanied minor refugees. I will first clarify some core constructs such as: *cumulative trauma, allostatic load, survival mode*, and *relational trauma*. Then, I will present the principles of early intervention after trauma exposure and elaborate on the experience gained with school-based interventions. Lastly, I will elaborate on the potential for *"compassion fatigue" or "secondary / vicarious traumatization"* and on the need to encourage self-care for professionals and volunteers working with traumatized people.

Ronnie Janoff-Bulman (1992) described the overwhelming impact of trauma in the following words: "Traumatic life events *shatter our fundamental assumptions* about ourselves and our world; the benevolence of the world; the worthiness of the self and the world as meaningful. In the aftermath of these extreme experiences, coping involves the arduous task of *reconstructing an assumptive world* and establishing a comfortable world that *incorporates the traumatic experience."* Further, Judith Herman in her book on *Trauma and Recovery* (Herman, 1992) wrote that "Traumatic events overwhelm the usual methods of coping that give people a sense of *control, connection and meaning*." These descriptions of the core phenomenology and experience of trauma can direct us to the efforts needed for trauma recovery.

It is important to acknowledge the *normal processes of recovery from trauma* that include: cognitive and emotional processing, oscillation between re-experiencing, avoidance and arousal dysregulation, working through of grief and traumatic grief, searching for meaning and re-building belief in safety and continuity. These processes take time and the role of social support in supporting this coping process is crucial.

From another angle, we can conceptualize the process of recovery from trauma – that tends to break the upper or lower thresholds of arousal levels – as regaining equilibrium, or *"bouncing back"* to the optimal level of arousal. In other words, the recovery process is aimed at re-establishing the arousal level within the "window of tolerance".

It is important to distinguish between the different types of traumatic events. *Single episode (type I)* refers, for example, to a car accident; *Complex trauma (type II)* describes a repeated similar traumatic episode that has ceased, for example sexual abuse; *Continuous trauma (type III)*, describes ongoing events of terrorism, war or racism; and *Cumulative trauma (Type IV)* is trauma experienced across the life time that includes events in the past and ongoing chronic traumas such as extreme poverty or slavery (Kira et al., 2013).

The concept of *Allostatic Load* (McEwen & Magarinos, 1997, in Brom, 2014) is highly relevant to *cumulative and continuous trauma*. It explains the dynamics that may lead to the detrimental effects of cumulative and continuous trauma. A lifetime exposure to traumatic events of diverse origins will have cumulative effects leading to the *dysregulation of multiple psycho-physiological systems.* Allostatic load is the total *accumulation of such dysregulation* across psycho-physiological systems.

Another relevant construct is *Survival mode* which describes the activation of the sympathetic system in the face of danger, and the shifts in the body's priorities (e.g. increased muscle tone and heart rate) that prepare it for fight-flight-freeze responses. *Being on survival mode*

means functioning with heightened vigilance, over-focused attention (on the danger), and increased secretion of cortisol (stress) hormone. Being on survival mode emphasizes the continual vigilance to "here and now", putting on hold planning, learning and future-oriented responses. Further, extensive use of survival mode may lead to dysregulation of anger, distortion in the perception, sensation seeking and exhaustion. Additionally, survival mode can also create "traumatic bonding" that is reflected in a strong "in group" identification and "out group" suspicious and hostility.

Lastly, Sheeringa and Zeanah (2001) proposed the concept of *Relational PTSD* as the: "co-occurrence of PTS simultaneously in parent and child", when the symptomatology of one partner (usually the adult) exacerbates the symptomatology of the other (child)". This conceptualization highlights the importance of the ability of the significant adult to mitigate the post-traumatic distress of the child. In the case of unaccompanied minor refugees, the absence of a parental figure may put them on higher risk.

Now, I would like to move from theory to practice, and share with you some of our experience with developing services for traumatized children and youth in Israel. Our school-based model was inspired by the work done in the US in the aftermath of 9/11. Christina Hoven from Columbia University and her colleagues (2005) conducted a large scale school based screening in New York City, six months after 9/11. It was based on a sample of 8,266 school children from 4th to 12th grade, some were near the Twin Towers at the time of the attack, some were in more distant places and the results were summarized in a report submitted to the Ministry of Education. In this report the following sentence (appeared in the conclusion) stood up for me as very important and with implications for interventions: *"Most of the students (66%) with post-traumatic symptoms did not turn or were referred to treatment either within the school or by mental health professionals in the community"* (New York City, 6.5.02).

This major finding stimulated our active attempts to search for the *children who may be suffering in silence*. It was apparent that if we want to find those children and to provide trauma services for them, we have to conduct a school-based screening in which we actively reach out for the students in their natural environment, in a non-stigmatic manner, and ask them directly to report on their symptoms of distress. We gradually broadened the scope of the screening to include both *risk and protective factors*. For example, we assessed risk factors such as: exposure (personal, "near miss" or indirect, media); PTSD and related distress symptoms (functional impairment, depression / anxiety, somatic complaints); behavioral aspects (keeping routine, risk taking behavior). We also assessed protective factors such as: social support, coping strategies, self-efficacy, ego resilience, emotion regulation, hope, optimism, flexibility, seeking help and posttraumatic growth. The comprehensive screening approach enabled us to triage students to treatment based on a more integrated measure of distress and strength (Pat-Horenczyk et al., 2007, 2009, 2014).

After conducting the school-based screening, we developed modular, or multi-tier school-based interventions that included (a) *universal interventions* for building resilience and enhancing coping strategies geared for all teachers, students and parents, and (b) *specific group interventions* geared for traumatized students in different levels of distress (Berger, Pat-Horenczyk & Gelkopf, 2007). The ecological perspective for school-based interventions led us to develop also a city-wide approach for intervention that includes the synergy of working with teachers, children, first responders, pediatricians and community leaders. Additionally, we realized that there is a need to provide a continuity of trauma and resilience services that include the development of programs for preparedness (to disasters), early interventions (after the trauma) and long-term psycho-social services (Pat-Horenczyk et al., 2011, Brom, Baum & Pat-Horenczyk, 2015).

I would like to mention two examples of important insights gained from our screening process among thousands of youth. We learned that youth express their *need of support*. When asked directly if they want to receive help, those adolescents who were in need of help – responded and indicated the source of help they would like to get. This simple and direct question proved to be a good indication of existing distress (Schiff et al., 2010). In another study (Pat-Horenczyk et al., 2007), we found strong associations between trauma exposure and risk taking behaviors among youth suffering from posttraumatic symptoms. This strong relationship should alert educators and clinicians to the higher risk of self-harm among traumatized youth.

We extended out research also to early childhood and learned to screen preschoolers, along with their parents, for posttraumatic distress and then referred the distressed dyads (parent and child) to dyadic treatment groups. These dyadic interventions are aimed at enhancing regulation capacities of both parents and child and increase the awareness of the significant other to the central role of *attachment and emotion regulation* in mitigating the distress of the young child (Cohen, Pat-Horenczyk & Haar-Shamir, 2014; Pat-Horenczyk et al., 2013, 2014, 2015, 2017).

In sum, a comprehensive approach for early interventions after adversities was formulated by Hobfoll and additional twenty leading trauma experts in 2007, who identified *five empirically supported intervention principles* that should be used to guide and inform intervention and prevention efforts at the early to mid-term stages of post disaster intervention. These essential elements are promoting: 1) a sense of safety, 2) calming, 3) a sense of self- and community efficacy, 4) connectedness, 5) hope.

An integral part of the development of services for traumatized children and youth is the consideration of the potential *responder stress,* or what was termed as *Compassion Fatigue*. As Charles Figley (2002) wrote: "There is a cost to caring. We professionals who are paid to listen to the stories of fear, pain, and suffering of others may feel, ourselves, similar fear, pain and suffering because we care…Compassion fatigue is the emotional residue of exposure to working with the suffering, particularly those suffering from the consequences of traumatic events." There is an apparent need to combat compassion fatigue and to develop services for self-care (often called "*helping the helper")* for workers and volunteers who face pain and prolonged distress as part of their work with traumatized individuals and groups.

References

Berger, R., Pat-Horenczyk, R. & Gelkopf, M.A. (2007). School-based intervention for the prevention and treatment of elementary students' terror-related distress in Israel: A randomized control trial. *Journal of Traumatic Stress, 20*(4), 541–551.

Brom, D. (2014). Thoughts about survival mode theory of posttraumatic reactions. In R. Pat-Horenczyk, D. Brom & J. Vogel (Eds.), *Helping children cope with trauma: Individual, family and community perspectives* (pp. 243–248). New York, NY: Routledge.

Brom, D., Baum, N.L. & Pat-Horenczyk, R. (2015). Systems of care for traumatized children: The example of a School-based Intervention model. In M. Safir, H. Wallach & A. Rizzo (Eds.), *Future directions in post-traumatic stress disorders: Prevention diagnosis and treatment* (pp. 155–170). New York: Springer.

Cohen, E., Pat-Horenczyk, R. & Haar-Shamir, D. (2014). Making room for play: An innovative intervention for toddlers and families under rocket fire. *Clinical Social Work Journal, 42*(4), 336–345.

Figley, C.R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58*(11), 1443–1441.

Herman, J.L. (1992). *Trauma and Recovery*. New York: Basic Books.

