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The Possible Effects of Adversity on Children and Understanding how Children Recover Displaying Resilience

Bachelor’s Thesis

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The purpose of this bachelor's thesis is to explore what are the possible effects of adversity on children focusing mainly on psychological trauma and post-traumatic stress disorder (PTSD). Along with these themes this work aims to provide some understanding on how children during adversities recover displaying remarkable resilience. All these will be answered through the primary and the secondary research question of this thesis: 1. What are the possible effects of adversity on children? and 2. How children deal with adversity displaying resilience and what are some of the protective factors for children's mental health?

The global refugee crisis of autumn 2015 led Finland to receive a record number of people as asylum-seekers and refugees reaching the amount of 32 476 people. Today, an unprecedented 68.5 million people around the world have been forced to flee their homes and countries. The numbers are growing constantly and the amount of children who have become refugees is shocking. Children as a group is the most vulnerable when considering traumatic experiences and traumatisation. Trauma is caused by an extremely anxious situation where one's normal capacities are exceeded. There is a prevalence of cognitive, social and affective impact of war exposure on children which calls for more multi-dimensional prevention and recovery. Resilience may be understood as an ability to overcome hardships due to the interaction of some personal and environmental factors.

The refugee experience consists of a complex combination of multiple stressors and losses along with the traumatic events. School context has been regarded as one of the potential cornerstones to develop children's resilience through positive school experiences, classroom belongingness and perceived social support.

Keywords: trauma, effects of trauma, post-traumatic stress disorder (PTSD), refugee, asylum-seeker, resilience

Oulun yliopisto
Kasvatustieteiden tiedekunta
Suurten menetysten mahdolliset vaikutukset lapsiin ja miten lapset toipuvat näistä osoittamalla resilienssiä (Magdalena Roti)
Kandidaatintutkielma, 49 sivua
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Tämän kandidaatin tutkielman tarkoituksena on tarkastella, mitkä ovat suurten menetysten mahdolliset vaikutukset lapsiin. Erityisesti tarkastelen traumaa ja traumaperäistä stressihäiriötä (PTSD). Lisäksi, tämä työ pyrkii tarjoamaan tietoa ja ymmärrystä siitä, miten lapset selviävät suurista menetyksistä osoittaen resilienssiä. Näihin aiheisiin etsitään tietoa vastaamalla ensisijaiseen ja toissijaiseen tutkimuskysymykseen: 1. Mitkä ovat suurten menetysten mahdolliset vaikutukset lapsiin? ja 2. Miten lapset selviävät suurista menetyksistä ja vastoinkäymisistä osoittamalla resilienssiä ja mitkä tekijät suojaavat lasten psyykkistä hyvinvointia?

Vuoden 2015 suuri pakolaiskriisi maailmalla vaikutti myös Suomen turvapaikanhakija- ja pakolaismäärään, jolloin Suomeen saapui yllättäen 32 476 ihmistä etsien turvapaikkaa. Nykyään 68.5 miljoonan ihmisen ennennäkemätön määrä ympäri maailmaa on pakotettu jättämään heidän kotinsa. Pakolaislasten suuri määrä on erittäin huolestuttava, sillä lapset ovat kaikista haavoittuvin ryhmä. Trauma syntyy erittäin stressaavasta tilanteesta, jossa yksilön perusvoimavarat ylittyvät. Kognitiiviset, sosiaaliset sekä affektiiviset sodan vaikutukset lapsiin vaativat moniulotteisempaa ehkäisyä ja toipumismenetelmiä. Resilienssillä viitataan kykyyn päästä yli vaikeuksista johtuen yksilön ominaisuuksien ja ympäristötekijöiden vuorovaikutuksesta.

Pakolaismatka ja kokemus on monen stressitekijän ja menetyksen yhdistelmä traumaattisten kokemusten lisäksi. Koulumaailma on nähty yhtenä potentiaalisena kulmakivenä lapsen resilienssin kehittymisen näkökulmasta positiivisten kokemusten, kuuluvuuden, sekä saadun sosiaalisen tuen myötä.

Asiasanat: trauma, trauman vaikutukset, traumaperäinen stressihäiriö (PTSD), pakolainen, turvapaikanhakija, resilienssi

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We can talk about hatred

We can talk about war

We can talk about killing

While we all keep score.

We can count all the bodies,

And count them once more---

How can this be?

Madly plunging into war

Marching to the lies once more

Who knows what they're dying for?

How can this be?

It's the same old tragedy

What a hollow legacy

No one learns from history---

How can this be?

"How Can This Be?", John Cannon and W. Harrison Childers (2002

1. INTRODUCTION

The research topic of this literature review is to explore what are the possible effects of adversities on children and gain some understanding on how children recover displaying resilience. By possible effects of adversities, I am primarily focusing on analysing trauma and post-traumatic stress disorder (hereafter PTSD). During my studying process for this topic I firstly intended to look at the possible effects of adversities on children more broadly but soon I realised that a lot has been said about trauma and PTSD. That is why I decided to concentrate mainly

on these two themes. However, previous research conducted in Finland about this subject was relatively quite limited. From the Faculty of Education at the University of Oulu one lecturer and researcher, Mervi Kaukko (2015), has studied the participation of children in a Finnish reception centre. A few more studies have been carried out about refugee population in Finland but not plenty enough. While familiarising myself with the body of knowledge about my topic two authors stood out; one national and one foreign author. The national author and researcher Soili Poijula (2016) is an acknowledged psychologist, psychotherapist and researcher who has contributed with her studies about trauma, grief and resilience. The foreign well-known author is Dyregrov Atle (2010) who is a clinical and research psychologist from Norway who has studied thoroughly trauma, disaster and bereavement. These two authors' work played a significant role in producing this bachelor's thesis. In general, there was a balance between literature found in Finnish and in English, even though scientific articles were mostly in English and written by foreign researchers.

In 2015, due to the global refugee crisis Finland received a record number of people as asylum-seekers and refugees reaching the amount of 32 476 people (Ministry of Interior, Finland-website, 2018). Nowadays, an unprecedented 68.5 million people worldwide have been forced to flee their homes and countries. "Among them are nearly 25.4 million refugees, over half of whom are under the age of 18" (UNHCR-website, 2018.) The numbers are constantly increasing and a growing number of children are under threat. During the pre-migration phase many children have faced the loss of their home, their friends, their family members or they might have witnessed torment, rape or execution of family members and others (Hamilton & Moore, 2004, p. 20). According to the Convention of 1951 relating to the status of refugees and its protocol from 1967 "refugee" by the United Nations High Commissioner for Refugees (hereafter UNHCR) is defined as "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (UNHCR, 1951, p. 3).

Refugee is someone who has been given refugee status and refuge in some country (Ministry of Interior, Finland-website, 2018). On the contrary, an asylum-seeker is someone "who has sought international protection and whose claims for refugee status have not yet been determined" (UNHCR, 2016, p. 4). Therefore, in this thesis by "children" I am referring to all children under the age of 18 years old but in several passages I am specifically describing possible effects or reactions from the viewpoint of refugee and asylum-seeking children and adolescents who are under the age of 18. By "adversity" I am mainly referring to war exposure, political

conflict and violations of human rights, abuse, deprivation and poverty, the refugee journey and in few cases natural disasters. Additionally, terms such as trauma, crisis, emergencies and traumatic events will be used interchangeably meaning the same thing with focus on trauma. In this thesis traumatisation refers to the one who has undergone trauma even though more attention is paid on defining trauma itself.

The aims of this thesis are to elaborate on what are the possible effects of adversities on children and reactions of children to traumatic events, what has been said about post-traumatic stress disorder so far and finally, how children under such circumstances recover showing admirable resilience. Through this elaboration my purpose is to provide an as adequate as possible picture of the reasons behind children's behaviour and actions in order to spread more understanding and eliminate stigmatisation. Including the aspect of resilience in this work aims to offer the reader a positive perspective on the chosen topic hoping to shift the attention of future studies and discussions on the strengths and opportunities for participation of especially refugee children instead of medicalising them. Considering the significance of this work to the Faculty of Education in Oulu and the wider society I believe this thesis serves as additional knowledge to the restricted, existing body of knowledge, it deals with concepts such as trauma and PTSD from the standpoint of a child instead of an adult, and it seeks to identify what structures and facilities can best meet the fundamental needs of children under crisis.

From a personal viewpoint, as a future educator, I believe there is an urgent need to receive knowledge about refugee population which is gradually being more represented in the Finnish schools as well. Schools have been reported as sources of resilience for children if they gain positive experiences in schools (Hamilton & Moore, 2004, p. 61). Teachers and other professionals working with children ought to have the necessary skills to support and guide these children. As an educator, being aware of the factors influencing one's resilience can contribute to the formation of a multi-professional team striving to see every child succeed in school and in life.

This thesis is a literature review and more specifically a narrative literature review. One of the main reasons to conduct this literature review is to develop the existing body of knowledge and create new knowledge. (Salminen, 2011, p. 3.) My intention is to produce a quite holistic picture of a certain research topic while evaluating the existing and already presented studies. (Dawidowicz, 2010, p. 5-6.) Moreover, a literature review seeks to find gaps and limitations in previous studies which partly took place in this thesis as well. This thesis is a qualitative, narrative review

and not a systematic literature review because it does not go through a very large and exhaustive range of sources due to its limited length and time frame (Aveyard, 2014, p. 2). Narrative literature review instead is characterised by its flexibility and the relevantly wide selection of literature, without methodological restrictions and fixed rules. This review's goal is to take the form of a narration which connects the previous studies coherently together. The research questions are more open-ended than in a systematic literature review. (Salminen, 2011, p. 6, 7, 9.) The first research question serves as a primary research question for this thesis and the second question is a secondary research question. The second question forms a secondary research question because it will only be answered briefly in the fifth chapter of this work. The reason why I wanted to include this secondary question was because I wished to end this bachelor's thesis in a hopeful and empowering manner.

