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Mental Health Problems of Refugee Children: A Case Study of Transit Center Intervention in the Republic of Macedonia

ABSTRACT

Mental health is defined as a state of well-being in which every individual realizes his/her own potential, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his/her community (World Health Organization, 2004). War and disasters have the greatest impact on mental health and psychosocial well-being. A considerable number of child refugees enter Europe to seek refuge from ongoing conflict and war in their home countries. Refugee children are at greater risk of psychological distress than non-refugee children and they may develop symptoms such as depression, PTSD, anxiety, physical problems or become aggressive. Trauma can impact the children's physical well-being, cognitive development and psychological/emotional well-being and behavior. Therefore, these children are identified as having unique; however, urgent mental health needs requiring timely interventions.

According to these findings, in this article the author is trying to explain the mental health problems and interventions among two refugee children (brother and sister) who stayed in the Transit Centre "Vinojug" in Gevgelija, Republic of Macedonia, two years ago. They had significant psychological disturbances such as depression and post-traumatic stress disorder, because they lost their home and their father. They have been here only with their pregnant mother. At the beginning they needed individual psychiatric or psychological support, but later also group psycho-social support. Verbal, art and game-based interventions proved effective in reducing the PTSD symptoms and depression. After that, the children showed positive emotions such as gratitude, hope, happiness, and optimism. At the same time they started to attend the local school and the first words in Macedonian language were: "Hello, how are you?" They have already learned the Macedonian language and counted in Macedonian; they

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knew how to ask for water and learned the basic terms. Hence, when they left the Transit Center with their mother, they were very sad: “Here we have many new friends who help and love us”.

Our study provides a strong evidence base regarding the use of verbal and clinical interventions for PTSD and emotional and behavioral difficulties, respectively. Also, the main goal of the psychological workshop is stimulation of the copy strategies, resilience and psychosocial development through structured playful activities such as voice, movement, painting, drawing, song, sound.

Keywords:

war, refugee children, mental health problems, mental health interventions

INTRODUCTION

Migration is the process of social change whereby an individual moves from one cultural setting to another in order to settle down permanently or for a prolonged period. Such a shift can be made for a number of reasons, such as war and economic, political or educational betterment. The process is inevitably stressful and stress can lead to mental illness. However, not all migrants go through the same experiences and/or settle in similar social contexts. The process of migration and subsequent cultural and social adjustment also plays a key role in the mental health of the individual (Bhugra & Jones, 2001).

According to the United Nations High Commission for Refugees (UNHCR), more than half of the 21.3 million refugees around the world are children (UNCHR, 2017). In fact, there has been a fivefold increase in refugee and migrant children numbers, from 66.000 in 2010 to 300.000 children, from 2015 to 2016 (UNCHR, 2017). This mass exodus is fuelled by conflict, persecution and poverty in the affected countries, including Syria, Afghanistan, Iraq, Somalia, and Sudan. Europe, generally, being a relatively stable and geographically adjacent region to most conflict areas, has predictably seen an exponential increase in vulnerable children and adults entering its territories to seek refuge and gain asylum. In response to violence, many people are forced to flee their countries in search of safety. How will the hardships experienced by these people affect them mentally, especially the vulnerable children?

The experience regarding conflict-related violence and concerns about the situation of the countries affected by war is compounded by war traumatic events, daily stressors of displacement, including poverty, lack of basic needs and services, ongoing risks of violence and exploitation, isolation and discrimination, loss of family and community supports, and uncertainty about the future. Recognizing

and appropriately treating mental health problems among migrants and refugees poses a challenge, because of differences in language and culture and specific stressors associated with migration and resettlement (Hassan et al., 2016).

Professional support should be used to facilitate and improve communication and increase disclosure of psychological symptoms among migrants/refugees and can also be used when delivering psychosocial interventions (Kirmayer et al., 2011).