Hobfoll, S.E., Watson, P., Bell, C.C., Bryant, R.A., Brymer, M.J., Friedman, M.J. et al. (2007). Five Essential Elements of Immediate and Mid–Term Mass Trauma Intervention: Empirical Evidence. *Psychiatry: Interpersonal and Biological Processes, 70*(4), 283–315.

Hoven, C.W., Duarte, C.S., Lucas, C.P., Wu, P., Mandell, D.J., Goodwin, R.D. et al. (2005). Psychopathology Among New York City Public School Children 6 Months After September 11. *Archives of General Psychiatry; 62*(5), 545–551.

Janoff-Bulman, R. (1992). *Shattered assumptions: toward a new psychology of trauma.* New York: The Free Press.

Kira, I.A., Ashby, J.S., Lewandowski, L., Alawneh, A.W.N., Mohanesh, J. & Odenat, L. (2013). Advances in Continuous Traumatic Stress Theory: Traumatogenic Dynamics and Consequences of Intergroup Conflict: The Palestinian Adolescents Case. *Psychology, 4*(4), 396–409

Pat-Horenczyk, R., Brom, D., Baum, N., Benbenishty, R., Schiff, M. & Astor, R.A. (2011). A city-wide school-based model for addressing the needs of children exposed to terrorism and war. In V. Ardino (Ed.), *Post-traumatic syndromes in children and adolescent* (pp. 243–254). New York, NY: Wiley/ Blackwell Press.

Pat-Horenczyk, R., Cohen, S., Ziv, Y., Achituv, M., Asulin-Peretz, L., Blanchard, T. et al. (2015). Emotion regulation in mothers and young children faced with trauma. *Infant Mental Health Journal, 36*(2), 1–12. Article first published online: 30 APR 2015.

Pat-Horenczyk, R., Cohen, S., Ziv, Y., Achituv, M.C, Brickman, S., Blanchard, T. et al. (2017). Stability and Change in Posttraumatic Distress: A 7-Year Follow-Up Study of Mothers and Young Children Exposed to Cumulative Trauma. *Journal of Traumatic Stress, 30*(2), 115–124.

Pat-Horenczyk, R., Kenan, A.M., Achituv, M. & Bachar, E. (2014). Protective factors based model for screening for posttraumatic distress in adolescents. *Child and Youth Care Forum, 43*(3), 339–351.

Pat-Horenczyk, R., Peled, O., Miron, T., Villa, Y., Brom, D. & Chemtob, C.M. (2007). Risk-Taking Behaviors among Israeli Adolescents Exposed to Recurrent Terrorism. *American Journal of Psychiatry, 164*(1), 66–72.

Pat-Horenczyk, R., Qasrawi, R., Lesack, R., Haj-Yahia, M.M., Peled, O., Shaheen, M. et al. (2009). Posttraumatic Symptoms, functional impairment and coping among adolescents on both sides of the Israeli-Palestinian conflict: A cross-cultural approach. *Applied Psychology*: *An International Review*, *58*(4), 688–708.

Pat-Horenczyk, R., Ziv, Y., Asulin-Peretz, L., Achituv, M., Cohen, S. & Brom, D. (2013). Relational trauma in times of political violence: Continuous traumatic stress vs. past trauma. *Peace and Conflict: Journal of Peace Psychology, 19*(2), 125–137.

Scheeringa, M.S. & Zeanah, C.H. (2001). A relational perspective on PTSD in early childhood. *Journal of Traumatic Stress, 14,* 799–815.

Schiff, M., Pat-Horenczyk, R., Benbenishty, R., Brom, D., Baum, N. & Astor, R.A. (2010). Seeking help: Do adolescents know when they need help? Jewish and Arab youths report on their posttraumatic distress in the aftermath of war. *Journal of Traumatic Stress, 23*(5), 657–660.

BIO:

Ruth Pat-Horenczyk, Ph.D., is an Associate Professor at the School of Social Work and Social Welfare at the Hebrew University of Jerusalem and the Director of Research at Meitiv: Israel Center for the Treatment of Psychotrauma at Herzog Hospital in Jerusalem. She is a clinical psychologist who received her Ph.D. from the Hebrew University and completed her post-doctoral training at the University of California in San Diego. Subsequently she was involved in clinical research and teaching in several areas of behavioral medicine such as sleep, eating disorders and trauma. Her current research topics focus on risk and protective factors for childhood PTSD, relational trauma, emotion regulation, coping flexibility, and posttraumatic

growth. Prof. Pat-Horenczyk co-edited the books *Treating Traumatized Children: Risk, Resilience and Recovery* (2009), and *Helping Children Cope with Trauma: Individual, Family and Community Perspectives* (2014).

A pilot evaluation study of an intercultural treatment program for stabilization and arousal modulation for intensely stressed children and adolescents and minor refugees, called START (Stress-Trauma-Symptoms-Arousal-Regulation-Treatment)

Eva Möhler (SHG-Kliniken Sonnenberg, Saarbrücken, Germany)

Background

During or after periods of intense stress, such as traumatic migration or other experiences, children and adolescents are in danger of developing psychiatric or physical symptoms. In these cases frequent barriers to treatment have recently been described for refuged minors, including language or cultural impediment. Therefore, a short, very low threshold, playful program for emotion regulation and self-soothing was developed, the Stress-Trauma-Symptoms-Arousal-Regulation-Treatment, START.

Methods

Adolescents in acute crisis at the age of 13–18 years participated in the START program for 5 weeks in multinational group settings, with two sessions per week. Compounds of START are derived from elements of dialectic behavioral therapy and trauma-focused cognitive behavioral therapy for children.

After informed consent, the first 22 adolescents completing the program were assessed for trauma (CATS, CPTCI), emotion regulation (FEEL-KJ), general mental and physical Health (RHS), experienced self-control (SCS) and perceived stress (PSQ) immediately before and after treatment.

Results

Trauma-specific symptom load (CATS; CPTCI) was very high in the first 22 adolescents. A positive effect of START on emotion regulation (specifically the scale adaptive strategies), and self-control can be found as well as a negative effect (reduction) of perceived stress (PSS-10). Also, on a visual analogue scale adolescents scored better for general subjective well-being in the refugee health screener after completing the START program. The largest proportion of our sample (80%) showed posttraumatic stress disorder. All 22 adolescents completed the program, showing good adherence and compliance, once started. The most prominent results, as expected, can be found for emotion regulation and self-control-being the primary target of the 5-weeks program. The expected reduction of perceived stress, however, was not significant, and neither had the general mental health improved on a highly significant basis. In our sample, in 9 cases TF-CBT or DBT was begun AFTER completion of START, as the patients were found to display enough behavioral stability and therapeutic motivation only after achieving fast success with emotion regulation and self-control.

Discussion

This pilot evaluation indicates a usefulness and applicability of START for highly stressed children and adolescents in acute crisis of different nationalities. The results are limited clearly by small sample size and the lack of a treatment as usual control group.

The primary motivation of START was to enable unaccompanied refugee minors in acute stages of desperation or tension to regulate their emotions in a way that does not imply harm

to self or others. This capability seems to be of utmost importance for a successful integration and for sustaining the strain of separation, loss and a completely insecure future. The capability to handle extreme stress without additional necessity for hospitalization, or involuntary constraint, involving potential re-traumatization is regarded as a major advantage of START.

Future studies should investigate a presumed improvement of self-confidence potentially accompanying the reduction of non-adaptive behavior with subsequent negative labeling by the immediate environment.

More perceived self-control could be an important attribute of a positive identity development. A more positive self-conception is expected if integration in schools or youth care settings can be mastered without behavioral disintegration.

However, due to the need for standardized settings, this study presents data gathered in a clinical setting. Originally START was designed to be applied by professionals within the youth welfare system or even in schools. Future studies should focus on these settings and include broader assessment tools.

Conclusion

The results are promising first data supporting the applicability and helpfulness of START in young refuged minors and other highly stressed adolescents, underlining intercultural use with an additional advantage of integration and strengthening of resilience in several at risk populations. Small sample size is a limitation, as well as the lack of a treatment- as -usual control. Regarding the fact, however, that START is a 5 week group program in a highly playful and low threshold manner without narrative elements or trauma exposition, it might be concluded that for a strong and significant lasting improvement in general mental health, a more profound and individualized therapeutic setting could be necessary. However, more complex and structured approaches such as DBT and TF-CBT require more behavioral stability than adolescents in acute crisis or transition situations can display or are willing to develop, and this is exactly where START comes in, according to our data, and this presentation has shown that START is able to achieve its primary goal: a fast behavioral and emotional stabilization for acutely stressed adolescents with a high load of traumatic experiences.

