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Mental Health Challenges of Refugee Children**

ABSTRACT: Worldwide, the number of refugee children and youth is staggering. It is well-documented that refugee children face various types and varying extents of mental health challenges. Providing an overview of the mental health challenges that this population faces, this chapter discusses the current mental health status of refugee children through the lens of prominent psychological theories. A psychosocial approach to human development is introduced, moving beyond the traditional approach of diagnosis and treatment of mental health symptoms, adopting a holistic ecological approach targeting both risk and resilience factors that promote sustainable mental health and well-being in refugee children. Through the motivational theory of human needs, refugee children's needs are outlined as their basic human rights, offering a rationale for comprehensive mental health services to be provided at the individual, family, and community levels. With the overarching aim of promoting complete mental health of refugee children towards a state of well-being, a system of interventions is outlined, which considers the complex needs of these children and their families. A family is a system of its own; however, it is also a subsystem within a larger societal system. A subsystem can thrive only if, at the societal level, an open-minded, prejudice-free, and tolerant approach is adopted towards refugee children and their families. Each child is primarily a child with human rights and deserves to thrive in a psychologically healthy environment to have a chance to achieve positive life outcomes.

KEYWORDS: refugee, child, mental health, ecological approach, human needs, intervention.

Over the past several years, the number of forcibly displaced people has been increasing, and by the end of 2022, it reached nearly 108 million,

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according to the United Nations Refugee Agency.[1] Nearly 40% of this population are children under the age of 18. Some displaced children are accompanied, while many others are unaccompanied, with the ratio differing by country. A refugee is 'someone who is unable or unwilling to return to their country of origin with a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion'.[2] In this chapter, all children who are forcibly displaced from their homes, regardless of the country or legal status (e.g. seeking asylum, stateless, seeking recognition of refugee status), are considered refugee children.[3]

Forced migration has long been considered a salient risk factor to mental health, particularly to the mental health of children who are displaced during vulnerable stages of their development. Childhood and adolescence are developmental stages characterised by rapid physical, cognitive, emotional, and social development, and being displaced from home, potentially experiencing traumatic events, can trigger long-term mental health consequences. Many children, however, despite being exposed to multiple and severe stressors, display remarkable resilience.[4] This chapter aims to discuss the mental health of refugee children from the perspective of several prominent psychological theories, promoting a comprehensive approach to mental health considering risk and resilience factors, psychosocial and ecological factors, human development, family functioning, and the role of the community. The discussion addresses the mental health challenges of refugee children, such as their traumatic experiences, daily stressors, individual and family characteristics, and societal specifics in the promotion of children's well-being. The chapter concludes with a brief review of mental health interventions available for refugee children and their families and a proposal for an integrative approach towards supporting the mental health of this population.

[1] UNHCR, 2022. [Online]. Available at: https://www.unhcr.org/globaltrends-report-2022 (Accessed: 10 February 2024).
[2] UNHCR, 1967, p. 3. [Online]. Available at: https://www.unhcr.org/protection/basic/3b66c2aa10/convention-protocol-relatingstatus-refugees.html (Accessed: 10 February 2024).
[3] Dangmann et al., 2022.
[4] Ibid.

1. Mental health of refugee children

The refugee status of children has been linked to a higher prevalence of mental health problems in this population. Many studies have focused specifically on post-traumatic stress disorder (PTSD), depression, and anxiety in refugee children six years and older. Results vary by age, gender, and country; for instance, PTSD prevalence in children from Afghanistan is twice as high as in children from Syria, because many children from Afghanistan arrive unaccompanied.[5] Overall, even after considering individual and country-specific differences, the prevalence rates of these disorders are significantly higher in refugee children.[6][7] PTSD prevalence rates in refugee children in Europe range from 19% to 53%, in refugee children worldwide, it is approximately 23%, compared to 16% of children exposed to trauma worldwide. Rates of depression in refugee children in Europe range from 10% to 30%, compared to 14% in refugee children worldwide, and 3% prevalence in children from other populations. Rates of anxiety in refugee children in Europe range from 9% to 32%, in refugee children worldwide, it is 16%, compared to the 7% worldwide prevalence in children from other populations.[8][9] Although these numbers are worrying, one must note that individual differences can be observed among refugee children. It has been observed that while the majority of children recover with time, a smaller group experiences worsening of symptoms, and the smallest group develops chronic mental health problems.[10][11] Other mental health problems commonly noted in refugee children are somatic complaints, mostly in the form of stomach aches and headaches, sleep disturbances, and behavioural and emotional problems,[12] particularly in younger pre-school children who display distress through changes in patterns of behaviour, and school-related problems as a consequence to

[5] Dangmann et al., 2022.
[6] Alisic et al., 2014.
[7] Polanczyk et al., 2015.
[8] Alisic et al., 2014.
[9] Polanczyk et al., 2015.
[10] Keles et al., 2017.
[11] O'Donnell, 2023.
[12] Jensen et al., 2019.

