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Diana Maria Diaków

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HUMANITARIAN WORKERS' PERSPECTIVES ON MENTAL HEALTH AND  
RESILIENCE OF REFUGEE YOUTH: IMPLICATIONS FOR SCHOOL PSYCHOLOGY

By

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First and foremost, I would like to thank all humanitarian workers for their tireless efforts to scaffold refugee youth's well-being during displacement, and their invaluable contribution to this research project. I would also like to recognize my academic advisor, Dr. Anisa Goforth for her thoughtful mentorship, unwavering support for this project, and confidence and trust she placed in my abilities. Another "thank you" goes to my dedicated research team, and lab family for their invaluable support and insights. Additionally, I would like to thank my dissertation committee for their investment in this project. Lastly, I am eternally grateful to my friends who were always ready to support me despite the Atlantic Ocean between us. Finally, I would like to share special words of appreciation for my ever-patient partner, my mom and sister, and refugee families who have taught me the greatest lessons of resilience. I would like to reach their hearts, therefore, the following paragraphs are written in their native languages.

### **Στον σύντροφό μου:**

Δε βρίσκω λόγια για να εκφράσω την ευγνωμοσύνη μου για την πονόψυχη καρδιά σου και το ήρεμο πνεύμα σου. Από τα βάθη της καρδιάς μου, σε ευχαριστώ για κάθε λεπτό που με υποστήριξες για να κυνηγήσω το όνειρό μου.

### **Kochana Mamusiu i Siostrzyczko:**

Wasza wrażliwość na drugiego człowieka i otaczający świat oraz wiara w moje możliwości stały się przyczynkiem do napisania tej rozprawy doktorskiej. Bardzo dziękuję Wam za wspieranie mnie bez względu na to jak nierealne byłby moje pomysły.

عزيزي الملهم النفوس:

شغفكم بالأطفال والسلام والحب بضياء الولؤ بالنسبة لي. وبهذا لكم مكانة خاصة في قلبي.

## ABSTRACT

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*School Psychology*

Abstract Title: Humanitarian Workers' Perspectives on Mental Health and Resilience of Refugee Youth: Implications for School Psychology

Chairperson: Anisa N. Goforth, Ph.D

Almost half of the 79.5 million forcibly displaced persons worldwide are youth under the age of 18, including refugees. Refugee youth face deliberate threats across all migration stages including violence, abuse, exploitation, poor living conditions, limited or no access to healthcare and education, interrupted family structure, and discrimination. Noteworthy, school psychologists who practice in host countries face new challenges as these diverse youth enroll in public schools. During the migration stage, humanitarian workers are a primary source of psychosocial and educational support for refugee youth and their families. Therefore, the aim of this research study was to inform school psychology practice by exploring humanitarian workers' perspectives on refugee youth's mental health and resilience during the transit stage in Southeastern Europe. To accomplish this goal, I conducted a qualitative research study using an online sociodemographic survey, and semi-structured interviews with 12 humanitarian workers who directly supported refugee youth in Southeastern Europe. The trustworthy thematic analysis allowed to identify 10 themes of displacement-specific ecological protective factors, and 13 themes of challenges that contributed to refugee youth's well-being. The key findings demonstrated that (1) humanitarian workers could either bolster refugee youth's resilience or hinder their recovery from trauma, (2) participants' responses were infused with Eurocentric bias, (3) the highest number of themes pertained to refugee youth's distant environment) (4) refugee youth faced unique challenges while accessing public education due to family, cultural, and environmental factors, (5) and refugee youth's individual protective factors focused on their ability to engage with the environment.

*Keywords:* refugee youth, resilience, humanitarian workers, forced displacement, transit in Southeastern Europe, refugee camps

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## **Chapter 1. Introduction**

In the midst of humanitarian crisis in Southeastern Europe, school psychologists are likely to work with forcibly displaced youth, including refugees, who have fled worn-torn Syria and other Middle Eastern, and African countries impacted by civil and military unrest. In countries that are a temporary home for refugee youth, such as Greece or Bulgaria, there is no or very limited psychosocial and educational support available to refugee youth and their families. Previous studies have repeatedly highlighted the urgency of developing culturally responsive assessments and interventions that would aim to mitigate negative outcomes of trauma while bolstering resilience among these youth. Despite sporadic research studies that discussed psychological treatments for refugee youth at the post-migration stage (i.e., after settling down in a new country), the indication of evidence-based culturally responsive programs designed to benefit refugee youth at migration stage are non-existent. School psychologists who practice in countries such as Greece are likely to face new challenges as the numbers of arriving forcibly displaced youth increase due to military conflicts, but also climate and health crises in other regions. Some of these challenges can include unfamiliar cultural backgrounds of students, lack of resources, and limited professional guidelines. However, the development of concrete intervention programs requires preliminary data on refugee youth's lived experiences that are intertwined with forced displacement and their cultural backgrounds. Importantly, scientific inquiries of these youth's mental health and resilience need to consider the vulnerability of the refugee population and respect the child protection guidelines that safeguard these youth. Therefore, my research study focused on exploring refugee youth's well-being through the perspectives of humanitarian workers who were one of the primary sources of support for these youth during their through Southeastern Europe; my goal was to obtain data that can further

inform school psychology practice as well as the future development of urgently needed culturally responsive psychosocial interventions that could foster these refugee youth's resilience.

To come one step closer to my long-term goal, I conducted a qualitative research study that explored humanitarian workers' perspectives ( $N = 12$ ) on refugee youth's trauma-related symptoms, factors that promoted these youth's well-being as well as hindered it, and strategies that humanitarian workers used to address these youth's needs during the migration stage. I incorporated an online sociodemographic survey and conducted semi-structured interviews. The trustworthy thematic data analysis produced ten main themes focused on ecological protective factors and 13 main themes related to ecological challenges.

My qualitative research study contributed to the existing literature allotted to refugee youth's mental health and resilience by offering five key findings. First, humanitarian workers played a role in fostering refugee youth's healthy development at the migration stage; however, their ability to deliver adequate support was hindered by high levels of stress and limited resources, as well as coping strategies and self-care practices that they utilized daily. In other words, humanitarian workers could enhance the well-being of refugee youth during the migration stage, just as they could exacerbate these youth's distress. Second, refugee youth who were at the transit stage were likely to have very limited access to public education, and if this opportunity was provided, these youth and their families were likely to be apprehensive to utilize it due to culture-specific beliefs, and safety concerns. Third, the most represented group of resilience and mental health factors emerged within the environmental influences (i.e., macrosystem) and their interactions with the refugee youth's imminent environment (i.e., mesosystem). Fourth, humanitarian workers' perspectives were often infused with the

Eurocentric bias, especially, when discussing gender-related cultural norms, and child-parent interactions. Fifth, the results in this research study confirmed previous research on resilience among culturally diverse youth (Ungar, 2008a) by showing that individual factors went beyond individual characteristics as they encompassed the youth's ability to express their strengths and adjust them to the resources available in their environment. Although not all school psychologists around the world may work with refugee students in the midst of their forced displacement, the results presented in this research study provided in-depth analysis of humanitarian workers' perspectives on these youth's lived experiences and factors contributing to their well-being. Therefore, my research study allowed me to contextualize how to provide effective, culturally responsive and interdisciplinary psychosocial services to refugee youth, their families, and communities during the migration stage.

## Chapter 2. Literature Review

Overall, the purpose of this research study was to explore humanitarian workers' perspectives of refugee youth's mental health, including their trauma-related symptoms, resilience, and strategies that humanitarian workers implemented to address these youth's mental health needs. In this chapter, I describe the terminology related to refugees, migration process, humanitarian assistance, and humanitarian workers' role in scaffolding refugee youth's healthy development. The second section of this chapter explores trauma-related symptoms and risk factors that exacerbate mental health challenges experienced by refugee youth during displacement. The last section explains the concept of resilience of culturally diverse refugee youth.

### **Refugees, Humanitarian Assistance, and Humanitarian Workers**

#### ***Refugee Youth***

Individuals referred to as “refugees” are a subgroup of forcibly displaced persons (FDPs), those who have been forced to flee their homeland due to life-threatening circumstances such as war, political oppression, famine, or a natural disaster (The United Nations Office for the Coordination of Humanitarian Affairs, [UNOCHA], 2003). Although in public discourse, the words “refugee” and “immigrant” are used interchangeably, they characterize slightly different populations of FDPs. The term “refugee” was first coined as a result of forced migration triggered by the onslaught of the First and Second World War to protect the safety of those who had to look for shelter elsewhere. According to the Universal Declaration of Human Rights ([UDHR], 1948) to obtain refugee status, one needs to cross an international border as a result of experiencing “well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion”. Given hazardous living conditions

in refugees' homelands, a person granted refugee status should not be returned to their home country, which is ensured by the non-refoulement principle of international law (i.e., UDHR, 1948). Importantly, the refugee definition is not inclusive enough to guarantee international assistance for people who may desperately need it due to crises such as natural disasters, poverty, organized gang violence, etc. In fact, the United Nations Higher Commissioner for Refugees ([UNHCR], 2020a) listed more than three million "forcibly displaced Venezuelans" as a separate category of FDPs because they have fled extreme poverty and other threats associated with a massive economic crisis in their homeland, but did not match the original refugee definition.

Similarly, the term "asylum seekers" described individuals who have been forced to seek shelter abroad but whose claim for refugee status has not been determined yet (UNOCHA, 2003). In contrast, "immigrants" have left their homes forcibly or voluntarily including reasons such as economic hardship or a desire to live or work in another country. To clarify, it does not mean that an immigrant is a person who has never experienced life-threatening circumstances. For example, a Syrian family may have enough financial resources to move to another country without relying on international humanitarian assistance. These individuals may prefer not to utilize their right to apply for asylum or look for shelter in a camp for forcibly displaced persons; however, they are still likely to experience psychological challenges similar to those faced by refugees. In other words, one's relocation is a common denominator that characterizes all forcibly displaced individuals regardless of their legal status.

Noteworthy, FDPs are not only those who have sought safety abroad; in fact, more than 50% of FDPs are "internally displaced persons" (IDPs) who have left their homes, relocated to a safer place, but remained within the borders of their home country (UNHCR, 2020). An

individual can start their journey as an IDP and then become an immigrant, asylum seeker, and later refugee.

**Refugees around the World.** In 2019, there were 79.5 million FDPs worldwide, and most of them, i.e., 45.7 million, remained within the borders of their home countries (UNHCR, 2020). More than 40% of the world's forcibly displaced population were minors under 18 years old (UNHCR, 2020). A common perception promoted in mass media was that refugees fled mostly to wealthy Western countries (e.g., Germany, the United Kingdom, Sweden, United States); however, 85% of the world's refugee population in 2019 sought rescue in developing neighboring countries, with 80% of the total forcibly displaced population being in countries and territories affected by acute insecurity and malnutrition (UNHCR, 2020). In 2019, Turkey hosted the highest number of refugees, with 3.6 million FDPs who were mostly survivors of war in neighboring Syria (UNHCR, 2020). The most recent UNHCR report (2020) indicated that 68% of FDPs worldwide came from only five countries: Syria, Venezuela, Afghanistan, South Sudan, and Myanmar.

Further, there were concerns about the number of refugee youth around the world. In 2019, 40% of FDPs were minors below the age of 18 (UNHCR, 2020). As of January 31, 2020, The United Nations International Children's Emergency Fund (UNICEF) estimated that 42,500 refugee and other forcibly displaced children lived in Greece, with 5,041 unaccompanied minors. Noteworthy, COVID-19 related restrictions and border closure in March-April 2020 complicated the reception of forcibly displaced youth in Southeastern Europe (UNICEF, 2020b). Despite the unprecedented circumstances of the global health crisis, among 26,800 refugees and other FDPs who have entered the Mediterranean region (i.e., Italy, Greece, Spain, Bulgaria) since January 2020, almost 20% were children. UNICEF reported that these youth came from Afghanistan,



Syria, Algeria, Tunisia, and Côte d'Ivoire. As COVID-19 has continued to unfold, refugee youth in Southeastern Europe have been congested in unsafe shelters. For example, Moria Reception and Identification Center located in Lesbos island, Greece, was completely destroyed by fires leaving 11,500 asylum seekers, including 4,000 children, in despair for several days (UNHCR, official press release, 11 September 2020).

### ***Refugee Youth's Migration***

Often, refugee youth experienced a long and arduous journey until they re-established their lives in a safe place (Sullivan & Simonson, 2016). It was difficult to estimate the exact length of displacement, however, the UNHCR data indicated the median duration of exile was four years, and the mean duration of exile was 10.3 years (Devictor & Do, 2016). These numbers varied, however, depending on the origin of refugees and the route that they took. For example, analyses showed that the approximate length of displacement was four years for forcibly displaced Syrians, and 35 to 37 years for forcibly displaced Sudanese, Somalis, and Eritrean (Devictor & Do, 2016). Despite differences in the length of forced displacement, there were underlying similarities in the process of migration that refugee youth undergo. Specifically, migration consists of three phases: (1) the pre-migration, (2) migration, and (3) post-migration stage (Bhugra & Jones, 2018).

**Pre-migration Stage.** Forced displacement was triggered by political oppression, prosecution, poverty, famine, and other types of life-threatening events (see, e.g., Sullivan & Simonson, 2016; UNHCR, 2015). During the pre-migration stage, war-affected youth experienced a number of stressors including physical, sexual, and emotional abuse, exploitation, famine, murder, torture and forced recruitment to armed groups (Betancourt et al., 2012).

**Migration Stage.** As the deliberate security concerns persisted in the pre-migration stage, families were forced to enter the migration stage, which occurred when people migrated from their homes to safer place. This transition included both moving to places within the borders of their home country as well as accessing shelters abroad, such as refugee camps. For example, refugee youth and asylum-seeking youth who arrived in Greece experienced “drowning in the Aegean Sea, separation from their families, adverse weather conditions, lack of supplies, abductions, trafficking, sexual exploitation, and mental health problems” (Anagnostopoulos et al., 2015, p. 121). During displacement, refugee youth’s basic needs, such as access to food, water, sanitation, shelter, or electricity often were not met (The Royal Institute of International Affairs [RIOIA], 2016). Noteworthy, some refugee families in Southeastern Europe (e.g., Greece) moved into illegal and inferior accommodations in urban settings because of limited resources offered in refugee camps such as low capacity and/or rampant violence.

Exposure to violence did not end at the pre-migration stage, however. For example, approximately 80% of Cuban refugees witnessed acts of violence and 37% of them saw someone attempt or die by suicide during their migration to the United States (Rothe et al., 2002). Lorek and her colleagues (2009) reported that youth placed in the immigration detention centers in the United Kingdom were likely to experience hunger strikes, incidents of deliberate self-harm, deaths, and suicides. Due to poor lighting and safety in refugee camps in Greece, gender-based violence was a common problem for refugee youth when visiting washrooms, toilets, and public spaces after dark (RIOIA, 2016). Another stressor that jeopardized refugee youth’s safety in Greece was due to tensions between different nationalities within camps, as well as between refugees and local communities (RIOIA, 2016).

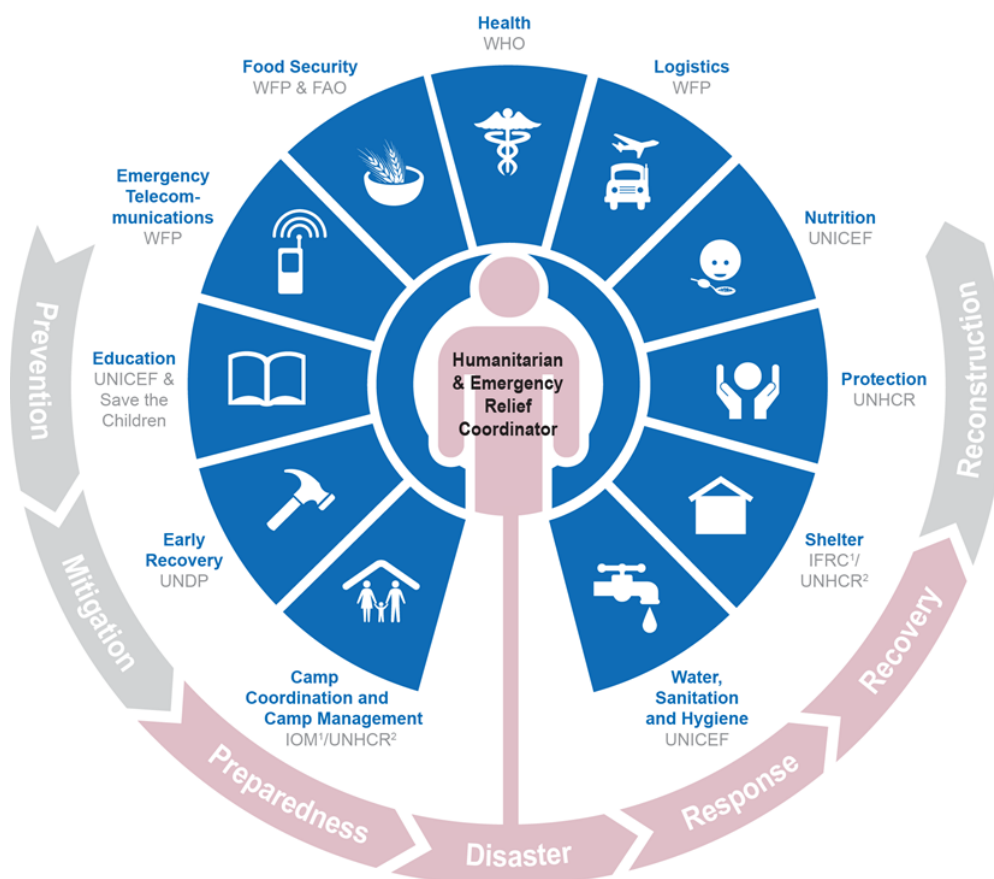
**Post-migration Stage.** Ultimately, refugee youth reached their destination country where they could settle down upon support received from resettlement agencies. Although it could be perceived that there would be fewer challenges that refugee youth faced when they arrived in a new, host country, this was certainly not the case. For example, refugee youth and their families experienced a sense of uncertainty, fear of being deported, grief, isolation from their family members and friends, and change in a social-economic status during the post-migration stage (see, e.g., Bhugra & Jones, 2018; Ellis et al., 2011; 2012; Tyrer & Fazel, 2014). In addition, refugee youth needed to navigate cultural differences including a new school system while acquiring a foreign language (Tyrer & Fazel, 2014). School psychologists should recognize that after resettlement to a new community, refugee youth were likely to experience discrimination and stigmatization due to their ethnic or religious background (Goforth et al., 2016; Link & Phelan, 2001). Montgomery and Foldspang (2008) reported that discrimination perceived by young refugees from the Middle East was related to their mental health problems and social adaptation.

### ***Humanitarian Assistance and Humanitarian Workers***

Humanitarian aid was defined as any activity that fell under the cluster system introduced by the Humanitarian Reform Agenda in 2005 (The Inter-Agency Standing Committee [IASC], 2008).

**Figure 1**

*Aid Cluster System Delivered in Emergencies (IASC, 2008).*



The cluster approach aimed to enhance predictability, accountability, and partnership in the humanitarian aid sector (IASC, 2008; see Figure 1). The main eleven sectors of humanitarian aid included health, logistics, nutrition, protection, shelter, water, sanitation and hygiene, camp coordination and camp management, early recovery, education, emergency telecommunications, and food security. Refugee youth typically received psychosocial support within the protection, health, and education sector.

Humanitarian workers were defined as “all workers engaged by humanitarian agencies, whether internationally or nationally recruited, or formally or informally retained from the

beneficiary community, to conduct the activities of that agency” (The United Nations Office for the Coordination of Humanitarian Affairs, 2003, p.10). IASC (2007) developed detailed guidelines of mental health and psychosocial support in emergency settings and highlighted an important role of humanitarian workers in supporting refugee youth and their families.

Humanitarian workers were often a primary source of psychosocial and educational support for refugee youth who were uprooted from their homes and lived in host countries in Southeastern Europe (e.g., Greece, Bulgaria). They provided humanitarian assistance to refugee youth and their families as part of operations coordinated by small grass-roots non-profit organizations, well-established humanitarian agencies, or delivered voluntary aid on-site. The example of the latter form of assistance can include FDPs who utilize their resources to deliver support to their community by organizing informal educational sessions to fellow FDPs.

The complexity of humanitarian aid provided to refugee youth required interdisciplinary collaboration; therefore, humanitarian workers may come from different educational backgrounds and fields, such as human rights, mental health, social studies, education, international relations, arts, sports, etc. According to job descriptions listed by the United Nations that focused on refugee youth, such as child protection officers, candidates were expected to have an academic degree in psychology, social work, or related discipline; however, some job positions, such as a “child-friendly facilitator/manager” or “youth engagement space facilitator” did not always require candidates to have a degree in the education or mental health field. The aforementioned humanitarian jobs entailed delivering psychosocial support to refugee youth through structured play, art, and sport activities. Noteworthy, based on my field experiences, oftentimes, even humanitarian workers who were not formally affiliated with the child protection or education sector happened to interact with refugee youth. For example,

interpreters may assist families who come with their children to see a psychologist. As far as I am concerned, no study has been conducted on how interpreters perceive refugee youth's mental health and resilience. Given their assistance in many situations that involve minors, my research study also explored their perspectives.

Humanitarian workers delivered humanitarian assistance to refugee youth under extremely hazardous conditions. For example, they were likely to work in regions impacted by political and military instability, diseases, and harsh weather conditions. Besides that, humanitarian workers experienced life threats of being a target of kidnapping (Runge, 2004), lack of privacy and personal space, prolonged separation from family and friends, as well as an overwhelming workload while being underpaid (Suzic et al., 2016). Previous research allotted to the well-being of humanitarian workers focused on reporting rates of mental health challenges in this population that were associated with the witnessing single-event and chronic trauma (Ager et al., 2012). Young and her colleagues (2018) explored humanitarian workers' perceptions and knowledge of stress that they experienced, as well as their coping strategies and reiterated the negative impact of fatigue and psychosocial challenges on the well-being and performance. Despite humanitarian workers' daily and crucial interactions with refugee youth in Southeastern Europe, there has been no research that would inform school psychologists and other clinicians about their perspectives of these youth's mental health and resilience, and therefore, my research study aimed to fill this gap.

### **Factors that Impact Humanitarian Workers Interactions with Refugee Youth.**

Humanitarian workers were an integral element of environmental support that refugee youth received during the migration stage (IASC, 2008). Although the goal of my research study was not to examine aid workers' personal experiences of trauma, it remained important for school

psychologists to understand the context and environment in which they assisted refugee youth. Due to hazardous work conditions, humanitarian workers were at risk of experiencing secondary traumatic stress (see, e.g., Shah et al., 2007), compassion fatigue (Mathieu, 2012), and psychological burnout (see, e.g., Leiter & Maslach, 2005). In this profession, secondary traumatic stress was considered an occupational hazard due to a continuous exposure to trauma narratives and stressful events at work, which contributed to the development of PTSD symptoms (Jachens, 2019). In addition to secondary traumatic stress, humanitarian workers were prone to experience burnout (Suzic et al., 2016). Compassion fatigue was another occupational risk and was characterized by emotional and physical exhaustion paired with progressive desensitization to clients' stories (Mathieu, 2012). All these psychological conditions were exacerbated by work overload, a sense of helplessness, workplace and community-related problems, inequality of salary, and a conflict between one's values and job expectations (Leiter & Maslach, 2005). Van Vegchel et al. (2005) showed that an imbalance between the effort put into work and reward such as money, promotion, prospects, and job security was the factor most contributing to humanitarian workers' distress. Specifically, 72% of humanitarian workers employed by UNHCR reported that their commitment to work was higher than the rewards they received. This was concerning in light of Van Vegchel et al.'s findings (2005) who showed that humanitarian workers who experienced this imbalance were at higher risk for emotional exhaustion, lower job satisfaction, and motivation. Finally, Shah and their colleagues' research study (2007) highlighted that aid workers demonstrated a tendency to overestimate their capacities to cope with trauma-related symptoms, which encouraged them to neglect their mental health until the moment they developed depression, anxiety problems, substance dependence, burnout, or PTSD.

## **Mental Health of Refugee Youth**

Due to the presence of multiple threats, refugee youth were at risk for developing various mental health disorders. The most commonly reported mental health problems included depression, anxiety, behavioral problems, and PTSD.