DEFINITION OF THE TERMS MIGRANTS AND REFUGEES

The terms “refugee” and “migrant” are frequently used in public discourse. However, there is a difference between the two, and for individual governments, this dysfunction is important. Countries deal with migrants under their own immigration laws and processes. Countries deal with refugees through norms of refugee protection and asylum that are defined in both national legislation and international law.

In the contemporary context, migration entails the movement of a person or a group of persons, across an international border or within a country. As explained by the International Organization for Migration (IOM), “it is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes” (IOM, 2013, p. 5).

According to the United Nations Commission for Refugees, Article 1A (2) of the 1951 Convention, a refugee is defined as “any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his/her nationality, and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country” (UNCHR, 1951, p. 16).

They have left their country of origin and formally applied for asylum in another country, however a decision regarding their application has not been made yet. They are allowed to stay in another country, provided that they prove that they would face persecution if they were to return to their country of origin. Refugees, however, leave their countries involuntarily with persistent danger at home, preventing their return (Lustig et al., 2004).

REFUGEE CHILDREN'S EXPERIENCE

Refugee children will have experienced many different stressful events even before they reach a new country to seek asylum. Crawley (2007) explains that refugee children who arrive with their parents may be at risk of not being carried for adequately due to the distress that their parents are in. Refugee children may also have to live with relatives that they do not know or if travelling unaccompanied, may be looked after by social services or may be living alone. In addition, refugee children experience a range of stressors during their refugee journey which consists of three phases: pre-migration, migration and resettlement.

During the pre-migration phase in their country of origin, refugee children may be exposed to violent conflict or they may experience persecution of family members, disappearances, death and deprivation (Bemak et al., 2003). Some might not even have any memory of a stable period, hence fostering general insecurity (Heptinstall, Sestina & Taylor, 2004). It is not a surprise that refugee children have been exposed to a high level of traumatic events in their country of origin (Hamilton & Moore, 2004).

The migration phase is characterized by a dangerous journey to the host country, during which many children are separated by their parents or friends, further facing conflict and a lack of basic resources. This phase may also involve lengthy stays in refugee camps or transit centres in countries of first asylum, where discrimination and inadequate access to food, water, security and education are a commonplace (Crowley, 2009).

The last stage begins with the arrival in the host country and it construes processes of accumulation and resettlement. This period involves culture shock, asylum application, integration process and compounding stresses such as identity crisis, bullying, discrimination and general insecurity (Fazel & Stein, 2002). In fact, this phase holds uncertainty about the future of the refugee children.

Refugee children will often face a difficult journey to a host country which may include a period in a refugee camp (Papadopoulos, 2001). They have to deal with the difficult process of adjusting to life in a new country and a new culture. Children will come into direct contact with a new culture when they start school in the host country. This challenge will often involve learning a new language, making new friends and adjusting to cultural differences in regard to behaviour. At the same time, children will need additional support and interventions to overcome their difficulties and challenges.

RISK AND PROTECTIVE FACTORS FOR REFUGEE CHILDREN

It is known that of all children who live in Europe, refugee and migrant children are most vulnerable to poor health and development. This is both a result of the effects of their personal experiences or their parents' experiences in the country of origin and during migration, and due to their social and economic circumstances in the host country. Refugee and migrant children are particularly vulnerable to mental health problems. They are at a higher risk of mental health problems when compared to their non-refugee peers. Public health experts advise that the mental health needs of children seeking asylum are underestimated and neglected.

Fazel and Stein (2003) report that refugee children are at significant risk of developing psychological disturbances, because of the number of risk factors that they faced. They divided these risk factors into three groups (parental factors – maternal depression, torture, death or separation from the parents; unemployment of parents...; child factors – number of traumatic events, expressive language difficulties; physical health problems from either trauma or malnutrition; older age...; environmental factors – number of transitions, poverty; time required for the determination of the immigration status; cultural isolation, period spent in a refugee camp, time in the host country...).