Clinical Relevance

A short and uncomplicated, low threshold program like START appears to become more and more necessary in the light of increasing numbers of behaviorally dysregulated children and adolescents with or without a history of migration. Due to the simple but structured construction of the manual with work sheets for each step in different languages, it can be applied by child care professionals without intense psychotherapeutic background. The need for improvement of resilience in a world of intense stress and stimulation seems mandatory for adolescents, specifically refuged minors. Resilience can potentially be strongly promoted by START, as emotion regulation can be regarded as one central aspect of resilience. This study shows that START can significantly contribute to improving emotion regulation and therefore potentially stress resilience in – not only refugee-adolescents. Future studies in different settings, different age groups and with larger sample sizes are underway

Abbreviations

START – Stress-Trauma-Symptoms-Arousal-Regulation-Treatment; BIS-15: Barrat Impulsiveness Scale – Shortversion; RHS-15: Refugee Health Screener; CATS: Child and Adolescent Trauma

Screen; CPTCI: Child Post-Traumatic Cognitions Inventory; FEEL-KJ: Fragebogen zur Erhebung der Emotionsregulation bei Kindern und Jugendlichen; PSS-10 Perceived Stress Scale; SCS-13: Self-Control-Scale

BIO:

Prof. Dr. Eva Möhler is consultant for child and adolescent psychiatry, lecturer at the Faculty of Medicine, Department of Child and Adolescent Psychiatry at the University of Heidelberg. She is Medical Director of the SHG-Clinics for Child and Adolescent Psychiatry Saarbrücken. Her areas of research are: child abuse and neglect, parent-child interaction, preventive interventions for refugeed minors.

Symposium 2:
Belonging, acculturation and identity issues in unaccompanied minor refugees

Attitudes towards unaccompanied refugee minors in Germany[1]

Paul L. Plener (Department of Child and Adolescents Psychiatry and Psychotherapy, University of Ulm, Germany)

Introduction

With 65.6 million displaced persons worldwide, of which more than 50% are below the age of 18 (UNHCR, 2017), a considerable number of both accompanied (ARM) and unaccompanied (URM) minors are among those seeking refuge. Within this group of minors, URM are reported to have experienced more potentially traumatic events, and they lack the support and protection of their family system (for review see: Witt, Rassenhofer, Fegert & Plener, 2015). It has to be kept in mind that the mental health of this population is not only determined by events taking part before or during their flight (such as experiencing violence and death of loved ones), but that the acculturation process in itself can also serve as a stressor with severe impact on mental health.

It has been shown in a study of 103 URM in Belgium that daily stressors in the new host country predicted the occurrence of Posttraumatic Stress Disorder, depression and anxiety over the long run (Vervliet, Lammertyn, Broekaert & Derluyn, 2014). Among the many influences on acculturation stress, hospitality or hostility of the host country´s population has to be taken into account. Germany has seen a sharp increase in numbers of asylum seekers, especially in 2015 and 2016 (BAMF, 2017), with most of them coming from the Middle East. Initially, rather positive attitudes to welcome those in need of help were encountered, with an overall fairly positive attitude towards asylum-seekers. This was exemplified in two independent studies, which were performed in May and August 2015. In the first study in May 2015 (n=1 453), 31% agreed that Germany has the potential to accept more refugees, and 31% as well agreed that Germany should be ready to accommodate as many refugees as possible (Petersen, 2015). In another study in August 2015 (n=1 809), 32% agreed that Germany has the potential to accept more refugees, and 35% agreed that Germany should be ready to accommodate as many refugees as possible. In addition, 54% stated that they would be open to have a refugee shelter established in their neighborhood (Köcher, 2015). Apart from these general questions, we were interested in attitudes towards URM, specifically. We therefore conducted a survey in a representative sample of the German population to assess these attitudes based on the items mentioned above.

Method

The study was conducted in a representative sample of the German population (n=2 524 participants aged 14 years or older). Participants were selected by using a random route method. They were visited by a research assistant at home, who performed a demographic interview. They were then handed out a set of questionnaires including items about the attitudes towards

[1] The full paper is open-accesible at: Plener, P.L., Groschwitz, R.C., Brähler, E., Sukale, T. & Fegert, J.M. (2017). Unaccompanied refugee minors in Germany: attitudes of the general population towards a vulnerable group. *Eur Child Adolesc Psychiatry, 26,* 733–742.

URM, as well as the "Fragebogen zum Rechtsextremismus-Leipziger Form" (FR-LF), which was used to evaluate right wing political attitudes as well as islamophobia. In addition, participants were asked to rate themselves on a left-right political spectrum on a ten-point Likert Scale. The survey was approved by the Institutional Review Board of the Medical Faculty at the University of Leipzig. A more detailed description of the methods is available in Plener et al. (2017).

Results

Of the 2 524 participants who took part in the survey, 22.8% supported Germany accommodating more URM, whereas 45.6% declined (with 31.5% stating that they were undecided on that matter). Younger participants showed higher rates of approval, which was also the case for participants who did not hold a German citizenship, who had graduated from high school and who had a monthly income above € 1 500. A binary stepwise regression analysis revealed that right-wing extremism, islamophobia and a general attitude towards rejection of asylum seekers explained 44.3% of the variance in rejection of the possibility of hosting more URM. Islamophobia and general rejection of asylum seekers were the strongest predictors in this model (OR 2.1; 95% CI 1.8–2.6 and OR 2.1; 95% CI 1.7–2.7, respectively), followed by right-wing extremism (OR 1.1; 95% CI 1.0–1.1).

When being asked whether URM should be directly deported back to their home countries upon arrival in Germany, in general 38.6% fully or somewhat agreed, while 61.5% were somewhat or fully opposed to this statement. When the question was varied and assessed attitudes towards direct deportation with regards to different regions of origins, answers differed. Whereas 62% somewhat or fully agreed that URM from the Balkan region should be deported back to their home country immediately, only 35.3% did so with respect to URM from the Middle East (and 50.1% with regards to URM from Africa). Female participants more often disapproved of immediate deportation of URM in general and also specifically for the different geographic regions. Using regression analysis, a model including the variables political attitudes, right-wing extremism, islamophobia, and general rejection of asylum seekers explained 44.0% of the variance.

Another set of questions were geared towards integration and living conditions of URM in Germany. A large majority (70.7%) fully or somewhat agreed that URM should be granted the same access to schooling and apprenticeship as children and adolescents born in Germany. Interestingly, there was also a large rate of approval (73.9%) for granting URM the right to stay in Germany after finishing school or job training. When questioned in which places URM should live, most participants answered that they would favor youth welfare homes (44.6%), followed by refugee housings (29.2%) and foster care (18.5%) (elsewhere: 7.7%).

Discussion

Our study focused on attitudes towards URM in a representative sample of the German population. Although – for reasons of comparability – some of the chosen items in this study were based on former studies regarding attitudes towards asylum-seekers in Germany (Petersen, 2015; Köcher, 2015), this was the first study to assess attitudes, specifically towards URM in Germany. Germany and many other countries had experienced a stark increase in numbers of asylum seekers, especially in 2015 and in the first half of 2016 (BAMF, 2017). This increase in numbers was first greeted with understanding and rather positive attitudes towards those seeking refuge from conflicts, mostly in the Middle East. However, the findings of our study showed lower numbers of acceptance towards providing further refuge for URM. Only 23% of the participants stated that Germany was able to accommodate more URM.

These rates were lower than the rates of acceptance towards hosting more asylum-seekers in general, as the studies of Petersen (2015) and Köcher (2015) reported. The lower acceptance rate might be explained through a general lower acceptance rate throughout time, as both the study by Petersen (2015) as well as the study by Köcher (2015) went into the field in mid to late 2015. The assessment of our study took place at the beginning of 2016, a time with heavy media coverage on the events of new-year's eve 2016 in Cologne, in which young male asylum-seekers from North-Africa were blamed for several cases of sexual harassment. An alternative explanation might be that our assessment was focused on URM for the first time, and there might be a more negative attitude especially towards this group among refugees.

When asked if the URM should be deported immediately, an interesting pattern based on their country of origin emerged. While a majority of participants agreed that URM from the Balkan region should be deported immediately, fewer said so for URM from Africa and even fewer for URM from the Middle East. This might be interpreted as a differentiation based on the perceived need for asylum, with a clearly more accepting attitude towards those URM seeking refuge from war. As there are no current armed conflicts in the Balkans, this might have influenced the attitudes towards immediate deportation of URM from this region. This idea is further supported by the results for URM stemming from Africa. This was a rather crude geographical description, including a whole continent and therefore URM from regions with armed conflict as well as URM from regions without such conflicts. The results showing a nearly exact 50:50 split between those supporting deportation and those who are against this measure underline this ambivalence. It would therefore be interesting to assess attitudes towards deportation based on a geographically more differentiated measure in future studies.

Interestingly, most of the participants were open to offer school or job training opportunities to URM, and nearly three quarters of the participants stated that those who finish school exams or job training should be granted a right to stay in Germany. Here the attitudes of the general population are in line with the interests articulated by URM. It has been shown in a systematic review that fast access to schooling and learning the new language is one of the most often expressed wishes of URM (Witt et al., 2015). Given this association of interests, it seems that provision of education can serve as a generally well accepted pathway to integration, a finding that is of interest to political decision makers.

References

Bundesamt für Migration und Flüchtlinge (2017). Aktuelle Zahlen zu Asyl. (assessed November 2017): http://www.bamf.de/SharedDocs/Anlagen/DE/Downloads/Infothek/Statistik/Asyl/aktuelle-zahlen-zu-asyl-september-2017.pdf?__blob=publicationFile

Köcher, R. (2015). *Kontrollverlust - die Besorgnis der Bürger wächst.* Dokumentation des Beitrags. (assessed November 2017): http://www.ifd-allensbach.de/uploads/tx_reportsndocs/FAZ_Oktober_Flu__chtlinge.pdf

Petersen, T. (2015). *Zaghafte Schritte auf dem Weg zur Willkommenskultur.* Dokumentation des Beitrags. (assessed November 2017): http://www.ifd-allensbach.de/uploads/tx_reportsndocs/FAZ_Mai_Flu__chtlinge.pdf

Plener, P.L., Groschwitz, R.C., Brähler, E., Sukale, T. & Fegert, J.M. (2017). Unaccompanied refugee minors in Germany: attitudes of the general population towards a vulnerable group. *Eur Child Adolesc Psychiatry, 26,* 733–742.