### ***Traumatic Stress***

Typically, researchers associated trauma with psychological maltreatment, sexual, and physical abuse (see, e.g., Spinazzola et al., 2014). However, in addition to various forms of abuse, refugee youth were likely to experience severe distress due to exploitation, famine, murder, torture forced recruitment to armed groups, and threats en route (e.g., drowning in the sea) (see, e.g., Anagnostopoulos et al., 2015; UNHCR, 2015). Across all migration stages, refugee youth's continuous exposure to trauma impacted their neurobiological development. It is well known that experiencing early trauma was associated with permanent functional impairments of neurobiological structures in the limbic system including the amygdala and hippocampus, which contributed to, for example, memory and concentration problems (De Bellis & Zisk, 2014). Specifically, Carrion and their colleagues (2007) argued that hippocampal atrophy observed in adults was a latent developmental effect of childhood trauma. Early exposure to trauma also accounted for disruptions in serotonin's regulatory functioning which contributed to onset of depressive symptoms in adulthood (De Bellis & Zisk, 2014). Furthermore, early childhood adverse experiences that involved emotional abuse or neglect dysregulated levels of oxytocin, which exacerbated difficulties in forming secure and stable personal attachments in adulthood (Smith et al., 2016). Overall, the continuous exposure to trauma at an early age was correlated with youth's poorer cognitive functions and academic achievement. Specifically, youth who experienced long periods of neglect tended to perform



poorly in the domains of visual attention, verbal memory, learning, inhibitory control, problem-solving, reading, math, and speeded naming (Pollak et al., 2010). Even though these findings focused primarily on a non-refugee youth population, school psychologists should consider how these results may translate to the challenges developed by forcibly displaced youth.

***Trauma-related Internalizing and Externalizing Symptoms.*** A byproduct of trauma-associated neurobiological changes was an increased risk of developing mental health disorders in the future, including internalizing and externalizing symptoms (De Bellis & Zisk, 2014), relational insecurity, and negative self-perception (Trickett et al., 2011). Overall, Spinazzola and their colleagues (2014) associated exposure to complex trauma (e.g., psychological maltreatment, physical abuse, and sexual abuse) with the exacerbation of psychological impairment in youth. For example, youth who experienced psychological maltreatment were likely to demonstrate externalizing problems, such as disruptive behaviors, self-injury, and criminal acts (Spinazzola et al., 2014). Traumatic experience also augmented refugee youth's symptoms of anxiety, depression, PTSD, traumatic grief, and somatization (Attanayake et al., 2009; Sirin & Rogers-Sirin, 2015).

Among refugee youth, the association between trauma and both internalizing and externalizing symptoms was notable. Studies found a prevalence of PTSD rates in this population ranging from 19 to 54% (Bronstein & Montgomery, 2011). Furthermore, Heptinstall et al. (2004) indicated that refugee boys exhibited more PTSD and depressive symptoms than girls. Their research study reported that girls did not only witness violence committed on others, but they also were at a higher risk of being sexually abused during the premigration and migration stages. Importantly, PTSD and anxiety symptoms intensified when children's needs for safety and security were not met due to hazardous conditions (Tufnell, 2003). Noteworthy,

child soldiers were a particularly vulnerable subgroup of refugee youth who were forcibly recruited by armed groups (de Silva & Hobbs, 2001). Research demonstrated that child soldiers were especially at high risk of developing depression, anxiety, suicidal ideation, and substance abuse because of their exposure to violence (de Silva & Hobbs, 2001).

In school settings, refugee youth demonstrated similar trauma-related challenges. In a research study conducted by Allwood et al. (2002), teachers linked adjustment issues demonstrated by refugee children in schools, such as attention problems, aggressive and delinquent behaviors, and withdrawal with these youth's prior experiences of war. Results of this study showed high rates of PTSD, anxiety, and depression symptoms in refugee youth who attended schools in the United States (Allwood et al., 2002). In the context of school psychology practice, it is critical to notice that repeated exposure to trauma across different developmental stages contributed to lower IQ scores (Jaffee & Maikovich-Fong, 2011).

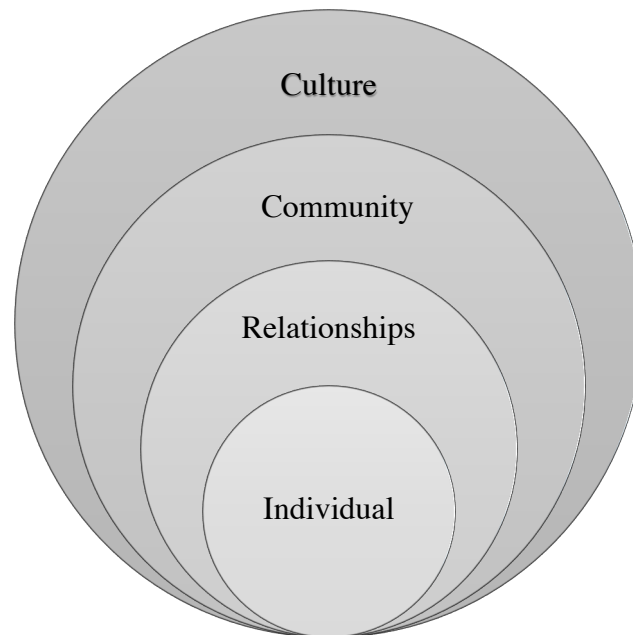
### **Resilience of Refugee Youth**

To understand refugee youth's experiences, school psychologists need to consider protective and risk factors that contributed to these youth's well-being during displacement. For decades, psychologists have been trying to understand what factors gave some individuals the ability to recover from trauma better than others. Traditionally, resilience was viewed as a developmental outcome, set of child's competencies, or coping strategies (Fraser et al., 1999). Fraser et al. (1999) argued that resilience was not merely a cluster of someone's characteristics and capacities, but it also included social and environmental factors, such as family relationships and access to resources in the society. Also, Seccombe (2002) emphasized the importance of taking into account how society and social policies contributed to a child's healthy development. Interestingly, Lenette et al. (2013) highlighted that resilience was presented in a polarized way so

it either pathologized or glorified refugees. They clarified that resilience was not only resembled by heroic acts of recovery but it was also expressed in refugees' "everydayness" (e.g., refugee families' efforts to find jobs or support their children in a new culture while recovering from trauma). Other researchers (see, e.g., Yates and Masten, 2004) also rejected the idea of resilience being a fixed trait and advocated for a more dynamic construct that would demonstrate one's posttraumatic growth across the lifespan. In other words, Yates and Masten (2004) emphasized that humans were living systems, implying that resilience evolved and adapted given the circumstances.

## Figure 2

*The Clusters of Resilience Factors Identified through the International Resilience Project (Ungar, 2008a).*



Since the theoretical foundation of resilience was grounded in Western values (i.e., individualism), there was a need to address this conceptual gap by conducting rigorous research on how resilience was fostered and expressed in non-individualistic cultures (Ungar, 2008; Wu et

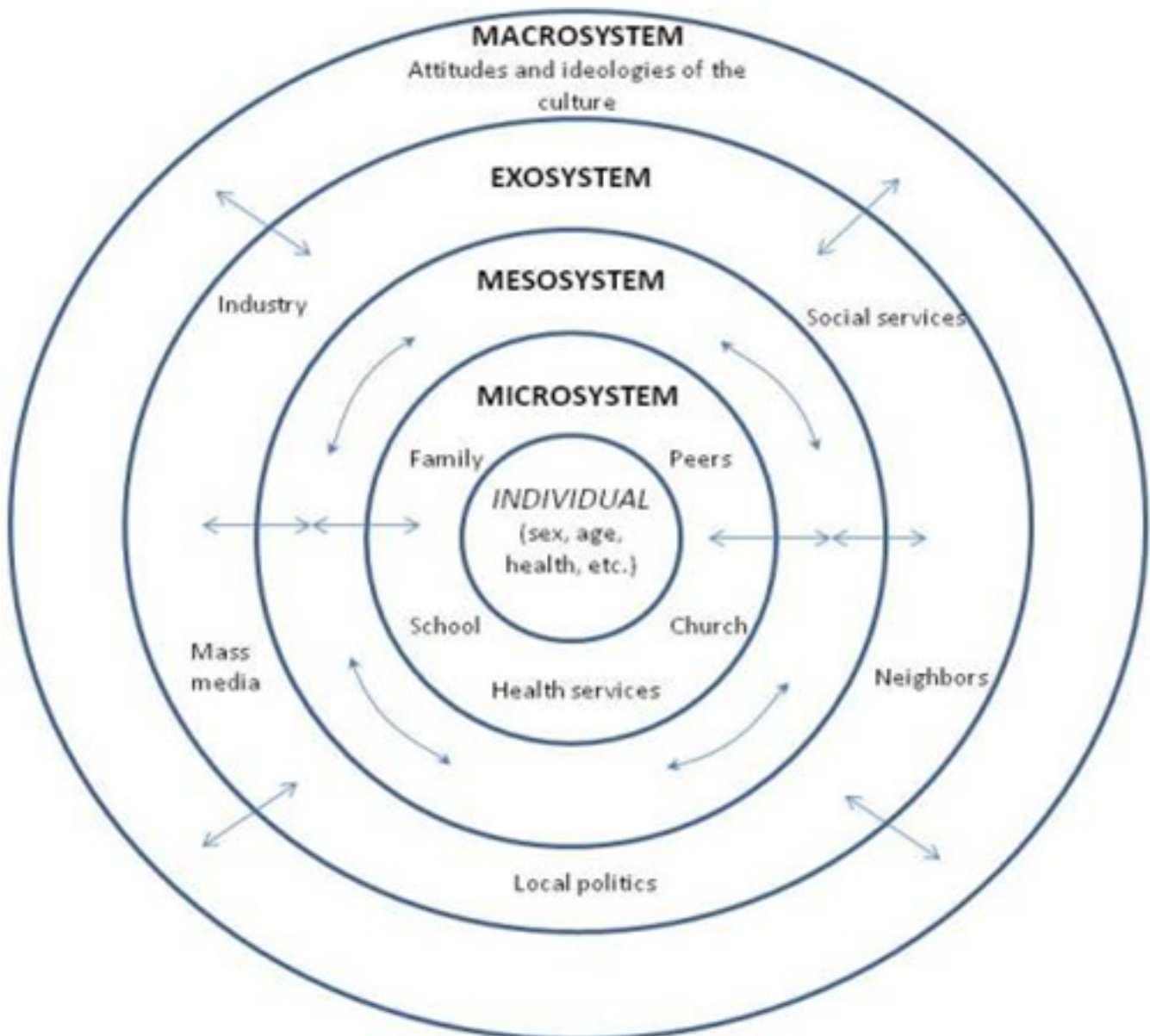
al., 2018). Through the International Resilience Project, Ungar explored the individual, social, environmental, and cultural resilience factors that contributed to the well-being of culturally diverse children and youth (see Figure 2). He found that even if two young people experienced similar adversity (e.g., psychological maltreatment), there was considerable variation across the cultures in a way how they coped with trauma. These findings allowed Ungar (2008a) to develop the following definition of resilience:

In the context of exposure to significant adversity, whether psychological, environmental, or both, resilience [was] both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community and culture to provide these health resources and experiences in culturally meaningful ways (p. 225).

This quote suggested that refugee youth's resilience factors should be viewed as a larger system of these youth's imminent and distant environment.

**Figure 3**

*Bronfenbrenner's Ecological Systems Theory (1979).*



The interactions between groups of risk and protective factors can be contextualized through Bronfenbrenner's ecological systems theory (1979) that discussed the individual, the micro-, the meso-, the exo-, and the macrosystem (see Figure 3). The individual system included one's characteristics such as gender and age. The elements of one's imminent environment

included family and peers, while larger community (e.g., school) accounted for the macrosystem. The interactions between one's macro- and microsystem were conceptualized as the mesosystem. The overarching factors of one's functioning such as culture or sociopolitical climate merged into the macrosystem.

Overall, given that previous research studies showed that refugee youth were not a culturally homogenous group (Yaylaci, 2018), I relied on the findings from the International Resilience Project (Ungar, 2008a) to better understand individual, social, environmental, and cultural factors that jeopardized and enhanced refugee youth's ability to cope with adversities during displacement. However, to explore interactions between clusters of factors that contributed to refugee youth's well-being, I utilized Bronfenbrenner's ecological system theory (1979).

### ***Risk Factors Among Refugee Youth***

**Individual Factors.** Within the individual system of Bronfenbrenner's theory, previous research showed that individual risk factors such as refugee youth's age, gender, and history of illness jeopardized these youth's mental health. Bean and et al. (2007) demonstrated that a refugee child's age was associated with more negative mental health outcomes. For example, in a comparison study of Syrian and Jordanian refugee children (ages 7 – 12) who experienced different levels of first-hand exposure to war, older children were more affected by the repercussions of conflict than younger ones (Jabbar & Zaza, 2014). The differences in outcomes observed by Jabbar and Zaza (2014) could be explained by the children's limited ability to self-report trauma-related symptoms. Additionally, Jabbar and Zaza's (2014) qualitative research study focused on mental health and social adjustment of Syrian refugee adolescents and found

that being female was a risk factor for developing psychological difficulties and experiencing social problems.

Other individual risk factors included the refugee child's history of physical illness. Previous research found that refugee children who suffered from physical illnesses or including physical disabilities were at a higher risk for developing mental health disorders than their healthy peers (Ehnholt & Yule, 2006). Another factor that exacerbated refugee children's mental health problems was associated with unresolved grief and loss. This risk factor contributed to disruptive behaviors and social withdrawal among refugee children (Kirmayer et al., 2010).

**Migration Status.** Refugee youth's migration status can be viewed as an example of the mesosystem given its connections with social and cultural contexts. The uncertainty of the current legal status exacerbated negative mental health outcomes experienced by refugee children. Specifically, Heptinstall et al. (2004) found that a refugee child's asylum status was one of the most common worries and was associated with high rates of PTSD. In other words, refugee children were worried about being returned to their home countries or not being allowed to resettle to a destination country, which was a source of distress for them. Noteworthy, these researchers observed that children who experienced PTSD symptoms due to pre-migration traumatic experiences were particularly fearful of returning to their countries of origin after being resettled to a new country.

**Acculturation Stress.** Numerous research studies found that navigating cultural differences in a host community and establishing own cultural identity upon resettlement was another risk factor that hindered refugee youth's recovery from trauma; these challenges are an example of the mesosystem. Upon finding safe shelter outside of heritage culture, refugee youth experienced distress associated with the acculturation process, a process of adapting to new

cultural norms (Berry et al., 2006). Namely, refugee youth had to learn about a new educational system, acquire a foreign language, and become familiar with new social norms which was a source of confusion and often, distress (Kirmayer, et al., 2010; Yule, 2000).

Acculturation-related risk factors for many refugee youth included discrimination in a host country (Borrell et al., 2015). For example, some refugee children experienced social stigmatization and isolation due to language barriers (Mucherah, 2008). Since language was an important tool to communicate with others and develop social interactions, refugee youth were likely to have difficulties in participating in social and school life due to their limited host language proficiency (Kaplan et al., 2016). Often, FDPs were viewed as an outer group whose cultural and political backgrounds were perceived by a local community as threatening (Borrell et al., 2015). For example, Muslim immigrant youth who lived in European countries reported a sense of rejection due to discrimination against their religious heritage (Phalet et al., 2018). Similarly, Syrian refugee boys resettled to Lebanon, Jordan, Turkey, and the Kurdish Region of Iraq reported being bullied, physically attacked, and feeling humiliated because of their previous experience of being child workers (Mercy Corps, 2014). Discrimination also emerged in light of cultural differences associated with polygamy and early marriages. For example, under Turkish law, polygamous marriages were not allowed; thus, children born to these families were not registered in Turkey, which put some Syrian refugee women at risk of social stigmatization (Yaylaci, 2018).

**Trauma-associated Factors.** Factors associated with the duration of exposure to violence and refugee youth's proximity to an adverse event were other examples of risk factors. Hasanović and his colleagues (2005) found that refugee children's prolonged exposure to war adversity had long-term detrimental effects on their mental health. As discussed earlier, refugee



youth experienced stressors across all migration stages. Noteworthy, refugee children continued to experience hardships, such as financial difficulties or insecurity about asylum status, after relocation to a safer place, or a foreign country; these challenges elevated risk of developing PTSD among these children (Heptinstall et al., 2004).

A critical factor that amplified the severity of trauma-related mental health problems was associated with the proximity to a traumatic experience (Jabbar & Zaza, 2014). That is, the farther a child was from the conflict and hostilities, the fewer symptoms of anxiety and depression they reported (Jabbar & Zaza, 2014). Nevertheless, not all the children who witnessed war violence developed the same trauma-related symptoms. The severity of these symptoms was moderated by one's perception of the degree of personal threat and level of personal involvement (Ehnholt & Yule, 2006). Overall, these trauma-associated risk factors merged a variety of clusters proposed by Bronfenbrenner (1979), with a refugee child's perception of threatening events, which represented the individual system, and the presence of war violence being a part of the exo- and the macrosystem.

**Violence During Displacement and Frequent Relocations.** Analogously to trauma-associated risk factors, the number of forced relocations reflected complex interactions between refugee youth's individual system, exosystem (e.g., access to humanitarian assistance), and macrosystem (e.g., sociopolitical climate, culture, and ideologies). Nielsen et al. (2008) found that overall, refugee youth's frequent relocations were associated with mental health problems.

The impetus for displacement itself was a significant stressor for refugee youth, whether that was a natural disaster, war, or prosecution (Kirmayer, et al., 2010; Yule et al., 2000). Before fleeing danger, refugee youth and their families were exposed to adverse events including conflict and violence, separation from caregivers and friends, interpersonal violence, hazardous

conditions during transitioning from one place to another, torture, imprisonment, food and shelter insecurity, arrest, witnessing violence and death, etc. (see, e.g., UNHCR, 2015). It is worth mentioning that the vulnerable group of refugee youth, child soldiers were frequently exploited, abused, and threatened during displacement (Human Rights Watch, 2015).

At the migration stage, an unstable refugee camp environment had long-term negative effects on the mental health of youth who have experienced war and contributed to long-term mental health problems such as substance abuse, personality, attachment, adjustment, or mood disorders in adulthood (Elbedour et al., 1993; Tufnell, 2003). Noteworthy, refugee youth were involved in a lengthy asylum process before receiving a final notice about the resettlement or permanent placement of their families (Tufnell, 2003). Not only the length of the whole process was stressful; during the asylum application, refugee children were likely to experience significant distress and re-traumatization (Tufnell, 2003). For example, to validate a child's exposure to traumatic experiences, an asylum officer frequently asked questions such as "Have you ever seen someone else get hurt badly?" or "Did someone important to you ever die?" which tended to evoke upsetting memories and relieve trauma.

One can mistakenly assume that fleeing danger in a home country guaranteed safety for refugee youth. Papadopoulos (2001) argued that the ongoing political problems in refugees' country of origin jeopardized their mental health even after resettlement to a new country. For example, nearly 70% of refugees resettled to London reported most often worrying about the welfare of their family's home country (Heptinstall et al., 2004). Yates and Masten (2004) emphasized the role of media in re-traumatization, especially among young children who were unable to distance themselves emotionally from the cruel scenes watched on TV or the Internet. These findings suggested that refugee children were vulnerable to experience distress when

receiving news about their family members who were left behind, as well as the events happening in their country of origin (e.g., bombings, famine, death).

**Limited Access to Education.** Disrupted education was another example of how the interactions between the exosystem and mesosystem negatively influenced refugee youth's well-being (Bronfenbrenner, 1979). Even though access to education was children's fundamental right expressed in the UN Convention on the Rights of the Child (The United Nations Office of the High Commissioner for Human Rights, 1989), in 2019, 1.8 million (48%) of all school-age refugee children across the twelve countries were out of school (UNHCR, 2020c). Disrupted access to education was concerning given that schools were likely to be one of very few educational and psychosocial resources available to these youth during displacement.

**Limited Access to Community-based Resources.** Limited access to community-based resources across all three stages of the migration process had a significant impact on refugee youth's mental health. These challenges illustrated some of the problematic interactions between the refugee youth's individual system and their exosystem (Bronfenbrenner, 1979). In the post-migration stage, refugee family was likely to face economic hardship, which made it more difficult for them to access community-based resources such as healthcare, education, legal support, not to mention leisure activities and entertainment (Ehnholt & Yule, 2006; Sirin & Rogers-Sirin, 2015). Due to the limited healthcare resources available to refugees in host countries, often their basic medical needs were not met (Yaylaci, 2018). For instance, refugee youth's health condition was affected by poor antenatal care during pregnancy (Benage et al., 2015). Noteworthy, Syrian refugees displaced in Turkey reported that the language barrier hindered their ability to access healthcare even when it was in place (Torun et al., 2018).

Similarly, access to mental healthcare was very limited among refugee youth during displacement. In 2018, Moria Refugee Camp located in Lesvos in Greece, the first entry point to Europe for many refugees from Syria (International Rescue Committee [IRC], 2018), did not provide sufficient mental health support to refugee youth. This camp had the capacity of hosting 3,100 people, yet, there were 8,500 FDPs in 2018 (IRC, 2018). International Rescue Committee reported that there were four psychologists in Moria in 2018. In this overcrowded facility, there were cases of refugee children who attempted to die by suicide at the age of ten (IRC, 2018). It was evident that these conditions did not promote the well-being of refugee youth.

**Interrupted Family Life.** The well-being of refugee families reflected the microsystem-level challenges that refugee youth faced during displacement (Bronfenbrenner, 1979) including separation from family members, parent's mental health history, parenting strategies, and changes in roles within the family. While fleeing homelands, many refugee children became disconnected from their family members and friends, which subsequently had an impact on their sense of safety (Sullivan & Simonson, 2016). Indeed, some research studies of child soldiers, refugees, and survivors of the war in the Balkans and Israel showed that separation from an attachment figure was far more detrimental for a child than exposure to war itself (Keles et al., 2015). Specifically, unaccompanied refugee children were at an elevated risk of developing mental health disorders compared to minors with parents (Keles et al., 2015; Michelson & Sclare, 2009). Heptinstall et al. (2004) reported that a child's separation from family members in the pre-migration stage was the second most traumatizing factor reported by refugee children with an onset of depression, right after the violent death of family members. Further, their study found that 60% of children resettled in London reported witnessing a violent death of a family member and 22.5% experienced a temporary separation from a parent. These high rates of

separation from a child's primary caregiver were even more concerning given that a child's mental health strongly depended on their caregiver's well-being (Lenette et al., 2013). Some refugee children were likely to endorse persistent worry about their family members who were still entrapped in the regions affected by danger or remain in refugee camps and other temporary shelters (Reed et al., 2012).

Another factor that contributed to refugee youth's mental health difficulties was their parents' or caregivers' poor mental health. Reed and their colleagues (2012) showed that the mental health condition of refugee parents impacted their children's psychological well-being, especially during armed conflicts. A combination of a child's exposure to war violence, poor parental mental health, and father's incarceration were associated with the child's vulnerability to developing mental health disorders (Ehnholt & Yule, 2006). Trauma experienced by caregivers was an added stressor for refugee youth who were already recovering from adverse experiences (Gadeberg et al., 2017).

These mental health challenges alongside hazardous living conditions during displacement were likely to expose refugee youth to maltreatment associated with domestic violence. El-Khani et al. (2016) found that hazardous conditions in temporary shelters contributed to the likelihood of Syrian refugee parents using punitive parenting strategies. Parents in their research study reported that they were more prone to use physical ways of disciplining their children compared to their previous experience in their homeland. Additionally, parents' cultural beliefs specific to children's disobedience contributed to punitive parental strategies. For example, Syrian refugee parents expected their children to respect them and comply with their instructions, and if they failed to do so, parents felt justified to discipline their children (El-Khani et al., 2016).

### ***Protective Factors Among Refugee Youth***

Even though refugee youth faced multiple adverse events during displacement, some of them did well despite the exposure to trauma (Yates & Masten, 2004; Ungar, 2008a). In other words, in the presence of adversity, some children managed to achieve positive developmental outcomes. Refugee youth's efforts to cope with trauma were affected by the quality of their interactions with the surrounding (see, e.g., Yates & Masten, 2004; Ungar 2008a), which was consistent with Bronfenbrenner's system theory (1979). Knowing the variety of risks that put refugee children in danger of developing mental health disorders, it is necessary to discuss in detail findings from the previous research studies focused on refugee youth's protective factors.