trauma exposure, such as working memory or emotion regulation deficits.[1314]

Research has shown that children exposed to traumatic events and catastrophes are likely to develop internalising behaviour problems, which are manifested internally in the form of anxiety and depressive symptoms that are considered a reaction to severe stress. Through proper social support from the child's environment, such family and school, children can bounce back from adversity and recover from these temporary symptoms.[15] Despite challenging circumstances, the majority of refugee children have some source of resilience and recover to good mental health. Most research on mental health of refugee children to date has focused on negative indicators of mental health. From the perspective of the dual-factor model, mental health should be viewed as complete mental health, including attention to both ends of the mental health continuum, that is, mental ill-health and psychopathological symptoms on one end and well-being on the other end.[16] These two ends work in tandem and complement each other; for example, a diagnosis of mental illness does not automatically mean loss of well-being.[17] Mental ill-health indicates that an individual suffers from the presence of psychopathological distress of varying degree and intensity, either in the form of milder everyday conditions such as stress or worry or conditions that significantly impact the quality of daily life such as depression or anxiety.[18] Well-being is considered a main indicator of positive mental, physical, and social functioning.[19] To provide a comprehensive view of complete mental health, both positive and negative mental health indicators need to be considered.[2021] Therefore, in line with current trends in psychology, a shift in the area of research on the mental health of refugee children is proposed, transitioning the focus from the negative aspects of mental health towards a complex understanding of children's mental health considering positive indicators such as well-being, social-emotional health, social support, meaning, belonging, and others.

[13] Mueller et al., 2021.
[14] Mirabolfathi et al., 2022.
[15] Danese et al., 2020.
[16] Suldo and Shaffer, 2008.
[17] Dowdy et al., 2015.
[18] Allen and McKenzie, 2015.
[19] Seligman and Csikszentmihalyi, 2014.
[20] Arslan and Allen, 2020.
[21] Dowdy et al., 2015.

2. Psychosocial approach to the mental health of refugee children

The psychosocial approach to human development integrates interactions of three major systems: biological, psychological, and societal systems. The integration of these systems results in a complex biopsychosocial pattern of development. The biological system comprises biological processes related to genetically guided maturation and environmental experiences, known in psychology as the 'nature and nurture' dichotomy.[22]

The psychological system refers to mental processes such as emotion, memory, motivation, perception, thinking, reasoning, etc. All these processes are dynamic and change over the lifespan as a result of interactions of genetic information such as intellectual ability, and environmental conditions such as access to education. However, change can also be prompted by an individual and her strengths and interests, known as self-insight, which has been associated with positive mental health.[23]

The societal system includes all aspects related to culture, social roles, social support, social expectations, family organisation, religion, conditions of war and peace, exposure to discrimination, intolerance or hostility, economic prosperity, or poverty. For refugee children, several change factors exist within the societal system, such as moving from one culture to another, entry into new social roles in a new community and school, or unpredictable societal events.[24]

In children, an example of mutual interactions among biological, psychological, and societal systems is the concept of child temperament, which represents the internal elements of emotion regulation and which serves as a genetically based set of individual differences in the domains of emotional reactivity and self-regulation.[25]

Reactivity refers to endogenous arousability that accounts for individual physiological and emotional responses to the environment. It is indicated by frustration, anger, fear, approach tendencies, and positive affect and is evident from birth onwards. Self-regulation entails processes that regulate reactivity through executive processes that control attention and behaviour, and it is normally measured as attention focusing, attention

[22] Newman and Newman, 2012.
[23] Wilson, 2009, cited in Newman and Newman, 2012.
[24] Newman and Newman, 2012.
[25] Rothbart and Bates, 2006.

shifting, inhibitory control, or attentional self-regulation at the end of an infant's first year of life.[2627] Although temperament is genetically based and relatively stable, it is partially shaped by the environment.[2829] Three broad dimensions of temperament in early and middle childhood have been identified: negative affectivity, surgency/extroversion, and effortful control, which have been associated with the Big Five personality factors of Neuroticism, Extraversion, and Conscientiousness, respectively.[30]

According to the goodness-of-fit theory, the fit between a child's temperament and their environment is what influences individual development;[31] therefore, not all children with difficult temperaments are predetermined to have negative outcomes. It is this good fit with their environment that shapes individual temperaments and vice versa, accounting for the bidirectional nature of the effect. Research has shown that a child's temperamental characteristics determine the child's individual reactions to environmental influences, such as family, societal, and cultural characteristics.[3233]

This trend has been reflected in recent years with the shift from an individual trauma-focused approach to a more comprehensive ecological model approach in the mental health care of refugee children. Ecological models consider both risk and resilience factors related to the stages of the refugee process.[34] The theoretical background is based on Bronfenbrenner's bioecological theory according to which individual development is influenced by several interconnecting systems, from the most immediate to the individual, such as family, to the broader societal environment such as culture. [35] Child development is thus viewed as a complex pathway linking these subsystems and their effect on the child from the microsystem, mesosystem, exosystem, and macrosystem, through to the chronosystem.[36]

[26] Kiff et al., 2011.
[27] Rothbart, 2007.
[28] Thomas and Chess, 1986.
[29] Kiff et al., 2011.
[30] Rothbart, 2007.
[31] Thomas and Chess, 1986.
[32] Kiff et al., 2011.
[33] Morris et al., 2007.
[34] Arakelyan and Ager, 2021.
[35] Bronfenbrenner, 1979.
[36] Ibid.

