Psychological Problems of Child Refugees

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Abstract

Children refugees are a lot more severely affected by flight than adults. Uprooting and traumata they experience in their own country, during the flight and in the host country cause later even up to 12 years after the immigration, severe emotional problems like grief, sadness, depression, anxiety as well as posttraumatic stress symptoms (PTSD) such as aggression, suicide, violence, nightmares, sleeping problems and lack of concentration.

Traumata hamper also child's cognitive and moral development; learning the new language and academic performance are impaired. Impaired memory, attention and abstract reasoning are common evidences.

Keywords: trauma, unaccompanied refugee children trafficking, PTSD, depression, anxiety.

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Çocuk Göçmenlerin Psikolojik Problemleri

Öz

Çocuk mülteciler, yetişkinlere kıyasla iltica sebebiyle çok daha ağır etkilenirler. Kendi ülkelerinde, kaçış esnasında ve daha sonar da iltica ettikleri ülkelede yaşadıkları köklerinden kopma ve tarvmalar göçten 12 yıl sonraya kadar ağır duygusal sorunlara, depresyon, üzüntü, korku ve travma sonrası stress semptomlarına (agresyon, şiddete meyil, intihar, kabuslar, uyku bozuklukları ve odaklanamama sorunları) sebep olabilmektedir.

Yaşadıkları travmalar kognitif ve moral gelişimlerine de zarar verir ; yeni dili öğrenmeleri ve akademik becerileri engellenir. Hafıza bozuklukları, dikkat ve odaklanma zorlukları, soyut düşünme kabiliyetinin azalması araştırmalarda sık sık görülmüştür.

Anahtar Kelimeler: travma, refakatsiz mülteci çocuk kaçakçılığı, PTSD, depresyon, endişe.

1. Introduction

Around 65 million people had been forced to flee from organized violence. Only approximately fled to Europe (7%) or Northern America (3%) whereas the major refugees' burden is carried by non-Western countries; 37% Middle-East, 27% Africa, 16% in Southern and Central Asia (Ingleby, 2005). Approximately half of the refugee population in the world (52%) are children and adolescents under the age of 18 years old (Bhabha & Young, 1999; Russell, 1999; UNHCR, 2004; Ingleby, 2005; Chak, 2018). Wilson (2012) states that 2 million children have been killed, 6 million disabled and 20 million have become homeless, 18 million children are forcibly displaced, a third of them are refugees or asylum seekers in another country, two-thirds being internally displaced with in their own country (Reed, Fazel, Jones, Panter-Brick, & Stein, 2012). A considerable number of them are children or adolescents who are separated from their parents or caregivers and who are the most vulnerable group among the refugees (Halvorsen, 2002). Bhabha & Young (1999) as well as Bruce (2001) estimated that approximately 2-5% of around 20 million children (Chak, 2018) are separated from their families. But Halvorsen (2002) and Hunter (2001) think that the number of separated children is larger than the officially registered. The legal term for this group of unaccompanied children and adolescents on flight "refugee minors" (Terr, 1991). At present, there are at least 170,000 unaccompanied child refugees in the EU, living under extreme duress, violence and sexual exploitation (UNICEF, 2017).

This article is based on the summary and synthesis of the results of primary research (interviews) about the psychological and cognitive damages of the flight on children. The main aim of this study is to demonstrate the intensity and scope of the psychological and mental disorders of refugee children so that it may be a guide and reference for the public authorities to a widespread setting up of treating institutions with specialized professionals. Every child has a right to be treated to emancipate themselves from the psychological results of flight trauma.