United Nations High Commissioner of Refugees (2017). *Global trends: forced displacement in 2016.* (assessed November 2017): http://www.unhcr.org/5943e8a34.pdf

Vervliet, M., Lammertyn, J., Broekaert, E. & Derluyn, I. (2014). Longitudinal follow-up of the mental health of unaccompanied refugee minors. *Eur Child Adolesc Psychiatry, 23,* 337–346.

Witt, A., Rassenhofer, M., Fegert, J.M. & Plener, P.L. (2015). Demand for help and provision of services in the care of unaccompanied refugee minors: a systematic review. *Kindheit und Entwicklung, 24,* 209–224.

BIO:

Prof. Dr. Paul L. Plener is Deputy Medical Director at the Department of Child and Adolescent Psychiatry and Psychotherapy, University of Ulm. Prof. Plener is a board-certified child and adolescent psychiatrist. His research focus is on suicidality and Nonsuicidal Self-Injury (NSSI) in adolescents. Prof. Plener has conducted and published several studies in the fields of epidemiology and neurobiology of suicidality and NSSI. He has conducted several clinical trials in the field of psychotherapy and psychopharmacology of mood disorders. Prof. Plener – together with Prof. Becker, University of Marburg – coordinated the German national clinical treatment guidelines for suicidal behavior and for NSSI in adolescents. He received (among others) research funding from the German Federal Ministry of Education and Science (BMBF), the German Research Foundation (DFG), the Baden-Wuerttemberg Foundation and the Volkswagen Foundation.

Dependent and self-reliant. The experiences of unaccompanied refugee minors in numbers and narratives

Brit Oppedal (Department of Child Development, Norwegian Institute of Public Health, Oslo, Norway)

In spite of the numerous traumatic events the unaccompanied refugee minors (UMR) have experienced, and the high levels of mental health problems they suffer from, researchers and caseworkers have noticed resilience and a strong will to succeed among them. Moreover, war-related traumatic events are inconsistent predictors of their mental health problems. To advance our knowledge about the psychosocial development and mental health of these children, it is therefore important to consider their current multicultural and transnational developmental context in addition to the past traumas. In this presentation, we summarize research findings from a three wave longitudinal, mixed-method study among 918 youths who entered the country as unaccompanied minor asylum-seekers. They all filled in questionnaires annually, and subsamples of about 30 carried out in-depth interviews related to identity development and coping. We address the following questions: In what ways does acculturation increase the risk for mental health problems, and what factor represent resources that contribute to reducing mental health problems? How do UMR cope with the challenges they are exposed to in their everyday lives?

The results show that the hassles they encounter on a daily basis are stronger predictors of their mental health problems than pre-migration traumatic exposure. The in-depth interviews indicate that the youth employ a variety of coping strategies to handle their developmental tasks, such as reaching the age of majority and making vocational choices. Above all, they describe the struggle of balancing between a sense of depending upon others and the need to be self-reliant.

BIO:

Dr. Brit Oppedal is a senior researcher in the Division of Mental and Physical Health of the Norwegian Institute of Public Health. She has a PhD in psychology from the University of Oslo. She is the director of the research program "Youth, Culture and Competence", YCC, and the PI of the various national and inter-national subprojects under this umbrella, such as e.g. "Social support, coping and mental health among unaccompanied minor asylum-seekers", "Identity, adaptation and well-being among Tamil children and youth", "Classroom psychosocial environment and well-being in multi-cultural schools" and "Social Integration of Migrant Children: Uncovering Family and School Factors Promoting Resilience". Her research focus is on predictors of the mental health of immigrant and refugee background children, and on factors promoting their positive bicultural development and psychological adjustment.

The provision of care and support to unaccompanied minors

Muireann Ní Raghallaigh (School of Social Policy, Social Work and Social Justice, University College Dublin, Ireland)

Countries throughout Europe and beyond face the challenge of providing care and support to unaccompanied minors. Drawing on research in the Irish context and in other jurisdictions, this paper explores the needs of unaccompanied minors and how care provision can respond to those needs. In particular, it examines both foster care and residential care. While international guidance from the UNHCR and the Separated Children in Europe Programme generally views foster care as preferable to residential care, it is acknoweledged that the needs of the individual child and their best interests should always be considered. This article discusses the benefits and challenges associated with different forms of care as practitioners attempt to address belonging, acculturation and identity issues among this cohort. It is argued that flexible approaches to care are needed, approaches that recognise not only the vulnerability of unaccompanied minors but also their resilience, their agency and their independence. It draws on experiences in Ireland, where care provision has moved from a widely criticised 'hostel' system to a system involving a mix of residential and foster care. The paper will raise questions for consideration with the aim of encouraging debate and discussion among attendees.

BIO:

Dr. Muireann Ní Raghallaigh studied social work at Trinity College Dublin and subsequently worked as a social worker with unaccompanied minors. Muireann's PhD research, undertaken in Trinity College, focused on the coping strategies of unaccompanied minors, with a particular focus on their use of religious coping. Before joining University College Dublin in 2008, Muireann lectured in the Dublin Institute of Technology and in Trinity College and worked as a research fellow with the Trinity Immigration Initiative. Muireann's primary research interests concern asylum seekers and refugees and cross cultural social work practice. Muireann has published in relation to foster care provision for separated children, the experiences of people transitioning from Ireland's 'direct provision' system for adult asylum seekers, and gender based violence in Ethiopia, amongst other topics. Muireann is vice chair of the Irish Refugee Council.

Symposium 3:
Interventions and clinical work in unaccompanied minor refugees

Advancing the care of refugee children with developmental delays or disabilities: An interdisciplinary approach spanning developmental-behavioral screening to specialty services

Abigail L. H. Kroening (Division of Developmental and Behavioral Pediatrics, Golisano Children's Hospital, University of Rochester, USA)

Children of refugee status are at high risk for developmental delays and disabilities, and developmental-behavioral screening is challenging for this vulnerable population. Sociocultural, environmental, and health-related influences on refugee child development have been discussed in the presentation. Refugee community perspectives on developmental screening and interpretation of developmental concerns were emphasized with a specific focus on barriers and facilitators to developmental care. Findings from implementation of standardized developmental screening in a refugee primary care clinic (Rochester, New York, United States) and a model for interdisciplinary collaboration between primary care and a developmental-behavioral pediatrics practice had been reported in the talk.

BIO:

Dr. Abigail L. H. Kroening is an Assistant Professor of Pediatrics in the Division of Developmental and Behavioral Pediatrics at Golisano Children's Hospital, University of Rochester in Rochester, New York (United States). She received her medical doctorate from the University of Rochester School of Medicine and Dentistry in 2008 and has since completed a pediatric residency and chief residency, and a fellowship in developmental and behavioral pediatrics (also at the University of Rochester). She is Board-Certified in both General Pediatrics and Developmental-Behavioral Pediatrics. Dr. Kroening serves and learns from children with special needs and their families. Her professional interests include medical education, developmental and intellectual disabilities in developing countries and refugee populations, and developmental and intellectual disabilities among children in foster or kinship care. Outside of medicine, Dr. Kroening enjoys spending time with her family.

PORTA – Providing Online Resource and Trauma Assessment for Refugees

Thorsten Sukale (Department of Child and Adolescents Psychiatry and Psychotherapy, University of Ulm, Germany)

Introduction

As it has been shown, minor refugees have a high prevalence of mental health problems (Fegert, Plener & Kölch, 2015). Witt and colleagues (2015) reported in their review that 97% of unaccompanied minor refugees had traumatic experiences, which is affecting the well-being and can lead to different types of problems in the daily life of these children and adolescents. It is crucial to manage the challenge of integration in order to prevent larger societal problems, as less integration has the potential to increase the risk of developing a mental illness. So local network and psycho-social support play an important role in prevention of mental distress in unaccompanied minor refugees. At this point, an increased number of refugees can be seen as a challenge for supporting environment (e.g. for caretakers, social workers, psychologist etc.). Interventions covering the needs of minor refugees due to their well-being have to be established to guarantee a proper assessment as well as best possible care.

PORTA – www.refugees-porta.de

PORTA is an internet-based tool for assessment of stress and planning of intervention for minors with experiences of seeking refuge. The goals of PORTA are: 1) an easy approachable and fast assessment of stress factors, 2) tailored intervention planning and 3) providing direct reports about stress intensity and appropriate solutions. PORTA consists of a multilingual assessment of demographic data, a screening of stress factors from a self- and caregiver-perspective, and validated questionnaires for anxiety, trauma, behavioral problems, self-injury and suicidality.