The first level in direct contact with the child is the microsystem, which includes primary relationships and environments such as family, school, friends, or neighbours. The child is not a passive recipient but an active agent navigating these relationships and environments. The mesosystem involves interactions between different microsystems, such as the communication of the teacher with the child's parents. If these interactions are not functioning well, for instance, the teacher does not inform the parent if there is an issue at school, tension is created, and the child is affected negatively. The exosystem may appear to be remote from the child, yet these broader structures such as media, policies, and community resources shape the child's microsystem, for instance, a family receiving funding for the child's education or extracurricular activities. The macrosystem relates to cultural elements that establish norms and values in a society, which may be significantly different for a refugee child. The last level is the chronosystem, and it refers to transitions in the child's life, such as personal events, relocation, divorce, asylum seeking, historical events, etc. The child's response to these expected or unexpected life events is dependent on the support she has received from the other systems.[37]

This model can serve as a good basis for understanding individual differences in children's reactions to coping with adversity. While some children demonstrate a very high level of resilience, others struggle when coping with adverse events and life challenges. Resilience is a complex construct defined as an ability to bounce back and to positively adapt to challenging life events and negative emotional or stressful experiences.[3839] The protective role of resilience in mental health has been strongly established by research, and resilience has been positively associated with a variety of positive mental health outcomes such as belonging and supportive relationships,[40] optimism,[41] life satisfaction, and positive affect. [4243] On the contrary, low resilience has been negatively associated with adverse mental health outcomes such as loneliness, psychological distress,[4445] depression,

[37] Bronfenbrenner, 1979.
[38] Lazarus, 1993.
[39] Masten, 2019.
[40] Yıldırım and Arslan, 2020.
[41] Souri and Hasanirad, 2011.
[42] Arslan, 2019.
[43] Hu et al., 2015.
[44] Kennedy et al., 2023.
[45] Zhang et al., 2018.

and anxiety.[4647] Resilience is also a predictor of positive mental health, such as well-being,[48] while its lack is a predictor of mental ill-health, such as depression and anxiety.[4950]

Discussion on the ecological approach to risk and resilience would not be complete without considering some of the most significant factors affecting an individual child's level of resilience. Individual factors such as age, gender, personality characteristics, temperament, self-efficacy, and coping strategies; family factors such as family functioning and family support; community factors such as school, neighbourhood, environment, and peer relationships; and societal factors such as cultural attitudes to acceptance, discrimination, tolerance, and cultural differences,[5152] all interconnect and form an individual as a unique human being with a unique level of resilience. Taken together, any child, either refugee or not, desires to be loved and accepted in family, school, peer group, and society. However, the success of this process depends on the interplay of a myriad of internal and external factors. Some important considerations on how to holistically support these children are discussed in the last section of this chapter. on interventions available for refugee children.

3. Human needs from the perspective of refugee children

Human behaviour is, according to Maslow, motivated by human needs.[53] Hierarchy of human needs is a motivational theory according to which human needs are ordered hierarchically in a pyramid. The five needs ordered from the bottom are physiological needs, safety, love and belonging, esteem, and self-actualisation. Maslow postulated that, first, the basic survival and short-term needs have to be met before moving up the pyramid to psychological longer-term needs, which are more challenging to satisfy due to interpersonal and environmental challenges.[54]

[46] Beutel et al., 2010.
[47] Hu et al., 2015.
[48] Satici, 2016.
[49] Beutel et al., 2010.
[50] Hu et al., 2015.
[51] Arakelyan and Ager, 2021.
[52] Dangmann et al., 2022.
[53] Maslow, 1943.
[54] Maslow, 1943.

First is the level of the physiological needs, which are biological needs necessary for survival such as breathing, food, water, shelter, clothing, and sleep. These are the most basic needs and the human body cannot function without these basic needs being met. Many displaced refugee children find themselves in situations where even this first level of needs is not met. Therefore, only once these needs are satisfied can attention be given to fulfilling the second level of needs: security and safety.[55]

The second level, safety and security needs, is fulfilled by family and society. Humans, especially children, naturally thrive when experiencing order and predictability in their lives. First, these needs in children are dependent on the most significant social units in their lives.[56] Unaccompanied refugee children are at a higher risk of exposure to traumatic events such as exploitation and mental health problems.[57] Parental physical and mental health have been repeatedly associated with children's health. Research has shown that in cases of parental distress, harsher parenting practices are used, such as verbal (reprimanding) or physical (e.g. spanking) abuse.[58] Emotional stability in a family is another aspect of the family environment that promotes children's need for safety and security. In children, the ability to manage emotions is known as emotional regulation. This concept is discussed in the next section.