**Table 1**

*The Attributes of Resilience Developed by Ungar (2008a) as Part of the International Resilience Project (p. 227).*

Individual	Social	Environmental	Cultural
1) Assertiveness	1) Quality of parenting meets the child's needs	1) Opportunities for age-appropriate work	1) Affiliation with a religious organization
2) Problem-solving ability	(e.g., the family is emotionally expressive, and parents monitor the child appropriately)	2) Exposure to violence is avoided in one's family, community, and with peers	2) Youth and their family are tolerant of each other's different ideologies and beliefs (such as gender roles)
3) Self-efficacy (a sense of control over one's world)	2) Social competence (person knows how to act socially)	3) Government plays a role in providing for the child's safety, recreation, housing, jobs when older	3) Cultural dislocation and a change (shift) in values are handled well
4) Being able to live with uncertainty	3) Having a positive mentor and role models	4) Meaningful rites of passage with an appropriate amount of risk	4) Self-betterment (not economic betterment, but the betterment of the person and community)
5) Self-awareness, insight	4) Meaningful relationships with others at school, home, perceived social support, peer group acceptance	5) Community is tolerant of high-risk and problem behavior	5) Having a life philosophy
6) Perceived social support		6) Safety and security needs are met	6) Cultural/spiritual identification
7) A positive outlook, optimism		7) Perceived social equity	7) Being culturally grounded: knowing where you came from and being a part of the cultural tradition, which is expressed through daily activities
8) Empathy for others and the capacity to understand others		8) Access to school and education, information, learning resources	
9) Having goals and aspirations			
10) Showing a balance between independence and dependence on others			
11) Appropriate use of or abstinence from substances like alcohol and drugs			
12) A sense of humor			
13) A sense of duty (to others or self, depending on the culture)			

**Individual Protective Factors.** Ungar (2008a) identified 13 different individual characteristics, skills, and abilities that contributed to the well-being of culturally diverse youth (see Table 1). Youth with a trauma background who were more self-reliant, introspective, empathic, goal-oriented, and wisely controlled use of substances were coping better than their peers who did not endorse these characteristics (Ungar, 2008a). For example, a child's curiosity, flexible coping strategies in overcoming adversity, a sense of worthiness, an internal locus of control, a task-oriented attitude, and optimism fostered healthy development. Another individual protective factor included youth's proactive attitude to seeking help from their parents (Montgomery, 2010). For example, refugee children upon their resettlement tended to display less trauma-related symptoms if they frequently approached their mothers and openly discussed their problems (Montgomery, 2010).

**Peers and Family.** As part of the refugee youth's microsystem, Mawani (2014) discovered that positive relationships with peers and family were the most impactful cluster of protective factors (Mawani, 2014). Additionally, Yasten and Masten (2014) argued that caregivers' positive coping strategies supported children's posttraumatic growth and mitigated negative outcomes of mental health problems. Similarly, greater parental support was associated with a higher sense of self-worth reported by adolescent refugees resettled in Australia (Kovacev & Shute, 2004). Also, Elbedour and et al. (1993) demonstrated that parents' success in coping with distress benefited their child's mental health through modeling positive behaviors and providing a sense of stability.

In addition to parents, peers also played an important role in refugee youth's life. Kia-Keating and Ellis (2007) reported that having peers to play with facilitated a refugee child's successful adaptation to a new culture. These positive peer interactions fostered refugee



children's sense of belonging to a local community, and contributed positively to their well-being. Specifically, upon resettlement, Somali refugee adolescents who felt like members of the school community displayed fewer depressive symptoms and demonstrated higher self-efficacy (Kia-Keating & Ellis, 2007). Noteworthy, refugee youth's success in utilizing available community support was linked to cultural matching between them and their community; Porte and Torney-Purta, (1987) reported that Indochinese refugee unaccompanied children who stayed with people of the same ethnic origin display fewer depressive symptoms than those who were placed in foster care facilities with people of foreign ethnic backgrounds.

**Access to Community-based Resources.** In addition to individual characteristics and a presence of social support, access to resources that refugee youth had during displacement was a crucial protective factor (Yates & Masten 2004). Importantly, the findings from the International Resilience Project and the follow-up research studies (see, e.g., Ungar, 2008a) emphasized that access to community-based resources was not enough; youth's capacity to seek help was a critical element, too. Furthermore, there had to be a match between these resources and the unique needs of an individual. For example, a refugee child may be able to navigate their way to mental health services provided in a refugee camp; however, if this support was not culturally responsive, this child would be likely to find these resources less meaningful. This case illustrates that the refugee child did not lack resilience, but their environment failed to navigate the cross-cultural differences and unique needs of this child.

**Positive Sense of Cultural Identity.** Ungar (2008a) also highlighted the role of cultural resources in bolstering youth's resilience, which corresponded with the macrosystem defined by Bronfenbrenner (1979). Mawani (2014) viewed culture as a prism through which an individual looked at their health and illness. One of the most commonly reported cultural protective factors

was faith, which, if practiced, had a positive effect on one's recovery from a traumatic past (Majumder et al., 2015). For example, refugee youth could rely on their faith in order to process traumatic experiences that have happened to them. Stichick-Betancourt and Khan (2008) argued that the belief system had the potential to further bolster refugee children's resilience when it was incorporated in services delivered by the organizational framework of refugee camps (e.g., spaces for praying).

As discussed earlier, one of the biggest challenges that faced by refugee youth and their families during displacement was the disconnection from their native environment. After fleeing a homeland, they needed to find ways to maintain their cultural and religious practices. Therefore, cultural identity was likely to play a protective role in refugee youth's lives. In fact, Hoersting and Jenkins (2011) reported that individuals who had a strong sense of their cultural identity endorsed higher self-esteem than those who did not demonstrate strong ties to their native culture. According to Pickren (2014), "maintenance of cultural identity [was] one widely used strategy by migrants that [could] serve as a source of resilience" (p. 21). On this note, Sadat (2008) proved that Afghan refugees used stories from their native culture to maintain the sense of "Afghan-ness" even when they lived in a very different cultural setting.

Further, Sirin and Rogers-Sirin (2015) emphasized that refugee youth's healthy development can be scaffolded by helping them to retain ties to their native culture. For example, lower rates of depression and anxiety were observed in the population of Syrian refugees who derived a sense of efficacy and meaningfulness from their cultural identity (Çelebi et al., 2017). A positive sense of ethnic identity also helped families to cope with social stressors such as stigmatization, sense of hopelessness, and lack of legal rights (Çelebi et al., 2017). Thus,

promoting a native cultural identity among refugee children yielded the potential to nurture their resilience.

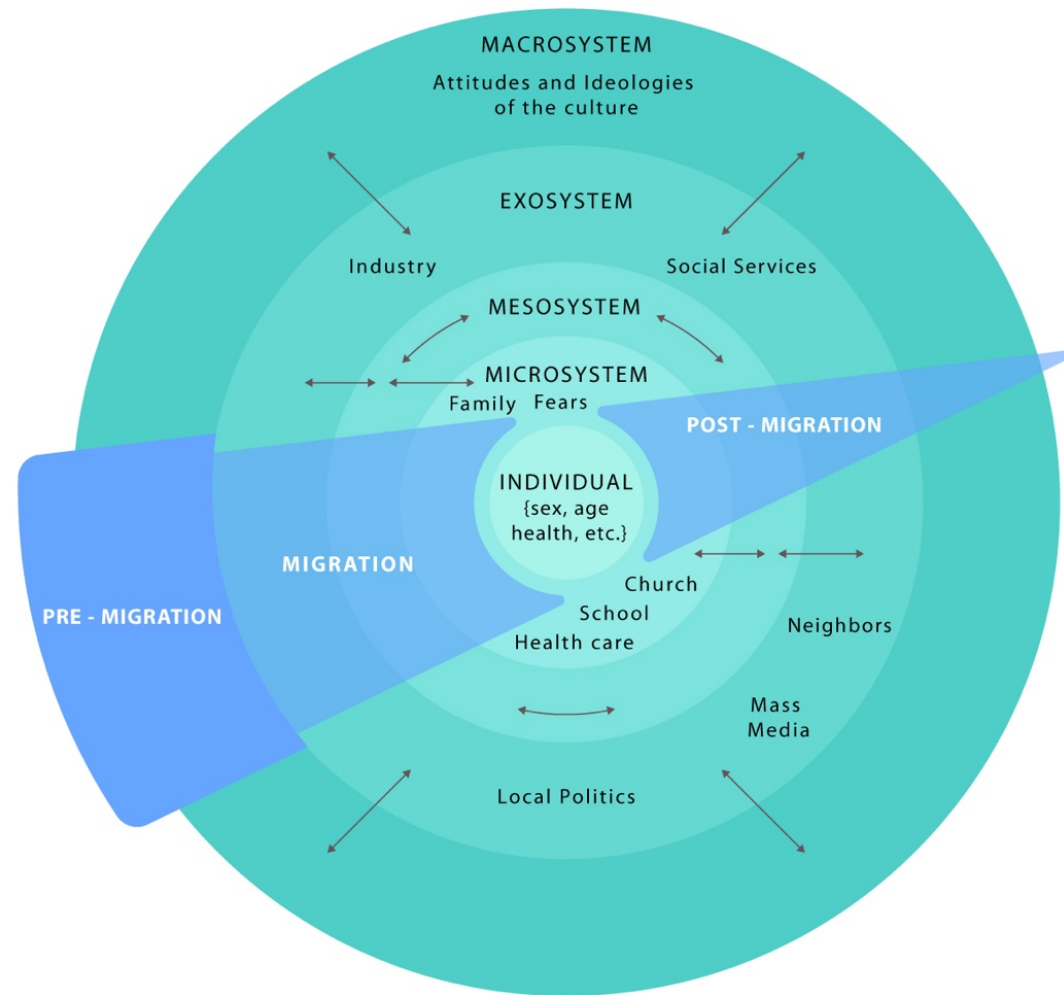
Once refugee youth resettled in a new country, they needed to learn a foreign language. Even though foreign language acquisition was a pivotal step to one's successful acculturation, Mawani (2014) emphasized that "there [was] a need to balance the promotion of ESL/FSL with the maintenance of mother tongues and recognition of speaking multiple languages as assets" (p. 42). Therefore, it remained crucial to support refugee youth's efforts to retain their first language (Sirin & Rogers-Sirin, 2015).

### **Current Study**

I merged Bronfenbrenner's (1979) ecological system theory with the previous research on resilience factors among culturally diverse youth (see, e.g., Ungar, 2008a) to develop a visual model of displacement-specific resilience and mental health factors among refugee youth (see Figure 4). Namely, this chart demonstrates refugee youth's resilience and mental health factors that were intertwined with their migration journey.

**Figure 4**

*Displacement-specific Model of Resilience and Mental Health Factors Among Refugee Youth.*



Recognizing urgent needs of refugee youth who have been forcibly displaced in Southeastern Europe (e.g., refugee camps) and scarcity of resources available to these youth, I decided to conduct a qualitative research study that aimed to contribute to existing literature allotted to refugee youth's mental health and resilience, and provide recommendations for school psychologists who served these youth during displacement. Importantly, the literature review showed that refugee youth were very vulnerable to numerous adverse events at all migration stages; this knowledge motivated me to gain insight into the factors that contributed to their resilience and mental health. I used the term "protective factors" to describe the conditions, attributes, and circumstances that humanitarian workers associated with positive psychosocial outcomes among refugee youth during the migration stage. The word "challenges" denoted all elements of refugee youth's life that threatened their well-being during the migration stage. To accomplish this goal, I decided to explore the perspectives and lived experiences of humanitarian workers who were one of the primary sources of psychosocial and educational support for these youth and their families during the migration stage. Additionally, my hope was that this research study would allow me to further identify humanitarian workers' needs for future training.

**Study Aims:** This study focused on the refugee youth's mental health and resilience factors during the migration stage by exploring humanitarian workers' views on:

Aim 1. Refugee youth's trauma-related symptoms.

Aim 2. Resilience factors that impacted refugee youth's well-being during the transit stage in Southeastern Europe.

Aim 3. The strategies that humanitarian workers used to address refugee youth's mental health needs.

### **Chapter 3. Method**

This qualitative research study aimed to fill a gap in current literature focusing on refugee youth's mental health and resilience by exploring humanitarian workers' views on (1) refugee youth's trauma-related symptoms, (2) factors that contributed to refugee youth's well-being during the migration stage, and (3) strategies that humanitarian workers used to scaffold refugee youth's healthy development.

#### **Participants**

Participants in this research study were humanitarian workers ( $N = 12$ ) who were (1) at least 21 years old, (2) identified themselves as anyone employed by a relief agency and provided immediate aid to refugee youth during migration stage in Southeastern Europe, (3) worked for at least three months with refugee youth, and (4) self-reported a minimum B2 English level proficiency per the Common European Framework of References for Languages [CEFR] (Council of Europe, 2001).

First, participants included in this research study were at least 21 years old because of standard policies endorsed by humanitarian organizations that delivered emergency aid in the displacement context. This criterion was informed by the PI's work experiences in the field of humanitarian aid. Namely, due to hazardous work conditions, high exposure to trauma, and the vulnerability of the served population, many relief agencies accepted only volunteers and employees who met the age requirement, typically 21 years old (e.g., European non-profit organizations that offered emergency aid to refugees arriving in Greece).

Second, participants were recruited if they have been employed by a humanitarian organization as staff members or volunteers and delivered aid to refugee youth during the migration stage in Southeastern Europe. Humanitarian workers included in this research study

provided aid in the sectors of health, education, and child protection (e.g., tracking, case management, referrals of vulnerable children), as well as cultural and linguistic support. Table 4 shows the aggregated information on the participants' self-reported backgrounds, and Table 5 presents the sociodemographic information paired with the participants' ID numbers assigned to them during the data collection.

Third, participants were expected to have at least three months of direct work experience in supporting refugee youth. For the purpose of this research study, it was critical to ensure that recruited humanitarian workers had minimum exposure to the context of forced displacement in order to discuss refugee youth's mental health and resilience. Importantly, this inclusion criterion was informed by the recruitment procedure employed by Young and her colleagues (2018), as well as the sampling used by Ager et al. (2012) who investigated coping strategies utilized by humanitarian workers.

Fourth, given the international nature of this research study, participants were enrolled if they declared at least a B2 level of English language proficiency according to CEFR (2001). This research study was conducted in English; therefore, it was crucial that participants demonstrated a sufficient ability to freely express their ideas and share their experiences with the PI. CEFR explained that B2 English language proficiency indicated (1) an ability to understand the main ideas of complex text on both concrete and abstract topics, including technical discussions in one's field of specialization, (2) an ability to interact with a degree of fluency and spontaneity that makes regular interaction with native speakers quite possible without strain for either party, and (3) an ability to produce clear, detailed text on a wide range of subjects and explain a viewpoint on an issue discussing advantages and disadvantages of various options. Participants

self-reported their language proficiency levels in an online sociodemographic survey before an in-person interview.

To increase triangulation of collected data, I recruited humanitarian workers who have had lived refugee experiences, who were proficient in the native language spoken by refugee youth and also shared their ethnic background, who worked as teachers with refugee youth both in refugee camps, formal, as well as informal educational settings in host countries, and individuals who delivered psychosocial support on-site (see Table 4 and 5).

Participant-specific sociocultural factors, such as religious affiliation, were further explored through in-person interviews only if the participant voluntarily decided to disclose particular information.

### ***Sample Size***

In the current study, sample size was determined by the recommended best practices on how to establish saturation as well as the criteria used in research studies conducted in the field of social and health sciences (see, e.g., Francis et al., 2010, Saunders et al., 2018). Guest et al. (2016) explained that saturation can occur at the data collection or data analysis level, and it can be viewed either as a cut-off point when data collection is stopped (Mason, 2010), or a process of constant evaluation of the data in light of research questions (Saunders et al., 2018).

At the data collection level, saturation helped to avoid redundancy in the data (Sandelowski, 2008), and ensured that a studied phenomenon was well-represented (Saunders et al., 2018). There were very limited guidelines on how to determine a sample size using saturation in the field of refugee youth's mental health. For example, a qualitative study by Young and her colleagues (2018) on coping strategies among humanitarian workers, included a large sample of 218 participants without providing detailed saturation criteria. Therefore, the proposed sample



size in this research study was based on prior qualitative investigations in related fields, such as health sciences. For instance, a systematic attempt to determine the sample size based on saturation was conducted by Guest et al. (2006) and showed that 12 interviews sufficed to collect meaningful data, particularly for homogenous samples. However, the same researchers advised caution in applying this guideline to heterogeneous groups of participants. There was also evidence to suggest that the sample size ranging from 7 to 12 was appropriate when a research study was based on semi-structured interviews and some degree of sample homogeneity (Jassim & Whitford, 2014). Given these accounts, I identified that it was sufficient to recruit 12 humanitarian workers from diverse cultural and professional backgrounds.

At the coding level, saturation was the point at which no new meaningful themes emerged (Given, 2016). At the data analysis level, my team and I were regularly evaluating the data using the thematic analysis described later to ensure that the research questions were answered, and all novel perspectives shared by the participants were identified and analyzed. Overall, saturation was an essential methodological criterion to inform when to discontinue the data collection and stop the analysis process in this research study.

### ***Participant Recruitment***

The snowball sampling technique with critical case sampling were used to recruit participants to this research study (Trotter, 2012). Snowball sampling relied on individuals with well-established professional networks that facilitated the enrollment of participants who could contribute to a research study due to their experiences, knowledge, or background. Critical case sampling represented a recruitment process focused on selection of information-rich participants. To identify study participants, two groups helped me to determine a list of contacts: (1) prominent researchers in the field of refugee youth's mental health, and (2) representatives of

leading humanitarian organizations that have delivered aid in Southeastern Europe. I contacted potential participants via work email and in person while collaborating with humanitarian organizations in Southeastern Europe in Spring and Summer 2019. Humanitarian workers who were interested in participating in the study were asked if they were willing to provide names and contact information of other humanitarian workers who have worked with refugee youth.

### **Proposed Design**

This research study utilized a qualitative approach to explore humanitarian workers' views of refugee youth's mental health and resilience factors, learn about strategies used by humanitarian workers to address these youth's needs, and identify humanitarian workers' needs for future training. I relied on both inductive and deductive reasoning throughout the research process (Nowell et al., 2017). Qualitative data was collected through an online survey and in-person semi-structured interviews conducted in English. Institutional Review Board approval was obtained prior to the study initiation.

### **Measures**

#### ***Sociodemographic Information***

An online sociodemographic survey written in English was used to obtain participants' background information to determine their eligibility to be interviewed. The online survey included an informed consent form. The following sociodemographic data was obtained: age, sex, cultural identity, educational background, length of experience in delivering aid to refugee children, English and Arabic language proficiency levels, countries where services were delivered, and ethnic and national backgrounds of served refugee youth (see Table 4, and Table 5). The survey format was based on the sociodemographic questionnaire utilized by Young and her colleagues (2018); I accessed this measure through private email correspondence on April

10th, 2019. Also, sociodemographic factors included in a quantitative study on the UNHCR staff's well-being and mental health informed the development of the survey in my research study (Suzic et al., 2016).

### ***Semi-Structured Interview***

I developed a semi-structured interview protocol to collect humanitarian workers' views and knowledge on: (1) observed risk and protective factors that impacted refugee youth's well-being at the migration stage, (2) acculturation and its effects on refugee youth's well-being, (3) refugee youth's trauma-related internalizing and externalizing symptoms, (4) strategies they used to support refugee youth's healthy development, and (5) needs for professional development and training in the future. In contrast to a group interview, an individual interview was an appropriate tool to explore humanitarian workers' views, experiences and beliefs on refugee youth's mental health as it allowed me to gather more in-depth testimonies (Gill et al., 2008). Another reason to use a one-on-one interview was related to the sensitive nature of discussed topics. Individual interviews also allowed to create a safe environment in which the participants could not only discuss the protection concerns related the refugee youth with whom they worked, but also felt comfortable to reflect on their vulnerabilities as aiders.

The protocol of this interview was created and vetted through a two-phase process using a panel composed of experts in the fields relevant to this research study, such as youth's mental health, multicultural psychology, linguistics, early education, as well as humanitarian aid. Among the experts were individuals with lived immigrant and refugee experiences. Also, doctorate-level researchers who specialized in qualitative data collection were consulted throughout the interview script formulation process. Based on current literature allotted to the field of refugee youth's mental health and resilience, my international clinical and humanitarian

experiences, I proposed questions to the experts. They provided feedback the content, structure, clinical, and cultural appropriateness of both a sociodemographic survey and an interview. Feedback was collected through email or in person, depending on the geographical location of the expert, and revisions to the questions were made as necessary.

Additional consultation with experts in youth's mental health (i.e., a psychologist and researcher) was obtained in case of ambiguous feedback comments. Following this process, I made final revisions to the survey and interview questions and presented it to the experts for final evaluation. Importantly, following CEFR criteria, interview questions were evaluated for their language level so that they were appropriate for non-native English speakers who self-reported a B2 proficiency level. Specifically, idiomatic expressions, jargon, and convoluted grammar structures were omitted. Furthermore, member checking was utilized to enhance the trustworthiness of the developed questions (Birt et al., 2016)

### ***Materials and Setting***

Interviews were conducted in private and confidential spaces. All interviews were audiotaped using a digital audio recording device, saved as MP3 files, encrypted, and uploaded to password-protected cloud storage. During transcription and data analysis, research assistants (RAs) were accessing audio files in a confidential lab working room without other people present during transcribing or data analysis. All audio recordings were deleted from the digital recorder once the audio files were converted to an MP3 format, and they were erased from the cloud storage following completed transcription. To provide another opportunity for triangulation, I wrote the reflexive journal entries and research notes throughout the research study (Janesick, 1999). These notes included my responses to the research process, reflections on my biases, and

impressions. Additionally, RAs' reflections and notes were discussed during weekly meetings to facilitate data analysis.

## **Researchers**

### ***Primary Investigator (PI)***

I am a multilingual doctoral School Psychology student who completed a five-year graduate program in Psychology with the specialization in Applied Developmental Psychology, and a three-year undergraduate program in Applied Linguistics specializing in Arabic at Kazimierz Wielki University in Poland. I am a certified English as a Second Language teacher and a fluent non-native Arabic speaker. I have conducted experimental research studies on cognition-emotion relations in children's foreign language acquisition, implicit biases towards Arabic native speakers, and Muslim refugee youth's resilience and mental health. The latter research project prompted the development of this current research investigation. I have received comprehensive training in conducting indigenous research studies.

Additionally, I have had nine years of experience in delivering psychosocial and educational support to disadvantaged youth and families who experienced various types of trauma (e.g., war violence, historical trauma, physical, emotional, and sexual abuse), neurodevelopmental disorders, and learning disabilities in seven countries across various settings (e.g., public and private schools, refugee camps, out-patient clinics, youth homes, humanitarian non-profit organizations). As for forcibly displaced youth, I have delivered on-site and remote psychosocial, educational, and policy support in refugee camps and shelters based in Southeastern Europe. I have collaborated with international non-profit organizations and humanitarian agencies that provided psychosocial and educational services to forcibly displaced

youth and their families across all migration stages in the Middle East, Europe, and the United States.

### ***Research Assistants (RAs)***

There were four RAs involved in the data analysis process including three undergraduate psychology majors, and one school psychology doctoral student; two RAs were bilingual. All research team members were part of a university research laboratory focused on culturally responsive evidence-based practices in school psychology. Three RAs also completed a Multicultural Psychology class that focused on forcibly displaced populations. The graduate school psychology RA had prior experiences in supporting migrant youth in detention centers in the United States, and Italy. All RAs received five-month training on qualitative research methodology including data analysis software NVivo, transcribing software InqScribe, humanitarian aid in refugee camps, forced displacement, and trauma-related psychological problems.

### ***External Auditors (EAs)***

External Auditors were experts in the field of refugee and immigrant mental health, academic performance, school psychology, socio-emotional learning programs for refugee youth, applied linguistics, gender-based and domestic violence, human rights and humanitarian aid including child protection. Importantly, I collaborated with multilingual and multicultural experts who were familiar with the cultural and linguistic context of refugee youth based in Southeastern Europe or had lived experiences relevant to the context of this research study. During the data analysis process, external auditors provided feedback, for example, on codes and themes that were culturally loaded, pertained to child and adolescent psychopathology and healthy

development, or educational system and humanitarian aid in the host countries where refugee youth attended schools.