Rousseau (1995) reviewed risk and protective factors together, and considered that there were three main areas that can generate risk or protection for refugee children: migration, the family and acculturation. Furthermore, he reported that a supportive family environment can be the best protective factor for a refugee child. Therefore, refugee children can be exposed to multiple risk or protective factors, and each individual refugee child will possess a unique range of these factors. One reason for the range of needs will be the unique set of risk and protective factors that each refugee child will have accumulated in their life.

MENTAL HEALTH PROBLEMS AMONG REFUGEE CHILDREN

Most of the literature dedicated to refugees' experiences (including children and adolescents), is related to stress, trauma, grief and loss. Systematic reviews confirm that refugee children are at substantially higher risk than the general population for a variety of specific mental health problems related to their exposure to war, violence, torture, forced migration and exile and to the uncertainty of their status in the countries where they seek asylum (Fazel, Wheeler, & Danesh, 2005; Norredam, Garcia-Lopez, Keiding, & Krasnik, 2009; Brough, Gorman, Ramirez,

& Westoby, 2003; Hamilton, Anderson, Frater-Mathieson, Loewen, & Moore, 2000).

Papadopoulos (2002) found that refugee children will lose many things from their home community such as their school, a job, and areas of play, friends and other family members.

Various studies have highlighted that a high percentage of refugee children display post-traumatic stress disorder symptoms (Allwood, Bell-Dolan, & Husain, 2002). In most of them it was found that the number of traumatic events experienced in the country of origin and the nature of events (e.g., death of family members) were associated with higher post-traumatic symptoms. Children can be affected directly by personal exposure to trauma and by the reactions of the adults. Parents' reactions to events can influence a child's capability to recover from the traumatic event.

Refugee children may furthermore experience greater problems related to stress, somatic illness, adaption difficulties, anxiety and depression compared to non-refugee children (Oppedal & Roysamb, 2004). Montgomery (2008) found that two thirds of refugee children (N=311) who had been exposed to war, violence and torture suffered from anxiety, and about 30% suffered from sleep problems. Separation from both parents appeared to be an important factor for mental health issues and contributed to a significantly increased level of depression, anxiety and PTSD (Sellen & Tedstone, 2000; Simich, Hamilton & Baya, 2006; Hodes et al., 2008). Fazel et al. (2012) explored the mental health needs of 101 refugee children in six schools in Oxford, aged 5 to 18 years. The results showed that more than a quarter of the refugee children had significant psychological disturbances, such as: anxiety, recurring nightmares, insomnia, secondary enuresis, introversion, academic difficulties, anorexia, somatic or separation problems. At the same time girls reported higher internalising scores for anxiety, depression or higher post-traumatic stress disorder symptoms, while boys had more externalising problems, such as hyperactivity or other behavioural problems.

REFUGEE CHILDREN AND MENTAL HEALTH INTERVENTIONS

The range of psychological reactions and comorbid diagnoses in refugee children should be carefully considered when choosing interventions. Psychological interventions can target disorders and risk modifiers such as social competence, they affect regulation, problem solving and coping skills, future orientation, the positive relationship with a supportive adult, parents' mental health and family

cohesion (deAnstiss et al., 2009). Different psychosocial interventions have been delivered to individual children with disorders or at risk of developing disorders, as well as to parents, families and identified groups in the community or school (Anders & Christiansen, 2016; Brown et al., 2017; Hassan et al., 2016; Nosč et al., 2017). The concept of these interventions reflects the dynamic relationship and intervention between psychological and social issues of individuals. As the prevalence of mental health problem is thought to be higher in refugee than non-refugee children, creative approaches are required to overcome barriers and to provide services to this population.

The needs of refugee children and their families may be best addressed through coordinate programmes which include children's mental health services that work closely with those who can "help shape a culture sensitive position", incorporating the social, cultural and political environments of refugee children. Hence, people who work with refugee children must seek the help of traditional health, religious and social systems to treat children in ways that are appropriate to their culture (NSW Refugee Health Service Working with Refugees, 2004).