At the third level, is the need for love and belonging, which manifests the innate human need for interpersonal relationships, connectedness, and group membership, experiences of affection, acceptance, trust, friendship, and love in family, peer groups, community, and other social units.[59] This need is salient in children who naturally strongly desire to belong and to be loved. The two primary environments of social interactions for children are the family and school.

Belonging, acceptance, and interpersonal attachment are concepts that have been the focus of psychologists for decades.[6061] These important concepts have inspired a lot of research on the topic of human motivation and well-being.[62] For instance, Vygotsky dealt with the topic of social

[55] Ibid.
[56] Ibid.
[57] Höhne et al., 2018.
[58] Bryant et al., 2018.
[59] Maslow, 1943, cited in Slaten et al., 2016.
[60] Maslow, 1943.
[61] Rogers, 1951, cited in Slaten et al., 2016.
[62] Baumeister and Leary, 1995.

environment in schools, while Erikson conducted studies on the topic of social identification in education.[6364]

A significant contribution to the research on the need to belong was the belongingness hypotheses by Baumeister a Leary, who proposed that 'human beings have a pervasive drive to form and maintain at least a minimum quantity of lasting, positive, and significant interpersonal relationships'.[65] According to this theory, the need to belong is innate and evolutionary as group membership has always produced more options for how to survive and secure more resources and affection. While the need to belong motivates individuals to establish and maintain relationships, its absence is related to psychological distress and physical health problems. The prerequisite for belonging is the need for frequent interpersonal interactions and the establishment of stable and meaningful social relationships. A significant contribution of this theory is that the need to belong is an inevitable precondition for individual well-being.[66]

In children's lives, the need to belong in a community is manifested by the construct of school belonging. In the literature, the most commonly used concepts referring to this need are school connectedness, school membership, school belonging, or school belongingness, which are used almost interchangeably, referring to affective and cognitive relationships of students and school employees and the school as an institution.[67] School belonging has been most widely defined as connectedness to school and feelings of acceptance and appreciation from peers as well as the whole school community. [68] The most commonly cited definition of school belonging is that it is 'the extent to which students feel personally accepted, respected, included, and supported by others'.[69] The basic feature of school belongingness is the component of social support in school from the teachers, who are available to support students both academically and emotionally.[70] For refugee children in a new country, fulfilling the need to belong and establishing a strong sense of school belonging are crucial for their well-being. Children start to navigate their social environment from

[63] Vygotsky, 1962, cited in Slaten, et al., 2016.
[64] Erikson, 1968, cited in Slaten et al., 2016.
[65] Baumeister and Leary, 1995.
[66] Baumeister and Leary, 1995.
[67] Goodenow, 1993.
[68] Chan et al., 2019.
[69] Goodenow, 1993.
[70] Osterman, 2000.

scratch, often exposed to a new culture, language, and everyday challenges connected with finding their place in already well-functioning school communities. Therefore, interventions at the school level aiming to support and integrate refugee students in classrooms are essential to satisfy this need in refugee children.

The fourth level of needs, esteem needs, is closely related to experiences the child gathers from the levels below. A child's experiences in school and community, and the level of satisfaction of the need to belong, are manifested in self-worth and esteem for oneself in the form of dignity, achievement, mastery, and independence.[71] The second category within the esteem needs is manifested in the desire for respect from others, which for a refugee child is to be respected, accepted, and valued as an equal member of a classroom or peer group. The underlying desire is to experience a sense of value and dignity about oneself.

The fifth and the highest level in the hierarchy of needs is the need for self-actualisation, which falls under self-fulfilment needs, meaning that the individual is aiming to achieve her full potential.[72] This need, if fulfilled, is generally satisfied later in human development. However, to attain it, lower-level needs have to be met first. Therefore, healthy pathways of development in childhood are crucial for maturing into a mentally healthy and fully functioning adult.

4. Role of the family in the mental health of refugee children

Family, as the primary social environment in a child's life, is normally the source of closest interpersonal relationships. In discussing the role of family in the mental health of refugee children, this section emphasises emotion regulation within the family context, parenting styles of primary caregivers, and the psychological outcomes of the child. Since the most commonly diagnosed mental health disorders in refugee children involve emotional symptoms, the emotional climate within the family can buffer the effect of negative and traumatising refugee experiences.