## **Procedure**

Snowball sampling was employed to distribute a recruitment email advertising the research study in humanitarian organizations that delivered aid to refugee youth in Southeastern Europe. Humanitarian workers interested in the research study contacted me, and then I shared with them a link to the online Qualtrics survey that included a consent form. I evaluated participants' responses in terms of inclusion criteria and invited those who met all requirements to an in-person or phone interview. Following the humanitarian workers' continuous interest, I contacted them to schedule an in-person or phone interview, depending on the participant's availability and preference. Before an interview, I sent a consent form to the participant via email so that they could review it and raise any questions or doubts. Also, at the beginning of each interview, I sought consent from the participant, emphasizing the voluntary format of participation in this research study, confidentiality, potential risks, the details of audiotaping and storing gathered information, and future dissemination of research findings. I asked for permission to take notes during the interview. Also, the contact information of my supervisor and I were provided should the participants have questions or concerns. No participants' identifiable information including names of refugees, humanitarian agencies or other organizations were collected. If the participant disclosed identifiable information, research team members erased it from the transcriptions of the recording. Following the informed consent process and answering participant's questions, I collected participants' signatures. The participant's confidentiality was protected by assigning an identification number to all pieces of data including consent forms, sociodemographic surveys, audio files, and my notes taken during an interview. I used a digital

device to record the conversation and took electronic notes, including follow-up questions and personal reflections. These notes were encrypted and saved on password-protected cloud storage. Given that participants were disclosing trauma-related content, and many of them were experiencing psychological difficulties (e.g., burnout, anxiety, secondary trauma, and were exposed to ongoing stressors in their work environment), I debriefed them and shared resources available in the participant's current place of residency. I always ensured participant's safety and excluded the risk of suicidality. During the data collection, I received regular supervision and debriefing from my academic supervisor, who also was a licensed psychologist, and utilized individual counseling due to high exposure to secondary trauma. Lastly, I wrote journal entries that incorporated my reflections on the research process.

Following interview completion, the research team used InqScribe software to transcribe the audio recordings and convert them into .PDF files. RAs transcribed interviews on a password-protected computer in a research laboratory without other persons present in the room. Following the end of a transcription session, RAs erased all files including trash from the computer, encrypted the files they created, and uploaded them to password-protected cloud storage. I validated the accuracy of all transcripts by comparing audio recordings and text, erased identifiable information, and asked the participants to review unclear sections of the transcription to ensure the trustworthiness of data (e.g., sometimes RAs had difficulty recognizing participants' foreign accents). All recordings were destroyed at the end of the transcription and verification process. My academic supervisor, an expert in school psychology and qualitative research, and I were regularly debriefing RAs and discussing their responses to the research process as well as the content of interviews. Lastly, I created a digital handout with online mental health and educational resources focused on fostering refugee youth's mental health including



websites, courses, books, programs, and professional networks, and shared them with all participants as they expressed interest and urgent need for receiving support.

## **Data Analytic Strategy**

### ***Survey Data***

Only fully completed sociodemographic surveys ( $N = 12$ ) were included in the data analysis. Given a small sample size, percentages rather than means were utilized to more accurately illustrate the sociodemographic information (e.g., language proficiency, work experience) (see Table 4 and 5). Suzic and their colleagues (2016) also used this method to present the results of their research study on UNHCR staff well-being and mental health.

### ***Interview Data***

Combined deductive and inductive approaches guided the thematic analysis process (Nowell et al., 2017). First, Bronfenbrenner's ecological systems theory (1979) and previous research on resilience among culturally diverse youth including refugees (see, e.g., Ungar, 2008a) informed the identification of factors that contributed to refugee youth's resilience. Second, an inductive approach was implemented to capture all culture and displacement-specific nuances that were not conceptualized by the aforementioned theoretical models.

Braun and Clarke (2006), as well as Nowell et al. (2017) recommended a trustworthy thematic analysis to draw similarities and differences between participants' perspectives, and identify nuanced and unanticipated insights. I followed the six steps of thematic analysis and ensured trustworthiness. To begin the analysis process, transcribed interviews were imported to NVivo, a qualitative data analysis software. Importantly, prior to the standard six steps, I prepared the research team to engage with the data by training all co-researchers on qualitative methods, the introduction to humanitarian assistance, and the realms of refugee camps. Also, I

provided the initial resources for self-care to all RAs given that the collected data included descriptions of unsettling events, such as violence, human trafficking, injuries.

The first data analysis phase allowed initial prolonged familiarization with the data in order to identify items of potential interest. Concretely, all researchers read interview transcripts at least twice to obtain an overview of potential codes and themes. During weekly meetings, we discussed potentially interesting features of the data, and documented our methodological and theoretical impressions in the meeting minutes, and annotations in NVivo. We also kept reflexive journal notes to document our initial analytic interests and thoughts. To ensure trustworthiness, but also prevent secondary trauma related to immersing ourselves into the data, we engaged in peer debriefings conducted by myself, as well as an external expert in the field of school psychology and qualitative research.

In the second phase, systematic coding began and preliminary codes were generated. Congruent with the steps described by Nowell et al. (2017), we generated initial codes deductively; these were both (1) semantic codes based on the conceptual framework, prior research, and my previous research study on Muslim refugee youth's resilience, and (2) inductive codes driven by the raw data (Braun & Clarke, 2006). Semantic codes were assigned to comments that were very transparent and easy to identify in the context of the conceptual framework (e.g., descriptions of children's disruptive behaviors, parents' poor mental health). On the other hand, latent codes revealed implicit ideas such as assumptions behind the semantic content (e.g., participants' biases towards specific cultures). The initial coding phase generated a list of codes and annotations (i.e., comments left by researchers in NVivo). I documented all weekly research team meetings, and initial lists of codes. An audit trial was conducted with

experts in the field of school psychology, Arabic linguistics, and mental health and psychosocial support in humanitarian settings.

In phase three of the thematic analysis, we analyzed participants' responses in-depth. We merged existing codes and organized them into themes, using diagrams to better understand the connections. We defined a theme as "an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole" (DeSantis & Ugarriza, 2000, p. 362). Importantly, we focused on the importance and relevance of emerging themes to the research questions as opposed to applying quantifiable measures to describe these themes (e.g., frequencies of words used) (Braun & Clarke, 2006). We used an inductive approach to further examine the codes that were not fitting the initial themes. These were mostly latent codes that further informed the development of themes and sub-themes (e.g., professional humility).

The fourth stage focused on reviewing potential themes stage and included two steps: (1) checking that the themes aligned to the research questions, and (2) ensuring that chosen themes corresponded to the whole dataset. We discussed saturation of the data throughout this process as well as the potential need to recruit more participants. We concluded that the data we had was sufficient to draw meaningful themes in order to answer the research questions. Braun and Clarke (2006) suggested that at this stage, it was important to ensure the validity of the analysis, and reduce the likelihood of coder drift. In other words, I re-trained RAs on the theoretical and methodological concepts that were key to this research study. This step allowed to reduce the risk of diverging from the theoretical foundations and infusing emerging themes with personal biases.

The fifth step aimed to define and name themes. During this phase, we generated detailed definitions of all themes and sub-themes, named them, and organized them into a logical framework.

At the last stage of thematic analysis, we concluded findings, re-assessed saturation, involved EAs to clarify doubts regarding specific themes (e.g., gender-specific cultural norms), and conducted member checking. I proceeded to write a thorough report of all the steps we took to analyze our data, and this text is the conclusion of the sixth step of the thematic analysis process.

Across all stages, I conducted peer debriefing and also received debriefing myself from an expert in the field of qualitative research and school psychology. Nowell et al. (2017) recommended peer debriefing only across phases 1–5, however, given the scope of the data collected in this research study and the potential to trigger emotional reactions among RAs, peer debriefings were conducted also at the first stage. Also, the notes that I took during interviews as well as my post-interview journal entries were discussed across all weekly research team meetings. These journal notes facilitated the code assignment and theme conceptualization across all data analysis stages.

### ***Triangulation and Trustworthiness***

Data collection triangulation and researcher triangulation were utilized to enhance the credibility of obtained results (Heale & Forbes, 2013; Lincoln & Guba, 1985). Diversifying my research sample helped to gain a complex overview of refugee youth's mental health and resilience, strategies used by humanitarian workers to support these youth's healthy development, and identify potential needs for training. Namely, participants came from diverse professional and educational backgrounds including yoga instructors, child protection specialists,

teachers, play therapists, interpreters, and volunteers who delivered psychosocial support. At the data collection level, triangulation was enhanced by recording sociodemographic data and conducting semi-structured interviews. As for the research team, diversified experiences related to multiculturalism and immigrants' well-being allowed us to analyze the data from multiple perspectives. The inclusion of EAs further strengthened the triangulation of data analysis.

To establish the trustworthiness of this research study, the following criteria were applied: (1) credibility, (2) transferability, (3) dependability, (4) confirmability, (5) audit trails, and (6) reflexivity. To establish credibility, I used data and research triangulation, peer debriefing, consultation with EAs, and member checking. EAs helped to ensure credibility by monitoring and controlling researchers' biases that otherwise could have affected data analysis and interpretation (Nowell et al., 2017). Member checking allowed to validate the interpretations by asking the participants about their impressions and examining whether they could relate their stories and experiences to the findings (Lincoln & Guba, 1985).

Transferability in qualitative research studies is concerned with the generalizability of inquiry (Nowell et al., 2017). I increased transferability of my inquiry through providing thorough descriptions of all steps taken during the research process. The goal of enhancing transparency was to provide sufficient information for other researchers so that they can decide whether the obtained findings were trustworthy and can be transferred to other contexts.

To ensure dependability and allow the audit trail, I chose a transparent qualitative data analysis process (i.e., thematic analysis) and thoroughly documented all steps taken by myself and my research team (i.e., reflexive journals, meeting minutes, annotations in NVivo) (Tobin & Begley, 2004; Koch, 1994).

Confirmability was another important dimension of trustworthiness and it was concerned with how I arrived to my conclusions (Tobin & Begley, 2004). To achieved confirmability, I included thick descriptions of all theoretical, methodological, and analytical decisions that I made throughout the study. Increasing confirmability aimed to demonstrate that all interpretations that I developed stemmed from the data. Guba and Lincoln (1989) also suggested that confirmability occurred when credibility, transferability, and dependability were all established.

To enhance the trustworthiness of my study, I also created opportunities for an audit trail (Koch, 1994). Namely, I archived all raw data, reflective journal entries, minutes from the research team meetings and debriefings, as well as research-related documentation. All these materials created tangible evidence of the decision-making process, and its outcomes. I used all of the aforementioned records to allow an audit trial, and thus validate my research findings, through weekly research team discussions and consultation with EAs.

The auditable materials included proofs of reflexivity that I also introduced to increase the trustworthiness of my inquiry. Together with my research team, I practiced reflexivity across all stages of this research study. Namely, we engaged in a self-critical reflection on the theoretical and methodological issues throughout the research study (Tobin & Begley, 2004). For example, my reflexive journal included notes from the semi-structured interviews, post-interview impressions, logistics of the research, methodological and theoretical decisions. Together with meeting minutes from the peer debriefings, and annotations posted in NVivo, these records became evidence of the decisions my research team and I made throughout the research study, and thus ensured the trustworthiness of the procedures at each stage.

## **Chapter 4. Results**

Using the displacement-specific model of refugee youth's mental health and resilience (see Figure 4), this chapter presents the primary themes derived from the data. Specifically, this section describes participants' perspectives on (1) factors that fostered refugee youth's healthy development and fostered their recovery from trauma during the migration stage, and (2) challenges that jeopardized these youth's safety and well-being, and thus, exacerbated their mental health problems during the transit stage. Humanitarian workers' comments that discussed examples of a stimulating and nurturing impact on refugee youth's mental health during the migration stage were classified as protective factors. On the other hand, threats that jeopardized these youth's safety and well-being, and exacerbated their mental health problems during the migration stage were considered as challenges. All factors were clustered in the individual system, microsystem, mesosystem, exosystem, and macrosystem. Within each system, main themes, subthemes and quotes were introduced. Individual sociodemographic characteristics of each participant as well as assigned ID numbers are presented in Table 5. Listings of the participants' contributions to individual resilience and mental health themes are provided in Table 6 (protective factors), and Table 7 (challenges).

### **Displacement-specific Protective Factors During the Migration Stage**

Participants reflected on refugee youth's strengths, resources, and other factors that helped these youth to develop positive and healthy social relationships, overcome challenges, and recover from trauma despite experienced adversities during the migration stage. Eleven main themes were identified alongside seven subthemes.

**Table 2**

*Socioecological Factors That Fostered Refugee Youth's Well-being During The Migration Stage.*

System	Main themes and subthemes	Quotes
Individual System	Theme 1: Refugee youth's engagement and creativity	"The young Syrian girl who was about thirteen was very involved in whatever activities she could be in, whether it was acting, or taking dance classes. I think being able to keep herself busy and not be totally bored helped her to cope".
	Theme 2: Refugee youth's psychological flexibility and openness to new cultural experiences	"The refugee parents were not so open to other nations; if they were from Syria, they preferred to engage with Syrian people; if they were Kurdish, they prefer to deal with Kurdish people. I observed that children did not have that problem."
	Theme 3: Refugee youth's self-awareness and self-advocacy	"If the child was sitting at a table with a lot of children and [they] were not necessarily wanting all of that sensory input, [they] would remove [themselves] and get to sit at table by [themselves], and I think that sort of thing was a great coping mechanism."
Microsystem	Theme 4: Refugee parents' sensitivity to children's needs	"Children who had parents who were not struggling and who were supportive, and understanding of their children's needs, were just like children from another world."
Mesosystem	Theme 5: Humanitarian workers' verbal and nonverbal communication strategies individualized to the refugee children's needs	"I tended to make sure [children] could see me so I sat out in the space and made sure there was visual contact so they could see what I am doing, and I just started playing with things. I had got an array of things; sometimes [children] would be watching me and that was okay because I knew that the message was going through ... a lot of times,



System	Main themes and subthemes	Quotes
	Theme 6: Humanitarian workers' assistance in navigating cultural differences	<p>[children] just came and join in.”</p> <p>“A huge percentage of Arabs did not have pets because there was the idea that pets had a lot of germs, they were unclean, they messed up the house, they brought bad luck ... some people believed that a dog could bring bad luck to you and all your house if it was black ... [refugee children] were taught that [having a pet] was wrong or not right ... maybe [humanitarian workers] could explain to [children] that [having a pet] was alright and nothing bad could happen to them. [Children] had not experienced [having a pet] and some of them could have fear of it.”</p>
Exosystem	<p>Theme 7: Nurturing spaces for refugee youth inside and outside of the refugee camp</p> <ul style="list-style-type: none"> <li>• Small and age-consistent groups</li> <li>• Clear and consistent rules and expectations</li> <li>• Trauma-informed psychosocial and educational interventions</li> <li>• Access to public education</li> </ul> <p>Theme 8: Humanitarian workers' self-awareness and positive attitudes toward refugee youth</p> <ul style="list-style-type: none"> <li>• Self-reflection and professional humility</li> <li>• Humanitarian workers' responsiveness to refugee youth's individual psychosocial needs</li> </ul>	<p>“An environment which provided [refugee children] with consistency every day would make the child's life easier; it would make them feel calm and more confident.”</p> <p>“I think schooling was an important part of children's well-being...When a child was in the school system, they were picking up the language a lot quicker; they had a strong incentive to learn the language; they were also being introduced to people from different cultures.”</p> <p>“We had a massive chalkboard ... [children] would map out their journey....It was all coming from them; we were just setting up the environment and resources so that the children could use them in that way, if they want to.”</p> <p>“I think that there was a need to reflect, and learn models of reflections, if reflection did not come naturally to someone”. “I kept a gratitude journal. I tried to write in it every morning; I wrote there things that I was grateful for, and all</p>

System	Main themes and subthemes	Quotes
		the things that were positive in life and that set me in the morning on a good note.”
	Theme 9: Humanitarian workers’ positive coping strategies	“I tried to talk with people, especially with people ... that were also in the same field and I could relate to [them].”
Macrosystem	Theme 10: Cultural practices and customs <ul style="list-style-type: none"> <li>• Faith</li> </ul>	<p>“... in the Middle East and Africa ... there was a storytelling culture; people liked telling stories and they would get together in groups and local communities and talked about things and share stories ... I think [storytelling] was a really good example for refugee children because it provided a support net where people were listening to each other and share their stories”.</p> <p>“Ramadan ... can give [children] the safe space they need”</p>

### ***Individual System***

The individual system encompassed refugee youth's characteristics, skills, and attitudes that humanitarian workers viewed as a source of resilience for these youth. Three primary themes arose from the data analysis and included (1) refugee youth's engagement and creativity, (2) refugee youth's psychological flexibility and openness to new cultural experiences, and (3) refugee youth's self-awareness and self-advocacy. Specifically, the cluster of individual protective factors encapsulated refugee youth's ability to identify their needs and freely communicate them to others, tolerate the changes and unfamiliar situations, and make choices that stimulated their growth.

**Theme 1: Refugee Youth's Engagement and Creativity.** The first theme that emerged within the individual system was related to refugee youth's willingness to actively seek and engage in organized activities such as language classes, art workshops, sports, and games. Eight participants (66.7 %) discussed this proactive attitude as refugee youth's strength that helped them to cope with daily stressors. Participant 2 recalled:

The young Syrian girl who was about thirteen was very involved in whatever activities she could be in, whether it was acting, or taking dance classes. I think being able to keep herself busy and not be totally bored helped to cope with her situation.

Similarly, Participant 11 highlighted that refugee youth tended to create a stimulating environment by themselves in light of scarce resources, "I think that because of lack of options children became self-starters". Overall, this theme highlighted refugee youth's engagement in creating a nurturing environment around them given the scarce resources available to them in the refugee camps.

## **Theme 2: Youth's psychological Flexibility and Openness to New Cultural**

**Experiences.** Based on testimonies made by eight participants (66.7 %), the second theme portrayed refugee youth's psychological flexibility and openness to unfamiliar and unpredictable situations that were an integral part of living in a culturally diverse refugee camp. In response to a question about characteristics of refugee youth who coped well, Participant 5 described a refugee child that was "more flexible, not rigid and needing things to be exactly in a schedule, or in a certain structure". In other words, humanitarian workers noticed that refugee youth who did not seek a rigid structure and adapted to unpredictable contexts of living in a refugee camp overall, coped better with the stressors. Importantly, daily life in refugee camps included very little structure that youth could have relied on, such as new volunteers working in the child-friendly spaces, activity schedule that changed a few times a month, emergencies that prompted the suspension of delivered services (i.e., games, lessons); therefore, refugee youth's ability to adapt quickly to an ever-changing environment was crucial to a healthy development.

Recognizing that one of the ongoing threats to refugee youth's safety was discrimination, Participant 8 highlighted the protective role of youth's openness to mingle with people with diverse, and often unfamiliar, ethnic backgrounds. This humanitarian worker contrasted youth's openness to cultural diversity with their parents' biases that did not encourage youth's cross-cultural interactions. Concretely, Participant 8 said

I think ... the parents were not so open to other nations; if they were from Syria, they preferred to engage with Syrian people; if they were Kurdish, they preferred to deal with Kurdish people. I observed that children did not have that problem.

The same humanitarian worker gave an example of preschool-age children's attitude and recalled them saying, "If I would like to play with [another child], I do not ask [them] where [they] are

from; I ask [them] what is [their] name, and if [they] want to play together”. This quote showed that preschool-age refugee children expressed willingness to play with other children who did not come from the same cultural background. To provide more context, all participants highlighted that refugee youth with whom they worked in Southeastern Europe were surrounded by individuals of very diverse cultural backgrounds including other refugee families, international humanitarian workers, and local people in a host country, and discussed that psychological flexibility and openness were a buffer that fostered refugee youth’s adjustment during the migration stage.

**Theme 3: Youth’s Self-awareness and Self-advocacy.** A third theme related to protective factors clustered perspectives of six participants (50.0 %) who discussed refugee youth’s ability to deeply reflect on their internal experiences in order to seek the support they needed at a given moment. For instance, Participant 5 explained that refugee youth demonstrated self-awareness during daily activities in the child-friendly space:

If the child was sitting at a table with a lot of children and [they] were not necessarily wanting all of that sensory input, [they] would remove [themselves] and get to sit at a table by [themselves], and I think that sort of thing was a great coping mechanism.

This quote showed that refugee children who had insight into their needs were able to choose an appropriate environment for themselves. Participant 3 echoed this strength

I think there were definitely some children who were aware of what they needed to do to feel comfortable or safe. They might address the fact that they wanted to have someone specific sitting next to them at a certain point.

The same humanitarian worker highlighted:

Having a child as young as five ... be self-aware to the extent that [they] could tell and adult, 'I want to talk to you right now' or 'actually I need to work on this, give me five minutes' ... showed a lot of resiliency regardless of the experiences [they] might have had.

These comments demonstrated that pre-school-age refugee children were able to recognize their needs and communicate them to adults, which increased the likelihood of receiving support on time.

### ***Microsystem***

Themes under the microsystem emerged from humanitarian workers' beliefs about the positive effects of refugee youth's imminent environment on their well-being. Namely, humanitarian workers' comments showed that refugee parents' sensitivity to their children's needs contributed to better mental health outcomes among these children during the migration stage. Overall, this was one of the two least represented themes in the group of protective factors.

**Theme 4: Refugee Parents Sensitivity to Children's Needs.** This theme illustrated the importance of positive parenting strategies and caregivers' responsiveness to refugee youth's mental health needs during the migration stage. Six participants (50.0 %) discussed this dimension of refugee children's well-being. Participant 12 reflected that the refugee youth who were coping best, "had parents who were not struggling and who were supportive and understanding of their children's needs". This comment highlighted that humanitarian workers' perceptions of the parents' coping and their responsiveness to their children's needs played an important role in fostering their overall well-being. Participant 12 expressed a belief that parents who were "more aware of what's going on; often the parents who [were] more educated, [came] from a more well-off background" were able to provide more parental guidance and strengthen

their children's coping strategies. Furthermore, participants discussed the positive impact of parents providing structure for their children and modeling positive engagement at home. To illustrate this conclusion, Participant 2 recalled a family case: "Parents were quite strict for the children ... after [children] stopped playing in our programming (activities in child-friendly space), [children] went home and would learn English or Greek, like on their computer or phones". The same participant further explained that these parents instilled in their children a positive attitude towards school and education, which overall, had a positive effect on their healthy development during the transit.

### ***Mesosystem***

In the mesosystem, refugee youth's functioning included interactions between the child's imminent environment (i.e., family), and a more distant environment that consisted of external resources (i.e., services provided by humanitarian organizations, schools). Based on humanitarian workers' reflections, two themes with protective factors emerged: (1) humanitarian workers' verbal and nonverbal communication strategies individualized to the refugee youth's needs, and (2) humanitarian workers' assistance in navigating cultural differences. Given multiple challenges that emerged from living in a highly multicultural and multilingual refugee camp environment, the participants commented on the importance of assisting refugee youth in becoming familiar with a new culture and choosing appropriate tools and strategies to communicate cross-culturally and cross-linguistically. Humanitarian workers associated these resources and supports with positive mental health and educational outcomes that refugee youth presented during the migration stage.

### **Theme 5: Humanitarian Workers' Nonverbal and Verbal Communication**

**Strategies Individualized to the Refugee Youth's Needs.** This theme entailed nine

participants' (75.0 %) perspectives on verbal and nonverbal communication strategies that they used to facilitate positive and culturally responsive interactions with refugee youth. Participants who worked with young refugee children (2–6 years old) in child-friendly spaces or pre-schools highlighted that these children had very limited communication skills in general, or communicated in languages that humanitarian workers did not speak. Results showed that humanitarian workers desired to create a welcoming environment for all refugee children despite the language barrier. For example, Participant 7 who specialized in play therapy disclosed, “I tended to make sure [children] could see me so I sat out in the space and made sure there was visual contact so they could see what I was doing”. The same humanitarian worker further explained, “I just started playing with things. I had got an array of things; sometimes [children] would be watching me and that was okay because I knew that the message was going through ... a lot of times, [children] just came and join in”. Participant 8 emphasized the importance of taking the effort to use verbal cues in the child’s native language in order to make them feel welcome: “I tried to learn some very basic words so at least I could say something that made [children] feel welcomed, made them feel like I wanted to know how they were feeling.” Participants reported that learning basic phrases such as “Hello!”, “What is your name?”, “Thank you!”, names of colors, animals, and games allowed them to create an inclusive child-friendly environment especially for young refugee children who recently arrived to a refugee camp or enrolled in school.