Log In, Consent And Demographic Data

To assess PORTA, the link www.refugees-porta.de can be used. It is necessary to enter a password for assessing the secured domain. Once on the platform, information about the study for employees, parents/guardian and child/adolescent can be found. The information and consent forms for the parents/guardians and children/adolescents are available in different languages (German, English, French, Dari/Farsi, Pashto, Arabian and Tigrinya). Consent to participate in the study and thus the collection of further data can be given by ticking a box. The assessment will start by assessing demographic questions and details about the trajectory of flight. A personalized token can be generated to establish multiple assessments within a longitudinal, anonymous approach.

Traffic Light Screening

A "traffic light screening" was developed to assess stressors in different domains. It is possible to select either caregiver-assessment or self-assessment. There are different criteria for personal stress factors (e.g. psychosocial situation) and external stress factors (e.g. sociocultural integration) and each criterion is individually assessed. Individual assessments are grouped by cluster topics and each cluster topic is evaluated based on a traffic light system: green = little stress, few problems; yellow = average stress, considerable problems; red = high stress level, serious problems. Directly after completing the questions, results can be reviewed. This allows a direct

visualization of areas in which problems are present as well as a comparison of both the refugee minor´s and the caretaker's perspective.

The traffic light screening is based on a concept which was developed by the National Child Traumatic Stress Network (NCTSN). The core stressors overview was adapted to meet German settings.

Questionnaires

Self-assessment also includes multilingual standardized, validated questionnaires assessing specific symptomatology:

- anxiety, depression, trauma (*RHS-15* Refugees-Health Screener, Hollifield, Verbillis-Kolp & Farmer, 2013; *CATS* – Child and Adolescent Trauma Screening, http://treatchildtrauma.de/cats-child-and-adolescent-trauma-screening-free-download)
- emotional problems, hyperactivity/attention deficit problems, problems when interacting with peers, behavioral problems (*SDQ* – Strengths and difficulties questionnaire, Goodman, Meltzer & Bailey, 1998)
- self-injury and suicidality (*SITBI* – Self-Injurious Thoughts and Behaviors Interview) (that's rather an interview, but we offer it as a questionnaire, Nock, Holmberg, Photos & Michel, 2007)

Directly after completing the questionnaires, results can be reviewed providing a quick and efficient intervention planning. Furthermore, this creates the opportunity to do a process rating of – for example – therapeutic interventions.

First Results

In a pilot study of Sukale and colleagues (2016), 33 male unaccompanied minor refugees (*M*=16,24, *SD*=1,03) were examined. Professional assistants (e.g. music therapist, psychologist) were asked, to assess the burden of the adolescents. The assessment took place in a clearing institution (n=17) and preclearing institution (n=16). Considerable differences emerged between the caregiver assessment of the adolescent´s stressors from the clearing and the preclearing institution, with higher stress load and a higher perceived burden in minors living in clearing institutions. As a conclusion, safety and stability lead to lower burden of stress assessed in caregiver-report.

References

Fegert, J., Plener, P. & Kölch, M. (2015). Traumatisierung von Flüchtlingskindern. *Recht der Jugend und des Bildungswesens (RdJB), 4,* 380–389.

Goodman, R., Meltzer, H. & Bailey, V. (1998). The Strengths and Difficulties Questionnaire: A pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry, 7,* 125–130.

Hollifield, M., Verbillis-Kolp, S. & Farmer, B. (2013). The Refugee Health Screener 15 (RHS-15): development and validation of an instrument for anxiety, depression and PTSD in refugees. *General Hospital Psychiatry, 35*(2), 202–209.

Nock, M.K., Holmberg, E.B., Photos, V.I. & Michel, B.D. (2007). Self-Injurious Thoughts and Behaviors Interview: development, reliability, and validity in an adolescent sample. *Psychological Assessment, 19,* 309–317.

Sukale, T., Hertel, C., Möhler, E., Joas, J., Müller, M., Banaschewski, T. et al. (2016). Diagnostik und Ersteinschätzung bei minderjährigen Flüchtlingen. *Der Nervenarzt, 88*(1), 3–9.

TreatChildTrauma. CATS – Child and Adolescent Trauma Screening. (accessed October 2017): http://treatchild trauma.de/cats-child-and-adolescent-trauma-screening-free-download

Witt, A., Rassenhofer, M. & Fegert, J.M. (2015). Hilfebedarf und Hilfsangebote in der Versorgung von unbegleiteten minderjährigen Flüchtlingen – eine systematische Übersicht. *Kindheit und Entwicklung, 24,* 209–224.

BIO:

Thorsten Sukale is a therapist for children and adolescents working at the day hospital in the Clinic of Child and Adolescent Psychiatry and Psychotherapy, University of Ulm. He is a certified music therapist. His research focus is on stress factors in the daily lives of refugee minors and therapeutic interventions. Thorsten Sukale developed an online based screening tool for this: PORTA (Providing Online Resource and Trauma Assessment for Refugees). He received (among others) research funding from the German Federal Ministry of Health (BMG).

Experiences concerning the adaptability of a PTSD-treatment for unaccompanied minor refugees

Rita Rosner, Margret Lang, Svenja Wintersohl and Johanna Unterhitzenberger
(Department of Psychology, Catholic University of Eichstätt-Ingolstadt, Germany)

Trauma-focused cognitive behavioural therapy (TF-CBT) by Cohen, Mannarino and Deblinger (2009) was offered to unaccompanied refugee minors (URM) fulfilling the criteria for posttraumatic stress disorder (PTSD) in a non-randomised feasibility study at the trauma outpatient clinic of the Catholic University Eichstätt-Ingolstadt. In a case series, TF-CBT had shown promising results in this highly symptomatic population (Unterhitzenberger et al., 2015). Although being objectively safe for the moment, URM lack the support of their family and face an uncertain future in the host country. TF-CBT is among the treatments for treating posttraumatic disorders in children and adolescents with the best evidence base. Several research groups showed the superiority of TF-CBT over untreated as well as treated control groups in Western and non-Western societies (Gutermann et al., 2016; Morina, Koerssen & Pollet, 2016).

Besides measuring clinical symptoms – where a clinically significant reduction of both PTSD and comorbid symptoms was shown at posttreatment – therapists were questioned about the fit of the manual for this particular group of children and adolescents. Results showed the expected high cultural sensitivity and adaptability of TF-CBT manual to each individual case.

Clinical experiences with TF-CBT while treating URM

TF-CBT is a short-term therapy (between 12–15 weekly double sessions) and includes the components *psychoeducation and parenting skills, relaxation, affective modulation, cognitive processing, trauma narrative, in vivo exposure, conjoint child/caregiver session,* and *enhancing safety and future skills*. If required, there is an optional component on grief. Every week the adolescent and the caregiver each receive an individual session. If necessary, conjoint sessions can be offered. The proportion of adolescent and caregiver sessions can be adapted to the individual case. As the young refugees in the study by definition lacked parents to accompany them to therapy, we involved a caregiver (educator, case manager, social worker, psychologist) from their residence in the therapeutic process. The following results are based upon the publication from Unterhitzenberger, Fornaro and Rosner (in press).

TF-CBT starts with *psychoeducation*. In the case of the young refugees, additional information about psychotherapy in general and about psychotherapy with an interpreter are necessary. This is facilitated by the use of fact sheets about psychotherapy and PTSD in the patient's mother tongue. Confidentiality is often an important topic which needs to be discussed in-depth, especially when a translator is involved.

In the component *relaxation,* modifications are necessary only rarely. However, the component *affective modulation* often takes longer than one session. As the use of pictures facilitates naming emotions, for many young refugees cards showing photos of emotional faces are helpful. Skills training is offered to adolescents who self-harm and experience dissociative symptoms. Additionally, religion plays an important role for emotion regulation for some young refugees.

Mostly the component *cognitive processing* can be conducted without major modifications. However, writing down the *trauma narrative* usually takes significantly longer than usual. On the one hand, this is due to the multiple traumatic experiences most young refugees have gone through. On the other hand, this provides space for the adolescents to share their flight experiences. This shows recognition for the flight experience and helps emphasize the strength and

resilience of the young people which helped them make it all the far and difficult way to their host country.

In most cases *in vivo exposure* is not necessary, due to the trauma narrative. But many UMR are highly impaired by strong grief, so this session can be used for the optional *grief* component the TF-CBT manual offers. The *conjoint session* does not need major modifications and proved to be very valuable. In our experiences it is especially important to URM who are in Germany without any family support to receive social support and appreciation ("I'm proud of you. You are strong. I'm here for you."). Also the last component *enhancing safety and future skills* plays an important role, as in most cases therapy is finished in a rather unstable situation: unsecure residence status, uncertainty about the security and health of family members as well as only very limited possibilities for making plans for the future. For this reason developing individual coping-strategies and problem solving strategies with the adolescents and, for example, practicing the asylum interview in role play proved to be very helpful.

Altogether, the small modifications on TF-CBT protocol described above correspond to the generally necessary tailoring of a manualized approach to the individual needs of a patient. Our experiences confirm once again previous results concerning applicability of TF-CBT with diverse cultural groups and with children and adolescents with severe posttraumatic stress symptoms.

References

Cohen, J.A., Mannarino, A.P. & Deblinger, E. (2009). *Traumafokussierte kognitive Verhaltenstherapie bei Kindern und Jugendlichen*. Heidelberg: Springer.