Emotion regulation is one of the most important social and developmental competencies that children acquire in their preschool years.[73] It develops over time as a set of 'extrinsic and intrinsic processes

[71] Maslow, 1943.
[72] Maslow, 1943.
[73] Bariola et al., 2011.

responsible for monitoring, evaluating and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals'.[74] Emotion regulation is a complex process that evolves across the life span and is therefore not limited to the developmental period of early childhood. Nevertheless, early childhood has been the focus of most of the research in the area of emotion regulation owing to its importance for the development of essential regulatory skills that are used throughout childhood, adolescence, and adulthood.[75] Poor emotion regulation contributes to a range of externalising and internalising behavioural problems, manifested through behaviour, emotional problems, such as depression and anxiety,[7677] and later psychopathology,[78] which is included in most of the Axis 1 and all of the Axis II disorders, according to the Diagnostic and Statistical Manual of Mental Disorders.[79]

Emotion regulation in infants is dependent on their caregivers. Eisenberg and Morris identified three stages in the development of emotion regulation from early to late childhood: first, the child changes the locus of reliance from extraorganismic to intraorganismic and, by the end of the first year of life, begins to actively control their arousal; second, as the executive functioning and the internal cognitive coping strategies develop during toddlerhood, the child becomes able to better grasp the meaning of emotions; third, the child develops the ability to regulate his/her emotions autonomously in a variety of situations.[8081]

According to Calkins, two sources account for individual differences in emotion regulation – internal and external. Internal sources include three factors innate to the child, which are neuroregulatory elements, behavioural traits, and cognitive components.[82]

At the neuroregulatory biological level, each child is born with a certain level of biological reactivity that is dependent upon the physiological activity of their body. According to the polyvagal theory,[83] the control of the

[74] Thompson, 1994.
[75] Cole, 2014.
[76] Gartstein et al., 2012.
[77] Karreman et al., 2010.
[78] Kim and Cichetti, 2010.
[79] Bariola et al., 2011.
[80] Calkins, 2004.
[81] Eisenberg and Morris, 2002.
[82] Calkins, 1994.
[83] Porges, 2007.

heart by the vagus nerve – termed vagal tone – is a measure of differences in emotion regulation. Research has shown that children with increased vagal suppression demonstrate better emotion regulation than their peers with lower vagal suppression.[8485] Increased vagal suppression is therefore related to better emotion regulation abilities, and those children who are not able to regulate, physiologically rely on their parents for guidance and help in acquiring the emotional competence necessary for their social and emotional development.[8687]

Behavioural traits, such as attentiveness, adaptability/reactivity in response to novelty, and resistance in response to frustration and soothability, develop depending on the level of biological reactivity displayed by the child.[88] The combination of behavioural traits and biological reactivity indicates a temperamental disposition in the child, which may either foster or hinder the development of emotion regulation, for example, if the child displays extreme distress in a particular situation, they may not be able to acquire the regulatory skills that will enable them to cope with such a situation in the future unless effective assistance is provided by the parent.[89]

Cognitive components, for example, beliefs and expectations about others and the environment, ability to apply strategies, and awareness of the need for regulation, which emerge gradually throughout the process of cognitive maturation, contribute to a child's ability to create an understanding of the world. The child thus forms an 'internal working model' of the world; for instance, it understands that it is not appropriate to display anger in public, and thus gradually learns to apply the appropriate emotion regulation strategies to particular situations.[90]

This combination of internal factors closely interacts with external factors represented by parenting styles and behaviours involved in child-rearing, such as modelling, induction, reinforcement, and discipline.[91] For example, behaviourally inhibited children, who are highly reactive and fearful in novel situations, benefit from warm and sensitive parenting, which

[84] Perry et al., 2011.
[85] Vasilev et al., 2009.
[86] Perry et al., 2011.
[87] Vasilev et al., 2009.
[88] Calkins, 1994.
[89] Ibid.
[90] Eisenberg and Morris, 2002.
[91] Calkins, 1994.

teaches them effective methods of emotion regulation. Therefore, the interaction of internal and external sources, dependent upon both the child and the parent, shapes individual differences in emotion regulation.[9293]

Next, safety and security in family is manifested by parenting strategies. Two dimensions that represent different approaches to parenting are acceptance-responsiveness and demandingness-control.[9495] Acceptance-responsiveness, as an expression of parental warmth, support, sensitiveness, and understanding, is an important predictor of positive outcomes in various domains, including interpersonal relationships and emotion regulation.[9697] Accepting parents are affectionate and involved with their children and provide them with a secure and warm family environment. Parental acceptance fosters well-being and is particularly important for young children. Children of accepting and responsive parents generally do not experience high levels of emotional and behavioural problems and show good social competency.[9899] Responsiveness refers to the way a parent reacts to a child in terms of general needs, emotions, or other cues. Maternal responsiveness to negative emotions in young children is related to higher expression of positive emotions as opposed to negative emotions such as anger.[100] The role of maternal responsiveness in a child's well-being has also been demonstrated by physiological measures; for example, infants of responsive mothers have vagal tones that indicate good emotion regulation. Maternal responsiveness in older children is related to high levels of prosocial behaviour, lower incidences of behaviour problems, and better emotion regulation.[101102]

Demandingness-control refers to the extent of control that a parent imposes upon a child. While consistent control combined with a strong acceptance-responsiveness orientation on the part of the parent is generally beneficial for the child, power-assertive type of control can have negative