Every form of uprooting but especially flight renders people psychologically vulnerable and places especially minors at a great risk

for the development of psychopathology.[3] The extensively described emotional problems which appear in the host country after the flight constitute severe grief and sadness, depression, withdrawal, anxiety, post-traumatic stress, somatic symptoms, sudden outburst of aggression, low self-esteem, severe guilt feelings, delinquency, suicide, violent behavior, psychosis, nightmares, lack of concentration, sleeping problems (Ajdukovic & Ajdukovic, 1998; Almqvist & Broberg, 1999; Burnett & Peel, 2001; Dyregrov, Gjestad, & Raundalen, 2002; Ferenci, 2001; Hodes, 1998; Hubbard, Realmuto, Northwood, & Masten, 1995; Steel, Silove, Bird, McGorry, & Mohan, 1999). Some studies reveal that these psychological disorders are five times higher in case of unaccompanied refugee children and adolescents than refugee children who arrived the host countries together with their parents (Fox, Cowell, & Montgomery, 1994; Kinzie, Sack, Angell, Manson, & Rath, 1986; Loughry & Flouri, 2001; Macksoud & Aber, 1996; McKelvey & Webb, 1995; Sack et al., 1993; Sourander, 1998).

Younger children show overt aggression, destructiveness, drawings of traumatic events and behavioral re-enactments. Pre-school children and the older group 8-10 years depend to a certain extent on parent's reactions toward traumatic events. If parents respond calmly, the child feels protected and secured, the older group even reflecting on the traumatic events. This means parental communication about traumatic events play a fundamental role (Dyregrov & Yule, 2006). There is a high correlation between mother's distress and child's psychological health: higher levels of depression among mothers is strongly associated with their children's morbidity (Murthy & Lakshminarayana, 2006 in Jabbar & Zaza, 2019).

To give some, empirical research finding on child refugees psychology: in a Kenyan refugee camp all children suffered from PTSD, all children had nightmares; in two camps of Kurdish families 87% of children and 60% of their families showed this symptomology – all with

3 "Younger children might have developemental problems, whereas older children often suffer from depression, psychosis, agressive behavior, and school problems." (Gold, 1992; Kinzie et al., 1990)

war experience. Gaza Community Mental Health found out that among children living in bombardments 54 % suffered from severe PTSD. In Zataari Refugee Camp in Jordan 56% showed symptoms of psychological distress including anger, fearfulness, nervousness, hopelessness and spells of terror and panic and difficulty to sleep. 37% reported to suffer from all distresses. 45% of Syrian refugee children at a Turkish refugee camp experienced PTSD symptoms and 44% depression (Jabbar & Zaza, 2019). %56 of Palestinian children living in war zones have PTSD.

Children are more strongly affected by loss and discontinuities in their life than adults. The multiple loses in uprooting; loss of home, loss of accustomed patterns and norms of family, friends and social relations and culture shake the youngsters deeply and their sense of security, which is, together with continuity of life, the basic prerogative for psychological health.

Traumatic experiences coin the whole child's psyche. Flight involves 3 different epochs of trauma: traumata in the homeland, which constitute the reason for the decision to leave home (ethnic violence, rape, state violence, wars, genocide etc.), traumata during the flight like months-long journey in trucks, trains or lorry containers, pressed in a crowd of many refugees, without sufficient food, dependent on smugglers, and traumata in the host country: not only cultural shock, isolation, deprivation of a private sphere, since almost all refugees first live in camps or other forms of collective housing and confrontation with racism, discrimination and insult and bad treatment. The detrimental impact on self-worth and self-esteem have proven to become a life-long psychological problem. Experiencing the fright to be killed during their residence in the home country and during the flight, watching that beloved persons are being tortured and then assassinated cause a life-long lasting deep anxiety and mistrust against other people as well as again and again repeating breakthroughs of aggression: traumatized children paint black holes or monsters which swallow themselves.

Most refugees have made the experiences that only the strength and physical power enable people to remain alive. Those who have two

options of becoming a culprit or a victim choose to slip into the role of aggressor in order to save their lives. And an illustrative case is that of Ali, who had lost two brothers during the flight. He had experienced that only the law of the strongers' counts. He wanted to belong to the group of strongers' in order never to flee again. He suffered under feelings of shame and guilt because he could not protect his brothers. He decided never to become a victim again. That means to victimize others (Yeşim Ahlers' interviews).