Gutermann, J., Schreiber, F., Matulis, S., Schwartzkopff, L., Deppe, J. & Steil, R. (2016). Psychological Treatments for Symptoms of Posttraumatic Stress Disorder in Children, Adolescents, and Young Adults: A Meta-Analysis. *Clinical Child and Family Psychology Review*, *19*(2), 77–93.

Morina, N., Koerssen, R. & Pollet, T.V. (2016). Interventions for children and adolescents with posttraumatic stress disorder: A meta-analysis of comparative outcome studies. *Clinical Psychology Review*, *47*, 41–54.

Unterhitzenberger, J., Eberle-Sejari, R., Rassenhofer, M., Sukale, T., Rosner, R. & Goldbeck, L. (2015). Trauma-focused cognitive behavioral therapy with unaccompanied refugee minors: a case series. *BMC Psychiatry*, *15*(1), 260.

Unterhitzenberger, J., Fornaro, P. & Rosner, R. (in press). Traumafokussierte Kognitive Verhaltenstherapie: Einblick in die manualisierte Arbeit mit einem unbegleiteten minderjährigen Flüchtling. Verhaltenstherapie.

BIO:

Rita Rosner, Prof. Dr. Dipl.-Psych., Psychologische Psychotherapeutin, is currently the chair of Clinical and Biological Psychology at Catholic University Eichstätt-Ingolstadt. In the 1990ties, Prof. Rosner studied the connections between flight, war, migration and psychological distress in the aftermath of the wars in former Yugoslavia. Current research projects focus on the treatment of Posttraumatic Stress Disorder in children and adolescents after sexual and physical abuse, migration specific aspects of service use after childhood abuse and the treatment of Prolonged Grief Disorder in adults.

From 2006–2008 Prof. Rosner served as president of the German-speaking Society for Psychotraumatology, and from 2009–2015 as board member of the European Society for Traumatic Stress Studies (ESTSS). She is a co-funder and co-editor of the European Journal of Psychotraumatology (EJPT).

Symposium 4:
Legal issues, education and children's rights

Children's rights and the best interest of the child[1]

Sabine Lee (Department of History, University of Birmingham, UK)

The concept of children's rights is of relatively recent origin. While the 19th century had seen some initial steps towards the protection of children, particularly in response to child labour, it was not until after the First World War, that children being seen as a distinct group with distinct rights that took into account not only the need for protection but also incorporated what was being developed in the broader context of human rights conceptualization, namely the right to certain provisions. The formulation of children's rights found its earliest general expression in the form of the Declaration of Geneva of 1924, adopted in that same year by the League of Nations. This would become the cornerstone of much of the child-focussed human rights legislation to follow throughout the 20th century. Special safeguards for children are found in the Universal Declaration of Human Rights of 1948 and more extensively in the UN Declaration on the Rights of the Child of 1959.

Thirty years after the Declaration on the Rights of the Child, in 1989, the Convention on the Rights of the Child (CRC) was adopted by the General Assembly of the United Nations. It entered into force in 1990 and today ALL states except the USA have signed and ratified the Convention.

The CRC is based on the understanding and recognition that children, especially children in crisis situations, require protection. Crucially, it is based on the idea of universality – both with regard to the states subscribing to its principles and rights formulated within it (evident in its almost universal ratification) and with regard to the applicability to all children, irrespective of circumstances, nationality, ethnicity or gender. Despite its near universal acceptance by states, the implementation of the idea of impartiality, i.e. the universal applicability of the provisions to all children, irrespective of their gender, nationality, religion or social status, is not realised for many groups of children, and it is often particularly vulnerable children who are prevented from exercising these universal rights.

The Convention has four guiding principles on which the formulation of all other children's rights are based: the principles of non-discrimination (Article 2); the best interest of the child (Article 3); the right to life, survival and development (Article 6); and the right to be heard (Article 12). Based on these guiding principles, the Convention contains 42 substantive provisions covering a wide range of rights and issues relating to children. They are understood as belonging to one of three groups, the 'three Ps' of Provision, Protection and Participation.

Provision rights are rights relating to provision of children's basic needs and include the right to the highest attainable standard of health and health care (Art. 24), the right to a standard of living adequate to ensure the child's development (Art. 27), the right to education (Art. 28, 29) and the right to play, rest and leisure (Art. 31). *Protection rights* relate to the protection of children from all forms of harm and exploitation and include the right to protection from discrimination

[1] This essay is a summary of the exposition of children's rights in Sabine Lee, *Children Born of War in the 20th Century*, Manchester University Press, 2017, chapter 6. As this is not new research I have refrained from using footnotes and refer the reader to the chapter above with its extensive catalogue of references and guidance on relevant literature.

(Art. 2), the right to protection from all forms of harm, neglect and abuse (Art. 19), the right of children without family care to special protection and the right to alternative care including adoption (Art. 20, 21), the right of particularly vulnerable children, including refugee children and children with disabilities, to have special protection (Art. 22, 23), the right to protection from economic exploitation and sexual exploitation (Art. 32, 34), the right to protection from drugs (Art., 33) and the right of victims of such abuse to treatment, counselling and support (Art 39). Finally, *Participation rights* are the rights of children to participate in decisions made about them and to contribute to society by expressing their views. They include the child's right to express his/her views and have them given due weight in accordance with the child's age and understanding in all decisions made about them and the child's right to be represented in legal proceedings (Art. 12), the child's right to express his/her opinion using a variety of means of expression according to the child's capacity (Art. 13), the child's right to express his/her opinion using a variety of means of expression according to the child's capacity (Art. 14), the child's right to freedom of religion and freedom of association (Art. 14, 15) and the right to privacy (Art. 16).

While the rights codified in the CRC are far-reaching, their enforcement is often difficult. International humanitarian law is state-centric; it is based on laws adopted by states as actors and these laws bind states rather than individuals as actors. The most common violations of human rights are directed at individuals and these individuals have to take on perpetrators through a legal system that presupposes access to the legal processes. For children, for instance unaccompanied migrant minors, in reality such access is not a foregone conclusion. Furthermore, in the case of children's rights, especially in volatile situations in countries that are unfamiliar and that do not offer very clear routes to support, the implementation of children's rights depends to some extent on the cultural legitimacy accorded to such rights in any given society.

As is clear from the many contributions in this volume, a rights- and need-based approach to the treatment of UM is not the norm in most receptor communities of large number of migrants, let alone unaccompanied migrant minors. The 'Best Interest of the Child' principle which ought to be the benchmark against which actions are measured, would require a holistic approach examining all rights and needs of the child, ensuring the child's participation; it would demand independent and impartial processes establishing the best way to implement rights, including due process with a right to appeal. As research presented at the conference has demonstrated, this approach is not the norm. In order to safeguard the interests of UM, it will be important to recalibrate efforts to put centre-stage the care, protection and safety of children, taking into account the children's views. Given the psychosocial impact of migration, in particular where forced migration results in children being left as unaccompanied minors in a foreign country, the CRC implies that receptor communities have obligations to provide for a child in a way that takes into account not only the child's right to physical health and education, but also to mental wellbeing, including focus on the child's identity; this is inextricably linked to the creation of safe settings that include meaningful relationships and protective environments.

BIO:

Sabine Lee is Professor of Modern History at the University of Birmingham. She has published widely on the social consequences of conflict. Her most recent book *Children Born of War in the 20th Century* (Manchester University Press, 2017) focusses on the experiences of children fathered by foreign soldiers and born to local mothers in diverse 20th century conflicts.

Outsourcing the 'best interests' of unaccompanied asylum seeking minors in Britain

Nando Sigona (School of Social Policy, University of Birmingham, UK)

This paper examines the governance of unaccompanied asylum seeking children (UASC) in the UK and reveals the expanding reach of asylum privatisation to unaccompanied children. In the process, the principle of the 'best interests of the child' enshrined in international and national law is being reconfigured through practices of service outsourcing and out of county placement that are used to distance local authorities (LAs) from their statutory responsibilities. Drawing on a mixed-methods approach that combines quantitative data on the distribution and circumstances of UASC and in-depth qualitative interviews with service providers, it identifies three intertwining processes that contribute to redefining 'best interests'.

References

Humphris, R. & Sigona, N. (2017). Outsourcing the 'best interests' of unaccompanied asylum seeking children in the era of austerity. *Journal of Ethnic and Migration Studies,* http://www.tandfonline.com/doi/abs/10.1080/1369183X.2017.1404266

Sigona, N., Chase, E. & Humphris, R. (2017) Protecting the 'best interests' of the child in transition to adulthood. *Becoming Adult Research Brief* no. 3, London: UCL, www.becomingadult.net

Sigona, N., Chase, E. & Humphris, R. (2017). Understanding causes and consequences of going 'missing'. *Becoming Adult Brief* no. 6, London: UCL, www.becomingadult.net

BIO:

Dr. Nando Sigona is Senior Lecturer and Deputy Director of the Institute of Research into Superdiversity at the University of Birmingham. His work has appeared in a range of international academic journals, including *Sociology, Social Anthropology, Journal of Ethnic and Migration Studies, Identities, Citizenship Studies* and *Ethnic and Racial Studies*. He is author or editor of books and journal's special issues including *The Oxford Handbook on Refugee and Forced Migration Studies* (with Fiddian Qasmiyeh, Loescher and Long, 2014), *Sans Papiers. The social and economic lives of undocumented migrants* (with Bloch and Zetter, 2014) and *Within and beyond citizenship* (with Roberto G. Gonzales, 2017). Nando is also Associate Editor of the journal *Migration Studies*. He has held visiting research and teaching positions at University of Oxford, University of Bergen, and the European University Institute.