Most researchers have found strong evidence about the effectiveness of verbal therapy-based interventions in the reduction of overall PTSD symptoms (Oras, de Ezpeleta, & Ahmad, 2004). Möhlen et al. (2005) articulated conventional clinical-based therapy with art/painting, dancing, acting and relaxation techniques. They identified positive effects of drama therapy, creative expression workshops and art therapy in their work with refugee children.

Individual intervention may be more appropriate for children who are more vulnerable, highly symptomatic or have cognitive or language problems. Nosč et al. (2017) suggest that expressive therapies (e.g., narrative exposure therapy, music or art therapy) may be more appropriate with refugee children who do not understand the language of the host country.

Some studies showed that there was a successful reduction in PTSD symptoms and PTSD subscale symptoms resulting from verbal-based interventions, while clinical management and parenting interventions effectively reduced emotional and behavioural problems. Verbal and art-based interventions were also successful in reducing anxiety and depression. Clinical-based interventions required a greater workforce with psychotherapists and specialized persons, including specialized child and adolescent psychiatric nurses, consultants in child and adolescent psychiatry and mental health teams.

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FOR REFUGEE CHILDREN IMPLEMENTED IN THE TRANSIT CENTRES IN THE REPUBLIC OF MACEDONIA FROM 2015 UNTIL 2017

In the largest refugee-migrant crisis since World War II, Macedonia is found in a very difficult and specific situation. In 2015 and 2016, approximately 1.000.000 refugees and migrants from Syria used the territory of Republic of Macedonia in order to reach the “promised” countries in Western and Northern Europe (UNCHR, 2017). This refugee-migrant crisis primarily had a transitive nature, that is, the country was a transit country. Following the higher numbers of refugees crossing through the country since June 2015, the Macedonian government adopted legislation in order to respond to this refugee crisis. Among the first legally adopted documents during this situation was the Standard Operating Procedure for Dealing (SOP) with Unaccompanied, Accompanied and Separated Children (UASC) adopted in November 2015. The aim of the SOP for UASC is to protect unaccompanied children in the reception and transit centers by deploying steps for identification, referral and protection of their rights as a special vulnerable category (The Government of the Republic of Macedonia, 2015).

My country had two “daily transport centers” for refugees on a daily basis, for a few hours, where up to 2000 refugees could stay (1500 in Gevgelija in the south of the country and 500 in northern Tabanovce), however most of the refugees spent a long period of time in these centers before they had left the country and continued their refugee journey. Children and youth under the age of 18 years made up about half of this refugee population (UNCHR, 2017). Many have suffered multiple traumas – the horror of war, violence, bereavement. Traumatic experience may create recurring memories that haunt these children to the point where their emotional, cognitive and social development is under impact. They are affected in different ways and require different kinds of support. The psychologists, social workers, educators and volunteers who worked with these vulnerable group of children and their families while they have been in the transit centers, implemented a wide range of approaches and activities. One of the key principles in ensuring the availability of complementary support is MHPSS (Mental Health and Psychological Support Systems), which required a layered system of complementary support that meets the needs of refugee children and their families (Inter-Agency Standing Committee – IASC, 2007).

The model illustrates a layered system of complementary support in the form of a pyramid and it has four levels of intervention (Inter-Agency Standing Committee – IASC, 2008). The first level was focused on providing basic services

and security, when the refugees/migrants reached and entered Macedonia. These basic services and security represent the response to refugee children, required to protect their psychological health, and they can include social, educational, vocational, recreational activities and focused non-specialized activities. When the borders were closed and when it was clear that a number of refugee children and their families will stay in the Republic of Macedonia for a longer time period, two transit centres were established in Gevgelija and Tabanovce. This situation opened space for the implementation of activities at the second layer (formal and non-formal educational activities, creative workshops, supportive parenting programmes, non-structural activities, etc.), and at the third layer (individual or group psychological support for children in distress and family support). After a prolonged stay in transit centres, a small percentage of refugee children have significant psychological and social difficulties. They need professional psychological and psychiatric support and a structured psychosocial intervention programme or a workshop. The main goal of this psychological programme is stimulation of the coping strategies, resilience and psychosocial development through verbal expression of thoughts or feelings and structured playful activities such as voice, movement, painting, drawing, song, sound.