[92] Bariola et al, 2011.
[93] Calkins, 1994.
[94] Holden, 2010.
[95] Rathus, 2014.
[96] Holden, 2010.
[97] Rathus, 2014.
[98] Kiff et al., 2011.
[99] Orta et al., 2013.
[100] Kiff et al., 2011.
[101] Kiff et al., 2011.
[102] Orta et al., 2013.

consequences for the child.[103][104] Research has identified two components of negative parenting in terms of control: hostility or behavioural control and psychological control. Hostility or behavioural control refers to apparent aggressive strategies used by the parent such as coercion, physical or verbal aggression, and strict monitoring, whereas psychological control is a type of indirect aggression intended to manipulate the child through unwarranted demandingness and criticism, inconsistent affection, guilt induction, and autonomy restriction.[105][106] Both types of control have negative effects on child outcomes throughout childhood to adolescence resulting in a range of behaviour and emotional problems.[107][108][109] Although parenting strategies may differ cross-culturally, negative and hostile parenting is particularly harmful to young children across different cultures.[110] Negative, power-assertive parenting, however, does not identically influence children's psychosocial development. Children with particular temperamental characteristics are more resilient than others towards the adverse effects of the different degrees of hostility and control imposed by their parents.[111]

Notwithstanding the temperament a child displays, parents may, directly and indirectly, affect the development of emotion regulation in children in many ways. [112] First, children internalise emotion regulation skills through observing and modelling their parents in emotional situations, thus learning about emotions and appropriate ways of handling them.[113] Research suggests that already during toddlerhood, children learn to model their parents' emotion regulation strategies at an age-appropriate level, starting with passive strategies such as distraction, and then applying more active strategies such as attention refocusing as they cognitively mature.[114][115] The preschool period is a critical period for the acquisition of

[103] Manzeske and Stright, 2009.
[104] Rathus, 2014.
[105] Kiff et al., 2011.
[106] Morris et al., 2002.
[107] Karreman et al., 2010.
[108] Kiff et al., 2011.
[109] Manzeske and Stright, 2009.
[110] Olsen et al., 2002.
[111] Yagmurlu and Altan, 2010.
[112] Kiff et al., 2011.
[113] Morris, 2007.
[114] Morris et al., 2011.
[115] Stansbury and Sigman, 2000.

emotion regulation skills, with parenting serving as the primary source for children. Once a set of strategies has been acquired from the parents in early childhood, it tends to be used into middle childhood and adolescence.[116][117] If, however, the parent often displays intense negative emotions, such as anger, the child becomes overwhelmed with fear and is less likely to learn how to regulate their emotions as a response to similar situations. Overly negative emotionality in the family environment elicits emotion contagion, a transfer of negative emotion onto the child.[118]

Second, parents use a variety of emotion-related parenting practices by which they induce an understanding of emotions in their children. They engage in specific parenting behaviours as reactions to particular situations that affect the emotion regulation skills of their children. Children thus learn to regulate their emotions through the pathway of emotion coaching. Warm and responsive parents often engage in emotional coaching of their children, that is, they discuss their emotions, label them, and advise their children on how to handle them, acting as 'emotion coaches' to their children.[119]

Parental reactions to a child's emotions are also important. If a parent punishes or minimises a child's negative emotions, the child's emotional arousal is increased. Consequently, the child experiences an increase in negative affectivity and displays more intense anger or sadness – seen particularly in young children.[120] Nonsupportive parental reactions to children's negative emotions[121] are related to problems in emotion regulation and consequently to impaired social functioning.[122] On the contrary, if a parent reacts positively and acknowledges a child's emotions, the child learns to effectively cope with negative arousal and to apply various emotion regulation strategies in various contexts. Supportive parents may also encourage and control the expression of negative emotions in children by remaining calm and understanding, allowing the child to express himself within an 'optimal' level of expression.[123] Another emotion-related parenting practice is to explicitly teach children about emotion regulation strategies by providing them with specific instructions, for example, on how

[116] Bariola et al., 2011.
[117] Morris et al., 2011.
[118] Morris et al., 2011.
[119] Morris et al., 2011.
[120] Ibid.
[121] Ibid.
[122] Orta et al., 2013.
[123] Morris et al., 2007.

to cognitively reframe a frustrating situation to change its meaning or how to redirect attention to something more pleasant, thus reducing the child's expression of negative emotions.[124][125]