The primary and the secondary research question of this literature review are the following:

1. What are the possible effects of adversity on children?
2. How children deal with adversity displaying resilience and what are some of the protective factors for children's mental health?

2. TRAUMA AND TRAUMATISATION

As it was already mentioned in the introduction this thesis will concentrate on trauma as one of the possible effects of adversities on children. From a psychological perspective trauma has been studied through a psychoanalytic approach while dealing with therapeutic interventions (Alayarian, 2011, p. 57-90; Leuzinger-Bohleber, 2015, p.49-79). This thesis does not intend to draw that deeply on studying trauma from the psychoanalytic point of view because that would require in depth knowledge and understanding of paradigms purely from the field of psychology. It would be unreliable and unethical to elaborate on such grand theories while not being an accredited professional or a psychology student. Trauma has also been studied from a medical prospect highly concerned with medical (i.e. traumatology) and specifically psychiatric diagnosis, identification of physiological and sometimes psychological symptoms in order to provide appropriate healthcare services. This work neglects analysing in extensive detail medical diagnostic criteria or certain mental illnesses such as post-traumatic stress disorder (hereafter PTSD), anxiety disorders and depression often related to refugee background individuals (Green, Bassuk, Donelan, Fairbank, Friedman, Jong & Keane, 2003 p. 67). However, some diagnostic criteria will be explored in relation to PTSD which is the most predominant mental health diagnosis in the refugee population.

Firstly, I am introducing the definition of "trauma" as it is provided by the dictionary of Oxford. In the dictionary trauma has three definitions from which I am presenting only the two of them. The third definition is a figurative definition of the word which I found irrelevant for a topic such as this presented in this thesis. The first definition derives from a pathological viewpoint. In this case, trauma refers to an external wound or injury and the possible "traumatised" condition caused by this wound. The second definition though, derives from a psychoanalytic and psychiatric point of view. (Oxford English Dictionary, online database, 27.10.2017.) Looking from that lens, trauma means "A psychic injury, esp. one caused by emotional shock the memory of which is repressed and remains unhealed;" and "an internal injury, esp. to the brain, which may result in a behavioural disorder of organic origin. Also, the state or condition so caused" (Oxford English Dictionary, 2017). The latter definition describes more adequately and relatively the psychological phenomenon itself. (Oxford English Dictionary, online database, 27.10.2017.) Quite similarly, Webster's dictionary (1968) defines trauma with psychiatric terms as "a painful emotional experience, or shock, often producing a lasting psychic effect and, sometimes, a neurosis" (Webster, 1968 p. 1942). Trauma is cited as any condition over-

stimulating one's psyche to the extent that one is incapable of functioning as usually using one's usual psychological defenses (Carey, 2006, p. 15).

Levine, Frederick and Pekkarinen (2008, p. 33-34) define trauma as a phenomenon caused by a stressful event which exceeds one's normal capacities and humane experiences and it is severely anxious. Besides, one who undergoes trauma experiences severe threat which is inflicted to one's life or physical immunity; severe threat or hurting which is inflicted on one's children, spouse or other close relatives; one's home or community's unexpected destruction; or witnessing the death of a person who has undergone physical abuse, witnessing a person who has been injured after an accident or witnessing the death of a person. This definition is both useful and simultaneously very misleading. There are many other traumatic situations that are left unexplained in the above definition. (Levine, Frederick & Pekkarinen, 2008, p. 33-34.)

There are four main characteristics by Levine, Frederick and Pekkarinen (2008, p. 144) that can be identified on a traumatised individual. These characteristics are the following:

1. High alertness (Finnish "Ylivireys")
2. Contraction (Finnish "Supistuminen")
3. Dissociation, separation from oneself (Finnish "Dissosiaatio")
4. Freezing, Immobilization related to helplessness.

High alertness of one's body refers to a reaction that gets activated when one is under a threat. This kind of high alertness cannot be controlled by oneself. At the beginning of a traumatic event one's senses and body get contracted. The nervous system makes sure that all the necessary processes and strategies associated with handling the threat are activated. Contraction leads to changes and contraction in one's breathing, muscles and posture. With these reactions one would be capable to survive the threat one is facing. In mild occasions dissociation can be seen and observed as withdrawal of a person and absent-mindedness. In the other extreme it could demonstrate itself as multidimensional multipersonality disorder. Because dissociation refers to a break in the normal feelings that body receives it unavoidably leads to a time and sense distortion. Finally, immobilization and helplessness are primitive reactions to an extremely threatening situation. During a traumatic event these elements in one's behaviour arise to the surface first. If these reactions can be observed at the same time and they last longer than they normally would in other cases then one may have most probably undergone some traumatic

event or events. Symptoms start to develop when one experiences constant and chronic reactions as the ones mentioned in this section. (Levine, Frederick & Pekkarinen, 2008, p. 144, 145, 147, 149,155.)

Saari (2003, p. 22-25) lists the following characteristics of traumatic events that are briefly mentioned without further analysis:

1. The event is unpredictable.
2. The event is uncontrollable, meaning that one cannot influence the course of events with one's actions and behaviour.
3. The events test the person's capacities and resources and transforms one's life values and worldview.
4. Everything changes due to the traumatic event.

Sinkkonen (2001, p. 157) speaks about trauma as something developed when one is exposed to witness a close family member's death or injury without one being able to get away from the situation or able to influence in any way possible the situation that is ongoing (Sinkkonen, 2001, p.157). In other words, psychological trauma according to Hamilton and Moore (2004, p. 14) means exposure to overwhelming experiences and a situation when one's earlier coping strategies are no longer suitable to deal with the situation (Hamilton & Moore, 2004, p.14). Then one's mind is being overwhelmed and overstimulated which causes one's psychological survival mechanisms to be paralysed, which lead to the experience of helplessness and powerlessness. (Sinkkonen, 2001, p. 157.)

The definition of the word "trauma" has developed with time especially among the field of medicine. Nowadays, the term refers to an overwhelming psychological constrain which usually consists of some crisis. In this literature review the term will be used as "trauma" instead of "a potentially traumatic events" for reasons of convenience. Based on Dyregrov (2010, p.12) the definition of trauma refers to "overwhelming, uncontrollable incidents entailing an extraordinary psychological strain for the child or young person exposed to them". Sometimes instead of the events to be sudden they are repeated during a certain period of time. This kind of cases may be sexual abuse or maltreatment, for example. (Dyregrov, 2010, p. 11-12.) According to Freud, one of the pioneers in the field of psychology, trauma meant a damage to the stimulus barrier referring to an injury to the brain. Until now the consequences of this damage had not been clear to experts of psychology and psychiatry but developed biological psychiatry has led to some new findings. For example, intrusive memories that occur in oneself suffering from

PTSD show signs of brain damage. (de Levita, 1991/1997, p. 152.) However, Dyregrov (2010, p. 11-12) reminds once again that not everyone who undergoes unexpected, life-altering, traumatic events will be traumatised and show long-term symptoms or reactions.

Traumas can be classified into four categories based on Sullivan and Simonson (2016, p. 505): 1. violence (loss of a close person due to violent death, war, terrorism, being a victim of physical abuse, being imprisoned), 2. sexual trauma (rape, sexual harassment, forced sexual engagement), 3. other physical injuries and traumas (diagnosis of a physical illness, severe accident, natural disaster, fire) and 4. witnessing trauma and receiving information about a trauma (secondary trauma and transgenerational trauma). Psychological distress and intergenerational trauma can also be experienced by refugee children as a result of direct or indirect exposure to trauma and through transmission of trauma between family members, respectively (Sullivan & Simonson, 2016, p. 505). Most children who experience a single trauma recover but approximately one third develop mental disorders due to the trauma. (Poijula, 2016, p. 36-37.)

Lenore Terr (1991) in Sinkkonen and Kalland's (2001, p.157) writings states that there are two types of trauma, Type I trauma and Type II trauma. Type I trauma develops when one, independent shocking situation occurs and leaves a strong and vivid memory on one's mind. The type II trauma refers to trauma that develops when traumatic events are repeated over and over again for weeks or months. Type II trauma example can be abuse, sexual abuse, or a child constantly witnessing one of the parents abuse the other. Both the preceding and the following events of a traumatic experience play their role in traumatising or not an individual and what kind of symptoms one may develop during that time. (Sinkkonen & Kalland, 2001, p.157-158; Dyregrov, 2010, p. 12.)

2.1 Some of the possible effects of trauma on children's development

A significant finding in recent studies according to Van der kolk, McFarlane and Weisaeth (1996, p. 342) was that children exposed to community and intrafamilial violence had disturbance with their narrative coherence, referring to one's ability to put narrations into beginning-middle-ending sequence. This skill when in imbalance can lead to challenges in reading, writing and communication skills. Additionally, a child with interfered narration construction may have difficulties with processing subsequent traumatic experiences resulting in possible development of a dissociative phenomenon. Moreover, traumatic images may be reproduced by selective

traumatic moments. These images might cause delayed behavioural expression and therefore have an impact on parent-child and peer interactions. (Van der kolk, McFarlane & Weisaeth, 1996, p. 342, 345.)

Van der kolk, McFarlane and Weisaeth (1996, p. 348) continue that traumatic memories of the traumatic event have emotional content embedded in them. However, the emotional content relies on the capacity of one to understand the metacognition of emotions. Because the traumatic event is complex it involves several emotions at a time such as fear, sadness, excitement and anger. In these situations, metacognition is needed to help on reconstructing the event. In cases that this ability is lacking children are either required to attach concurrent emotions to various portions of the experience or neglect totally a competing emotion. When one is capable of differentiating these emotions, it is easier to identify emotions linked to complex moments helping one to recover. (Van der kolk, McFarlane & Weisaeth, 1996, p. 348.)