Also parents play the most important role in helping children understand and manage emotions, develop resilience and foster positive relationships.

Each family had its own “home”, food, water. Children went to kindergarten or to a local primary school; they had a room for table tennis, and satellite TV with Arabic channels. The volunteers who had worked here were familiar with the life of every child refugee, and all the more, they knew their characters and their problems.

RESEARCH METHODS

The aim of this study is to determine the mental health problems and interventions among the refugee children. For that purpose, the method of a case study was used, as it provides a comprehensive understanding of the refugees’ experience during their journey as well as their accessibility to the system of protection in Macedonia. Before the collection of the data, a separate document named “Methodology for Case Studies” was developed which served as guidance for the research.

The research was divided in two stages. In the first stage, a desk research had been carried out, after which field research was conducted. The field research started in the beginning of January 2016 and finished in April. During this period,

the semi-structured interview was completed for the participants of this study. Hence, during work with them, they were familiarized with their therapist. The small part of our case study with changed names of the participants could be found in the article “Refugees Make best of Camp Life in Macedonia” (Balkan Insight, 2016).

Interviewing a child who has experienced trauma can be difficult for the child and also for the field worker trying to assist the child. So the questions were used in a conversational manner, aimed at promoting a two-way dialogue and empowering young people. The establishment of rapport was aided by using features of an informal conversation, such as open-ended questions and an emphasis on narrative and experience. During our work with the children we used an interview in three stages:

Stage 1. Opening

Opening permits the child first to express the trauma through play, fantasy and metaphor by use of projective free drawing and storytelling. Younger children (under 5 years) may play while they draw, but they can be encouraged to “make up story”.

Stage 2. Trauma

Trauma: therapeutic exploration. In this stage, there is a move from the child’s drawing and story to explicit discussion of the event. At this point, the child becomes very emotional and it is very important that child feels that field worker is supportive and will protect the child from becoming overwhelmed by his emotional reactions. We need to be prepared to share and to provide comfort for the child. It is relevant to bring the child to the point of experience where he/she is not too frightened by his/her emotional responses.

Stage 3. Closure

Closure: assist children in their current life concern

It is helpful to get the child to participate in reviewing and summarizing the session. Children should be supported that their feelings are understandable, universal and realistic. This will help the child to feel less alone and more ready to accept further support. Child self-esteem should be encouraged. It is important to ask the child to describe what was helpful or difficult during the interview. This will help him/her gain control back over what is happening to him.

After individual work with the therapist, the children continued their treatment in psychological workshops where everybody has to be heard, everybody should be respected and could express their needs, thoughts and emotions.

CASE STUDY

28-year old Zenep was from Aleppo, Syria. She and her two children were in the last group of refugees when the borders were closed. She was in the seventh month of pregnancy and together with her children (8-year old son and 5-year old daughter) she travelled illegally across Macedonian territory and planned to continue their travel to Germany. Together with her children she travelled about two months from Syria to Macedonia, they spent 15 days in the mountains; they only had biscuits and shared them one for the morning and one for the evening. They had all fled their destroyed home in Syria in mid-2015, first to Damascus and then, after the travelling escalated, to Macedonia. They acquired a protection status from the UNHCR.

Her husband waited for her and their children in Germany, but it was becoming more uncertain that they would see each other soon. She said:

My husband had left Syria previously; he is in Germany and now has a German passport and an identity card. They turned me down when I applied for asylum. The situation in my country was so terrible that I had to leave the country with my children. Here we had everything, but my children did not feel well.