A children's rights approach to the refugee convention

Samantha Arnold (European Migration Network, Economic and Social Research Institute, Trinity College Dublin, Ireland)

Introduction

Children make up half of the world's refugees and over 40 per cent of the world's asylum seekers. Yet, children are largely invisible in historical and contemporary refugee law. Furthermore, there has been very limited interaction between the burgeoning children's rights framework, in particular the Convention on the Rights of the Child (CRC), and the 1951 Convention relating to the Status of Refugees (Refugee Convention) in the context of asylum decision making.

A child as defined in the CRC is every human being below the age of 18 (unless under national law majority is attained earlier). A refugee as defined in the Refugee Convention is any person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country'.

A child in the context of the Refugee Convention must show that they are individually at risk of persecution. They must be able or enabled to travel out of their country of origin. They must (be able to) demonstrate that they are unable or unwilling to avail of the protection of their country of origin. This may involve demonstrating that they sought the protection of the country and the country failed to provide protection. In addition, children who seek refugee protection on grounds of political opinion and religion, for example, may be required to show that they are capable of having opinions or views that put them at risk. While children may satisfy the definition of refugee as set out in the Refugee Convention as a result of views/opinions that are imputed onto them – views/opinions that belong to the parent/s, the definition focusses more on the individual experience of persecution. In this way child refugees could be constructed as agents and subjects of the law in the same way or similar way to their adult counterparts. However, children's experiences are different than adults, so how do we assess child claims that have to fall within the narrow and very specific definition of refugee as contained within the Convention?

One suggestion is that the CRC could be used as a tool to interpret persecution in the assessment of child claims.

The research summarised here explores how the CRC might be used to assist decision makers in interpreting 'persecution' in child cases. In order to encourage decision makers to use the CRC in child refugee decision making, it is necessary to develop a children's rights approach to the interpretation of the Refugee Convention. This approach is discussed herein.

The research which informed the development of this approach analysed to what extent the Refugee Convention is capable of dealing with claims from children based on the modern conceptualisation of children which is underscored by two competing ideologies – the child as a vulnerable object in law to be protected and the child as subject with rights and the capacity to exercise their agency.

The approach

UNHCR provides specific examples of child specific forms of persecution including: female genital mutilation, child soldiering, domestic violence and witnessing domestic violence, etc. However, UNHCR does not provide a framework for the assessment of any potential rights violation and how that may or may not relate to persecution. The CRC does not provide a framework either.

The CRC provides specific protections to child refugees, namely Article 22:

> *1. States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.*
>
> *2. For this purpose, States Parties shall provide, as they consider appropriate, co-operation in any efforts by the United Nations and other competent intergovernmental organizations or non-governmental organizations co-operating with the United Nations to protect and assist such a child and to trace the parents or other members of the family of any refugee child in order to obtain information necessary for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his or her family environment for any reason, as set forth in the present Convention.*

However, this does not assist us in determining persecution in the case of children as the focus of this provision is procedural in nature – protecting the right of refugee or asylum seeking children to access the other rights contained within the CRC (para. 1), including the right to family and within that family tracing (para. 2). It does however show that there is a link between the CRC and refuge, which may assist in making the case that the CRC can be used as a tool in the context of refugee status determination. It may also be arguable that para. 1 somewhat sets the scene for the use of the 'applicable rights' such as non-discrimination, a General Principle, of the CRC in the interpretation of the Refugee Convention.

The starting point for this approach is one of the other four General Principles, Article 6:

> 1. *States Parties recognize that every child has the inherent right to life.*
> 2. *States Parties shall ensure to the maximum extent possible the survival and development of the child.*

Article 6, generally and in interpreting persecution, should be read in conjunction with the Committee on the Rights of the Child *General Comment No. 5 (2003) General measures of implementation of the Convention on the Rights of the Child (arts. 4, 42 and 44, para. 6)*:

> *The Committee expects States to interpret "development" in its broadest sense as a holistic concept, embracing the child's physical, mental, spiritual, moral, psychological and social development. Implementation measures should be aimed at achieving the optimal development for all children.*

Using the Committee's guidance, one can go back to the CRC and identify provisions that relate to development. In other words, Article 6 is defined by the content of the CRC, content that includes: health, family, culture, spiritual needs, social integration, economic support, education, moral education and language.

Challenges – justification for the need of such an approach

An analysis of higher court child refugee decisions globally pointed to a number challenges to implementing such an approach:

1. Article 6 or the right to survive and development was not used as a tool to interpret persecution.
2. Article 6 was infrequently mentioned in judgments.
3. The CRC was infrequently mentioned in judgments.
4. Rights violations that related to a protection right such as protection from trafficking more frequently resulted in positive decisions.
5. Rights violations that related to a participation right linked with, for example, religion or political opinion, less frequently yielded positive decisions.
6. Decisions makers often viewed child applicants with trepidation, in particular child applicants who were demonstrating their agency.

The overarching finding was that positive decisions more often involved cases where the child's vulnerability and their need for protection were emphasised. While this does not reflect the breadth of the CRC, which includes participation rights and rights relating to self-determination *as well as* protection rights, it does suggest that emphasising vulnerability might be beneficial for the applicant. I suggest that utilising a children's rights approach might encourage decision makers to look beyond children's vulnerability, where relevant, and consider their agency as well and how their own actions and behaviours may place that at risk of persecution. However it is still important to remember that decision makers seems to be somewhat biased towards vulnerability in the way that they conceive of child applicants. This is consistent with the general and global difficulty that exists in conceptualising children. Are children vulnerable and in need of protection? Are they persons with agency with important parts to play in society? Or, are they both?

A children's rights approach to the interpretation of the Refugee Convention may encourage decision makers to look beyond protection rights and to consider the other rights including provision rights (the right to education, the right to the highest standard of health, etc.) and participation rights (the right to have his/her voice heard, the right to his/her identity, etc.). The adoption of such an approach might improve decision making by making it more child-centred.

Reflections on symposium

This research did not look at the implications of the findings on professionals who work with child refugees in a therapeutic capacity. However, reflecting on the symposium, I suggest that psychologists, counsellors and other mental health professionals may not only be able to support young people while they navigate the complex and stressful application process, but that they may also have a role in making submissions, in consultation with, and with the consent of, the child to assist their asylum case. Submissions may involve information about the young person that might support their claim, which could involve emphasising their vulnerability or agency, depending on the individual circumstances of the young person. It would be useful for the professional to also reflect on the rights of the CRC and to make links between the child's individual circumstances and the rights that are enshrined in international law.

References

Arnold, S. (2017). *Children's Rights and Refugee Law: Conceptulisaing Children within the Refugee Convention.* New York: Routledge.

Bhabha, J. (2014). *Child Migration and Human Rights in a Global Age.* Prinston: PUP.

Fortin, J. (2009). *Children's Rights: The Developing Law* (3rd ed.). Cambridge: CUP.

Foster, M. (2007). *International Refugee Law and Socio-Economic Rights: Refugee from Deprivation.* Cambridge: CUP.

Hathaway, J. (1991). *The Law of Refugee Status.* Toronto: Butterworths.

BIO:

Dr. Samantha Arnold is a Post-Doctoral Research Fellow at the European Migration Network Ireland based in the Economic and Social Research Institute. She is an Adjunct Assistant Professor at Trinity College Dublin School of Law. Prior to joining the ESRI, Samantha was the Children's and Young Persons' Officer at the Irish Refugee Council. Samantha's research interests include refugee and immigration law and policy and children's rights law.

Conclusion and Outlook

Heide Glaesmer (University of Leipzig, Department for Medical Psychology and Medical Sociology, Germany) and **Sabine Lee** (University of Birmingham, Department of History, UK)

The international and interdisciplinary symposium on unaccompanied minor refugees was an extraordinary collaborative effort bringing together junior and senior researchers from different scientific backgrounds. Our heartfelt thanks goes to the Volkswagen Stiftung, which generously supported the meeting financially, through its excellent organisation and its hospitality in Hannover. Our particular gratitude goes to Anke Harwardt-Feye and her colleagues who helped the academic organisers run the event as smoothly as it did and who dealt with any last-minute concerns in a professional and always light-hearted manner. All this made the workshop a joy to be involved in for all presenters and participants.

The two days presented us with a multi-facetted opportunity of academic research exchange. The early-career workshop with its fascinating qualitative and quantitative studies covered a variety of topics including cultural sensitive diagnostics, traumatic experiences, psychological wellbeing, and psychotherapy. It provided an intellectually stimulating, opportunity for interdisciplinary cross-fertilisation and exciting discussions on future research collaboration. We hope that the contacts forged among young researchers and between junior and more senior colleagues will be the foundation of further work in this field.

Ilse Derluyn's keynote address which opened the proceedings of the core conference on the first day delivered a critical reflection on the homogenous portrayal of unaccompanied young people as 'vulnerable children' and 'victims' on the background of human rights and ethics – a portrayal that often neglected their strengths and resilience. John Berry's keynote address on the second day highlighted integration and multiculturalism as general principles of acculturation with the best outcome for society and individual wellbeing.