Despite the benefit of being proficient in refugee youth’s native languages, humanitarian workers explained that the shortages of staff forced humanitarian organizations to rely on individuals who were available and had the relevant skillset, but did not speak desired foreign languages. For instance, Participant 10 said:



I think that having language was incredibly critical in this context, but with the limitations that we had and the lack of resources, I tried my best to do also nonverbal things and what little I could do as far as introducing kids to other kids so that they at least had someone to speak with if it was not me.

This quote also demonstrated that the participants tried to navigate language barriers between them and refugee youth by assisting these youth in interacting with peers who spoke the same language.

To mitigate negative outcomes of language barriers, all participants who did not speak native languages of refugee youth developed nonverbal strategies that facilitated positive communication with the community. For example, Participant 4 navigated the language barrier by “pointing to things, hand gestures, communicating visually, using different Arabic and English words”. During the conversation about addressing conflicts and violent fights between children, Participant 8 who was a preschool teacher in Greece said, “I used picture sequences and showed to the children what happened. We would put pictures in the correct order. Maybe this helped children to understand more about what I would like to explain to them”. This comment illustrated a creative and nonverbal method of teaching refugee children safety rules and expectations when interpersonal conflicts occurred. Similarly, Participant 9 who led relaxation and mindfulness exercises for refugee youth reflected that in order to facilitate these activities he “had some basic material translated in the refugee youth’s language, or something recorded, for example, a video of [a humanitarian worker] or someone else with subtitles, or even songs that [he] could use in the classes”. Overall, this theme was related to strategies and resources that the participants utilized to foster culture-, and language-inclusive verbal and nonverbal

communication with refugee youth during activities in refugee camps and formal educational settings in local communities.

**Theme 6: Humanitarian Workers' Assistance in Navigating Cultural Differences.**

This theme introduced perspectives of eight participants (66.7 %) on the strategies that they used to help refugee youth and their families to become familiar with policies, customs, and traditions of a host country and community. Overall, humanitarian workers commented on refugee families' hesitancy toward enrolling their children in public schools in a host country. The participants attributed parents' reluctance to collaborate with schools to their cultural beliefs. Asked about strategies to collaborate with refugee parents, Participant 8, a preschool teacher, said, "I explained to the parent how we are working in the school and why specific policies and activities were important". The same participant disclosed that some refugee parents tended to express hesitancy to allow their children to interact with peers from specific ethnic backgrounds due to their lived experiences of persecution due to ethnicity, nationality, or religion. To encourage refugee parents to allow their children to mingle with culturally diverse peers, Participant 8 offered an explanation she would share with hesitant parents:

You talked to me about how you do not like other nations; now you are in a different country than your home country so all the children have to learn to accept everyone no matter the religion, color if they wear nice clothes ... everyone has to be accepted.

Noteworthy, this quote may sound imperative to an English native speaker; to clarify, this humanitarian worker's self-reported English proficiency level was intermediate (B2).

Participant 6 who self-identified as Syrian Arab with lived refugee experiences worked as an interpreter and described specific cultural differences that refugee youth from the Middle East encountered in Southeastern Europe and shared his suggestion on how to support these youth's

cultural transition. For example, when discussing differences in cultural norms associated with having a pet, Participant 6 explained:

A huge percentage of Arabs do not have pets because there is the idea that they have a lot of germs, they are unclean, they mess up the house, they bring bad luck ... some people believe that a dog can bring bad luck to you and all your house if it was black ... [refugee children] were taught that [having a pet] is wrong or not right ... maybe you can explain to [children] that [having a pet] is alright and nothing bad will happen to them. [Children] have not experienced [having a pet] and some of them may have fear of it.

Similarly, Participant 4 explained how to support refugee children's efforts to navigate multicultural environment:

I think it is really important that children learn that the two cultures are both okay ... and we respect them. It's okay to adapt and preserve the native culture. I think part of my work is to show children that way of life as well.

These comments demonstrated that humanitarian workers could directly assist refugee youth in learning about the culture of a host country by clarifying confusing or even threatening cultural norms in a new environment. Overall, this theme delineated strategies that humanitarian workers pursued to support refugee youth's efforts to adjust to a new cultural environment including the public school system in a host country.

### ***Exosystem***

Factors organized within the exosystem pertained to refugee youth's relationships and interactions with the distant environment including humanitarian workers alongside the types and quality of services that they provided to refugee youth, as well as safe and nurturing spaces available to these youth in refugee camps and in local communities. There were three main

themes: (1) nurturing spaces for refugee youth inside and outside of the refugee camp, (2) humanitarian workers' self-awareness and positive attitude towards refugee youth, and (3) humanitarian workers' positive coping skills. The first theme encompassed four subthemes: (a) small and age-consistent groups, (b) clear and consistent rules and expectations, (c) trauma-informed psychosocial and educational interventions, and (d) access to public education. The second theme of humanitarian workers' inward attitude consisted of two subthemes, (a) humanitarian workers' self-reflection, (b) professional humility, and (c) humanitarian workers' responsiveness to refugee youth's individual psychosocial needs.

**Theme 7: Nurturing Spaces for Refugee Youth Inside and Outside of the Refugee Camp.** This was one of the two most represented themes within the group of protective factors. It encapsulated humanitarian workers' perspectives on protective environmental factors that created a stimulating space for refugee youth. All participants (100.0 %) contributed to the development of this theme and their comments were organized in three subthemes: (a) small and age consistent groups, (b) clear and consistent rules and expectations, (c) trauma-informed psychosocial and educational interventions, and (d) access to public education.

***Subtheme 7.1: Small and Age-Consistent Groups.*** All participants who worked as psychosocial humanitarian aid workers in child-friendly spaces ( $n = 9$ ) emphasized that having relatively small groups of refugee children of a similar age helped to respond to the refugee youth's needs. For example, Participant 2 recalled an experience of working in one of the refugee camps in Greece, and explained:

The ratio of children to adults was one to three... I think we were able to keep control of the atmosphere; the children were able to get along more ... they got more attention; they learned some skills, and we did not really have issues as far as violence and aggression.

However, working with small groups of refugee children was rare, and typically referred to as a desirable set-up, not the reality. The interviews showed that the participants tended to supervise about 30 up to even 150 hundred children during programming in refugee camps, with one or very few adults being present in the space at the same time. Despite these challenges, Participant 12 explained that it was possible to facilitate activities for refugee youth as long as they were split into groups, “we had two hundred children a day and we split them into four age groups so we would have fifty children in the room at a time, four time a day, doing the same structure”. This comment showed that humanitarian workers had to deliver services to refugee youth in hazardous settings, but at the same time, they tried to enhance safety of these youth by creating same-age groups.

***Subtheme 7.2: Clear and Consistent Rules and Expectations.*** This theme captured humanitarian workers’ beliefs about the importance of establishing a consistent and predictable environment in supporting refugee youth’s healthy development during the migration stage. Participants who worked in child-friendly and play spaces, as well as schools ( $n = 9$ ), emphasized the protective role of providing clear rules and expectations to refugee youth (i.e., “We welcome kids of all backgrounds”) in order to foster their sense of safety. Specifically, Participant 8 explained, “an environment which provided [refugee children] with consistency every day would make the child’s life easier; it would make them feel calm and more confident”. This participant further explained that a safe environment included consistent adults including teachers, long-term volunteers, clear and simple rules and expectations, and supports to explore this environment, such as adult guidance, instructions.

Given the language barrier and varying literacy levels, humanitarian workers discussed strategies they used to implement rules and expectations in their work. For example, Participant 12 who managed a playschool for refugee children in the refugee camp said:

We had basic rules written down and displayed on the wall: there was no violence allowed in the room because [the child] would be asked to leave if [they] intentionally hurt someone, and [they] would get a fresh start on the next day. We were always very strict on that because refugee children could be very violent, and we wanted them to know that they were safe in space and they were not going to get hurt.

This quote showed that the participants viewed rules and expectations as helpful in preventing unsafe behaviors and conflicts in the spaces that refugee children used.

***Subtheme 7.3: Trauma-informed Psychosocial and Educational Interventions.*** Another subtheme that emerged within the nurturing space theme included psychosocial and educational interventions that were responsive to refugee children's needs and recognized the presence of trauma symptoms. All participants identified play, movement, and arts as activities that promoted refugee youth's emotion regulation, cross-cultural communication, and processing trauma. Nine participants (75.0 %) who worked with young refugee children focused on the importance of play in these children's development. Participant 2 who specialized in play therapy provided a detailed description of how play-based activities were used by a child to cope with an adverse experience:

We had a little boy attending the play space ... he was around three or four years old ... he were a bit scared, quite apprehensive, would not let go of mom's hand at all ... the only thing he really reached for after walking the space and walking around was a train ... that was his playing scheme, his mental scheme ... the family had a longer night train

journey... they left in the middle of the night for safety reasons ... so he was obviously recreating that with this [event] in his play, and trying to cope with that.

Participant 12 who run a playschool for refugee children in a Bulgarian refugee camp said:

There was a racist protest outside of the camp and things were thrown in, like stones and rocks; it really riled up the camp so the kids had a sleepless night, the parents were angry ... the next day in the play school, a group of boys age five to eight took sunglasses and plastic knives from the play house and formed a gang; they were marching around the room together totally enacting what they had seen the night before. They were not violent with the children and it was not really serious; it was kind of their way of processing it all and acting it all out.

This comment showed that preschool-age refugee children benefited from having access to toys and a safe space that they could explore in order to express their troubling internal experiences.

Participant 12 provided another example of creating an environment that encouraged free emotional expression:

We had a massive chalkboard ... [children] would map out their journey. They would draw a long, sort of wavy line, and draw a car on this line, a police car, a little prison ... a detention center ... and then it would always be Germany at the end. [Children] would draw it all out and then encouraged us to come over and talk to us about it. It was all coming from them; we were just setting up the environment and resources so that the children could use them in that way, if they wanted to.

Three participants reported that they removed potential triggers for trauma from the play spaces, such as toy weapons, because children saw these objects during the war. Participant 12 explained how to encourage refugee youth's expression:

I was teaching [children] words for emotions as part of our English lesson; we kept little journals for the children ... I tried to encourage them to draw a picture of one thing that makes them feel that emotion. We had a lot of children drawing their experiences at the border, being separated from family members.

These comments illustrated that refugee youth were engaging with the elements of their physical environments such as toys, chalkboards, or paper journals to express their emotions, process traumatic experiences, or communicate their needs. Besides that, these means of expression helped these children to initiate interactions with humanitarian workers despite the language barrier. Overall, all participants who engaged with refugee youth in child-friendly spaces, educational, and play settings emphasized that a nurturing environment that offered appropriate play options encouraged refugee youth's emotional expression, coping with ongoing stressors, and recovery from past adverse events.

***Subtheme 7.4. Access to Public Education.*** The participants commented on the positive role of governmentally supported access to education in refugee youth's efforts to cope with acculturation and language acquisition during the migration stage. For example, Participant 10 said:

I think schooling was an important part of children's well-being. In some contexts, a refugee child was allowed to go to school because [access education] was a part of the national school system, but in other cultures that did not apply. When a child was in the school system, they were picking up the language a lot quicker; they had a strong incentive to learn the language; they were also being introduced to people from different cultures.



This comment emphasized that access to public schools was a cultural buffer between refugee youth and a host community and provided an opportunity for these youth to learn about the culture of a host country, including language.

Overall, comments discussed within Theme 7 demonstrated that humanitarian workers noticed a positive impact of providing stimulating and safe spaces that encouraged refugee youth's recovery from trauma across various settings. The subthemes emphasized the importance of having enough adults to supervise children divided into similar-age groups, establishing clear rules and expectations, including psychosocial and educational activities, and supporting refugee youth's enrollment in public schools during the migration stage.

**Theme 8: Humanitarian Workers' Self-awareness and Positive Attitudes Towards Refugee Youth.** The third theme clustered perspectives shared by 11 humanitarian workers (91.7 %) who discussed their efforts to evaluate their work performance and personal well-being in order to improve the support they delivered to refugee youth. The participants discussed the importance of engaging in continuous reflection on the implemented interventions and their responsiveness to refugee youth's needs, as well as identifying professional and personal weaknesses and strengths. In light of scarce resources that refugee youth could access during displacement, humanitarian workers were a primary source of support for many of these youth; therefore, participants' self-reflection allowed them to advance their skillset, and thus, offer meaningful services to refugee youth. Two subthemes emerged within Theme 8 and described humanitarian workers' (1) self-reflection and professional humility, and (2) responsiveness to refugee youth's individual psychosocial needs.

***Subtheme 8.1: Self-reflection and Professional Humility.*** The self-reflection and professional humility subtheme consisted of humanitarian workers' efforts to evaluate and reflect

on the strategies they have used to support refugee youth. Participant 7 explained that reflecting on the weaknesses and strengths of services delivered to refugee youth was crucial and disclosed, “I think that there was a need to reflect, and learn models of reflections if reflection did not come naturally to someone”. The same participant mentioned one strategy they used to grow professionally and maintain mental health hygiene at work:

I kept a gratitude journal. I tried to write in it every morning; I wrote in there things that I was grateful for, and all the things that were positive in life and that set me in the morning on a good note.

These comments showed that some humanitarian workers identified self-reflection practices as strategies that could enhance the quality of support offered to refugee youth during the migration stage.

This subtheme included humanitarian workers’ sensitivity to ethical dilemmas, awareness of possessed and lacking competencies, and proactive attitude to seeking training and feedback. For example, Participant 8, a preschool teacher who worked both in public schools and child-friendly spaces speculated:

Although there were a lot of people that were volunteering ... they did not have the educational background to support [children] ... maybe they were very good economists or doctors, but they might treat the child as a parent, not as a teacher ... I think that [for the child] it was important to receive education from a teacher, and not from someone else that cared about the child a lot and gave their best, but did not have enough knowledge.

On the other hand, Participant 10 disclosed their concern:

I am not a mental health professional, and therefore, I am not sure I am the right person to be working in this context; but at the same time, if everyone who was not trained professionally in [mental health] said, ‘I am not qualified’, then how would those vacancies go filled?’” These comments revealed challenges faced by humanitarian workers in making professional decisions, and their continuous effort to provide the best quality of care given scarce resources.

All of the 11 participants discussed openness to professional development as a factor that increased the quality of services that refugee youth received. For example, Participant 9 stated that humanitarian workers needed to “keep an open mind, be receptive to feedback, and open to different backgrounds, experiences, and understandings of culture, and try to seek help”. Four participants who had experiences in working with refugee youth in formal school settings, as well as in refugee camps, discussed the differences between working in a regular classroom and educational setting in refugee camps, and emphasized the importance of being flexible in adjusting their methods to adequately serve refugee youth. Reflecting on these differences, Participant 11 recalled their strategies to address disruptive behaviors demonstrated by students in a regular public school, and in a refugee camp:

I have found that what I have learned to do in the classroom did not work when I was working with refugee children. What I started doing was ... meeting the refugee child exactly where they were and for example saying, ‘I understand that you are upset, I am sorry that you are upset’ ... just physically staying in their space and not bringing any personalized aspect to it because they were not acting out to me; they were acting out because of so many other things going on.

This quote showed that some humanitarian workers incorporated self-reflection and considered refugee youth's complex experiences in order to tailor the most adequate behavior management strategy.

Summing up, humanitarian workers' self-reflection and professional humility subtheme illustrated that participants' personal and professional attitudes translated into their openness to feedback, training, and allowed them to adapt their toolkit to provide the best support possible given the scarce resources.

***Subtheme 8.2: Humanitarian Workers' Responsiveness to Refugee Youth's Individual Psychosocial Needs.*** Given traumatic experiences that refugee youth have undergone, 11 participants emphasized the importance of a personalized and flexible approach in addressing refugee youth's emotional needs; Participant 3 who delivered psychosocial support to young refugee children in a refugee camp said:

I did witness quite a few children that were withdrawn. With those ones, I took the time every day to speak to them. Often if I saw them outside of our programming in the camp, I would talk to them or try to get them engaged in some type of activity. Some children did not want to talk to anyone; all they wanted to do was coloring. To me, that was fine because at least they were engaging with something.

This quote showed that Participant 3 recognized refugee youth's individual preferences and offered adequate support in order to foster these youth's engagement.

Recognizing individual challenges that refugee children faced, Participant 3 who run a child-friendly space said, "I tried to find some independent activities that [three to five-year-old children] could engage in ... something more therapeutic that could help them exploring their own self and their abilities to build up confidence". This participant provided further examples:

Puzzles were really good because there was an immediate accomplishment when you finish one. Coloring for certain children could also be very therapeutic because as opposed to drawing, [they] were just coloring in lines ... it was a much simpler task for a lot of children because there was no frustration of ‘I do not know what to draw’, or ‘I am not a good drawer’.

These examples showed that Participant 3 adjusted psychosocial activities to adequately address the emotional needs of three to five-year-old refugee children who tended to be withdrawn and self-doubting.

Furthermore, one participant commented on the importance of respecting refugee youth’s dignity. Specifically, Participant 11 self-identified as Caucasian explained:

I really think treating each individual child with respect is so important ... I think that as an U.S. American adult, you are taught that when you meet someone new, if they are an adult, you treat them with respect, but nobody correlates that to when you meet a child, particularly an adult meeting a child.

The same participant further clarified cultural norms regarding respectful communication, “In U.S. American culture, if a child interrupts, it is inappropriate, but if an adult interrupts, it is not a huge or as big of a deal”. When asked about the best ways to convey respect to a refugee child, Participant 11 recommended, “respect could be given [to the child] in a patient or a simple smile, [child] bumps into you and you smile, you do not get angry ... or walk away, or become irritated.” Comments made by Participant 11 highlighted the importance of acknowledging cultural differences regarding child-adult interactions, and addressing personal biases in order to appreciate child’s dignity regardless of their background.

Overall, Theme 8 provided examples of participants' efforts to identify refugee youth's individual needs, and tailor psychosocial and educational interventions that promoted these youth's growth given the limited resources available to them at the migration stage.

**Theme 9: Humanitarian Workers' Positive Coping Strategies.** This theme distilled humanitarian workers' positive coping strategies that helped them to continuously support refugee youth despite exposure to secondary trauma and other stressors. Namely, all humanitarian workers' (100.0 %) disclosures informed the development of Theme 9. Their comments illustrated various forms of physical and psychological coping strategies, such as socializing, mindfulness and relaxation, crafts, meditative practices, physical exercises, and traveling.

Hazardous work conditions prompted all humanitarian workers to schedule breaks and utilize forms of physical and psychological distancing from work to reduce the load of emotional distress. For example, Participant 4, who did not self-report experiencing signs of burn-out, said that "trying to structure regular breaks, and taking a proper break every couple of months" was helping her maintain good psychological well-being. Along those lines, Participant 1 mentioned, "We were living in the little city nearby the refugee camp, so I tried to go to Athens (another city) and just escape the environment a little but ... I was also reading books, listening to music, or watching movies to escape". Participant 3 discussed a similar form of coping, but also disclosed doubts about relying on this strategy:

I removed myself from the space that I lived in and shared with other staff members ... I would visit another city once for a night ... or go for a long drive. I did not know if that was healthy time to remove myself completely from where I was living, but I found that really helped me.

Other coping strategies included forms of cognitive or psychological coping that involved efforts to rationalize disturbing feelings or thoughts. For example, humanitarian workers reported experiencing thoughts, such as the one disclosed by Participant 7 “the children did not have access to proper sanitation, education, play. Obviously, at first, I was taken aback, but then I thought they were safe; they were out of conflict”. This quote showed that Participant 7 engaged in rational and analytical thinking to combat emotional distress evoked by witnessing refugee youth’s difficult living conditions.

Humanitarian workers also utilized social interactions as an outlet to mitigate negative outcomes of work-related emotional distress. Participant 1 reported that speaking with people who had shared experiences was especially helpful, “I tried to talk with people, especially with people ... that were also in the same field and I could relate to [them]”. Participant 11 highlighted that “remaining social even when I was so tired was a huge aspect of keeping my mental health strong”. This comment demonstrated that socializing allowed humanitarian workers to balance overwhelming work experiences.

Nine participants, in particular, disclosed that they experienced anger and a sense of helplessness and reported that these feelings impaired their daily functioning at some point. These participants emphasized the importance of using coping strategies, such as mindfulness and relaxation, crafts, or physical exercise to combat these troubling internal experiences. Asked about specific examples, Participant 9, a yoga instructor, said, “I was doing intense practices such as pranayama .... [it was] a breathing exercise that released emotional as well as mental blockages in the flow and pattern of breath”. The same humanitarian worker described that he pursued creative activities such as woodcarving and digital design to express uncomfortable feelings including anger and sadness. Participant 10 disclosed:

I ran more than I ever would back home (laughing) ... I left work, came home, and it was eight o'clock, and I almost immediately went out and ran ... fast because in my head, I was so angry that things were not different (i.e., refugee youth's life situation). I could run out that anger. I was literally physically letting that anger go by hitting the pavement as hard as I can.

Concluding this theme, humanitarian workers delivered daily psychosocial and educational support to the refugee youth in a very stressful environment; therefore, participants' positive coping strategies were paramount to the quality of services provided to the refugee youth during the migration stage.

### ***Macrosystem***

The macrosystem was associated with themes related to culture-specific customs, rituals, beliefs, and traditions that humanitarian workers associated with refugee youth's positive mental health outcomes during the migration stage. Theme 10 focused on cultural practices and customs. Participants also discussed the importance of faith and religion in these youth's well-being, which was represented as a subtheme.

**Theme 10: Cultural Practices and Customs.** Nine participants (75.0 %) reflected on a supportive role that cultural practices and customs played in refugee youth's coping with daily distress as well as their recovery from trauma. These cultural norms and rituals included a sense of community and story-telling.

Participant 1 explained that "a culture is definitely ... a community coming together ... practicing the same rituals and sharing somewhat the same ideas and beliefs". This humanitarian worker further explained that a sense of cultural membership fostered children's sense of safety and psychocultural integrity. Participant 5, who self-identified as Kurdish American reflected



that “Middle Eastern culture is very collectivistic so the families tend to look out for each other and the community also will look out for other people’s children if someone is facing some challenges; it is kind of a unit”. This quote explained the important role that the community played in children’s upbringing in Middle Eastern culture.

Theme 10 also shed light on a tradition specific to Middle Eastern and African cultures that fostered refugee youth’s well-being during the migration stage. Asked about factors that scaffolded these youth’s mental health, Participant 7 explained:

In the Middle East and Africa ... there was a storytelling culture; people liked telling stories and they would get together in groups and local communities and talked about things and share stories. I think that was one thing that was really valuable, and we (i.e., British humanitarian workers of non-Middle Eastern and Non-African origin) perhaps did not have that in the Western communities; we really did not get together and tell stories; we gossiped, but we did not tell stories. I think [storytelling] was a really good example for refugee children because it provided a support net where people were listening to each other and share their stories.

This quote demonstrated that Participant 7 identified cross-cultural differences in story-telling practices. The reflections on story-telling practice highlighted that refugee youth who came from Middle-Eastern and African backgrounds were likely to have access to story-telling groups that provided social support and promoted mutual listening.

***Subtheme 10.1. Faith.*** Participants discussed faith and religious rituals as a distinct form of cultural practices that fostered refugee youth’s well-being during the displacement stage. For example, Participant 2 reflected on the role of faith and said that “the majority of the children I worked with in Greece were Muslim” and further explained that “for these children growing up

with a certain set of beliefs and being told that there was a higher power and that things were supposed to be a certain way gave [the children] strength”. Participant 10 confirmed that “faith was incredibly important for the [Middle Eastern] families” and elaborated that “religion provided a feeling of protection and purpose or a sense of some greater being watching out for them”. These quotes demonstrated that some Muslim refugee youth used faith to ease difficult feelings during difficult times.

Participant 4 and 6 mentioned that refugee children in Muslim communities participated in Ramadan, a one-month religious observance focused on fasting, prayer, reflection, and community, and they partook in the customs and traditions that occurred at the end of Ramadan. Participant 4 emphasized that the engagement with these cultural practices gave the children “a sense of home”.

Overall, Theme 10 represented humanitarian workers’ perspectives of culture-specific practices among Middle Eastern, African, and Muslim refugee youth and their families. The participants’ comments substantiated the importance of community, story-telling, and faith in refugee youth’s well-being during the migration stage.

### **Displacement-specific Challenges That Contributed to Refugee Youth’s Well-being During the Migration Stage**

The displacement-specific model of resilience and mental health factors among refugee youth (see Figure 4) informed the identification of themes. Humanitarian workers’ comments contributed to the development of fourteen main themes and twelve subthemes organized in the individual system, microsystem, mesosystem, exosystem, and macrosystem. These themes illustrated risk factors that were associated by humanitarian workers with causing significant

distress to refugee youth, and further jeopardizing their safety and well-being during transit in Southeastern Europe.