As Parens (1991) claims in Van der kolk, McFarlane and Weisaeth (1996) "the birth of intense negative emotions indicates ways in which childhood traumatic experiences may challenge maturing mechanisms of emotional regulation" (Van der kolk, McFarlane & Weisaeth, 1996, p. 342). Parent-child relationship is accentuated after traumatic events, especially the trust between the parties. However, it has been studied that children may have disturbed balances between dependent and independent behaviour. The child might feel less capable to rely on one's parents and their protective skills leading to a lost sense of safety. On the contrary, some children may show clingy behaviour with other adults in school contexts which prevents them from developing necessary relations with their peers. (Van der kolk, McFarlane & Weisaeth, 1996, p. 343-344.)

Poijula (2016, p. 86, 92, 94) and Dyregrov (2010, p. 89) bring up the meaning of attachment during traumatic experiences. Attachment is the special bond between children and their parents. Based on the attachment theory the child has the need to be closely related and in interaction with one's parent. Traumatic experiences have an influence on one's way of attachment with parents. Traumatisation might change the trust that has been built through the attachment. In order for a child to survive a traumatic experience one utilises all his/her resources. Children who are safely attached to their parents have many and more resources than children who are insecurely attached. What a safely attached child does is to try finding practical ways to influence the traumatic experience, try using mental abilities to calm down and soothe oneself, try finding ways to manage one's moods, try finding and creating new ways to seek meaning and

adaptation, and finally try seeking safety from other people. (Poijula, 2016, p. 86, 92, 94; Dyregrov, 2010, p.89.)

Children's level of development has an impact on how children experience and comprehend traumatic events. To begin with, children have short capacities for concentration, they cannot concentrate on one thing for a very long time. That is why children react to an event more often and in repeated time periods. Secondly, children think about situations in a very concrete manner. They tend to understand the traumatic event in a very concrete way and their ability to observe is heightened. Thirdly, children have a tendency to think of the world and others in a very self-centred, egocentric style. In the child's understanding he/she is the centre of the child's world. Usually, the child finds explanations to what has happened based on what one has done, said or thought. Therefore, children may feel huge guilt for what has happened. Often, adults think those children's thoughts and feelings are irrational and they do not pay much attention even though the child would need help and support. (Saari, 2003, p. 254-255.)

In Poijula's (2016) view there are two ways in which a child's development may be disturbed by the trauma. On the one hand, the traumatic event may be so intense that one's development and social interaction are disturbed with a result of psychosocial adaptation difficulties. On the other hand, if the traumatic event takes place when a child is going through a vulnerable, sensitive stage the damages may be larger even though the traumatic event may not be that intense. In both cases the consequences of trauma get accumulated if the surrounding environment does not take into account the child's efforts to regulate and understand the trauma and come to terms with it. (Poijula, 2016, p. 85.)

Traumatic events always generate uncertainty and insecurity. That is the reason why children seek for safety. This accentuated need for safety can be visible from children's need to be more with their parents and long for physical closeness. Children are oftentimes afraid that something bad or similar will happen again or to other family members. Besides, Saari (2003, p.262) states that children may show developmental regression and start behaving as children younger than them would behave. A child may lose one's abilities and skills in some developmental area for a while. For instance, the child might start wetting one's bed again, speech might show some disturbances or the child's motor skills might be weakened. (Saari, 2003, p. 262-264.) As Montgomery (1998) explains via Hamilton and Moore (2004, p. 15) children adjust to trauma in healthy ways depending on their cognitive competence, coping strategies, self-esteem, a stable emotional relationship with a parent and access to support (Hamilton & Moore, 2004, p.15).

However, children without adequate support and well-developed coping strategies might face alterations in their cognitive, emotional and moral development (Hamilton & Moore, 2004, p. 16).

In a study of emotional and behavioural problems amongst Afghan unaccompanied asylum-seeking children by Bronstein, Montgomery and Ott (2012, p. 289-291) nearly one-third of the participants scored high or very high on scales measuring internalisation of problems, referring to prevalence of anxiety and depression. One of the meaningful correlations that was found through this study was that the longer children stayed in the United Kingdom (hereafter as UK) or the greater the number of events of pre-migration, the greater children's behavioural problems were. Nevertheless, the generalisability of the results of this study must be carefully discussed given the specific ecological model contexts of Afghan unaccompanied asylum-seeking children in the UK. There is no previous research that specifically investigates the emotional and behavioural problems of Afghan unaccompanied asylum-seeking children. One explanation for less comfortable and positive living attitude in the UK may result from the fact that the more supportive the network around unaccompanied children is the more decreased negative reactions they have. Besides, only thirty percent of these children displayed emotional and behaviour challenges which meant that the rest of the children showed great amount of resilience even though more resilience-based studies are needed in this field. (Bronstein, Montgomery & Ott, 2012, p. 289-292.)

Both Poijula (2016, p. 47) and Saari (2003, p. 264-265) agree that the most essential component in the process of healing is play, which might, however, be disturbed in the case of traumatisation. Through play children re-experience the trauma, stressors are being faced, and the trauma is being looked at from different perspectives, roles and outcomes through playing. What is important to remember is that play ought to have some kind of theme meaning that children are able to utilise their creativity and imagination in order to give new meanings to the traumatic events and heal with given time. On the contrary, there are also these repetitive games or repetitive play which seem compulsive and show excess anxiety in children's behaviour. They lack creativity and imagination and do not help children process the trauma that has occurred. That is when parents and adults need to interfere and help children change the course of their play. (Poijula, 2016, p. 47; Saari, 2003, p. 264-265.)

2.2 Children’s asylum-seeking journey and trauma

In Finland most of the children who arrive without their parents as asylum-seekers come here because of civil war and other political conflicts in their homelands. Mostly in such cases the society has been highly ruined, social order has been destroyed and living a normal life becomes impossible under war and terror conditions. Most of the children who arrive to Finland have undergone armed conflicts, other fights and violence, been displaced many times in a short period of time, have lost family members and friends whereas they have been living in refugee camps for longer periods of time. (Helander & Mikkonen, 2002, p. 48.)

This either long or short fleeing journey induces multiple and contradictory feelings to children. To begin with, children might have felt scared and sad about leaving their families while simultaneously they have been happy about seeking a safer place to live. Despite that, according to Helander and Mikkonen (2002, p. 48-50), children have always reported feeling frightened about leaving their country and family members behind travelling towards the unknown. However, younger children due to their less developed capacity to comprehend they might have felt excited about this new adventurous journey. If children have had the chance to say goodbye to their loved ones this has protected children psychologically up to a degree. (Helander & Mikkonen, 2002, p. 48-50.)

Unaccompanied children who arrive to Finland have lost their sense of safety and their familiar places and people. That is why the major emotions children feel at those times are insecurity and rejection. Feelings of longing and missing home are expected reactions from children while they keep worrying about relatives who were left behind in their home countries. Helander and Mikkonen (2002, p. 103) comment that children may be traumatised the most due to the loss of and separation from their families. Sometimes they are unable to engage into play, attend school or feel being free again. It is said by Helander and Mikkonen (2002, p. 103) that children accompanied by their parents have a safety and support network which safeguards their mental well-being. (Helander & Mikkonen, p. 103-104.)

Moilanen (2004) has studied the refugee journey and experience therefore the following paragraphs rely mostly, but not solely, on her findings. The journey to safety always calls children to adapt to new conditions and abandon some aspects of their old life. According to Moilanen (2004, p. 86) there exist several key elements that affect children's and youth's journey to refuge. Firstly, parents’ experiences influence strongly their children’s feelings and behaviour. (Moilanen, 2004, p. 86.) Meier (2002, p. 626) indicates that feelings of separation and unfamiliarity

have increased because of mass population displacements from cities to other cities, centres or refugee camps. Thus, many parents stay unemployed and whole families live under impoverished conditions. (Meier, 2002, p. 626.)

Parents' emotions are easily transferred to their children. It is commonplace that parents go through serious low mental health conditions, such as depression, which children easily sense and adapt to it. Smaller children are at a higher risk of expressing signs of depression while their parents deal with possible depression. Nevertheless, parents' positive experiences in the host country are shown to play an essential, positive role in children's well-being. Moreover, numerous studies have proved that parental presence affects immensely children's well-being. (Moilanen, 2004, p.85-86.) Children do not only carry the weight for their parents' worry but they stress and worry about their own survival as well even if they have done the journey with their parents. While children are young the effects of the journey can be seen at school performance and peer relations. On the opposite, for older children the impacts of the journey are visible in their identity development process. That is why it is concluded that asylum seeking routes are harder and more challenging for youngsters. (Moilanen, 2004, p.86-87.)

The refugee experience consists of a complex combination of multiple stressors and losses along with the traumatic events. Many refugees' migration journey along with diverse stressors and violence related to pre-migration and trans-migration causes one to exceed his/her natural coping capacities leading to severe everyday life challenges. Even though refugee children adapt to the host society more easily than adults they need three elements to develop healthily: a sense of safety, an encouraging social network and opportunities to develop. Nevertheless, in the refugee children's case their possible traumatisation and upbringing may not have provided them with necessary sense of security in order to develop holistically. Hamilton and Moore (2004, p. 12) express that refugee children may show delays in learning, cognitive or identity development. (Hamilton & Moore, 2004, p. 12.) Refugees' displacement experience is considered as one of the most traumatising experiences because one loses his/her sense of belonging, feels alienated and disoriented causing possible mental health problems (Hamilton & Moore, 2004, p.13).

Displacement is the aftermath of some disasters. Children and whole families experience numerous social losses after and during displacements. To be more specific, children may feel a wide scope of reactions and challenges while dealing with evacuation, displacement, and relocation. The more extreme and shocking the past events and experiences before relocation the

greater risk children have to show a prevalence of PTSD. Before and after displacement pupils of a study by Pfefferbaum, Jacobs, Van Horn and Houston (2016, p. 70-71) had lower levels of academic achievement and higher levels of non-promotion. Also common for these children were suspension and expulsion at school. Drop-out levels and percentages were also quite high among children who had been displaced in that study. For instance, children relocated because of a tsunami in equivalent tests showed a number of variables such as environmental disruption and family economic status associated with functional and emotional results. (Pfefferbaum, Jacobs, Van Horn & Houston, 2016, p. 70-71.)