Sarah, on the other hand, seemed to have retreated to a psychic mode of "powerlessness" and to have sworn never to become like the perpetrators who exercised horrible, terrifying acts on their victims. In a kindergarten, when she was attacked by other children she became mute and motionless, surrendered completely, never defended herself and let the aggressor do on herself whatever he wanted to (Yeşim Ahlers' interviews).

Trauma has the property to repeat itself in case of a trauma-trigger. The reaction of a group of refugee children demonstrates how the sound of an approaching helicopter leads to the repetition of an unhealed trauma caused by the bombs and shots before or during their flight: some children hid themselves under the tables, crying and closing their ears with their hands, others become stiff, not able to move. For those children the helicopter noise had become a trigger for death.

Deniz flew with his parents as he was 1 year old and could later remember nothing about the flight. But he showed symptoms of retraumatization, when parents started to pack in suitcases to go on a vacation or visit a relative for few days; it reminded her the preparation for their flight. So babies, young children and youngsters suffer under the consequences of trauma during the flight even if they can not remember, but their total organism reacts (Fischer & Riedesser, 2003).

In their home country many refugee children and adolescents are confronted with prolonged wars, armed conflicts and violence (Jaycox et al., 2002), the context of which impose an enormous stress on passive bystanders. A special group of war victims are those children who are forced to participate actively in war as soldiers, spies or sex slaves. Almost half a million of children are currently serving as child soldiers

in over 50 different countries (Machel, 2001), who have to exist in extremely difficult living circumstances and participate in extreme violence (Derluyn, Broekaert, Schuyten and De Temmerman, 2004). Terr (1991) differentiates between two basic types of traumata: type I refers to childhood traumata characterized by a single, sudden and unexpected exposure to an overwhelming stress and type II which is a result of a process of prolonged exposure to repeated traumata, like repeated sexual abuse or repeated threat. Keilson and Sharpati (1979) use the term "sequential traumatization".

Adult as well as child refugees yearn for arrival in the country of destination which has been idealized as the place of relief, joy and hope. The arrival after long-lasting suffering is interpreted as the begin of a new future. Yet shortly after arrival, the child acknowledges the unfamiliarity of the new society, the different school system and its completely different expectations which the child is doomed to fail to fulfill, unfamiliar rules, and cultural habits, inability to communicate because of the language barrier. Yet traumatized people are usually unable to learn a new language or to concentrate. Lack of social contacts is a result both of language deficiency and of avoidance of the native population any relationship with refugees which alleviate the sense of marginality and isolation.

We often speak about "acculturative stress" (Williams and Berry, 1991) without really comprehending what that means for children and adolescent: lack of complete orientation in life since all internalized the norms, values and standards of behavior are suddenly no longer valid but the new ones are even not recognized so that the identification with them and their internalization are out of question; the process of formation of a super-ego or in other words the developments of a conscience which is based on the internalization of culture and its norms and values is disrupted. Identity confusion and a deficient formation of normative aspects of the new enculturation, that means an unsolved clash of values, their long-lasting contradiction in the personality, are predictable problems of identity development. The acceptance and internalization of new norms, standards of conduct and underlying values of the host country,

against which the youngsters may develop hostility due to the repeating experiences of rejection by the native population, are retarded..

The statistics show that most accompanied refugee youths are between 15 and 18 years of age, in the middle of their adolescence, a critical development period characterized by important physiological, emotional and cognitive changes.