**Table 3**

*Socioecological Factors That Challenged Refugee Youth's Well-being During the Migration Stage.*

System	Main themes and subthemes	Quotes
Individual System	Theme 1: Continuous trauma and ongoing stressors among refugee youth	“Even though [preschool-age refugee children] have left whatever areas that might have initially caused them trauma, it did not mean that trauma has stopped. Often times, trauma continued within whatever humanitarian setting they were living in.”
	Theme 2: Trauma-associated psychosomatic problems and sleep disturbance among refugee youth	“I have seen sleep issues and tiredness in all the three places (refugee camps) that I have been working with kids. Kids were rubbing their eyes, and parents were saying frequently ‘my child did not sleep well last night’”.
	Theme 3: Refugee youth's poor emotional regulation skills	“If the smallest thing happened the child's reaction was major ...[children] acted out when they did not get exactly what they wanted.”
Microsystem	Theme 4: Parents' poor mental health	“Parents had their own psychological problems and maybe were not in the condition to support their children simply because they could not support themselves.”
	Theme 5: Disrupted family life <ul style="list-style-type: none"> <li>• Lack of routine</li> <li>• Age-inappropriate responsibilities</li> <li>• Uncertainty about the future</li> </ul>	“[Refugee children] could do nothing all day in the refugee camp if [they] wanted to. No adult was going to expect [them] to go out, to walk around, to get fresh air because people were really just taking care of very, very basic needs there.”
	Theme 6: Unstable and interrupted social relationships	“A factor for a number of children that would exacerbate or contributed to trauma-related symptoms would be having ... incomplete family structure.”

System	Main themes and subthemes	Quotes
Mesosystem	Theme 7: Interrupted collaboration with families	“No matter how much we worked with [children] in a space, they went home and they were exposed to whatever was going on there, and they brought it into the space (e.g., child-friendly space, school) and it was difficult to challenge those beliefs and behaviors because of a lack of a consistent approach.”
	Theme 8: Language barrier between humanitarian workers and refugee youth and families	“Sometimes I wondered whether it was just more harmful to be working in a space where I was putting children in a situation where they could not explain everything to me because of language barrier... that had to be very frustrating for the children.”
	Theme 9: Social exclusion and discrimination of refugee youth	“Sometimes the campground ran out of water so [refugee families] did not get to wash their clothes or ... take a bath, and [children] were wearing the same clothes pretty much every day. In the camp, it was fine because everyone was wearing the same clothes but often, it was hard for [children] to feel like they could not blend in with other children in Greece.”
Exosystem	Theme 10: Humanitarian workers’ high level of stress <ul style="list-style-type: none"> <li>Humanitarian workers’ psychosocial challenges</li> <li>Humanitarian workers’ preconceived beliefs about delivering aid to refugee youth</li> </ul>	<p>“I experienced anxiety and I have had also ... two moments where I felt like this anxiety was affecting my body ... I had problems breathing.”</p> <p>“I had dreams, and those dreams lasted at least six months, or longer, and then, I was still having disturbing dreams about certain kids. [Exposure to trauma] was affecting me subconsciously. I did not know if it was affecting me outwardly in a mental health way.”</p>
	Theme 11: Hostile and unstable conditions of the refugee camps	“I saw a group of people including children who witnessed a person setting himself on fire.”

System	Main themes and subthemes	Quotes
	<ul style="list-style-type: none"> <li>• Refugee youth's exposure to unsafe behaviors</li> <li>• Living in confined spaces with limited privacy</li> <li>• Shortages of humanitarian staff and mental health services</li> </ul>	<p>"When kids lived in close confinement with their parents, things that parents do, did not stop when they were in a refugee context; for example, they were still going to be having sex. A child was going to be exposed to that at a much younger age. Whereas back home ... the kids might have had their own bedroom."</p>
Macrosystem	<p>Theme 12: Gender differentiation</p> <p>Theme 13: Mental health stigma</p>	<p>"Boys were allowed to be boisterous ... whereas girls were not allowed to run around ... play football. Then there were also quite shy and withdrawn girls who had to ask for permission to do things and they were not sure within themselves what they could do, what they could not do."</p> <p>"There was not enough programming or resources devoted to [Muslim teen girls]. Parents might say to their daughters 'now you are too old to engage in child-friendly space; we are not going to let you go to the youth space because there are too many men around there.'"</p> <p>"People that came from the Middle East did not place an importance on mental health, and often when things happened to children, adults were not willing to sit down and listen to them; so I think children either buried their problems deep down inside or let them out violently."</p>

### ***Individual Systems***

Challenges categorized as a part of the individual system included child-specific experiences such as trauma, and characteristics (e.g., personality, communication skills, and emotion regulation skills). Within this cluster of the individual challenges, three themes emerged: (1) continuous trauma and ongoing stressors among refugee youth, (2) trauma-associated psychosomatic problems and sleep disturbance among refugee youth, and (3) refugee youth's poor emotional regulation skills.

**Theme 1: Continuous Trauma and Ongoing Stressors Among Refugee Youth.** This theme represented refugee youth's continuous experiences of trauma due to daily exposure to life-threatening circumstances in the migration stage. Ten humanitarian workers (83.3 %) shared a belief illustrated by a comment made by Participant 11 that "each of these children was really suffering from the trauma they had gone through, and they were still experiencing trauma". Participant 12 mentioned "even though [preschool-age refugee children] have left whatever areas that might have initially caused them trauma, it did not mean that trauma has stopped. Oftentimes, trauma continued within whatever humanitarian setting they were living in". This quote showed that refugee youth were vulnerable during displacement, even though they fled the initial life-threatening situation. The same participant provided further explanation of the events that were traumatic to refugee youth, "I have worked with a lot of children who have lost parents crossing over from Turkey to Europe ... they were suffering extremely because their trauma was just so raw and fresh." Furthermore, humanitarian workers commented on the variety of types of trauma experienced by refugee youth during the migration stage. For example, Participant 12 said that within the first few years of the impetus of forced displacement in the Mediterranean region, it was common to see "pre-school and school-age children who had seen people shot, and

literally seen war, death, and violence.” This participant further explained that there were many refugee children who were born during the displacement, including settlement in refugee camps, and discussed types of trauma that these youth were facing during their re-location to a host country. Specifically, Participant 12, who delivered psychosocial support to refugee youth in Bulgaria, said that “now (Fall 2019) we see children who have grown up in refugee camps their whole lives ... they came here before they were walking. Their trauma is very different; they are more down.” This quote demonstrated that some participants identified differences in types of trauma experienced by refugee youth during displacement.

Malnutrition was another example of many ongoing stressors that hindered refugee children’s healthy development during the migration stage. Participant 8 who worked primarily with refugee children from infancy to twelve years old in a refugee camp and public Greek schools provided an explanation of how malnutrition affected refugee children:

Many children stayed at the hospital for a long time to feel better; they were malnourished. Then they did not come to school, or play with other children. They did not grow up like the other kids; their bones were not strong enough. They could feel hungry and so they were not able to stay at school. In play spaces, they tried to eat plastic play foods.

This comment revealed a set of physical and psychosocial challenges that refugee youth faced in schools due to malnutrition.

On the other hand, Participant 2 found it difficult to discuss refugee youth’s experience of trauma as she was not sure about its exact source:



There was a family with Kurdish boys; all over their faces and their arms, their skin was slightly discolored and there were hundreds of tiny scars. It was either because of their experience of war, or the abuse they were suffered from their parents.

Overall, the continuous trauma and ongoing stressors theme showed that the experience of trauma varied among refugee youth and it was influenced by their prior experiences, duration of displacement, events that happened prior to their arrival in a host country, and stressors such as malnutrition.

**Theme 2: Trauma-Associated Psychosomatic Problems and Sleep Disturbance.** This theme emerged from the perspectives shared by eight participants (66.7 %) that focused on refugee youth's psychosomatic symptoms associated with trauma, such as breathing problems, physical exhaustion, and aches, as well as sleep disturbance.

When asked about trauma-related symptoms observed in refugee youth, humanitarian workers mentioned breathing problems. For example, Participant 9 who was a yoga and pranayama instructor described the trauma-associated breathing difficulties observed in four- and five-year-old refugees. This humanitarian worker said:

At young ages, the breathing pattern was still developing. These children should not have a lot of issues with breathing in certain areas of their body, for example, in the belly. In the group of refugee children, I worked with, there were several issues. Usually, I saw problems with belly breathing in the kids who were four and five years old... the breath was not reaching the rib cage ... it looked like something was stored physically in this part of the body ...or there was something blocking them ... my guess would be that they have been through some emotional trauma.

Importantly, the comment made by Participant 9 should be viewed through the lens of pranayama practice, which is an integral part of yoga; pranayama clusters various breathing techniques that aim to release physical tensions accumulated in the body. In light of this humanitarian worker's background, refugee youth demonstrated breathing patterns induced by experienced emotional trauma.

Humanitarian workers believed that poor sleep and fatigue exacerbated refugee youth's trauma-related problems. Participant 7 summarized sleep-related challenges observed in refugee children, "I have seen sleep issues and tiredness in all the three places (refugee camps) that I have been working with kids. Kids were rubbing their eyes, and parents were saying frequently 'my child did not sleep well last night'". Interestingly, Participant 2 speculated that children were sleep-deprived due to environmental stressors, not necessarily trauma, "it was hard to link these sleep problems to trauma because a lot of children did not have a set schedule. For example, a lot of kids would stay up all night and sleep in the day". Participant 11 who also worked in refugee camps in Greece said, "I definitely saw children suffering from sleep deprivation too". Also, Participant 12 echoed this observation, "parents tell us about their children having nightmares all the time". These comments showed that humanitarian workers suspected that refugee youth's healthy development was likely to be interrupted by poor sleep and difficulties to rejuvenate their energy due to external stressors.

This theme also included somatic complaints that humanitarian workers observed among refugee youth. For example, Participant 4 said that "stomach aches and headaches were the most common concerns" she observed among refugee children. Also, Participant 9 who had an educational and work background in trauma-sensitive yoga practice discussed common aches and pains observed among refugee children:

I worked with three- and four-year-old children and observed intense pains in their knees and back. I mean, you do not see these problems in a healthy developing four-year-old kid without an injury, which was not the case in the group of kids I am talking about.

They had not experienced injuries; they had chronic pain in their back and knees.

The same participant added that he observed “migraines, headaches, and neck issues”. Overall, the participants believed that young refugee children were likely to demonstrate atypical pains and aches that could be associated with trauma. Humanitarian workers were ambiguous about the potential causes of sleep problems and linked them both to environmental stressors and adverse experiences.

**Theme 3: Youth’s Poor Emotional Regulation Skills.** This theme was related to humanitarian workers’ perspectives of refugee youth’s limited ability to regulate their emotions and these youth’s tendency to demonstrate unsafe behaviors. Specifically, all participants (100.0 %) emphasized that refugee youth were prone to strong and abrupt emotional reactions including tantrums, outbursts of anger, violent behaviors, or a complete emotional disengagement. They also discussed refugee youth’s difficulty in self-soothing and communicating their emotional needs to adults. All humanitarian workers mentioned aggressive behaviors observed among refugee children across all age groups and. For example, Participant 7 described them as “really aggressive children who had a lot of rage and wanted to hit things and throw things, and get it all out because they just did not know how to cope with the frustration and anger”. Apart from illustrating emotion regulation problems, the first part of this comment (i.e., “really aggressive children”) also revealed humanitarian worker’s bias in perceiving disruptive behaviors as an integral part of refugee child’s persona; noteworthy, other participants highlighted in their

responses that they believed no child was aggressive. They explained that any disruptive behaviors communicated the child's suppressed needs.

To provide more context, Participant 11 explained refugee youth's difficulties in accepting undesirable outcomes, "if the smallest thing happened the child's reaction was major ...[children] acted out when they did not get exactly what they wanted" and compared this situation with a regular classroom setting:

If the child wanted a purple marker but someone else was using it, my response in a classroom setting would be, 'alright, when she is done, she will give it to you', but that was not happening with a refugee child who was suffering. [Refugee children] would try to grab this marker or just leave the environment. This comment showed that refugee youth's responses to common social situations were different from those observed in regular classrooms.

Participant 3 mentioned that some preschool refugee children tended to respond violently when someone else intruded their space:

If someone was to interact with [the child] or enter [their] space in a negative way by like touching something that [they] were playing with or another child was demanding the attention of someone that was spending time with [them] ... [the child] could very quickly become violent.

To elaborate on the emotion regulation problems demonstrated by young children (2–5 years old) Participant 5 shared her insight on the relation between children's aggressive behaviors and their limited ability to communicate, "they were extremely young and maybe had not developed language yet. For example, they were less likely to be able to express what they were feeling, so they would possibly be more aggressive or act out". Noteworthy, Participant 3 described

situations in which preschool-age refugee children disengaged emotionally as a response to an environmental trigger

There was one child who if someone was to make a fast movement or punch him; he would actually kind of pause. I had this one moment where his brother had punched him and he completely went limp and laid on the ground for like five minutes and just completely disconnected.

This comment showed that refugee children's responses to threats included emotional disengagement. Overall, humanitarian workers observed that refugee youth demonstrated multiple problems associated with emotion regulation including aggression and withdrawal. The participants associated these challenges with poorer mental health outcomes among these youth during the migration stage.

### ***Microsystem***

Humanitarian workers' comments on challenges present in the refugee youth's imminent environment (e.g., family, other close social relations) were identified as part of the microsystem. There were four main themes: (1) parents' poor mental health, (2) disrupted family life, and (3) unstable and interrupted social relationships. The disrupted family life theme included three subthemes, namely, (a) lack of routine, (b) age-inappropriate responsibilities, and (c) uncertainty about the future.

**Theme 4: Parents' Poor Mental Health.** Seven participants (58.3 %) associated poor mental health of refugee youth's primary caregivers with children's psychosocial problems during the migration stage; participants believed that mental health difficulties experienced by refugee parents impaired their ability to supervise their children. Specifically, "often parents were under a lot of stress, so I think that children were lacking parental support or parental

guidance,” said Participant 2. Similarly, Participant 8 reported that “parents had their own psychological problems and maybe were not in the condition to support their children simply because they could not support themselves”. These two comments demonstrated that refugee youth were in a vulnerable position because they were likely to receive insufficient parental supervision due to high levels of stress endured by their parents.

Participant 5 was concerned that poor mental health of refugee youth’s parents could contribute to neglect or abuse:

Parents could become very withdrawn, and then the child might become neglected and experience their own trauma that way. Other parents could also become very aggressive and take it out on the child, or the child could witness the parents being aggressive to other people.

Another form of neglect was illustrated by Participant 2: “parents were experiencing certain mental health problems, and thus, several of the children did not bathe in a long time, had wounds that were not taken care of”. Participant 12 recalled the moment when a single mother arrived with young children in a refugee camp after a very dangerous journey during which the father died, “[children] saw that one parent was left to take care of them, the mother; she was unable to take care of them. She was literally falling unconscious ... she was in such a state of shock”. This quote showed that a single refugee mother who experienced psychological challenges during displacement was especially vulnerable and their children were at risk of being neglected.

Noteworthy, Participant 12 expressed a bias towards parents who provided limited supervision to their children, “I think it was a very cultural thing to see not much support from the family and their emotional needs of the kids”. Also, Participant 2 echoed this perspective

I currently live in the Middle East, so I gained more insight... I do think that in some of the Middle Eastern cultures, the children just go off to play and only see parents at night, or only see them be disciplined. It is not as much of a personal bond. [The refugee children] with whom I worked in Greece were allowed to run around in groups of other children unsupervised.

Importantly, Participant 2 reflected that it was challenging to comment on the parental involvement that she observed in refugee camps in Greece because:

When [she] was working with a refugee population in Greece, [she] was working as a foreigner. There was just a lot [she] did not understand, for example, what the norms were for people that were raising children, how children were being treated in society, which all could be very different in each culture.

Overall, the refugee parents' poor mental health theme discussed the presence of psychosocial challenges in refugee youth's imminent environment and shed light on how these issues contributed to the parental supervision these youth received. Overall, the comments related to parenting styles should be interpreted with the caveat of cross-cultural differences that were likely overlooked in the conducted interviews due to humanitarian workers' limited direct exposure to refugee families' cultural backgrounds.

**Theme 5: Disrupted Family Life.** The disrupted family life theme aggregated perspectives of all participants (100.0 %) who commented on displacement-related changes in the family daily life that challenged refugee youth's well-being during the displacement. Three subthemes emerged: (1) lack of routine, (2) age-inappropriate responsibilities, and (3) uncertainty about the future.

***Subtheme 5.1: Lack of Routine.*** This subtheme showed that during the migration stage, refugee youth could not rely on a fixed schedule or routine which humanitarian workers associated with poor mental health outcomes among these youth. Participant 11 spoke about young refugee children being on their own, staying all day long inside the caravan:

Refugee children could do nothing all day in the refugee camp if [they] wanted to. No adult was going to expect [them] to go out, to walk around, to get fresh air because people were really just taking care of very, very basic needs there.

This comment illustrated that refugee families were preoccupied with securing basic needs (e.g., safety, shelter, food, water, and sanitation) and thus, establishing a schedule that the child would follow was not a priority in this ever-changing environment.

The participants also commented on unclear expectations or lack thereof. Participant 11 explained that “all children thrive on having boundaries set and being held accountable” and mentioned that many refugee families were distressed due to ongoing stressors, such as lack of resources, domestic violence, single parenthood, mental health problems, no parenting experiences. This subtheme showed that some refugee parents felt overwhelmed and consequently, were challenged to set and execute the expectations and rules in their families.

***Subtheme 5.2: Age-inappropriate Responsibilities.*** This subtheme represented humanitarian workers’ perspectives of refugee youth’s age-inappropriate responsibilities. Importantly, this subtheme involved a discussion of cultural factors delineated by humanitarian workers who came from Middle Eastern backgrounds. White humanitarian workers of European and the U.S. American backgrounds tended to view refugee youth and children’s involvement in caregiving as a challenge. For example, Participant 10 said: “A lot of kids were on their own, a vast majority of the time, or they were taking care of siblings almost entirely. I think ... it could



be harmful for a child's development". This participant further explained that especially infants and preschool-age children should be supervised only by adults. Participant 10 perceived refugee children's involvement in caregiving as harmful and associated it with cultural norms.

Importantly, Participant 5 who came from a Kurdish American background said that in the Middle Eastern culture, it was common to see siblings taking care of each other even without parents being around, and clarified that raising up children was the responsibility that the community shared (e.g., close and extended family members, neighbors, friends). Only one non-Middle Eastern humanitarian worker, Participant 11, expressed positive connotations related to youth supervising younger children, "I think it was absolutely so beautiful when I would see and an eleven-year-old showing a baby around and treating that baby with such love and care". The age-inappropriate responsibilities subtheme revealed a child-rearing pattern commonly observed in the Middle Eastern displaced population, namely, older children taking care of younger siblings, and also captured cultural bias in participants' perceptions of this caregiving practice.

***Subtheme 5.3: Uncertainty About the Future.*** This subtheme demonstrated the family's uncertainty about their migration status and the negative effects of this condition on refugee youth's ability to pursue education or initiate and maintain positive social interactions. The participants who worked in Greece highlighted that refugee families felt confused and had difficulty making decisions regarding their children's education. For example, Participant 12 reported that "[refugee families] were stuck [in refugee camps]; they did not know whether to get their kids to school... they did not know what to do with their lives."

In the context of receiving education in a host country, such as Greece, families' expectations and hopes regarding reaching their final destination contributed to refugee youth's hesitancy in learning languages or mingling with the locals. Participant 3 stated:

Some of the children did not want to learn Greek; they did not want to go to the Greek school because their parents did not want to be in Greece. This was a huge challenge in terms of acculturation with the local population because Greece was treated [by refugee families] as an interim transfer space rather than the place where they lived.

Furthermore, the same humanitarian worker explained:

It was three or four years of a child's life so it meant that the family lived here (in Greece); but it was constantly expressed that Greece was just a temporary shelter and the families hoped to move at some stage.

These quotes reflected humanitarian workers' beliefs about the barriers that refugee families faced while settling down and accessing public education in host countries. These challenges stemmed from refugee families' limited interest in establishing ties with a host community in light of future migration plans and hopes.

Participant 4 provided further context and expressed their concern over families experiencing uncertainty regarding their future:

The big challenge was that families came to ... Greece originally, and the kids went to school and learned Greek; they were also trying to learn English because a lot of people spoke English in the camp, but also the families did not know where they were going to end up. They could go to Germany... France... they were not sure what language they should learn... a language was important to fit in somewhere, to make friends.

Theme 5 substantiated that humanitarian workers believed that some refugee families were uncertain about their future, and thus, hesitant to allow their children to enroll in public schools in a host country, which challenges refugee children's ability to develop nurturing social relationships in the public-school context and receive formal education.

**Theme 6: Unstable and Interrupted Social Relationships.** This theme illustrated that the displacement environment made it challenging for refugee youth to develop and maintain lasting and trusting relationships with their peers and adults including their own families. Six participants (58.3 %) mentioned that refugee youth were separated from their primary caregivers and extended family members, as well as close friends due to forced displacement. Participant 3 summarized, “A factor for a number of children that would exacerbate or contributed to trauma-related symptoms would be having ... incomplete family structure”. This comment suggested that some refugee youth were deprived of a primary source of social support. Furthermore, Participant 8 mentioned barriers faced by refugee youth in forming safe attachments with their peers and other adults including humanitarian workers:

Volunteers could not stay a long time in refugee camps and the children sometimes became attached to them, and then volunteers had to leave. This did not happen only with the volunteers, but with some of the refugee friends in the camp. They had to move to another camp or country, and then the child tried to have consistency and lost it from one day to another.

This quote portrayed the daily challenge that refugee youth navigated, namely, frequent relocations of staff and community members that contributed to an ever-changing network of imminent social support. Even though Theme 10 revealed the protective role of the community, Participant 10 noticed that in the refugee camp setting, this sociocultural buffer was interrupted. She said:

I think the children are very unsupported here ... if you are living in your native community where a grandma or grandpa is there, or there are your neighbors... the

children will be supervised. It was hard in the refugee camp because there was no community support system.

In general, Theme 6 showed that humanitarian workers associated dynamically changing and short-lived social relationships with poorer psychosocial outcomes among refugee youth during the migration stage, such as difficulties in developing nurturing relationships.

### ***Mesosystem***

Interactions between factors present in the refugee youth's individual system, microsystem, and exosystem accounted for the mesosystem. Three main themes emerged from the interviews conducted in this research study, namely, (1) interrupted collaboration with families, (2) language barrier between humanitarian workers and refugee youth and families, and (3) social exclusion and discrimination of refugee youth. Overall, these three themes portrayed the challenges at the level of the collaboration between refugee youth, their families, and the external providers such as schools and humanitarian workers.

**Theme 7: Interrupted Collaboration With Families.** This theme delineated challenges reported by six humanitarian workers (50.0 %) in establishing collaboration with refugee families. The participants associated some of these difficulties with families' beliefs and educational backgrounds, or their biases. Participant 7 spoke about their efforts in providing support across settings to ensure the generalization of psychosocial and academic skills, as well as culturally new norms, taught to refugee children, and mentioned challenges encountered in this process:

No matter how much we worked with [children] in a space, they went home and they were exposed to whatever was going on there, and they brought it into the child-friendly

space or school and it was difficult to challenge those beliefs and behaviors because of a lack of a consistent approach.

On this note, Participant 8 who also worked with refugee children in a public preschool recalled the situation where a refugee child was playing only with their siblings in the classroom. Given that the school rules aimed to foster intercultural exchange and inclusiveness, Participant 8 followed up on this issue with the child's parents and disclosed, "these parents forbade their children to play with peers and asked them to play only with the children who were neighbors and came from the same culture". The same participant explained that as a result of inconsistent expectations across the school and home environment, "the child was confused what was the correct way to behave... the parents' way or the teacher's way". Participant 12 who worked in Bulgaria recalled a case of an elementary school-age refugee child that attended a public school and became a victim of physical violence and bullying. She said that their parents were not following up on this incident, and she had to take on this role to support the child.

Participant 12 provided more context that could explain some of the barriers faced by humanitarian workers in collaborating with refugee families. She explained:

Some refugees came from rural backgrounds where most people were uneducated and often parents were illiterate, and they had never been to school. Moms were likely to be married when they were fourteen or fifteen, aside from having children, these families were thrown into a risky situation in a different country, trying to work out another culture.