Some key conclusions which emerged in several of the presentations and discussions stood out and were summarised in our final discussion. One key issue arising out of discussions concerned research methodologies. It was generally acknowledged that the mixed-methods approaches, combining quantitative and qualitative methods, were best suited to this research topic because it was most likely to do justice to the complexity of the phenomena under investigation and the individual experiences of unaccompanied minors. However, it was also recognized that interdisciplinarity, which was already the feature of many of the research projects, could and should be further enhanced, as could the comparative work within and beyond disciplinary boundaries. A second concern that was comprehensively discussed was psychosocial wellbeing of unaccompanied minor refugees as a core determinant of the wellbeing of these children and adolescents in the future. The phenomenon has become even more pressing with the dramatically increasing number of asylum applications of unaccompanied minor refugees registered during the last two years in Western European countries. Contributors to the symposium discussed how research on the psychosocial impact of being an unaccompanied minor refugee can be addressed more globally in order to reflect the diversity of administrative and legal specifics in different host countries.

Moreover, International Humanitarian Law, in recent decades, has developed an extensive body of legal instruments to safeguard human, and specifically children's, rights, most notably in the UN Convention on the Rights of the Child. Preliminary research has shown that for unac-

companied minor refugees these rights, including the right to life, non-discrimination, and the right to know about and be with one's parents are often compromised, in particular where children's rights are in conflict with refugee or asylum seeker rights or the perceived 'best interest' of the children themselves. The symposium addressed this issue in the context of historic and contemporary examples to explore how the rights and needs of unaccompanied minor refugees can be met in the face of mounting levels of trauma-related experiences of these children and adolescents before, during and after their forced migration.

While much has already been achieved in the field of psychosocial wellbeing of unaccompanied minor refugees, the meeting alerted researchers to the many remaining open questions. What requires much closer analysis are the life course experiences, and several researchers emphasized that a lifespan perspective and prospective studies are essential in getting a clearer sense of factors which support coping strategies and greater resilience. Which circumstances foster resilience, which hinder it? How do these factors impact over time? When are they of greater and when of lesser significance? What roles do parental/familial absences play? What impact do local and regional support mechanisms have? Beyond the individual case studies, the next steps have to include the development of sound models that allow us to compare different cases (age groups, girls/boys, different countries of origin, different host countries) on a methodologically persuasive basis. This leads back to a significant point which dominated the concluding session of the workshop and which has already been alluded to. Research into unaccompanied refugee children is linked closely to impactful academic engagement at different levels. Psychological and psychiatric research has so far primarily been focused on enhancing our understanding of the challenges faced by unaccompanied minor refugees; in a second step, these findings need to be translated into practical interventions which will help overcome negative outcomes with regard to physical and mental health, but also with regard to social and economic wellbeing. But the impact of research can go beyond this and address the challenges also at policy-level. By exploring in more detail which local and regional support set-ups are most helpful in alleviating disadvantages of unaccompanied minor refugees, recommendations for transitional justice mechanisms that are sensitive to the needs of these children and adolescents should be aimed for.

The two-day symposium has demonstrated clearly that huge progress has been made in the last years of research relating to unaccompanied minor refugees. It was equally shown that the research outcomes to date have raised as many new questions as they have answered older ones. We very much hope that the extensive exchanges during the meeting will lead to further collaboration across national, interdisciplinary, and sectoral boundaries and will lead to more positive outcomes both at an academic level and at the level of design and implementation of interventions – medical and policy-oriented – in the future.

As a result of the final discussion at the end of the symposium, we agreed on a number of main outcomes / recommendations / challenges we have to deal with, which should be further addressed by both research as well as policy in the near future:

1. Multiple future societal and economic costs arise from denying refugee children's needs and rights along with a lack of integration actions. Thus economic arguments of not investing in these children are largely obsolete. Furthermore, there is no (empirical) evidence that immigration has a negative impact on (economic) development of the receptor country. The long-term societal benefits of integration are much higher that the short-term costs of integration activities.

2. Research has shown the negative outcomes of predominantly post-flight stressors on children; nevertheless an alarming level of unhelpful bureaucracy negatively affects their integration and national comparisons demonstrate an alarming level of discrepancy across different countries with respect to dealing with unaccompanied refugee minors.

3. Beside focussing on unaccompanied minor refugees more attention should be paid on accompanied minor refugees as a similarly vulnerable group.

4. Academic knowledge and research should be made more visible, not only to politicians, but also to the public.

5. Critical discussions around prejudices of dualistic thinking in so-called majorities and minorities should be encouraged and the benefits that immigration can bring to a society should be foregrounded in order to support multicultural thinking and behaviour.

6. Engagement of researchers in this field in political debates should be encouraged in order to ensure that political and public debates are faced on facts and knowledge rather than stereotypes and preconceptions.

7. There remains an urgent need to establish community-based initiatives, evidence-based decision making, early psychosocial support, supervision and training of service providers, presentation of scientific results to the public, connecting people in the field, and to support critical discussions.

8. The following aspects were identified as particularly urgent research foci: Youth and adolescence as a developmentally sensitive period for mental disorders; Distinctions between spontaneous and managed flight and migration; Evaluation research of prevention programs; international collaborations to exploit full international funding opportunities.

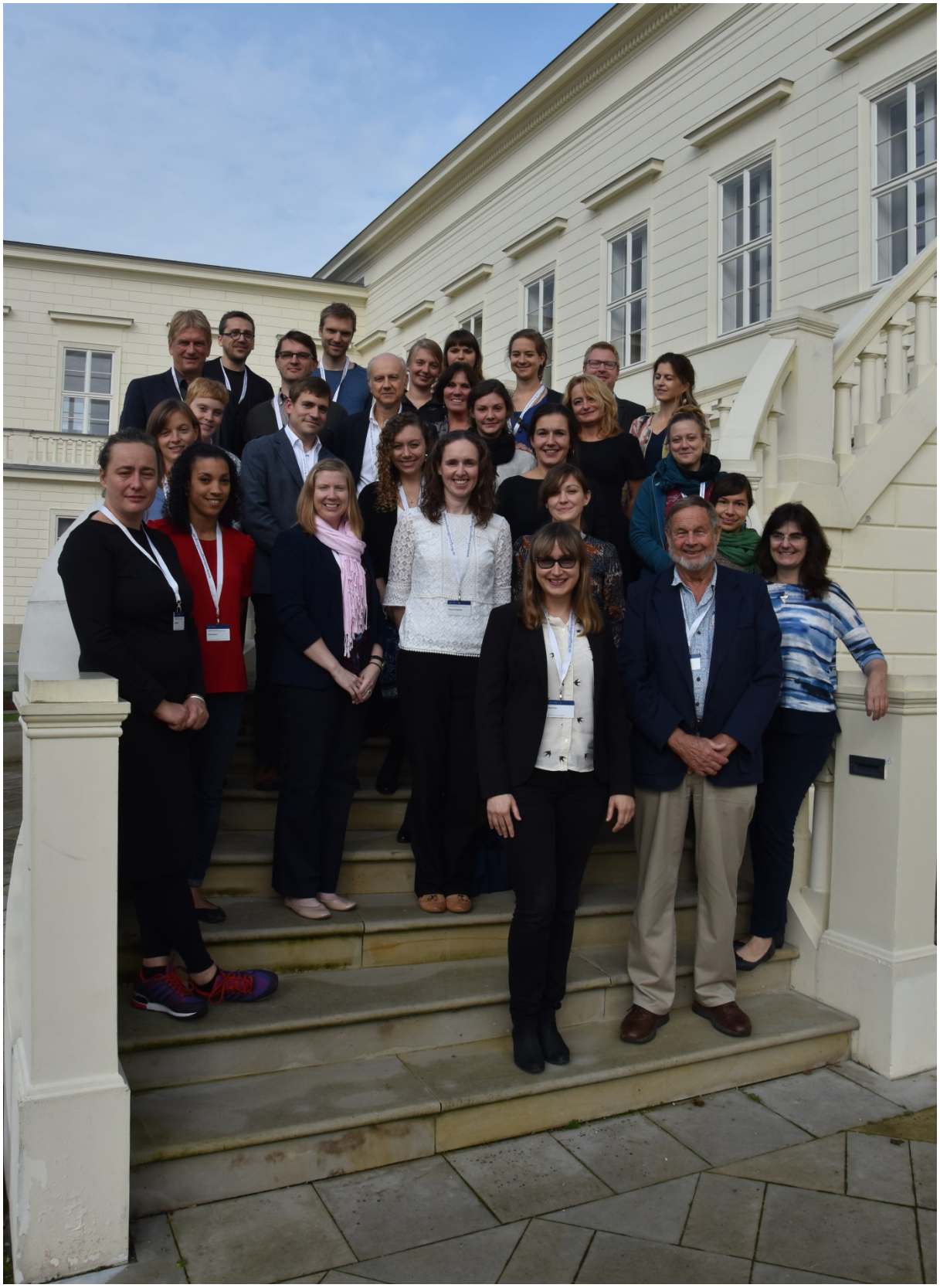


Photo: Participants of the symposium

Photo:
© hydebrink/Fotolia

Editorial staff / Design:
Dr. Susan Sierau
Dr. Yuriy Nesterko
Barbara Brendel

03/2018