Finally, the article by Kaplan, Stolk, Valibhoy, Tucker and Baker (2015, p. 83) suggests that the refugee experience influences the child's cognitive functioning. Pre-arrival trauma, psychological sequelae of traumatic events, developmental impact of trauma, and the quality of family functioning have been found to influence cognitive functioning, learning and learning a new language, and academic performance. (Kaplan, Stolk, Valibhoy et. al, 2015, p. 83.) Not only war trauma and refugee experience but also after one's arrival one might feel anxiety and hopelessness related to one's resettlement process and waiting for permit decision. As Helander and Mikkonen (2002) reveal the waiting without knowing is frustrating and nerve-wracking for everyone. The process until one receives an answer either to stay or to leave complicates some other administrative work to be done such as one's possibilities to apply for schools or to look for a possible job. (Helander & Mikkonen, 2002, p. 108.) Kohli and Mather (2003, p. 206) state that asylum-seeking children have the need to share their experiences, losses and stories in order to gain control of their lives and discover themselves the paths to self-recovery. The role of an outsider is to stay still, listen to their stories and provide space for healing. (Kohli & Mather, 2003, p. 206.)

3. REACTIONS TO TRAUMATIC EVENTS

Children can be part of the traumatic event, someone close to the child may be a victim or the child might need to call for help during the event. It is believed by Saari (2003, p. 252) that the character of the event and the role of the child in it influence what the child experiences and how one reacts to it. Especially, children's previous experiences play their role in shaping their view of the event. The older the child and the wider the child's understanding of one's

worldview is the more the reactions to a crisis seem similar to the reactions of adults. (Saari, 2003, p. 251-252.)

Children respond to crisis in various subjective ways. Some common emotional responses though have been stated in relevant literature. According to Dyregrov and Teva (1994, p. 124-141) children's emotional responses or reactions can be classified into three main categories: primary or immediate responses, secondary responses after primary responses have somehow faded away and responses of a long-lasting manner. Primary responses often include unrealistic feelings or being suspicious of what has happened, fear and confusion, sense of extraordinary control, capability and strength, and omen-taking. Common secondary responses, which comprise of and are manifested by multiple other responses, emotions and behaviours, are some of the following: fear and anxiety, powerful memories, concentration difficulties, grief and longing succeeding loss, avoidance of things and situations reminding or triggering the event, guilt and self-blaming, posttraumatic play, sleep disturbances and physical impairments or pain. Long-lasting responses are secondary responses that have continued to reside in oneself after quite a long period of time after the actual traumatic event has passed. Yet, the most intensified responses occur right after a crisis. (Dyregrov & Teva, 1994, p. 124-141.)

When children undergo constant life-altering events some emotional mechanisms are activated to help the child survive. Most often children are seen to adopt reactions such as denial, rejection and repression of their own reactions and emotions. Some children may be paralysed by strong, shocking events while others may start protesting and behaving with rage as responses to the events. Children might also show signs of dissociation. Dissociation, according to Dyregrov (2010, p.13), is the division formed between feelings, thoughts and behaviour. Poijula (2016, p. 48) adds that during dissociation one has experienced a highly overwhelming event which led one to be incapable of being present. Dissociation serves as a defense mechanism to protect oneself when one has not been yet traumatised. (Poijula, 2016, p. 48.) Dissociation is a challenging psychological mechanism since once it has been employed one is more prone to apply it often and later on in life to handle one's emotions. (Dyregrov, 2010, p. 13-14, 20; Poijula, 2016, p. 95.) Children's personalities and previous emotional experiences influence how they bounce back from trauma and how they react. Emotionally unstable and inhibited children might confront larger challenges than emotionally stronger individuals. (Dyregrov & Teva, 1994, p. 150.)

Emotional responses are unavoidably connected to some cognitive reactions. Responses are distinct from effects of trauma explained in literature, however they share many similarities making the separation of them challenging at times. Figley (2012, p. 89-90) mentions some cognitive and emotional effects related to traumatic experiences that serve as further elaborations of the secondary responses provided above by Dyregrov and Teva (1994). On a clearly cognitive level a child's previous belief systems and schemas are shaken leading one to question close relationships and feel pervasive insecurity towards the world as a whole. Trust is frequently lost making a child shift to a guarded mode of functioning. Additionally, some children may adopt strong fantasies of revenge if they have been threatened or if they are unable to handle their natural feelings of anger. Specifying on Dyregrov and Teva's (1994) descriptions about children's responses Figley (2012, p. 89-90) points out that children may feel guilt, helplessness, shame and regret if they believe they could have done something they were not able to at that time. (Figley, 2012, p. 89-90.)

During an intensive traumatic event, the child's defense mechanisms are activated such as denying of emotions and disruption of one's reality. It is difficult for the child to comprehend one's own reactions and they frighten him/her. Children who are traumatised might also soothe themselves by rationalising and denying feelings of fear. (Poijula, 2016, 95.) Existing fears may be reactivated or novel fears may develop when children are exposed to triggering sounds, images, events or changes in everyday routines. As adults undergo depressive phases and immense sadness also children share these emotions as a consequence of unsteady future and losses. Figley (2012, p. 89-90) also relates these depressive behaviours of children to their inevitable social withdrawal and isolation. (Figley, 2012, p. 89-90.) All responses are influenced and depend on the character of the traumatic event or type of exposure to it and the intensity of the experience. (Dyregrov & Teva, 1994, p. 145; Figley, 2012, p. 89.).

Usually children after traumatic events are more restless and have difficulties concentrating. As a result, their school and academic performance may be weakened. Additionally, children have less abilities to comprehend and perceive the future. They are less able to see and perceive long-term goals or consequences. They are more focused on the present moment and may not see them having a future of their own. Similarly to Saari (2003), Poijula (2016, p. 48) points out that children who have experienced trauma internalise the notion that people are actually very fragile and they lose their trust in the future. The future seems too frightening for them. (Poijula, 2016, p. 48; Saari, 2003, p. 264.)

Meier (2002, p. 626-627) focuses on how, from a developmental perspective, children's reactions to death and grief differ, meaning that their moral understanding is different. Smaller children may feel that death is a punishment when slightly older school-age children might feel that they are responsible for the lost members of the family. Much older primary school children comprehend the consequences of the losses and may want to become perfect in making up for those losses somehow. (Meier, 2002, p. 626-627.)

Helander and Mikkonen (2002, p.106) along with Saari (2003, p. 264) add that children may also have some somatic symptoms and symptomatology after adversity. For example, headaches, stomach aches, muscle pain and tension are common long-term symptoms children experience. Appetite might also be diminished and physical development might be slowed down or there might be some physical regression. (Saari, 2003, p. 264; Helander & Mikkonen, 2002, p. 106.)

3.1 Reactions of pre-school and school-age children to traumatic events

During traumatic situations pre-school children are usually observers. This can be distinguished in children as strong passivity or freezing of one's own will and mobility. Some other children show regression in their development or become very clingy and dependent. They may also become very highly alert or present disturbances in their sleeping routines. School-age children are capable of stepping into others' shoes and see the situation from different perspectives. That is why they are able to visualise, imagine and sympathise with what the victims, perpetrators and third parties are feeling and experiencing. Older children might imagine themselves as saviours of the victims. (Poijula, 2016, p. 45-46.)

Traumatic events have an impact on how a pre-school child tolerates emotions and how to separate emotions. These may also affect how one feels compassion and empathy for others and how one expresses intense emotions. If children's parents are traumatised and depressed they will have difficulties responding to their children's emotional needs which may shape negatively the children's development of emotional skills and emotional world. Because of their young age some children are left without adequate information about the events which is not healthy for them. Nevertheless, younger children are not able to comprehend everything and event's consequences which serves as a protective factor for them. (Dyregrov, 2010, p. 50.)

School-aged children have developed a wider scope of coping strategies to deal with adversity. They think about events more concretely, they are fond of details and they consider the unfairness of things. However, older children may present more challenges dealing with trauma since adults often expect more from them. (Dyregrov & Teva, 1994, p. 146-147.) Dyregrov (2010, p. 51) characterises school-age children to understand the sequence of events more easily and use their imagination to picture how events could unfold. That is why they are more afraid of the reoccurrence of events. They are capable of thinking of what they could have done or do and what they could not have done or cannot do to influence the events. This is a double-edged skill. They may feel extreme guilt, sorrow or anger if they think they could have done something to prevent the events. Because of their developed cognitive skills compared to preschool-age children school-age children are able to regulate their emotions by verbalising them. However, this skill becomes very difficult to utilise for children who are traumatised since they avoid facing their emotions. Besides, children may fear to express their thoughts to their friends because they are scared of being labelled as weird or exceptional. (Dyregrov, 2010, p. 51.)

Hedrenius and Johansson (2016, p. 144) have summarised a list of reactions common to school-age children after crisis:

- **Sleep disturbances:** challenges falling asleep, nightmares, need to sleep with parents.
- **Unrealistic restlessness or aggressive behaviour:** challenges sitting still and reacting to even “the smallest of things”.
- **Questions about the event:** “What are normal reactions and others’ reaction”, “What will happen in the long run”.
- **Fear of one’s own and other’s reaction, and fear that the event will happen again:** Difficulties understanding one’s own and others reaction and fearing those reactions. Difficulties finding words for emotions and fearing of event to take place again.
- **Feeling responsible for the event and feelings of guilt:** Restlessness because one feels responsible of the event or feels guilt of things one could have done differently or prevented even.
- **Physical reactions:** headache, stomachache or muscle pain without explanations.
- **Repeatedly telling about the event or repeating it through a repetitive play.**
- **Very close observation of parent’s reactions to the event:** Observing how adults deal with the situation. Not wanting to disturb parents with own restlessness or thoughts.
- **Worry about others’ and own safety:** Wanting to know what should be done in other dangerous situations. Fear for parents’ and siblings’ safety.