> "It is a time when persons become increasingly aware of themselves as social beings, and the establishment of an adult identity, a complex and demanding process, is initiated (Ajdukovic, 1998). Family values are challenged as the adolescent strives for independence, and the identity development process includes identifications with past and present significant figures, modified to fashion a unique and integrated individual (Erikson, 1968). In times of war or migration however, war brings many traditional ethical values into question, such as 'do not kill' and 'love your fellow man', and basic processes characterizing adolescence – such as separation from parents, choice of social role, the search for an adult identity – cannot proceed normally. As a result, establishing a personal, group and 'philosophical' identity is (Derluyn and Broekaert, 2008), at best, difficult (Ajdukovic, 1998), and the war- and migration-related stress may intensify adolescents' anxiety, impulsiveness, and identity crises. Moreover, war and migration often involve the breakdown of family and other social structures that in times of normalcy provide the institutional framework by which adolescents are socialized into the roles they are expected to occupy as adults (Bruce, 2001). This is certainly true for unaccompanied refugee youths: the separation from parents can complicate this adolescent process even more through the lack of role models or the absence of normal dependence-independence issues (Ajdukovic, 1998; Van der Veer, 2002). How does one challenge the establishment when this has been swept away? What is one's own role when parents may be injured, dependent, missing or dead? How does one reconcile the conflicting claims of parents who may be demanding greater loyalty to ethnic identity, and the demands of the host country for rapid assimilation? (Jones, 1998). The uprooting, disruption and insecurity inherent to migration may thus affect the psychological and social development, making the process of identity formation a more difficult balancing act between two or more sets of cultural notions and values (Fantino & Colak, 2001). And once the young person has been in the new country for several months or years and is adjust-

> ing well, a serious identity problem can develop (Baker, 1982), also because identity development tends to be a more complex process among migrant adolescents who employ more diverse reference models than other adolescents (Hicks et al., 1993)."

In case of unaccompanied refugee children and adolescents, all these processes and psychological conflicts are ongoing without any support and protection of the parents. The presence of parents and other family members may reduce the extend of perceived trauma and of the feeling being overwhelmed by terrifying experiences (Hicks et al., 1993). Being devoid of this role of the family, missing protection and social support, reduces the ability to cope with the psychological effects of distress and trauma. The role of "significant adults" is lost and with it the security, stability, safety and roots of the child.[4]

2. Unaccompanied child refugees in the EU

The west majority of child refugees coming to Europe are from war-torn countries, Syria, Afghanistan, South Soudan, Myanmar and Somalia (UNCHR, 2017). There are nine major migration routes for child refugees to Europe:

- Western African path
- Western Mediterranean path
- Central Mediterranean path
- Apulia and Calabria path
- Circular path from Albania to Greece
- Western Balkan path
- Eastern Mediterranean path
- Eastern Borders path
- Arctic route (newly discovered path)

4 "Among children, success in coping with stress corresponded with the mother's coping skills. Sleeping and eating disorders, separation fears, and withdrawal or aggression were common in case of absence of a mother. Children in a collective shelter were at greater risk for mental disorders than those with host famiIies." (Ajdukovic and Ajdukovic, 1993).

The East Mediterranean Root was the main root for refugees to reach EU until 2014. But as the EU Border Patrol Agency refrained from rescuing and transferring refugees to the Italian costs, the migratory root shifted to the Central Mediterranean path, followed by the Apulia and Calabria path (Alexandridis and Dalkiran, 2017; Dimitropolous, 2017; Frontex online, 2017).

The closure of borders by EU members means lack of safe and legal roots for children seeking asylum and their reliance on smugglers and traffickers. These children often become victims of sexual exploitation (UNICEF, 2016; Gerretsen, 2017). Since the living conditions in refugee camps are extremely poor, many children leave and consequently become targets of organized gangs and criminal networks. The Chief of Staff of Europol, Brian Donald, reported that nearly ten thousand refugee children went missing in 2016 (Vidal, 2017).

Refugee children in Europe becoming victims of criminal groups which exploit them for labor (slaves) and sex are spread all over Europe. To give an example: in 2016 91% of all child refugees arriving in Italy for example were unaccompanied, without parents or guardians, numbering to 25,846 (IOM, 2017). But only 17,245 are registered in reception centers, the difference being missing.

In 2016 UNICEF reported (UNICEF, 2016) dire situation of child refugees living in France in details of rape, slavery and enforced prostitution but also that sexual exploitation by aid workers and volunteers in the camps has become a routine and not even the police help the abused.