Third, emotion regulation is influenced by the 'emotional climate' of the family, which refers to the quality of relationships between family members, that is, parent-child attachment, parenting styles, marital relationships, and the overall emotional stability and expressivity of the family (such as the level of expressed positive and negative emotions as well as the predictability of expressed emotions). The quality of parent-child attachment, as the first interpersonal relationship experienced by the child, is associated with effective emotion regulation from infancy through adulthood.[126] Parenting styles, particularly individual variations in responsiveness and negativity, are important components of the 'emotional climate' of the family that contribute to effective emotion regulation in children. Whereas maternal responsiveness predicts good emotion regulation skills from childhood through adolescence and young adulthood,[127][128] maternal hostility contributes to emotional dysregulation and, later, possibly to psychopathology, particularly in traumatised children.[129] For example, children regularly exposed to intense parental anger displayed higher levels of internalising symptoms such as fear, stress, anxiety, and tension, than children from more positive family contexts.[130] Children who live in a conflicted family environment experience 'background anger', which, even if it is not directed at them, endangers their emotional security and thus makes them more vulnerable to emotion dysregulation.[131] The negative effects of parental conflict are accentuated among children high in negative emotionality, making them more vulnerable than children with other temperamental characteristics.[132]

The final component of the 'emotional climate' of the family is family expressivity, which reflects the level of emotions expressed by family members. Children benefit not only from positive emotions but also from an

[124] Morris et al., 2007.
[125] Stansbury and Sigman, 2000.
[126] Morris et al., 2007.
[127] Manzeske and Stright, 2009.
[128] Morris et al., 2007.
[129] Kim and Cicchetti, 2010.
[130] Robinson et al., 2009.
[131] Cummings and Davies, 2002.
[132] Morris et al., 2007.

appropriate level of negative emotions, which helps them learn how to regulate them without being exposed to high levels of distress.[133][134]

Connecting to the psychosocial approach, negative parenting and children high in negative affectivity suffer the most from the adverse consequences of harsh parenting.[135][136] These children generally require more parental assistance in regulating their emotions and appear to elicit parenting higher in control and lower in warmth. Moreover, they react more sensitively to negative parenting practices and learn to regulate their emotions more effectively in the presence of warm and responsive parenting.[137]

Apart from the family context, the development of emotion regulation skills in children is affected by the interplay of other parent characteristics (e.g., reactivity, regulation, mental health) and child characteristics (e.g., temperament, gender, development) interacting with each other in different combinations and various directions.[138][139][140]

This section has been discussed in length to provide a rationale for the implementation of a multi-tiered system of interventions, where the mental health symptoms of refugee children are not treated individually but the needs of the child's family are acknowledged and addressed in terms of mental health care. Therefore, interventions targeting parental mental health including strategies for healthy emotion regulation, coping skills, and parenting skills are introduced in the next section.

5. Mental health interventions for refugee children

Refugee children, same as any other children, have basic human rights and, therefore, have the right to receive professional support and services. Referring to the psychosocial approach and ecological models as holistic frameworks that address both risk and resilience indicators at individual, family, and societal levels, the interventions are divided according to a

[133] Bariola et al., 2011.
[134] Morris et al., 2007.
[135] Bariola et al., 2011.
[136] Kiff et al., 2011.
[137] Ibid.
[138] Bariola et al., 2011.
[139] Kiff et al., 2011.
[140] Morris et al., 2007.

pyramid approach known as the Inter-Agency Guidelines for Mental Health and Psychosocial Support (see Figure 1).[141]

The first level is represented by the basic services and security, depending on the country and current societal situation. In the context of Maslow's pyramid of needs, in a humanitarian crisis, these are steps towards securing basic needs in the form of food, shelter, water, etc. In stable countries, this level includes services related to resettlement. Overall, many interventions can be offered at this level. Most positive outcomes in terms of mental health care and education are achieved when refugee children experience a low level of discrimination in their new country of residence.[142]

The next level is represented by the community and family support with a focus on supporting positive environments, particularly family and school. Viewing family as a system where each member interacts with other members, parents and families benefit from interventions targeting the mental health symptoms of parents and providing appropriate psychological interventions such as parent-training programmes.[143] These programmes teach parents how to create psychologically safe home environments for their children, how to handle negative emotionality, and how to avoid ineffective parenting strategies. In schools, interventions could target the topics of tolerance, acceptance, individual differences, discrimination prevention, and the development of intercultural competencies of teachers and students, as well as activities promoting positive relationships, positive school climate, and school belonging of refugee children.

The third level is the level of the focused, non-specialised support aiming to provide psychosocial interventions including elements of psychotherapy, art therapy, relaxation techniques, psychoeducation, and counselling, to strengthen individual coping strategies, stress management, well-being, and other positive outcomes.[144] These are non-clinical interventions offered in families and schools in a group setting, and their

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[141] IASC. Mental Health and Psychosocial Support in Emergency Settings, [Online]. Available at: https://interagencystandingcommittee.org/sites/default/files/migrated/202011/IASC%20Guidelines%20on%20Mental%20Health%20and%20Psychosocial%20Support%20in%20Emergency%20Settings%20%28English%29. df (Accessed: 11 February 2024).

[142] O'Donnell et al., 2022.

[143] Dangmann et al., 2022.

[144] Bennouna et al., 2019.