This comment illustrated that refugee families' ability to collaborate with care providers could be hindered by the parents' limited educational experiences, life-challenging events, such as early marriage, and ongoing adjustment to unfamiliar contexts of displacement. Noteworthy,

Participant 10 discussed potential reasons for the families' hesitancy to mingle with the local community:

If the host country did not have necessarily a positive perception of this refugee community and then, children were put in a school system where local children were saying not very nice things to the refugee children, that could give a bad perception of that host country's culture.

This comment showed that families' attitude toward a host culture was associated with the sentiments endorsed by the hosting communities. Humanitarian workers believed that parents refused to enroll their children in school to reduce the likelihood of being marginalized.

**Theme 8: Language Barrier Between Humanitarian Workers and Refugee Youth and Families.** This theme distilled challenges in communication due to the language barrier between humanitarian workers, refugee youth, and their families. Particularly, eight participants (66.7 %) described their failures to deliver appropriate psychosocial support to youth and respond to unsafe behaviors while maneuvering cultural differences.

All non-Arabic or Kurdish speaking participants expressed frustration over not having an ability to foster refugee youth's mental health due to limited proficiency in the youth's native languages, "I could not really help with the mental health of the children outside of delivering programming because ... I did not speak their language", said Participant 1. Similarly, Participant 10 said:

Sometimes I wondered whether it was just more harmful to be working in a space where I was putting children in a situation where they could not explain everything to me because of language barrier... that had to be very frustrating for the children.

The presence of linguistic diversity in refugee camps prompted humanitarian workers to utilize interpreters. Participants who worked in child-friendly spaces shared stories that presented biased and unprofessional behaviors demonstrated by people who were assisting in multilingual communication. For instance, Participant 10 disclosed that some interpreters were biased in their approach towards specific ethnicities, thus they were not fostering a welcoming climate in the child-friendly space which contributed to the exclusion of some children from activities. The same participant expressed frustration over being incapable to intervene promptly in this situation due to her limited language proficiency. Participant 10 also disclosed why she believed it was important to speak the child's language: "[language barrier] was so incredibly frustrating for a child who was trying to tell me that something just happened, or communicate that they wanted something". To provide further rationale for acquiring refugee youth's native languages, this humanitarian worker emphasized that language barrier could contribute to misunderstandings, "I might see [the child] hitting [another child] and I addressed the physical thing that I could see, but I could not necessarily understand that the child they just hit called them an incredibly bad insult". This comment showed that Participant 10 was likely to fail to address refugee youth's needs adequately, specifically in conflict situations, due to the language barrier.

Humanitarian workers' perspectives highlighted that interrupted cross-language communication impeded the delivery of trauma-sensitive psychosocial and educational activities. For example, Participant 9, a yoga instructor, shared, "I would like to do guided relaxation for children but I could not do it because of the lack of common language". Participant 11 described her experience in navigating cultural differences given no proficiency in the refugee youth's native languages:

I noticed culture-wise that teen girls [from the Middle Eastern background] would laugh when they were embarrassed. At first, I did not understand what was going on. Then I realized that was the way they were reacting when they did not know how to do something.

As a response, Participant 11 encouraged these youth to give it another try, however, this participant also disclosed that “because of the language, it was difficult to communicate [cultural norm regarding being unfamiliar with something], but with an interpreter, we kind of got on the same page”. These comments showed that in the displacement context, lack of language proficiency constrained the humanitarian workers’ abilities to deliver culturally responsive psychosocial support to refugee youth. Additionally, this theme pronounced potential risks that stemmed from relying on interpreters, which was concerning for some participants given the vulnerability of the refugee youth population.

**Theme 9: Social Exclusion and Discrimination of Refugee Youth.** Eight humanitarian workers (66.7 %) reported that refugee youth were vulnerable to discrimination and social exclusion in the host community, but also within refugee camps. Some of the triggers for discrimination included poor living conditions in the refugee camps. For example, Participant 2 explained:

Sometimes the campground ran out of water so [refugee families] did not get to wash their clothes or ... take a bath, and [children] were wearing the same clothes pretty much every day. In the camp, it was fine because everyone was wearing the same clothes but often, it was hard for [children] to feel like they could not blend in with other children in Greece.



This comment demonstrated that refugee youth strove to make friends, but their ability to do so was challenged by their underprivileged background. Participant 2 mentioned that refugee youth had unequal opportunities to mingle with their peers outside of the refugee camp, “[refugee youth] were going to public schools and ... right away they were separated. They had to leave Greek school at lunchtime”. Noteworthy, consultation with external auditors revealed that refugee youth’s limited opportunity to participate in a school routine could be related to transportation. For example, in the Evoia region of Greece, the bus was taking refugee children back to a refugee camp around lunchtime. Participant 3 echoed the beliefs surrounding discrimination against refugee children in Greek communities, “attending local schools and facing bias or racism coming from the local children definitely would affect the mental health of the refugee children.” This humanitarian worker emphasized that refugee children from ethnic minority groups were also socially isolated within the refugee camp environment, “I have had in the past year only five African children from Congo and Cameroon, and definitely they experienced bullying within the child-friendly space”.

Humanitarian workers explained that the non-profit organizations that delivered aid in the displacement setting were funded by donations, and thus, they needed to demonstrate to their donors that their on-site operations supported a wide population. One way to do that was to create a space that aimed to welcome all genders and ethnicities so that it had the potential to serve more persons as compared to a female-only space, or one-ethnicity-only space. In reality, given gender-specific cultural norms, and tensions between ethnicities within the refugee community, these all-encompassing spaces were not viewed as safe for vulnerable groups of refugee youth (e.g., females, or underrepresented ethnic groups). To illustrate this problem, Participant 10 stated, “if [a humanitarian organization] had a predominantly one ethnicity in the

youth space, the other ethnicities were probably not going to come”. Overall, the social exclusion and discrimination of refugee youth theme merged comments that explored refugee youth’s unequal opportunities and access to services due to biases endorsed by a host community, discriminatory policies, and limited resources in refugee camps.

### ***Exosystem***

Challenges within the exosystem included elements of the refugee youth’s distant environment that directly and indirectly jeopardized their well-being during the emigration stage. This entailed two themes: (1) humanitarian workers’ high level of stress, and (2) hostile and unstable conditions of the refugee camps. The first theme was represented by three subthemes: (a) humanitarian workers’ psychosomatic symptoms of mental health fatigue, (b) humanitarian workers’ sense of helplessness, and (c) humanitarian workers’ preconceived beliefs about delivering aid to refugee youth. The second theme clustered three subthemes: (a) exposure to unsafe behaviors, (b) living in confined spaces with limited privacy, and (b) shortages of staff and mental health services

**Theme 10: Humanitarian Workers’ High Level of Stress.** This theme emerged from the responses of eight participants (66.7 %) and described their mental health vulnerabilities and the ways in which these conditions impacted the delivery of aid to refugee youth. Specifically, there were two subthemes: (1) humanitarian workers’ psychosocial challenges, and (2) humanitarian workers’ preconceived beliefs about delivering aid to refugee youth.

***Subtheme 10.1: Humanitarian Workers’ Psychosocial Challenges.*** All eight humanitarian workers spoke about the negative impact of their work environment on their mental health. The psychosocial concerns that the participants reported included signs of burnout, anxiety, depression, stress-related disorders, and adjustment problems. For example, Participant

3 who worked in understaffed teams described the onset of symptoms similar to an anxiety attack, “I experienced anxiety and I have had also ... two moments where I felt like this anxiety was affecting my body ... I had problems breathing”. Participant 5 spoke about persistent worries and ruminations over interactions with refugee youth:

I experienced a lot of thinking and reflecting on things that have happened during the day. For example, if a child had told me something that maybe was not the most positive experience that they have had and they shared it with me, or I witnessed something aggressive or violent, and I was repeating it in my mind throughout the day and not being able to get my mind off of it, which at some point was beyond my control.

One of the two participants who denied experiencing mental health problems during their humanitarian service, Participant 10, disclosed that she had developed psychological problems after she stopped working:

I had dreams, and those dreams lasted at least six months, or longer, and then, I was still having disturbing dreams about certain kids. [Exposure to trauma] was affecting me subconsciously. I did not know if it was affecting me outwardly in a mental health way.

This quote pronounced the tendency endorsed by some humanitarian workers to compartmentalize mental health so that persistent and disturbing dreams were not associated with mental health.

The participants disclosed experiencing a sense of helplessness – a subjective feeling of being useless, incapable of helping, or not having control over upsetting events. Specifically, Participant 2 explained that she felt helpless daily:

After work, I ran through the town and I saw kids with their parents, or kids during fun things at the playground and that made me more upset. Obviously, I was happy for the kids doing that, but I also wanted that for all the kids.

This comment demonstrated that observing social injustice and disparities evoked feelings of helplessness in some humanitarian workers.

Participant 11 described sadness over a failure to adequately support three- to five-year-old children who arrived in the child-friendly space:

If a child was acting out because of things that were going on at home, came into the setting, and did not get what they wanted, and just left, I found it such a missed opportunity. I found that pretty sad.

Participant 6 who came from a refugee background and worked as an interpreter said, “I had failed many times to help families that had difficult situations such as arriving on the boats [from Turkey to the shores of Greek islands]. This awareness was tragic for me”. This quote exemplified the psychological burden that some humanitarian workers experienced as a result of a failure to support refugee families in emergencies.

***Subtheme 10.2: Humanitarian Workers’ Preconceived Beliefs about Delivering Aid to Refugee Youth.*** This subtheme described humanitarian workers’ biases toward working with refugee youth. These beliefs created a barrier for the participants to seek mental health support, and thus, impacting the quality of aid that refugee youth received. Participant 10 disclosed that humanitarian workers tended to belittle their own mental health problems and rationalize their severity and that “there was entire group mentality of ‘I will just work through trauma and my mental health comes second’”. This participant elaborated, “people did not do [relief work] unless they were strong and independent ... it was almost like a savior complex, like ‘the hero

could not get hurt’’. This comment demonstrated that some humanitarian workers tended to overlook their mental health needs and continue exposing themselves to second-hand trauma believing that this was the right thing to do. This bias could negatively impact refugee youth because humanitarian workers’ ability to deliver high-quality psychosocial support was likely to be interrupted by their unaddressed individual mental health needs.

Overall, Theme 10 substantiated that humanitarian workers were exposed to a plethora of traumatizing and distressing events directly and indirectly, and were likely to develop mental health problems. This theme also demonstrated that the participants endorsed specific beliefs that prompted them to diminish their psychological needs. Notably, refugee youth relied on daily support delivered by humanitarian workers (e.g., play, lessons, psychosocial programs), which often were the only resource that these youth could access. Therefore, the well-being of humanitarian workers was crucial to sustaining the delivery of humanitarian aid during the migration stage.

**Theme 11: Hostile and Unstable Conditions of the Refugee Camps.** This theme encompassed environmental threats that refugee youth were exposed to daily, including very violent behaviors that had the potential to exacerbate these youth’s trauma-related problems. The environmental challenges and hazards were discussed by all participants (100.0 %). Specifically, there were three subthemes that clustered these environmental risk factors into: (1) refugee youth’s exposure to unsafe behaviors, (2) living in confined spaces with limited privacy, and (3) shortages of humanitarian staff and mental health services.

***Subtheme 11.1: Refugee Youth’s Exposure to Unsafe Behaviors.*** All humanitarian workers identified refugee youth’s exposure to unsafe behaviors as one of the most impactful risk factors. Reported behaviors included fights, violent demonstrations, domestic violence,

sexual assault, self-injury, substance use, tensions between refugee communities, and access to unsafe objects such as sharp rocks. Participants tended to comment on preschool-age refugee children who joined child-friendly spaces and initially did not demonstrate disruptive behaviors, however, over time, they became more violent. For example, Participant 10 said:

I have seen over time kids that came in and were very sweet and polite and after a couple of months, they started learning the behavior from maybe the other kids and then, [their behavior] rapidly changed to grabbing things, yelling, and getting in more fights.

Participant 12 said, “one child’s behavior was spiraling out of control; he was becoming violent and threatening to other children with a stick... he had to be removed from the room several times because his behavior was so unsafe”. These quotes highlighted the negative influence of peer modeling on new-coming children. Furthermore, from the earliest age, refugee youth were exposed to multiple unsafe behaviors in their own families (e.g., “kids witnessing their parents fighting”), and the refugee camp community in general (e.g., “kids witnessing a lot of drug use and alcohol abuse at a young age”). On this note, Participant 6 reported that “[he] saw a group of people including children who witnessed a person setting himself on fire in a refugee camp”. In addition to all self-injurious and violent behaviors, some humanitarian workers mentioned tensions, including violent fights, within the refugee community, and between refugees and host communities. It is self-evident that exposure to rampant violence and acts of despair contributed to refugee youth’s well-being during the migration stage.

***Subtheme 11.2: Living in Confined Spaces and Lack of Privacy.*** In refugee camps, families lived in tents, trailer-houses called ISO Boxes, or other improvised shelters, such as tents made of plastic shields). These confined spaces were typically shared by multiple families

who also had children. Participant 10 commented on the lack of privacy, including exposure to adult sexual activities at an early age:

When kids lived in close confinement with their parents, things that parents do, did not stop when they were in a refugee context; for example, they were still going to be having sex. A child was going to be exposed to that at a much younger age. Whereas back home ... the kids might have had their own bedroom.

This quote highlighted the problem that was likely to contribute to the psychosocial well-being of all family members, not only children. Furthermore, refugee youth typically did not have their own space to have their quiet time because “everything was communal” in the living spaces.

Participant 10 reported that refugee youth’s safety was threatened because they could not easily avoid interpersonal conflicts and violence in the refugee camp:

Being in such close confinement with all of the kids meant there was no escape; if [the child] was having a problem with a kid at school, [they] could go home and did not have to see that kid except for the eight hours [they] go to school. In the displacement context, [the child] was with the children all the time; [other children] knew where [the child] lived. [The child] could be afraid to come back to their caravan.

This comment, in particular, showed that some refugee youth could feel unsafe in their living spaces due to the risk of being threatened by their peers and having no possibility to find a safe place. This subtheme also showed that the lack of a quiet environment challenged refugee youth’s ability to rejuvenate, rest, and get proper sleep.

***Subtheme 11.3: Shortages of Humanitarian Staff and Mental Health Services.*** This subtheme entailed humanitarian workers’ concerns about understaffed teams that served refugee youth during the migration stage, in particular, shortages of trained mental health professionals

and specialized services in refugee camps. The participants worked in the child or youth spaces in refugee camps where there were less than five adults per 50 to 100 refugee youth. Participant 1 concluded that working in understaffed teams on-site jeopardized refugee youth's safety, "being understaffed in the organization made the environment sometimes unsafe for the kids ... we definitely could not concentrate on observations of specific behaviors". Additionally, this comment explained that participants were not able to pay attention to concerning behaviors of refugee youth because their team was understaffed and each person had to attend to many issues at the same time to ensure safety.

When it comes to specialized mental health support, Participant 10 highlighted that it was challenging to refer refugee youth:

There were so many kids we wanted to refer to psychologists so that they could have someone to speak with, but that just did not happen... not all the cases reached this level of severity where they became the top priority and that was so unfortunate.

This quote showed that refugee youth's access to specialized mental health support depended on the severity of their problems; given the shortage of professionals, those refugee youth who endorsed moderate mental health conditions, or did not meet the vulnerability criteria, such as ongoing abuse, disability, unaccompanied minors, they were unlikely to access to specialized psychological support. Participant 6 who was an interpreter mentioned that "[he was] helping to translate because [in one of the refugee camps on the Greek island], was not enough translators. In this refugee camp, there were two thousand people and only one humanitarian organization on-site." This comment among many similar ones reiterated massive shortages of specialized mental healthcare in refugee camps. Lastly, Participant 9 who delivered yoga classes and other stress relief sessions spoke about the lack of data tracking systems in humanitarian organizations.



He highlighted that these evaluation tools would have allowed him to design appropriate trauma-sensitive materials in order to address refugee children's needs. This humanitarian worker described:

There was no record of what was happening with the child ... if I was coming to one of the camps and someone else was there before or after me and told me that this kid could not close their eyes because of prior experiences and fear ... I could have given a different exercise to this kid and not force them to do something they were not happy to do.

This quote showed that humanitarian workers were not fully aware of refugee youth's health backgrounds which made it challenging to design nurturing activities for these youth. Overall, Theme 11 was one of the three most represented themes within the group of challenges that contributed to refugee youth's well-being during the migration stage. This theme revealed environmental threats and hazards associated with living in temporary shelters, such as refugee camps, and barriers to providing mental health support to refugee youth.

### ***Macrosystem***

Humanitarian workers described culture-related challenges that contributed to refugee youth's well-being during the migration stage. There were two main themes that illustrated the macrosystem challenges: (1) gender differentiation, and (2) mental health stigma.

**Theme 12: Gender Differentiation.** This theme described harmful gender norms and expectations that humanitarian workers associated with Muslim Middle Eastern culture. Six participants (50.0 %) reported that girls faced different social expectations than boys. For example, Participant 10 mentioned, "I have worked mostly with Middle Eastern children and within Muslim culture, girls were not supposed to have contact with boys after a certain age ...

usually around puberty”. Participant 2 echoed this perspective by saying that “traditionally, Arab and Kurdish families aren’t as willing to let their daughters out of their house”. On this note, Participant 7 highlighted that cultural norms promoted different behaviors in boys and girls:

Boys were allowed to be boisterous ... whereas girls were not allowed to run around ... play football. Then there were also quite shy and withdrawn girls who had to ask for permission to do things and they were not sure within themselves what they could do, what they could not do, and there were some loud boys running around ... because they had been allowed that freedom of expression.

This comment showed the cultural norms that the participants attributed to differences in emotional expression across girls and boys. Importantly, this quote needed to be viewed in light of the potential cultural bias given that Participant 7 came from a non-Muslim, and non-Middle Eastern background.

Furthermore, humanitarian workers reported that girls had limited access to resources in the refugee camps. For instance, Participant 10 said:

There was not enough programming or resources devoted to [Muslim teen girls]. Parents might say to their daughters ‘now you are too old to engage in child-friendly space; we are not going to let you go to the youth space because there are too many men around there.

As it was presented in this comment, some refugee families were hesitant to let their daughters join the youth spaces that were attended by youth older than twelve years old, and also young male adults. Given that in refugee camps, the child-friendly spaces and youth spaces were two primary venues where psychosocial support was provided, Muslim teen girls had a limited opportunity to access this resource, which was concerning in light of scarce aid.

Importantly, Participant 5 who self-identified as a Syrian Arab explained gender-specific cultural expectations in-depth, “Typically, in the Muslim community, we did not let girls walk alone, or talk to strangers. They had to be accompanied by someone. Girls did not wear short-sleeved clothes. That was different in Greece”. This comment showed that Muslim cultural norms also delineated appropriate ways to socialize and dress up, and these rules were not present in host countries such as Greece. Importantly, many participants highlighted that refugee families tended to be very protective of their daughters due to gender-based violence that their families experienced, and high exposure to aggression and violence in the refugee camps. Overall, Theme 12 proved that some gender-specific cultural norms challenged teen girls’ access to resources during the migration stage, and that cultural bias was likely to contribute to humanitarian workers’ interpretation of these norms.

**Theme 13: Mental Health Stigma.** The mental health stigma theme was extracted from participants’ responses to represent culture-specific negative mental health beliefs endorsed by some refugee youth. Even though factors captured by this theme were discussed by three participants only (25.0 %), my research team and I decided to separate this concept as it was very relevant for understanding a larger picture of the refugee youth’s psychosocial well-being during the migration stage. Participant 2 mentioned:

People that came from the Middle East did not place an importance on mental health, and often when things happened to children, adults were not willing to sit down and listen to them; so I think children either buried their problems deep down inside or let them out violently.

Also, Participant 5, who self-identified as Kurdish American echoed this belief:

Middle Eastern cultures ... typically do not have a lot of emphasis on mental health ... I think they may not be as likely to identify, possibly in their children or within themselves how to process challenging behaviors and how to cope with that and understand whether a problematic behavior is natural or caused by a certain incident.

The same humanitarian worker clarified that some refugee families from Middle Eastern backgrounds “may be unsure how to reach out and get help because they do not know their children’s problematic behaviors as something that needs intervention”. Those quotes suggested that some refugee families endorsed negative culture-specific beliefs of mental health that were likely to impact the quality of psychosocial support that children receive within their family unit.

## **Chapter 5. Discussion**

The purpose of this research study was to explore humanitarian workers' perspectives on refugee youth's mental health and resilience during the migration stage, the strategies and interventions humanitarian workers used to scaffold these youth's healthy development during displacement, and lastly, to identify the needs for future training. Using the displacement-specific ecological model of resilience and mental health factors (see Figure 4), the overall results of the study delineated main themes and subthemes that portrayed individual, social, environmental, and cultural factors that contributed to refugee youth's well-being at the transit stage in Southeastern Europe. I will use the term "protective factors" to discuss the elements of refugee youth's socioecology that the participants associated with positive mental health and academic outcomes of these youth during the migration stage. On the other hand, "challenges" denote factors that humanitarian workers viewed as hindering refugee youth's well-being during the transit stage. This Chapter discusses protective factors and challenges clustered in individual, micro-, meso-, exo-, and macrosystems, implications for school psychologists organized in an analogous way, study limitations, and lastly, future directions.

### **Displacement-specific Protective Factors Among Refugee Youth**

#### ***Themes of the Individual System Protective Factors***

The protective factors within the refugee youth's individual system included their engagement and creativity, psychological flexibility and openness to new cultural experiences, and self-awareness and self-advocacy (Theme 1, 2, and 3). My findings were consistent with the previous literature related to resilience among culturally diverse youth (Ungar, 2008a; Wu et al, 2018). For example, Ungar (2008a) identified self-efficacy, self-awareness, and insight as individual protective factors. It was interesting that humanitarian workers' responses showed that

refugee youth's individual characteristics were very intertwined with the external environment and its cultural responsiveness to these youth's needs. Ungar (2008a) demonstrated that individual characteristics, such as self-advocacy, benefited youth only when the environment was responsive in providing adequate support. In light of these findings, I wonder whether refugee youth who demonstrated strong self-advocacy skills continued to be challenged given that humanitarian workers had limited ability to respond to these youth's needs in an appropriate manner due to the language barrier and cultural differences. It may be that participants were prone to contextualize refugee youth's well-being only in terms of behavioral outcomes that can be observed regardless of the language barrier. That is, it could be easier to notice self-advocacy in a form of youth's gesticulation (i.e., pointing to an object that the youth wanted to access) than for example, a sense of humor or optimism that could be identified if humanitarian workers were proficient in the youth's language. Overall, to identify refugee youth's individual protective factors, humanitarian workers tended to rely on behavioral clues and highlighted characteristics that allowed these youth to engage with their environment despite the scarcity of resources.

### ***Themes of the Microsystem Protective Factors***

Theme 4 accorded with previous cross-cultural resilience research conducted by Ungar (2008a) who found that the family's emotional expression and parental guidance scaffolded the youth's healthy development. Importantly, during the migration stage, not all refugee youth could rely on their caregivers' emotional support. For example, previous research showed that unaccompanied refugee minors were one of the most vulnerable groups because they were deprived of the family support and often required increased attention for their mental health needs (Keles et al., 2015; Michelson & Sclare, 2009). However, Clark-Kazak (2012) shed new light on unaccompanied minors, and discussed an example of Congolese refugee youth who

demonstrated resilience through their independent migration-related decision-making despite being alone. For example, they could take the responsibility over planning their journey including the destination country, or access to education. Overall, only one theme emerged within the microsystem, therefore, in general, I speculate that humanitarian workers tended to view family as a primary source of social support for refugee youth during the migration stage. Alternatively, the participants might have had scarce opportunities to learn about the quality of refugee youth's peer interactions due to the language barrier, cultural differences, and limited time they spent working with these youth in the field.