In fact, children experienced traumatic life events in their native country. At the same time they have been separated from their father for a long period of time and lived only with their mother. In the host country they did not have family, peers, or friends. Everything was new for them. Her son was very hyperactive, aggressive and more destructive. Sometimes he had some somatic problems, such as headaches, dizziness or pain in the stomach, nightmares or sleeplessness. He thought that only bad things will happen in the future. His sister did not want to sleep alone, to regain physical independence, refusing to dress, feed or wash herself. Sometimes she cried, felt grief, helplessness and did not want to play with her toys.

It was very clear that they had significant emotional and psychological disturbances such as post-traumatic stress disorder and depression, because they lost their home and their father.

At the beginning, they needed individual psychiatric and psychological support. Verbal, art and game-based interventions proved effective in reducing PTSD symptoms and depression. The psychologist who worked with them encouraged drawing, painting and playing with toys to ventilate their feeling and to assure them that their parents will protect them from traumatic events in the future. Also the psychologist tried to connect the children with peers and encouraged them

to same age group activities. Afterwards, the children showed positive emotions such as gratitude, hope, happiness and optimism. The little boy started to go to the local school, while his sister went to kindergarten. They have already learned Macedonian language and their first words in Macedonian language were: “Hello, how are you?”. They counted in Macedonian, knew how to ask for water, they knew the names of their friends and learned the basic terms. Hence, when they left the Transit Center with their mother, they were very sad. “Here we have many new friends who help and love us”.

CONCLUSION AND RECOMMENDATIONS

Experience of conflict-related violence and concerns about the situation of countries affected by war are compounded by the war traumatic events, daily stressors of displacement, including: poverty, lack of basic needs and services, on-going risks of violence and exploitation, isolation and discrimination, loss of family and community supports, and uncertainty about the future. Recognizing and appropriately treating mental health problems among migrants and refugees poses a challenge, because of differences in language and culture and because of specific stressors associated with migration and resettlement (Ellis, MacDonald, Lincoln, & Cabral, 2008). Professionals (psychologists and psychotherapists) should be used to facilitate and improve communication and increase disclosure of psychological symptoms among migrants/refugees and can also be used when delivering psychosocial interventions.

This study provides an overview of the system of protection, identification of mental health problems and effective interventions of refugee children in Macedonia. The case indicated that the Republic of Macedonia had adequate protection system for refugees, particularly women and their children. Therefore, on the basis of the presented case study and my experience as therapist in Transit Center, following recommendations can be given:

- Enhancement of the involvement and coordination among all relevant stakeholders, including national authorities, the civil society and the international community;
- Creating and implementing pre-integration programs for refugees accommodated at the reception and transit centers;
- Close monitoring of the actual situation on the field in the country, the movement of the refugee groups, the pushback, obtaining data on the trends and

routes, recording incidents related to child protection and assistance of children;

- Establishing special spaces (safe houses) for unaccompanied minors where they can receive emotional support;
- Incorporating child specific questions or activity (for example, children's drawing) into the psychosocial procedure to provide a window for the views of the children or providing child friendly information at interview on where, how and when children can disclose their own individual protection concerns;
- Helping affected children from different age groups and recognize the mental health problems of children;
- Creating intervention model for mental health and psychosocial support for refugee children (individual, group and family psychosocial support);
- Support the affected child's potential for coping with life difficulties and stimulate his/her knowledge and skills;
- Develop a plan of action with the person you want to help and write report at the end of the implemented activity;
- As helper– be positive, be respectful, give clear and positive instruction, adjust intervention according to the crisis and the kind of support the crisis affected children need;
- Creating supportive parenting program, formal and non-formal educational activities, various social/recreational activities to activate social and strengthen community system;
- Supporting the parent/caregiver to stimulate infants (0–2 years), preschool children (2–6 years), children of school age (6–12 years), and young people from 12–18 years.

At the end, I hope that this review will provide information for future policies, it will increase the allocation of resources for program evaluation, and it will promote the development of integration strategies for refugee children and youth. The healthy integration of refugee children and their families has the potential to improve integration outcomes, to reduce the burden on healthcare and the mental health system, and provide a better quality of life.

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