Child refugee trafficking is a serious crime with increasing prevalence throughout the EU. Article 3 of the UN Protocol terms human trafficking as:

> "the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments and benefits to achieve the consent of a person, having control over another person, for the purpose of exploitation". Moreover, the objectives of human trafficking are numerous and "shall

> include, at a minimum, the coerced prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or removal of organs. Enforced criminality, such as, "pickpocketing, shoplifting, drug trafficking and other similar activities which are subject to penalties and imply financial gain." (UNODC, 2016).

Other than that, the children are sold and pregnant women are trafficked into the EU, whose babies are sold to the illegal market (Nielsen, 2016).

We can conclude that none of the EU countries fulfill their legal responsibility to child refugees for protection outlined both in the Geneva Convention (1951) and in the UN Convention on the Rights of a Child. At present, more than 170,000 unaccompanied and separated child refugees in a lawless vacuum in the EU.

3. Conclusion

Studies of child refugees show that the prevalence of emotional and behavioral disorders, especially post-traumatic-stress-disorder (PTSD), anxiety and depression is high. As the number of risk factors accumulates, the likelihood that children will develop psychological disturbances dramatically increases: risk factors can be summarized as below:

Risk factors for mental health problems in refugee children

- Parental factors
  - Post-traumatic stress disorder (PTSD) in either parent
  - Maternal depression
  - Torture, especially in mother
  - Death of or separation from parents
  - Direct observation of the helplessness of parents
  - Underestimation of stress levels in children by parents
  - Unemployment of parents

- Child factors
  - Number of traumatic events—either experienced or witnessed

  - Expressive language difficulties
  - PTSD leading to long term vulnerability in stressful situations
  - Physical health problems from either trauma or malnutrition
  - Older age
- Environmental factors
  - Number of transitions
  - Poverty
  - Time taken for immigration status to be determined
  - Cultural isolation
  - Period of time in a refugee camp
  - Time in host country (risk possibly increases with time) (Fazel and Stein, 2002)

Summary of common presenting symptoms of psychological disorders in refugee children

Common symptoms of psychological disorders constitute:

- Post-traumatic stress disorder
  - Persistent avoidance of stimuli: specific fears; fear of being alone; withdrawal
  - Re-experiencing aspects of the trauma: nightmares; visual images; feelings of fear and helplessness
  - Persistent symptoms of increased arousal: easily aroused; disorganized and agitated behavior; lack of concentration
- Other anxiety symptoms
  - Marked anxiety and worry: irritability, restlessness
  - Other sleep disorders
  - Somatic symptoms including headaches and abdominal pain
- Depression
  - Low mood
  - Loss of interest or pleasure
  - Declining school performance
- Conduct disorders (Fazel and Stein, 2002)

Traumata tremendously affect child's emotional, cognitive and moral development but few studies show that the cognitive functioning, learning including learning of a new language and academic performance are also hampered. The relationship between traumatic events and cognitive functioning is particularly strong for children with PTSD (Kaplan et al., 2016). High rates of PTSD can persist up to 12 years after resettlement (Henley and Robinson, 2011). Evidence has shown and association between trauma and impaired memory, attention, executive skills and abstract reasoning (Beers & De Bellis, 2002; Pynoos, Steinberg, & Wraith, 1995; Toth & Cicchetti, 1998).

Symptoms of PTSD, anxiety and depression interfere directly or indirectly with learning (Beers & De Bellis, 2002).

"Poor concentration, one of the symptom criteria of PTSD, anxiety, and depression, could have direct adverse effects on both the acquisition of new information and cognitive skills, and performance. Intrusive memories of traumatic events may cause the child to be distracted from a learning task and to develop a style of forgetting that dispels the traumatic memories but also inhibits spontaneous thought. As one second grade girl lamented, "I hear everything at school, and then it's just gone. What happened to my mommy comes right back to me"… Symptoms such as hypervigilance, dissociation, altered states of consciousness, and amnesia may adversely affect executive functioning, understanding instructions, working memory (including retention of instructions when problem solving), committing knowledge to long-term memory, category formation, shifting between abstract and concrete thinking, generating problem-solving strategies, and demonstrating a solution to others" ((Kaplan et al., 2016)

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