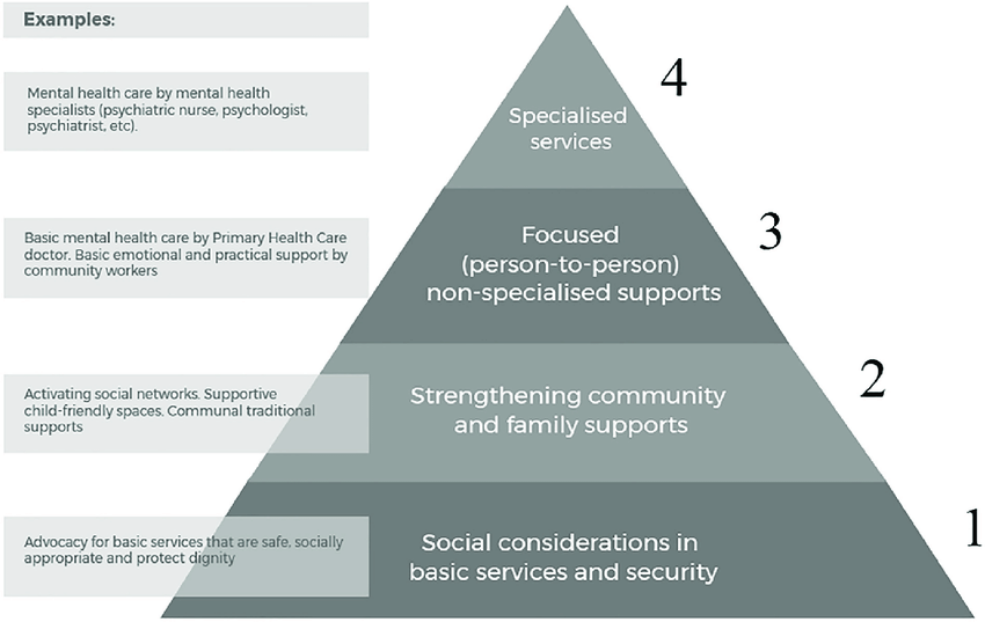
effectiveness varies depending on many factors, for example, age of children, method of delivery, professional qualification, etc.

The final level is the level of specialised support with individual clinical interventions, for example, trauma-focused cognitive-behavioural psychotherapy (TF-CBT) as the treatment of first choice for PTSD and complex trauma, or narrative exposure therapy (NET). NET has been effective in the reduction of PTSD symptoms in adults as well as children and adolescent refugees.[145]

These levels, however, should not be considered as separate levels in a hierarchical order. Referring repeatedly to the family as a system, the family system of a refugee family has been disturbed by many significant, even drastic, changes in their daily functioning. Depending on the level of psychological distress of individual family members, the interventions may be offered in a carefully considered combination targeting multiple symptoms within the family such as mental health symptoms of the parent and the child, parenting programmes for parents, and psychosocial support for children at school.[146]

[145] Dangmann et al., 2022.
[146] Gillespie et al., 2022.

Figure 1 *Inter-Agency Standing Committee (IASC) intervention pyramid for mental health and psychosocial support in emergencies (2017).*



6. Conclusion

This chapter discussed mental health challenges faced by refugee children, through the lens of the psychological aspects of human behaviour. According to the United Nations Convention of the Rights of the Child (UNCRC), refugee children have rights to personal life and development, normal family life, health and well-being, safety and protection, and participation in the community.[147] Refugee children, however, are generally susceptible to and experience higher prevalence of mental health problems and mental health diagnoses due to the traumatic experiences that they have faced. Although many of them recover, some continue to suffer, leading to long-term mental health problems. Traditionally, the focus in psychology has been on alleviating mental health symptoms to help individuals recover. In line with the psychosocial theory that considers several systems of human functioning, an ecological approach to risk and resilience factors was

[147] Suldo and Shaffer, 2008.

introduced. This approach provides a framework for a holistic mental health care support system for refugee families considering individual, family, school, and societal factors that play significant roles in the lives of refugee children. Through the human needs theory, the importance of contributing to the support and development of refugee children as whole individuals was outlined. The significant role of the family in human development, with a focus on emotional development in children, was discussed at length. For children, it is primarily parents and/or primary caretakers who consciously and unconsciously transfer their behavioural and emotional patterns on them; thus, in addition to genetics and nature, parents and/or primary caretakers contribute to individual children's resilience and well-being. The interactions between biology and environment and their impact on individual human development served as a framework for the introduction of the mental health psychosocial support system. The need to integrate a comprehensive approach to mental health support for this population was reiterated, particularly stressing the involvement of family and the community of refugee children. From the perspective of the dual-factor mental health model, mental health is viewed as complete mental health comprising both ends of the mental health continuum, from ill-health to well-being.[148] Thus, a proposition is made to consider the mental health of refugee children from an ecological psychosocial perspective, with an emphasis on alleviating negative stressors and enhancing positive mental health indicators such as well-being, social-emotional health, social support, meaning, and belonging.

[148] Lawrence et al., 2019.

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