3.2 Reactions of adolescents to traumatic events

Adolescents are the most able to realise the events' long-term consequences. Adolescents are going through a period of life where they are developing their own identity, they are becoming more independent, they ponder existential questions and the significance of friendships grows. Adversities might affect negatively an adolescent's growth and development. They may blame themselves and feel extreme guilt for what they could have done to help the situation. As a result, they might suppress their emotions and reactions, and avoid facing strong emotions. (Dyregrov & Teva, 1994, p. 147-148.) Youngsters have developed their cognitive and executive functions skills to a quite large extend. They are able to comprehend reasons behind actions and consequences and think about the future. Adolescents may think as almost adults do but their emotional capacities might still be underdeveloped. After traumatic events adolescents may take more responsibilities for themselves and begin behaving more maturely distancing themselves from their peers or previous interests. Adolescents run a high risk of behaving in self-destructive ways to feel alive and handle strong, pervasive emotions. (Dyregrov, 2010, p. 52.)

The sense of security and trust in the case of adolescents may be interfered in a negative way while adolescents seek to form and preserve their interpersonal relationships (Porterfiel, Akinsulure-Smith, Benson, Betancourt, Ellis, Kia-Keating, Miller, 2010, p. 28). According to Western psychology during adolescence the formation of identity is one of the most significant tasks to take place. However, unaccompanied refugee minors might often face serious challenges in this task feeling confused and isolated. These challenges may also be reflected as difficulties in school performance and rejection by peer relations. (Carlson, Cacciatore & Klimek, 2012, p. 262.)

Hedrenius and Johansson (2016, p. 148) have also summarised a list of reactions of adolescents and young adults after crisis:

- **Feelings of ignorance, guilt and shame:** They often feel that nothing really matters and feel very ashamed of what has happened.
- **Being self-conscious:** They are afraid to express their fears or their vulnerability in order not to be labelled as abnormal or weird.
- **Acting out:** Acting based on short impulses such as using drugs or have impulsive sexual behaviour.

- **Feeling afraid of own and others' reactions, and being afraid that the event will occur again:** A lot of worrying about own and others' reactions and what is normal to feel.
- **Changes in relations with others:** Strong reactions towards parents' behaviour and decisions, feeling of being more mature than other peers after the adversity.
- **Wanting to make large decisions about one's future:** for example, return back to school.
- **Worry about others and their well-being.**

4. POST-TRAUMATIC STRESS DISORDER IN CHILDREN AND CONNECTION TO WAR EXPOSURE

There has been a constant debate if PTSD should be considered a normal or abnormal response to traumatic experiences and stress. Looking from a social and cultural lens we need to take into consideration the possible role of culture and cultural issues related to PTSD. While this part of study has gained very little attention the role culture plays in understanding and observing trauma is significant. It cannot be ignored since the definition of trauma is usually culturally specific. Not to forget mentioning the role of religious and social rituals and ceremonies which impact dealing with losses and support healing. (Van der kolk, McFarlane & Weisaeth, 1996, p. xii, xv.) World Health Organisation (hereafter as WHO) defines mental health through a more positive lens consisting of the social and psychological well-being of the individual and does not focus only on symptomatology (Tol, Song & Jordans, 2013, p. 446).

While humans have been evolving they have encountered many dangerous and dreadful experiences without however being traumatised or developed psychiatric disorders. Traumatic events can, however, affect individuals more than usually leading to changes in one's psychological, biological and social balance to an extend where one perceives the present very differently due to memory alterations. PTSD ought to be seen as a result of "complex interrelationship among psychological, biological, and social processes" (Van der kolk, McFarlane & Weisaeth, 1996, p. xi). Two factors play a key role in influencing the development of PTSD: the maturational level of the victim and the length of exposure to adversity. (Van der kolk, McFarlane & Weisaeth, 1996, p. xi, 3,4; Meier, 2003, p. 626-627.) On the contrary, Poijula (2016, p. 46) specifies that the definition of post-traumatic stress disorder is very similar to the definition

of traumatisation. PTSD is thus defined by Sullivan and Simonson (2016, p. 506) and Poijula (2016, p. 46) as a disorder when a person has undergone a traumatic event, where one experienced, saw or faced a situation which was related to death, severe injury, immense threat or one's own or others' immunity was under threat. Traumatic stress can be visible in children through scattered or disconnected behaviour and restlessness. (Poijula, 2016, p. 46; Sullivan & Simonson, 2016, p. 506.)

It is natural for children who have experienced trauma to show some post-traumatic reactions (Dyregrov, 2010, p. 21). Dyregrov (2010, p. 13) notes that the experience of cumulative traumatic incidents influences the duration and type of post-traumatic reactions that a child may face. Based on research it can be assumed that PTSD affects the development and formation of personality through the child's thoughts, emotions, behaviour and body reactions. Depending on the severity of the trauma the child's worldview and expectations towards the self and others may be disrupted. As comorbid diagnosis children affected by trauma can reveal having apart from prevalence of PTSD also anxiety, depression, separation anxiety and other mental disorders. (Poijula, 2016, p. 35-36; Carlson, Cacciatore & Klimek, 2012, p. 261.) Children exposed to trauma may also have difficulties in rebuilding trust, disorders related to attachment and finally overall worsening of functioning (Carlson, Cacciatore & Klimek, 2012, p. 261). However, there is contradictory knowledge about the psychiatric diagnoses refugee children might receive. Sullivan and Simonson (2016, p. 507) argue that children react to extreme conditions in a way which is natural and expected while others support the notion that symptomatology is culturally bound.

PTSD is one of the common consequences of trauma, war and exile experiences (Hamilton & Moore, 2004, p. 13). Dyregrov (2010, p. 42) comments that there are certain criteria that need to be reached to diagnose a child with PTSD. To begin with, "they must have experienced by witnessing or being confronted an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. They need to have reacted with intense fear, helplessness, or horror" (Dyregrov, 2010, p. 42). Besides, the presence of these symptoms need to have lasted for one month and one's functioning abilities at school need to have been deteriorated. There are also three more criteria that need to be fulfilled for the diagnosis. These are persistent re-experiencing of the event in several ways, avoidance of stimuli connected with the trauma and activation of the nervous system in a manner that was not present before the trauma. Nonetheless, one needs to keep in mind that these criteria and groupings were first developed for adults and it is more challenging to measure symptoms in children.

(Dyregrov, 2010, p. 42-44; Poijula, 2016, p. 45-46.) Some of the syptoms of children are linked with experienced trauma and also unresolved grief (Hamilton & Moore, 2004, p. 19).

A research conducted on the prevalence of PTSD in refugee children resettled in Western countries revealed percentages of prevalence from 10% to 46.8% after one year. Studies have been carried out to find out about the prevalence of PTSD, anxiety and identification of risk factors among refugee children and their family. For example, one study conducted in the United States showed high prevalence of PTSD and anxiety symptoms in refugees even after a year or two of resettlement with attention paid on migration and resettlement stressors. These results stress the importance of including mental health aspects while assessing refugees' well-being and adaptation. Additionally, in this study of Javanbakht, Rosenberg, Haddad and Arfken (2018, p. 209-210), parental reactions and well-being seemed to affect children. Children rely on their parents in order to make sense of adverse events. It has been proved that mothers can protect their children while at the same time their reactions may cause or moderate anxiety, hyperarousal and behavioural dysregulation in their children. However, fathers and their reactions have been less studied. Some of the limitations of this study, though, were the small sample and the usage of self-report screens. (Javanbakht, Rosenberg, Haddad &Arfken, 2018, p. 209-210.)

In another study which was conducted in 2015 by Ullmann, Barthel, Taché, Bornstein, Licinio and Bornstein (2015, p. 1483-1484) the patients had anxiety-related symptoms according to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (hereafter as DSM-V). Patients displayed unrest, sleeping difficulties and flashbacks in relation to recently experienced events of war, forced migration and torture which had resulted in giving patients the diagnosis for PTSD. (Ullmann, Barthel, Taché et. al, 2015, p. 1483-1484.) If the individual does not recover properly from the trauma one may stay in a high or low state of alertness for a longer period of time causing harm to oneself as described by Poijula (2016, p. 39). As a special consequence of this prolonged traumatisation Poijula (2016, p. 39) mentions the brain cortex area's thinking processes disruption. Especially a low state of alertness leads to numbness of emotions and senses, difficulties in cognitive tasks and one feels physically paralysed. On the contrary, when the recovery process is in balance both left and right cortex of the brain work properly maintaining knowledge and then connecting it on a cognitive, emotional and sensorimotor level. (Poijula, 2016, p. 39.)

Relying on a research that was conducted with Angolan adolescents in 1993 McIntyre and Ventura (1993) summarised that the amount of exposure to war was associated with both behavioural and affective indicators influencing negatively adolescent's development. Exposure to war and adversity is linked to cognitive development and PTSD impacting verbal and non-verbal skills. Children who are constantly exposed to traumatic events present higher levels of PTSD and developmental damages. Protective factors in these cases are the children's social support system referring mainly to parental presence and protection and connections with tribal values providing culturally appropriate ways of recovering and healing. (Krippner, McIntryre, Hobfoll et.al, 2002, p. 51.)

Derluyn and Broekaert (2007, p. 152, 155) in their study found that a little under 50 percent of refugee youth were suffering from severe or very severe depression, PTSD and anxiety. Emotional problems such as the abovementioned occur predominantly more often in girls and in those who have experienced more traumatic life events. The girls scored higher on some of the scales on these internalising problems. One explanation for this difference in gender might be the fact that some girls might have been obliged to undergo more traumatic events such as forced marriage or sexual abuse. Not only being a refugee but more specifically being an unaccompanied refugee entails more challenges on one's emotional well-being. Without the protection of parents, children go through more traumatic experiences than their fellow peers do. (Derluyn & Broekaert, 2007, p. 141, 143, 148, 152-156.)

The most common and persistent diagnosis given to individuals affected by war is once again PTSD (Krippner, McIntryre, Hobfoll et.al, 2002, p. 51). A large-scale study in the UK indicated that up to 40 percent of children showed some psychological problem as a result of their experiences (Hamilton & Moore, 2004, p. 61). Nowadays, clinicians and researchers have come to a mutual understanding of several features of traumatic experiences associated with more severe post-traumatic reactions. The following list has been drawn by clinicians and researchers and it presents the factors that are immensely connected with the onset and the persistence of PTSD in children and adolescents:

1. "Exposure to direct life threat
2. Injury to self, including extent of physical pain
3. Witnessing of mutilating injury or grotesque death (especially to family members and friends)
4. Perpetrating violent acts against others

5. Hearing unanswered screams for help and cries of distress; smelling noxious odors
6. Being trapped or without assistance
7. Proximity to violent threat
8. Unexpectedness and duration of the experience(s)
9. Extent of violent force and the use of a weapon or injurious object
10. Number and nature of threats during violent episode
11. Witnessing of atrocities
12. The relationship to the assailant and other victims
13. Use of physical coercion
14. Violation of the physical integrity of the child
15. Degree of brutality and malevolence" (Van der kolk, McFarlane & Weisaeth, 1996, p. 336-337).

Van der kolk, McFarlane and Weisaeth (1996, p.341) explain that continuous efforts are being made in order to develop the measurement of PTSD in children and adolescents. The measurements have been developing in such a manner that a broader scope of symptoms from other diagnoses as well is taken into account when assessing PTSD. Thus, the focus has been shifted towards differential etiologies and interactions. (Van der kolk, McFarlane & Weisaeth, 1996, p. 341.

Still PTSD studies on children are on an early stage but the research conducted so far can shed some light on understanding children and their reactions. The criteria for PTSD do not consider ethnocultural, religious and socio-political contexts nor cultural aspects related to refugee children experiences. It is necessary to bear in mind that the effects of trauma and war are more complex and extensive compared to the ones named in the PTSD diagnosis. (Hamilton & Moore, 2004, p. 17-18.) Western psychology and psychiatry have focused on mental illness, trauma and PTSD which sometimes do not align with the concepts of other cultures about mental health issues. Applying Western interventions based on Boothby, Strang and Wessells (2006, p. 22-23, 25) without considering individual's culture may lead to more harm. Thus, interventions ought to focus more on positive aspects and mental health than illness because this enables taking into account social, spiritual, political and economic aspects as well. In some cases, the terminology medicalises individuals even though in reality, from a macro-perspective, the political and social systems of a country are dysfunctional. (Boothby, Strang & Wessells, 2006, p. 22-23, 25.) According to Poijula (2016, p. 46) the amount of children indicating

PTSD in the Finnish health care system is very low. On the opposite, the United States (hereafter as the US) and Europe hold very different views about PTSD. In the US the updated version of DSM-V from 2013 is suitable for application for both adults and in cases of adolescents and children over six years-old. (Poijula, 2016, p. 46.)

5. EXPLORING PROTECTIVE FACTORS, RISK FACTORS AND RESILIENCE WHILE RECOVERING FROM TRAUMA

Many children exposed to adversities have managed to survive, recover and succeed again in their lives in a brilliant manner. These children are often called to be resilient. (Mohamed & Thomas, 2017, p. 251.) Resilience is what factors assist an individual to overcome hardships and continue developing. Resilience consists of risk, vulnerable factors and protective factors. According to Anderson (2004) in Hamilton and Moore's literature (2004, p. 53), refugee children are thought to face challenging circumstances because of their refugee experiences needing resilience in their lives. Masten et. al (1991) in Hamilton and Moore's (2004, p. 54) writings describe resilience as a process, a capacity and an outcome. Resilience is the ability to overcome challenging circumstances due to some personal and environmental factors. Resilience is something that develops from early childhood and it emerges as an outcome from adversities. Resilience is therefore strongly associated and influenced by environmental factors. (Hamilton & Moore, 2004, p. 53-54; Poijula, 2016, p. 159.)

Resilience has been proved to be a factor influencing positively surviving life hardships. Resilience is defined by Poijula (2016, p. 158) as one's flexibility and ability to revert back to a previous state after an intense or long stressful situation. Rutter (2012) via Khawaja, Ibrahim and Schweitzer (2017, p. 286) completes that resilience refers to one's ability to cope, adapt and confidently trust in one's own abilities. Besides, resilience is called as one's ability to seek for assistance in interpersonal and environmental resources. (Khawaja, Ibrahim & Schweitzer, 2017, p. 286.) Representatives of positive psychology have for a long time emphasised the importance of paying attention to individual's strengths which help oneself to tolerate, revert back and survive difficult life situations instead of emphasising on one's lacking abilities or on diagnoses and symptoms only. Psychologist Emmy Werner in 1955 was one of the first researchers to study resilience from an early stage of life. In her study one-third was able to name a person who believed in them and could help them in case of need or they had one specific

ability in which they were good at and they could gain the acceptance of their peers. (Poijula, 2016, p. 158.)

Hamilton and Moore (2004, p. 58), Boothby, Strang and Wessells (2006, p. 27-28) and Daud, af Klinteberg and Rydelius (2008, p. 2) all have summarised factors affecting resilience categorising them into three main groups: 1. individual factors such as internal locus of control, problem-solving ability, agreeableness, self-reliance and good self-management skills, high IQ, physical attractiveness, emotional regulation skills, good self-image, a sense of humour, 2. familial factors such as family structure, upbringing, family functioning, sense of coherence, and 3. contextual and institutional factors such as financial security, positive network outside family circles, religious affiliations, access to special services and school experiences. Part of individual factors are also individual's coping styles and skills that Wainrib and Bloch (1998, p. 49) emphasise in their literature, which play a determining role on how people are affected by such hardships (Wainrib & Bloch, 1998, p. 49). A good relation with at least one emotionally available adult is seen as one of the most essential protective factors. (Hamilton & Moore, 2004, p. 58; Boothby, Strang & Wessells, 2006, p. 27-28; Daud, af Klinteberg & Rydelius, 2008, p. 2.) Resilience helps the child receive as many stimuli as possible from the environment while being in a tough environment, helps not to internalise the negative aspects of the surrounding environment, helps grab opportunities to gain positive influences from outside the family environment and finally with time helps the child step out of that tough environment (Poijula, 2016, p. 159).

Challenging in defining resilience is the fact that it has been researched from various different perspectives such as developmental perspective, stress and coping perspective and recovery perspective to name a few (Hamilton & Moore, 2004, p. 54-56). Instead of focusing only on understanding the possible effects life-altering events have on children studies have also shifted research towards protective factors securing children under crisis circumstances (Loughry & Eyber, 2003, p.8). Garmezy (1983) is cited in the book published by Loughry & Eyber (2003) named "*Psychosocial Concepts in Humanitarian Work with Children: A Review of the Concepts and Related Literature"* illustrating three groups of factors that protect children in such cases. These three groups align with the three main groups of factors affecting children's resilience described in the previous paragraph. It can be concluded that protective factors are at the same time considered to be the factors impacting resilience. (Loughry & Eyber, 2003, p. 8.)

There has been very little research done on the resilience of refugee children (Hamilton & Moore, 2004, p. 54). Researchers have come across with the term "resiliency" through studies related to children who are at high risk of having mentally ill parents or children growing up in very challenging economic conditions in the United States. The field of child development has paid attention on identifying "risk factors" and "protective factors" linked to resilience. Apfel and Simon (1994, p. 125) via Robben and Suárez-Orozco (2000, p. 125-126) have discovered through their study seven characteristics that alleviate aggression and reinforce resiliency. These seven characteristics are the following:

1. *Resourcefulness:* ability to be warm and kind even in the most challenging circumstances, including persecutors and enemies.
2. *Curiosity and intellectual mastery, the ability to conceptualise, and generate knowledge:* being active instead of passive.
3. *Flexibility in emotional experience:* not denying or suppressing emotions, ability to overcome some anxiety and depression when acute resources are required.
4. *Access to autobiographical memory:* ability to recall images of good and sustaining figures in one's life.
5. *A goal for which to live, a purpose:* sense of empowerment and decreased helplessness.
6. *Need and ability to help others:* altruism or "learned helpfulness" which has been learned by the parent's altruistic example.
7. *A vision of a moral order:* desire to restore moral order in order to rebuild community and to survive (Robben & Suárez-Orozco, 2000, p.125-126).

This list reveals that resilience is a result of interacting factors. Adults' behaviour and the behaviour of other children around a child play an essential role in influencing the child. Resilience then derives from the child's interactions, relations and present and past world. (Robben & Suárez-Orozco, 2000, p. 126.) According to another study resilience refers to the ability to sustain a stable and healthy psychological and physical functioning apart from the exposure to adversity. Another term close to resilience is the term of post-traumatic growth which means that one displays positive psychological change and personal development that occurs due to adaptation after trauma. (Measham, Guzder, Rousseau, Pacione, Blais-McPherson & Nadeau, 2014, p. 209.)

What Dyregrov (2010, p. 79) and Poijula (2016, p. 163) believe is affecting how a child recovers and copes with trauma is how one utilises various strategies and coping mechanisms. Individuals exhibit different coping styles when dealing with traumatic experiences. It is argued by Mohamed and Thomas (2017, p. 255) that active coping styles compared to avoidance coping styles increase mental health (Mohamed & Thomas, 2017, p. 255). Both Dyregrov (2010) and Poijula (2016) write in their literature that a protective and simultaneously risk factor is one's temperament. Temperament means how one reacts and perceives stressful situations. Initially after trauma increased fear and anxiety are very natural emotions which serve as safety mechanisms to protect oneself. However, if these emotions overwhelm a child for a longer period of time it begins to be more harmful. Feelings of guilt serve to assist oneself to realise what one can learn and do differently next time. Intrusive thoughts and memories also help oneself to face his/her fears and the trauma so that one can then recover. Children who are characterised as inhibited and cautious by temperament have more difficulties facing new situations and they often feel physiologically and psychologically more overwhelmed. Temperament, however, does not by itself protect from or predispose to stress but crucial is how the environment understands the child and responds to one’s needs. (Dyregrov, 2010, p. 79-80; Poijula, 2016, p. 163-164.)

Resilient individuals also need support and guidance. Being resilient does not mean that one is able to survive totally by themselves or that certain life experiences do not leave a mark on them as well. What is important to bear in mind about resilience is that one may be resilient in certain domain of their lives but may not be so resilient in some other situation. (Hamilton & Moore, 2004, p. 59.) It cannot be emphasised enough that resilience is viewed as a multidimensional phenomenon describing the interaction between context-, development- and gender-dependent variables. Therefore, careful attention is asked when researching resilience. (Tol, Song & Jordans, 2013, p. 457.)

The aim of some of the prevention programmes and initiatives has been on reinforcing the communities and assisting them on creative positive communities for the future of their children instead of focusing only on the trauma and traumatisation of the individuals involved. (Krippner, McIntyre, Hobfoll et.al, 2002, p. 190.) Schools have been reported as sources of resilience for children if they gain positive experiences in schools (Hamilton & Moore, 2004, p. 61; Boothby, Strang & Wessells, 2006, p. 130). In school contexts it is believed that enhancing children's resilience by offering them opportunities to take control of their lives, increase

their agency, adopt new skills to support coping, and providing them with possibilities to express their emotions will assist them to recover given time (Boothby, Strang & Wessells, 2006, p. 130).

School-based interventions have been proved to assist children and increase their well-being, however little research has been done in this area of research so far. Creative expression interventions were adopted the most but presented the least consistent results. One of the limitations though of applying these interventions in school is that they are costly and not all the schools are able to afford them. Cognitive behavioural therapy (hereafter as CBT) was chosen as one of the most efficient way of therapy to heal trauma in children and even though teachers may not be trained to provide such therapy school psychologists and other specialists ought to have already acquired a basic training in this kind of therapy. While organising these kind of interventions to children teachers should also receive appropriate training about these children's background, experiences and possible traumatic experiences which may impact their socio-emotional development and school performance. (Sullivan & Simonson, 2016, p. 522-524.)

Interventions improving school-age children's resilience require more empirical validation. Teachers and other educators ought to be trained from clinicians in order to learn about strengths and vulnerabilities of refugee children and how to best guide them. There is also need for assisting and guiding the caregivers after traumatic events so that they can continue taking care of children's basic needs. Most interventions have been designed for children but some interventions could be designed for parents so that the fundamental role of the child-parent relationship, parental sensitivity and patterns of attachment could be also seen as ways to reinforce children's resilience. Through a study by Wolmer, Hamiel, Pardo-Aviv and Laor (2017, p. 7) they expressed the necessity to integrate psychotherapeutic and socio-educational programmes focused on dealing with children's changing worldviews. Therefore, these programmes could prevent the formation of stereotypes and possible clusters of violence in the future. (Wolmer, Hamiel, Pardo-Aviv & Laor, 2017, p. 6-7.)

Sleijpen, Boeije, Kleber and Mooren (2016, p. 159) observed that there is little consensus about defining what resilience is. One of the challenges that arose from the study of Sleijpen, Boeije, Kleber and Mooren (2016, p. 159) was in measuring resilience in adolescent refugees and the issues of cross-cultural equivalence. Six sources of resilience were highlighted in their texts: social support, acculturation strategies, education, religion, avoidance, and hope. Four elements were mentioned as sources of social support: (1) family, (2) people from the same cultural

background, (3) peers, and (4) professionals. (Sleijpen, Boeije, Kleber & Mooren, 2016, p. 159, 172.) Faith was raised in the literature of Majumder (2016, p. 335) several times as a protective factor and factor influencing resilience positively. (Majumder, 2016, p. 335).

Some of the major results and conclusions of the abovementioned study were the following. There were many commonalities in sources of resilience among young refugees from different countries of origin. Youngsters socio-cultural background supported their levels of resilience through two elements, spirituality and cultural traditions. This means that resilience processes have both specific, culturally bound and universal elements. Refugees try to fulfill some of their basic needs by the usage of these sources of resilience. For instance, "feeling safe and secure, having a sense of personal control, maintaining self-esteem, having meaningful relationships, and reducing stress". Especially the component of personal control was highlighted. This study validated other studies which have shown that young refugees most often feel powerless in their new lives lacking agency. (Sleijpen, Boeije, Kleber & Mooren, 2016, p. 172-173.)

Conclusively, a systematic review that was carried out on resilience found 53 studies on resilience of war children in low- and middle-income countries. Tol, Song and Jordans (2013, p. 457) report that the socio-cultural aspect of the studies determines how mental health is approached and what are the processes to define results. Discussing the support children and adolescents of war need parental guidance and supervision were significantly the most influential contributors. (Tol, Song & Jordans, 2013, p. 457.) In order to develop suitable interventions political, sociological, anthropological and psychoanalytic aspects need to be taken into consideration with focus on strengths of families and communities. (Robben & Suárez-Orozco, 2000, p.127-128.) Otherwise, young refugees may keep getting labelled based on responses to stressors in terms of psychopathology in the Western models of research. Instead of putting emphasis only on risk factors there is an urgent need for emphasis on also protective factors that reinforce one's capabilities to address adversities. (Sleijpen, Boeije, Kleber & Mooren, 2016, p.158-159; Rumsey, Golubovic, Elston, Chang, Dixon & Guvensel, 2018, p. 97.) Within this research field the resilience of children during displacement needs to be further studied (Ajdukovic, 2009, p. 194).

6. DISCUSSION

The first aim of this thesis is to introduce various literature about what trauma consists of, what the most predominant psychiatric diagnosis in refugee population called post-traumatic stress disorder (PTSD) means and encompasses, and what are the possible effects of and reactions to trauma in children. The second aim is to bring up the concept of resilience and connect it with trauma because it is associated with the ways children in adversities recover. Above all, my purpose is to activate discussion about all children's needs after traumatic experiences or crises. Sharing this knowledge will hopefully prove the importance of being knowledgeable about the possible effects of the abovementioned circumstances on children and adolescents and direct the future discussions and research towards a more positive direction. Meaning, that refugee children's resilience, engagement, support, agency and sense of safety and belonging are prioritised both in school contexts and in the society.

As far as the first research question is concerned this literature review tries to define what psychological trauma is and what are the possible effects of that trauma on children. Children as a group is the most vulnerable when considering traumatic experiences and traumatisation (Poijula, 2016, p. 36). Trauma from a pathological viewpoint means external injury or wound. From a psychoanalytic point of view, though, it means a psychic, caused to the brain emotional injury which may lead to other behavioural problems. A thorough psychoanalytic approach, however, and definition of trauma has been excluded from this work. Previous functioning is disturbed and often one's defense mechanisms are activated or paralysed. Trauma is caused by an extremely anxious situation where one's normal capacities are exceeded. Besides, the key characteristic of trauma is threat; threat inflicted on oneself, on close relatives or on the community. Some definitions of trauma, however, are lacking explanations about other possible situations that may be traumatising as well. According to Saari (2003, p. 22-25) traumatic events are unpredictable and uncontrollable. A child whose needs are not being met, who is neglected and rejected, who is being abused and/or sexually abused gets traumatised based on Jari Sinkkonen's (2001, p. 157) writings. Despite those cases, this study focuses on trauma caused by war exposure, conflict, violence and disasters.

To continue answering the first research question some of the possible effects of adversities are the following. It can be concluded that children are affected cognitively, socially, physically and emotionally by adversities. Children's level of development has a great impact on how children deal with adversities. Older children have more developed mental capacities which

help them navigate through the aftermath of traumatic events. However, these developed abilities make them be more aware of the realities and consequences of such events feeling a wider scope of emotions than younger children. The prevalence of PTSD in children varies from 25-70 percent depending on the type of war and the degree of exposure (Dyregrov, 2010, p. 46). PTSD is defined as a result of a complex interrelation of biological, social and psychological processes. Both the level of maturity of a person and the length of exposure to adversity impact the formation of PTSD. This thesis has focused on the prevalence of PTSD during pre- and trans-migration phases only. Poijula (2016) mentions that PTSD can be actually quite similar to traumatisation. There has not been consensus if PTSD is a normal or abnormal response to traumatic events. However, Dyregrov (2010) points out that some post-traumatic reactions of children after adversity are normal and expected. What was raised in literature was that the role of culture has to be taked into account when researching PTSD. Consequently, the definition of trauma is also thought to be culturally specific.

Salli Saari (2003, p. 251-252) writes that the character of a traumatic event and the child's role in it influences how the child will react (Saari, 2003, p. 251-252). Children's reactions to trauma also depend on their age, environment, cognitive development and prior experiences, degree of the trauma and parental support and reactions (Hamilton & Moore, 2004, p. 14). Most of the reactions are related to diverse emotions, emotional mechanisms and concentration issues. Dissociation is stated as an extreme psychological mechanism and state which serves to protect one from psychological damage but if lasted for long time it becomes unhealthy. Children process grief in different ways depending on their developmental level. Besides, children may display some somatic symptoms after adversities apart from mental reactions. All these reactions may contribute to challenges in school performance and relationships. There are some differences between pre-school and school-age children compared to reactions of adolescents which have been briefly explained in chapters 5a and 5b. Nevertheless, it can be observed that children and adult's reactions to trauma have more in common than it has been believed (Dyregrov & Teva, 1994, p. 151).

As far as the second research question is concerned this work intends to find literature about children's resilience and what are some protective factors during adversities. The research area has expanded and when discussing children in war resilience is often considered as well (Masten, 2014, p. 12). Resilience factors are very situation specific and vary for every individual to some extent. Some definitions of resilience explain that during adversity and when one exceeds one's own resources then only the resilient ones survive. (Hamilton & Moore, 2004, p. 57.)

Based on literature resilience consists of vulnerable, risk factors and protective factors. Some authors emphasised and focused only on this division of factors whereas other authors adopted a more holistic approach to study resilience as a dynamic process. Resilience may be understood as an ability to overcome hardships due to the interaction of some personal and environmental factors. Reviews on resilience have pointed out that it should be studied as a dynamic concept which is present at multiple levels of the social ecology. Besides, resilience gains different meanings across various socio-cultural environments. (Tol, Song & Jordans, 2013, p. 446.) Nonetheless, there has been very little research done on the resilience of refugee children (Hamilton & Moore, 2004, p. 54). Resilience has been studied from various perspectives and in other fields of studies gaining different meanings. That is one reason for less unanimity in defining resilience. Despite that, Apfel and Simon (1994, p. 125) via Robben and Suárez-Orozco (2000, p. 125-126) have discovered through their study seven characteristics that alleviate aggression and reinforce resiliency (Robben & Suárez-Orozco, 2000, p. 125-126).

Next, the reliability and some of the limitations of this literature review will be discussed. As it has been defined children in this review are all individuals under the age of 18, including especially refugee and asylum-seeking children. More studies on refugee children have been conducted abroad than in Finland indicating that this review represents more those countries. Conflict- and disaster-related studies bring into light some challenges that complicate the gathering of empirical data. Such challenges are associated with categorisation of types of traumatic exposure, ability to research individuals and communities after exposure to a disaster keeping in mind ethical issues, funding concerns and overall chaotic circumstances, and finally utilisation of assessment tools for parents' engagement because of their own distress. (Wolmer, Hamiel, Pardo-Aviv & Laor, 2017, p. 7.) Moreover, it is challenging to conduct research related to refugees' mental health because of the difficulty of collecting data in unsafe areas and data being biased since most prior research has been conducted in high-income host societies. Low- and middle-income host societies are less represented. (Pacione, Measham & Rousseau, 2013, p. 3.)

Research among refugee population might have been conducted in a short period of time or researchers had sought for immediate answers by using diagnostic reports, self-reports or questionnaires. As a result, outcomes may not be as adequate or they may take forms of lists of symptoms instead of more descriptive narrations. Another matter is the trust between researchers and subject of research which in this case refugees may not have been established in order for refugees to share their personal experiences with authorities or other professionals. Not to

forget mentioning that often children's young age and the necessity to use interpreters during data collection due to language barriers may result in losing remarkable data in translation. Robben and Suárez-Orozco (2000, p. 151) point out that children affected by war showed to have fears and conflicts which have been accumulated with time even before the actual adversity. It was also emphasised that children have their prior conflicts and personality structures that they carry with them much before the actual trauma. That is why distinguishing between prior and pre- and trans-migration trauma might be difficult. (Robben & Suárez-Orozco, 2000, p.151.) Besides, gender differences were not taken into account in this bachelor's thesis.

Furthermore, grief is an essential subject of research related to the refugee experience. Grief unavoidably plays its role in determining how children and families react and feel. Grief as a process may have overlapping attributes with trauma or PTSD but it differs significantly from both of them. This aspect has been left out of this thesis and further research about children's grief processes are required. Finally, ethical issues arose in literature utilised for this work since research has been done in collaboration with children. Questions such as "Is this right and ethical?, Is this hurting children in a physical or psychological way?, Who is this research primarily serving?, What motives does the researcher have to engage in this process?, Is this research done in a culturally respectful way promoting children's rights?"

What is then suggested by authors of articles that were used for this literature review is that future research is more longitudinal with greater sample sizes, a combination of quantitative and qualitative methodologies is adopted, attention is shifted more on positive aspects of health, and early childhood experiences linked with biological elements are considered during analysis (Tol, Song & Jordans, 2013, p. 457; Sleijpen, Boeije, Kleber & Mooren, 2016, p. 174). Trauma symptoms on children are similar to symptoms that parents and adults show. How children recover from trauma depend on how directly the family has been affected by adversity (exposure) and how the parents themselves react to traumatic events. (Hamilton & Moore, 2004, p. 59.) The influence mothers' reactions have on children has been somehow studied but fathers' reactions have been studied less. The link between parental separation and more emotionally challenging migration journey also requires further exploration through research (Derluyn & Broekaert, 2007, p. 156).

Cultural differences should be taken seriously into consideration when conducting studies and designing interventions with asylum-seekers and refugees because relying solely on Western psychology and psychiatry leaves various perspectives totally out of the discussion (Derluyn &

Broekaert, 2007, p. 157). There are not many studies that have researched resilience in the refugee context. Nevertheless, it is known that the pre-migration stage as well as the trans-migration stage may include some risk and other factors that may influence one's coping skills and resilience. The interaction between many stressors and the content of those interactions could be further studied. (Hamilton & Moore, 2004, p. 60.) Eventually, sense of belonging as part of resilience could also be researched more.

Regarding risk and protective factors, the individual has been the object of most of the studies with less attention being paid on the other contributing factors. The research done so far has presented that good-quality social support correlates to fewer mental health issues but how social support mediates or accelerates the possible effects of trauma has been studied very little. Instead of focusing on listing risk and protective factors research should focus on assessing various interventions that are supported by social, economic and health care sectors with aspects of psychological services addressed for families as well. There is still an urgent need for further studies on how children make sense and what meaning do they give to adversities and how do these meanings affect their mental well-being. In low- and middle-income countries researchers face challenges while trying to find suitable funding for their studies. (Reed, Fazel, Jones, Panter-Brick & Stein, 2012, p. 260-262.)

War changes a child's life on an individual level but it simultaneously affects negatively other layers of one's life such as family, social network, schools and peers (Ager & Metzler, 2017, p. 68). "It has been estimated that more than 10 million children in the past decade have suffered psychological trauma as a consequence of civil and international wars" (Hamilton & Moore, 2004, p.13). It is mentioned that children may form PTSD and other psychological diagnosis such as phobias, depression and behavioural problems (Dyregrov, 2010, p. 13; Hamilton & Moore, 2004, p.13). Children respond to trauma by experiencing sadness, fear, apathy, anger, irritability, anxiety, somatic problems, sleep disturbances and challenges in school performance to state a few (Sullivan & Simonson, 2016, p. 506). Refugees share loss of their home and belonging but not trauma. Home is a wider concept referring not only to the physical entity but foremost to the psychological foundation. (Kohli & Mather, 2003, p. 206.)

Krippner, McIntryre, Hobfoll, Achterberg, Fish et. al (2002, p. 52) emphasise the importance of having an understanding and to acknowledge what possible effects war has on children so that appropriate interventions can be designed and previous ones can be improved. Kaplan, Stolk, Valibhoy, Tucker and Baker (2015, p. 83) discuss that it is essential to be aware of the

possible effects of the refugee journey in order not to overreact with faulty diagnoses related to for example some learning disability (Kaplan, Stolk, Valibhoy et. al, 2015, p. 83). There is a prevalence of cognitive, social and affective impact of war exposure on children which calls for more multi-dimensional prevention and recovery. Parties and organisations involved with children need to be aware of the consequences of war exposure on children in order to better assist their holistic development. (Krippner, McIntryre, Hobfoll et.al, 2002, p. 52.) Even if in the Western psychology the core behind therapies and psychological support is discussion and dialogue, in the cultures and countries where refugees are from they may not follow the same paradigm (Helander & Mikkonen, p. 109). Cultural aspects need to be taken into consideration while planning assessment and evaluation measures since socio-cultural sensitivity is lacking from the current body of research (Wolmer, Hamiel, Pardo-Aviv & Laor, 2017, p. 6; Tol, Song & Jordans, 2013, p. 457).

An essential protective factor that emerged from Carlson, Cacciatore and Klimek's (2012, p. 266) research was good school performance and high value of education (Carlson, Cacciatore & Klimek, 2012, p. 266). Professionals and practitioners working with refugee children are asked to co-operate with each other to strive for common goals in helping children, adopting an approach conveying therapeutic care instead of providing therapy. Multi-dimensional expertise is requested in guiding refugee children. (Majumder, 2016, p. 336.) Apart from the above-mentioned there are also a few other important points that I would appreciate teachers who read this work to pay attention to. The following sentences are related to skills and abilities, attitudes, mindsets and perceptions and personal characteristics that teachers already have or are encouraged to develop given time. Teachers ought to be culturally sensitive while working with children from various backgrounds. Especially when it has already been discussed that PTSD might be up to a point culturally specific, there is a greater need for teachers as observers of children's behaviour to be sensitive and aware of their own and other's cultures.

Moreover, teachers are asked to be prepared and willing to offer more emotional support to children who have experienced adversities since many reactions to and effects of traumatic events are tied to emotions and strong emotional experiences. Additionally, the trust between parents and children or adults and children might be negatively affected by adversities meaning that trust needs to be built again. So, it is essential for teachers to invest in forming trusting relationships with their pupils in order for children to have eager adults to whom they can confide to. The role of school, teachers and friends is major in providing positive experiences and

a sense of safety in children. Related to the school environment, it is suggested that well-organised welcome and induction practices and programmes can significantly assist children's resettlement process. Educators and teachers ought to be flexible to adapt their teaching and learning methods according to each child's individual needs and abilities. Related to resilience, knowing which factors are protective factors for children's development teachers will know what elements and areas in children's everyday life they can try to support and strengthen. Encouraging refugee children and giving them the opportunity to tell their life stories helps them form a coherent picture of their current situation. Teachers need to have patience and persistence but most significantly faith that every child can succeed in school, succeed in life and that previous experiences can make children stronger. Children should be seen as children instead of captives of their past experiences. Their voices ought to be heard more often while conducting research and as part of their fundamental rights. (Mohamed & Thomas, 2017, p. 256, 258-259.)

Children have to pay the price

For debts they do not owe

Time and time again they pay

The children can't say no.

Grieve for every wounded child

Shrapnel, mines, and bombs gone wild

Innocence and love defiled---

How can this be?

Now this madness all must cease

The entire world cries out for peace

Sing along and share the dream,

When will this be?

It's up to you and me.

"How Can This Be?", John Cannon and W. Harrison Childers (2002)

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