### ***Themes of the Mesosystem Protective Factors***

Theme 5 highlighted the protective role of humanitarian workers' efforts to bridge linguistic and cultural barriers between them and refugee youth, while Theme 6 emphasized participants' assistance in navigating cultural differences. For example, humanitarian workers used nonverbal clues to support refugee youth's language acquisition and believed that learning a foreign language allowed these youth to develop social ties with a host community. Noteworthy, Guo (2007) argued that foreign language acquisition was not only an opportunity to develop social connections with the host culture, but it also fostered communication and high-order thinking skills. Given that the language proficiency levels were diverse among refugee youth, humanitarian workers frequently relied on visual aids such as picture stories, drawings, symbols, and gestures. Similar to what the current research study showed, Guo (2007) and Millar (2011) reported that diverse Korean youth who transitioned to Australian schools and learned a foreign language benefited from hands-on, open-ended, and cooperative activities. My findings suggested that humanitarian workers' efforts to scaffold refugee youth's foreign language

acquisition enhanced these youth's social functioning and fostered their ability to cope with daily challenges.

### ***Themes of the Exosystem Protective Factors***

The exosystem (i.e., refugee youth's distant environment) protective factors were mentioned by all participants, and therefore, this section separately discusses the main themes: (1) nurturing space for refugee youth inside and outside of the refugee camp (Theme 7), (2) humanitarian workers' self-awareness and positive attitudes toward refugee youth (Theme 8), and (3) humanitarian workers' positive coping strategies (Theme 9).

**Theme 7: Nurturing Spaces for Refugee Youth Inside and Outside of the Refugee Camp.** Humanitarian workers observed that refugee youth responded well to familiar and structured environments both in the refugee camps and also public schools. This theme aligned with existing research that showed that clear and consistent behavioral expectations and rules helped refugee youth to feel safe and that trauma-sensitive activities and physical spaces bolstered these youth's resilience (see, e.g., Sullivan & Simonson, 2016; Tyrer & Fazel, 2014). For example, my findings illustrated that clear expectations presented visually helped humanitarian workers to minimize aggressive behaviors in the spaces, while consistent adults and programming fostered refugee youth's sense of safety.

Interestingly, even though humanitarian workers believed that age-consistent groups fostered refugee youth's safety and healthy development, participants had difficulties reporting specific ages of children in general. Potential explanation was that despite the use of a multimethod approach, including medical, dental, and psychosocial assessments, refugee youth's age was often incorrectly stated upon admission to a host country (Busler, 2016). This was a pervasive issue that emerged due to missing documents, convoluted screening procedures that



often, employed intrusive methods, or any combination of these. The procedural and methodological challenges used to assess refugee youth's age tended to produce inaccurate results. In fact, refugee youth's age was typically reported with an error of two to three years on either side of the suggested age during initial assessments (Busler, 2016). The age assessments were especially problematic to conduct among unaccompanied refugee minors. For example, 65% of unaccompanied youth from Afghanistan reported a lack of documentation as a reason for leaving Iran, where they were living (UNICEF, 2017), which might have contributed to incorrect age assessment in this group of children upon their arrival to a host country.

As for psychosocial and educational strategies utilized by humanitarian workers to support refugee youth's well-being, current findings that indicated the use of creative and play activities overlapped with some of the previous studies. Specifically, Tyrer and Fazel (2014) found that during the migration stage, alternative methods of treatment, such as artistic activities, were often implemented to address emotional problems due to scarce specialized mental health services. For instance, creative arts were utilized in schools in the IDP Uganda camp area to address trauma-related problems in children from seven to 12 years old (Ager et al., 2011). Previous research also showed that in addition to arts, play activities fostered children's social and cultural learning. In particular, activities that involved music and movement helped bicultural displaced children to negotiate their native cultural identity and expectations and norms emulated in a host country (Marsh, 2016). Noteworthy, music activities were a form of communication when the verbal expression was limited or social situations were ambiguous including significant life transitions, establishing inter-group relationships, or personal crises (Cross & Woodruff, 2009).

In addition to play, humanitarian workers tried to respond to refugee youth's individual needs by creating opportunities for these youth to self-soothe or express their emotions in a spontaneous way. Humanitarian workers' efforts aligned with the recommendations issued by Save the Children (2013) that highlighted the importance of informed and voluntary child engagement in fostering refugee youth's post-traumatic growth and respecting their dignity. To support refugee youth's mental health, humanitarian workers tended to rely on non-evidence-based strategies despite the plethora of research-supported interventions. For example, previous research showed that in a refugee camp setting, individual KIDNET therapy, an adapted version of narrative exposure therapy for children and adolescents, was delivered altogether with meditation and relaxation techniques to refugee youth in a camp in Sri Lanka to address trauma-related symptoms (Catani et al., 2009). The KIDNET also helped to decrease PTSD symptoms in refugee youth placed in a refugee camp in Uganda (Onyut et al., 2005). Nonetheless the efficacy of trauma-informed interventions, my findings showed that refugee youth were likely to rely only on the aid delivered by humanitarian workers who had limited capacities to provide more specialized mental health support. Noteworthy, the unprecedented circumstances of the global health crisis have resulted in the closure of most psychosocial activities delivered to refugee youth who lived in refugee camps in Southeastern Europe in Spring 2020; however, despite these challenges, for example, psychosocial group activities were still delivered remotely to refugee youth in Southeastern Europe (e.g., Italy) (UNICEF, 2020).

**Theme 8: Humanitarian Workers' Self-awareness and Positive Attitudes Towards Refugee Youth.** Within Theme 8, the most interesting finding pertained to humanitarian workers' self-reflection and professional humility that indirectly supported refugee youth's well-being during the migration stage. This finding broadly supported the work of other studies in the

area of self-reflection and cultural humility (Goforth et al., 2016). Importantly, professional humility entailed humanitarian workers' ability to withdraw in the face of experiencing the deterioration of their own mental health and willingness to seek coping tools. This skill was crucial given high rates of burnout in this professional group. For example, those participants who engaged in self-reflection were likely to identify early signs of mental health challenges, seek help, and rejuvenate in order to continue serving refugee youth. Theme 8 also aligned with the research findings that demonstrated a positive role of journaling and practicing gratitude in sustaining personal well-being among aid workers despite ongoing stressors (Coaston, 2017).

**Humanitarian Workers' Positive Coping Strategies.** Previous research explored humanitarian workers' coping strategies only in the context of their mental health challenges and high exposure to secondary trauma (Young et al., 2018); whereas, the current results contributed to the existing literature by showing that humanitarian workers' positive coping strategies could enhance their ability to deliver high-quality aid to refugee youth despite the high levels of stress. As for the coping strategies reported by the participants, apart from socializing and creative activities, regular breaks, traveling and other forms of "disconnecting" from the work environment allowed them to maintain positive mental health in the guise of multiple stressors. At the same time, I argue that this form of coping could sustain humanitarian workers' psychological issues long-term because it had the potential to reinforce a psychological mechanism called experiential avoidance (Murrell & Kapadia, 2011). The aforementioned coping strategy was motivated by a desire to suppress unwanted internal experiences including thoughts, emotions, memories, and bodily sensations. In other words, some participants were likely to rely on psychological distancing as a form of avoidance that helped them to control their emotional distress in the short term, but at the same time, it was possible that this coping strategy

maintained the mental health problems, especially anxiety symptoms, in the long-term perspective (Spinoven et al., 2014) For example, if humanitarian workers felt helpless, distracting themselves from this feeling allowed them to rejuvenate short-term and continue working, but it could produce undesirable mental health outcomes long-term if the source of humanitarian workers' sense of helplessness remained unaddressed.

### ***Themes of the Macrosystem Protective Factors***

**Cultural practices and customs.** Theme 10 included the first direct speculation of story-telling playing a protective role on the mental health of refugee youth who came from Middle Eastern and African backgrounds. Interesting arguments on the meaning of stories in refugee youth's lives came from an ethnographic perspective, "stories are constructions; they have to be created – by someone, for someone, in a particular situation. They are a complicated form of social engagement" (French, 2019, p. 124). Noteworthy, Moore (2017) described a strengths-based narrative story-telling intervention that incorporated trauma-informed practices and an occupational therapy approach to bolster the resilience of unaccompanied refugee minors in Greece. This intervention enriched story-telling with creative forms of expression such as comic books, audio recordings, and photography (Moore, 2017). Overall, my findings supported the evidence on story-telling being an effective tool to facilitate refugee youth's recovery from trauma by emphasizing the importance of this cultural practice in accessing social support.

My research findings supported the previous evidence on the role of community, faith, and spirituality in refugee youth's coping with adversities (see, e.g., Ungar, 2008a). Importantly, humanitarian workers' ability to reflect on the cultural and spiritual practices was affected by the language barrier as well as their familiarity with the cultural norms endorsed by refugee youth.

## **Displacement-specific Challenges that Contributed to Refugee Youth's Mental Health During the Migration Stage**

### ***Themes of the Individual System Challenges, and Mental Health***

Consistent with the previous research (see, e.g., Jaffee & Maikovich-Fong, 2011), Theme 1, 2, and 3 delineated multiple externalizing and internalizing problems, such as aggressive behaviors, temper tantrums, emotion regulation problems, withdrawal, or tendency to destroy own artwork. Noteworthy, the participants who also worked with refugee youth in school settings noticed frequent adjustment issues, such as delinquent and aggressive behaviors, withdrawal, or difficulties with staying on task. Theme 3 in particular aligned with the results of a research study conducted by Allwood et al. (2002) that showed that teachers observed similar behaviors among refugee students in schools and associated them with prior exposure to war violence. Curiously, humanitarian workers did not mention specific mental health disorders in their responses, such as PTSD that affected from 19 to 54% of the refugee population (Bronstein & Montgomery, 2011), depressive symptoms especially among refugee girls (Heptinstall et al., 2004), or anxiety that ranged from 13.5% to 92% among Syrian refugee young adults in camp and non-camp settings in Germany (Georgiadou et al., 2018). One possible reason for this lack of discussion among participants may be their limited work experience and no educational background in the mental health field; namely, 66.7% of participants reported less than three months of work experience with refugee youth. In other words, humanitarian workers could be unable to develop sufficient rapport with refugee youth due to time constraints, especially given these youth's difficulties in trusting others that were also identified in this research study. Additionally, participants delivered psychosocial support to refugee youth in a very culturally and linguistically diverse setting with minimal access to resources. In fact, participants

frequently disclosed having difficulties in understanding the causes of some problematic behaviors, including refugee youth's internal experiences, due to the language barrier. Similar bias in identifying and interpreting youth's mental health problems was observed in teachers who worked with refugee students (Allwood et al., 2002).

The numerous refugee youth's mental health challenges could trigger concerns related to humanitarian workers' limited training on the mental health of refugee children. Only one participant reported during an interview that they received education in a mental health-associated discipline (i.e., an undergraduate degree in social work). The other participants said that they received sporadic informal training only. Humanitarian workers' limited background in mental health including assessment and intervention (i.e., Functional Behavioral Analysis), might have contributed to the quality of observations that humanitarian workers shared in this research study. For example, humanitarian workers tended to associate refugee youth's withdrawal and shyness with trauma without considering individual differences. I speculate that in the chaotic environment of a refugee camp, children who had a natural inclination to be more introverted could also demonstrate resilience. For example, potentially, they could be attracted to nurturing activities such as puzzles and be apprehensive to interact with peers, who sometimes modeled unsafe behaviors, which this research study highlighted in the microsystem risk factors.

Overall, themes clustered within the individual system pronounced difficulties in tracking refugee youth's mental health problems in the context of forced displacement. I speculate that a failure to identify these youth's needs accurately may be a barrier to initiating a referral process in refugee camps, which can further jeopardize the well-being of these youth.

### ***Themes of the Microsystem Challenges, and Mental Health***

Similar to previous research on refugee youth's resilience (see, e.g., Daud et al., 2008), humanitarian workers viewed refugee parents' mental health problems as a significant challenge for these refugee youth's well-being during the migration stage (Theme 4). My research study highlighted that refugee families experienced deliberate acts of violence (e.g., human trafficking, military violence) during border crossings on their way to Southeastern Europe. This was a very important finding given the impact these events were likely to have on refugee youth's cognitive functioning. Namely, Daud et al. (2008) found that those refugee youth who were six to 17 years old, whose parents were tortured in Iraq before coming to Sweden, scored significantly lower on the IQ test than the youth with non-traumatized parents. These findings demonstrated that refugee youth's cognitive abilities were likely to be affected by their parents' pre-migration traumatic experiences. My research study also enriched our understanding of punitive parenting strategies used by some refugee parents who experienced distress during displacement, which accrued with El-Khani et al.'s (2016) research study that focused on Syrian refugee families in immediate displacement.

As Theme 5 showed, humanitarian workers noticed changes in the family structure that prompted refugee youth to undertake responsibilities that were not suitable for their age, such as supervising much younger siblings. Previous research has shown that refugee youth commonly expressed an unusual sense of personal responsibility for protecting their family members, including parents (James et al., 2014). For example, during displacement, a sixteen-year-old child may be a caregiver for their younger siblings due to their parents' deaths, parental withdrawal, or limited parenting capacities. This child may become responsible for securing food, clothing, ensuring the safety and health of their siblings during the migration process, and also providing emotional support to their distressed parents. This new role may be overwhelming

for a refugee youth who also is likely to be exposed to a number of stressors, such as hazardous living conditions. On the other hand, holding these age-inappropriate responsibilities can be viewed as hidden resilience that these refugee youth endorsed (Malindi & Theron, 2010; Diaków & Goforth, 2021). In other words, refugee children's involvement in child-rearing was typically viewed negatively by non-Middle Eastern participants, and yet this practice could be an important source of strength given other challenges associated with the migration stage (e.g., separation from the family and friends). Importantly, only 16.6% of participants (see Table 4) shared the same ethnic identity as served refugee youth; therefore, I speculate that the cultural bias might have contributed to perspectives shared by the participants who came from non-Middle Eastern backgrounds. In fact, Lewig et al. (2010) demonstrated that the most common reason for referring Middle Eastern refugee families to child protection authorities in Australia was related to leaving children unaccompanied by adults; the same research study further explained that these families were accustomed to viewing child-rearing as a collective responsibility held by a wider community, older children, and of course the parents.

Another factor associated with interrupted family structure was refugee family's worries about their future (Subtheme 5.3). Importantly, previous research has proved that refugee families' worries over their immigration status were correlated with the onset of PTSD in refugee youth (e.g., Heptinstall et al., 2004), while the number of relocations during displacement was associated with the negative mental health outcomes in general (Nielsen et al., 2008). However, there has been limited discussion about the ways that the refugee parents' worries and hopes about the future could contribute to refugee youth's success in establishing positive relationships with and within a host community. When comparing my results to those of previous studies, it must be pointed out that in some Southeastern European countries, such as Greece, at the



beginning of 2020, the resettlement process has been significantly slowed down due to the global pandemic and nation-level changes in politics (UNHCR, 2020a). These unprecedented circumstances alongside scarce resources in general, and continuously emerging risks were likely to further weaken refugee families' abilities to look after their children.

### ***Themes of the Mesosystem Challenges, and Mental Health***

The current research study showed that refugee youth experienced challenges related to acculturation stress, the process associated with adaptation to new cultural norms (Berry et al., 2006). Also, Kirmayer et al. (2010) highlighted that adjusting to a new educational system and acquiring new languages and social norms contributed to challenges experienced by refugee youth upon arrival in a new country. Theme 8 showed that the language barrier impeded humanitarian worker's ability to deliver psychosocial support to refugee youth. This finding supported the results obtained by Satinsky et al. (2019) showed the language barrier was one of the factors that impaired the delivery of mental health and psychosocial support services to refugees and asylum seekers in European host countries. Importantly, even though humanitarian workers did not conduct mental health diagnoses, participants who worked in public school settings were involved in the evaluation process of these youth's educational abilities. Kaplan et al. (2016) emphasized that the misdiagnosis of refugee youth's cognitive abilities was associated with the shortage of suitable assessment, low literacy level among these youth, and evaluators' failure to appropriately estimate their developmental age.

Unexpectedly, Theme 9 indicated that refugee youth were hesitant to attend public schools during forced displacement. This finding was surprising in light of reports that suggested that one in three refugee primary caregivers who have fled to Europe disclosed seeking education for their children as one of the primary reasons for leaving their home countries (UNICEF,

2017). Also, Subtheme 7.4. discussed that access to public education in a host country was associated by humanitarian workers with positive mental health outcomes among refugee youth. Despite the protective role of school enrollment, my research findings echoed previous research that highlighted that refugee youth were likely to experience discrimination and bullying in public schools in Southeastern Europe (UNHCR, UNICEF, & the International Organization for Migration [IOM], 2019). This finding was especially important given the previous research that showed that approximately 50% of the refugee children interviewed by Save the Children in Syria disclosed that they never or rarely felt safe at school, and 99% of refugee parents who arrived in Greece reported that their children's formal education was interrupted due to military attacks on schools, forced conscription, and high education costs (UNICEF, 2017). Makarova and Birman (2016) also showed that conditions of acculturation in the school setting impacted the adjustment and academic success of minority students. Additionally, previous research studies suggested that refugee youth were likely to feel uncomfortable participating in social and school life due to their limited language proficiency (Kaplan et al., 2016), being viewed by the host community as a foreign or even threatening group (Borrell et al., 2015), or being discriminated against due to religious backgrounds (e.g., Phalet et al., 2018). Overall, my research results showed that humanitarian workers noticed refugee families' hesitancy in enrolling their children in public schools and described challenges associated with discussing this issue with the parents.

### ***Themes of the Exosystem Challenges, and Mental Health***

Similar to protective factors, the exosystem was the most represented group of risk factors that humanitarian workers identified as hindering refugee youth's well-being during the migration. Given the breadth of the exosystem challenges identified by humanitarian workers,

this section discusses main themes separately: (1) humanitarian workers' high level of stress (Theme 10), and (2) hostile and unstable conditions of the refugee camps (Theme 11).

**Theme 10: Humanitarian Workers' High Level of Stress.** Humanitarian workers were challenged to continuously provide aid to refugee youth while experiencing their own psychosomatic symptoms of mental health fatigue, sense of helplessness, and endorsing preconceived beliefs about delivering aid to refugee youth. Humanitarian workers' overall tendency to overestimate their capacities to cope with stress, making them neglect their mental health needs until they failed to endure severe distress was consistent with the existing literature (e.g., Shah et al., 2007). A possible explanation for this finding may be the lack or shortage of adequate psychological debriefing and supervision in humanitarian organizations that participants also disclosed. Alternatively, I speculate that it was likely that humanitarian workers were reinforced by the environment, including their coworkers, for prioritizing refugee youth's well-being over their own psychological needs, and thus, developed concerning mental health beliefs. Another reason for a high level of stress among humanitarian workers may be humanitarian workers' limited background in mental health. For example, they might have failed to recognize early signs of burnout or other mental health problems or lacked skills in addressing these issues effectively once they identified them.

**Theme 11: Hostile and Unstable Conditions of the Refugee Camp.** This study reiterated previous research findings and humanitarian reports that associated unsafe living conditions during displacement with refugee youth's poor mental health outcomes. At the same time, my research study offered an important contribution to the existing literature; a large body of research has explored refugee youth's poor mental health during the pre-migration stage only, delineating multiple stressors such as the length and time of exposure to war violence (Hasanović

et al., 2005), or the youth's proximity to a traumatic experience (Jabbar & Zaza, 2014). My findings focused on the migration stage and confirmed numerous media reports on scarce mental health services in refugee camps in Southeastern European countries, such as Greece and Bulgaria. This shortage of mental health services on-site may be due to financial hardships that humanitarian organizations faced, extremely high levels of stress including frequent emergencies that aid workers were likely to navigate with limited support on- and off-site, threats against humanitarian workers, long working hours, and often insufficient financial reimbursement (Runge, 2004; Suzic et al., 2016).

Noteworthy, the COVID-19 pandemic brought new barriers to reaching vulnerable refugee families. For example, UNHCR (2020c) estimated that 50% of refugee girls in secondary school were not likely to return to school when their classrooms reopened as a result of COVID-19. Despite these challenges, European countries have been implementing solutions to sustain the delivery of services to refugee youth in these difficult times. For example, in light of the pandemic, Greek public schools were closed in Spring 2020, and the digital learning platforms were utilized to include unaccompanied refugee youth in some safe zones and shelters who were especially vulnerable (UNICEF, 2020b). Furthermore, consistent with the literature, my findings showed that refugee youth were frequently exposed to unsafe and violent behaviors in their imminent environment (e.g., refugee camps), including violent demonstrations, fights, self-injurious and suicidal attempts, and domestic violence (see, e.g., IRC, 2018; UNHCR, 2020a; UNICEF, 2020a). These results partially corroborated the findings of El-Khani et al. (2016) who reported that Syrian refugee parents were more prone to employ corporal punishments during displacement as compared to the time when they were living at home. I speculate that the reported presence of domestic violence may be due to the parents' poor mental health condition,

fatigue, and other trauma-related experiences that stemmed from the exposure to life-threatening circumstances, and underlying uncertainty over their family's migration status.

Interestingly, humanitarian workers highlighted a desire to use better data tracking strategies to deliver more effective psychosocial aid to refugee youth. However, despite the abundance of mental health and trauma screeners used in clinical settings, there have been a few assessments developed for refugee youth that would be culturally responsive (Gadeberg et al., 2017). Although there were some data related to refugee youth's mental health, Gadeberg et al. (2017) reported that no validated tools that would assess refugee children below six years of age has been developed. Given the importance of preventing future negative outcomes of early trauma, the need to screen young children is evident.

In addition to a lack of appropriate assessment tools for young refugee children, humanitarian workers had limited or no access to refugee youth's background information in general, such as medical records. There are several possible explanations for this result. First of all, interviewed participants worked for non-profit humanitarian organizations that typically did not collect sensitive information, such as the medical history of the refugee youth. In the displacement context, this information is recorded by main humanitarian agencies that have a child protection team responsible for tracking vulnerable cases. Additionally, even if a non-profit organization has access to refugee youth's records due to being part of a larger aid network, humanitarian workers who are volunteers typically are denied access to this information due to confidentiality. Alternatively, data recording protocols may not be in place in some relief organizations due to the lack of resources (i.e., no qualified staff who could introduce these tools), or frequent emergencies (e.g., fires in refugee camps) that may destroy existing records.

### ***Themes of the Macrosystem Challenges, and Mental Health***

Within the gender differentiation theme, humanitarian workers identified culture-specific norms as challenges that interfered with female refugee youth's well-being during the migration stage. This finding was important because it revealed that Middle Eastern refugee girls had limited access to psychosocial services due to culture-specific beliefs and safety concerns endorsed by their families. Previous research focused mostly on gender-based violence during displacement (UNHCR, 2003). For instance, female gender was associated with increased likelihood of experiencing sexual assaults during displacement including gang rape, violence committed by fellow refugees, but also by humanitarian agency staff and security forces in Haiti, West Africa, Syria, Turkey, and Greece (UNHCR, 2003). Based on the report published by UNHCR (2003) some unaccompanied refugee girls entered voluntarily or forcibly 'protection marriages' to avoid sexual violence. That being said, culture-specific gender norms described by participants in my research study can be viewed as a protective factor in light of previous research allotted to the expressions of hidden resilience among marginalized, and refugee youth (Diaków & Goforth, 2021; Malindi & Theron, 2010). In fact, Leet-Otley (2019) demonstrated that Muslim gender norms (e.g., wearing "hijab") were advantageous for refugee girls given that strong ties to cultural heritage were associated with better educational outcomes. A note of caution is warranted since only two interviewed humanitarian workers declared Muslim background and thus, some humanitarian workers' responses could have been biased. Leet-Otley's (2019) findings similarly showed that sixth-grade immigrant and refugee Somali Muslim girls who wore the "hijab", a traditional head-covering veil worn by Muslim women, encountered cultural biases in their schools. For example, these girls reported being mistakenly perceived by the non-Muslim persons as oppressed by a patriarchal culture, even though for many of these youth, the hijab was a symbol of their cultural identity, and an act of resistance to

the sexualization and Islamophobia they faced in the mainstream U.S. culture. That being said, it remains unclear whether Muslim gender-specific norms and expectations contributed to the refugee girls' withdrawal and absence from on-site activities. Overall, my research study showed that humanitarian workers associated a shortage or lack of safe spaces and adequate programming for Middle Eastern refugee girls, especially those that were Muslim with threats to these youth's cultural identity and safety. Therefore, refugee families' preferences to have their daughters stay at home instead of allowing them to participate in mixed-gender activities may be a form of hidden resilience.

**Mental Health Stigma Theme.** In accordance with the previous research (Merhey, 2019), the mental health stigma theme showed that humanitarian workers noticed that refugee families who came from Middle Eastern backgrounds demonstrated hesitancy to access mental health services. There were similarities between the mental health stigma reported by humanitarian workers in my research study and the impact of negative attitudes endorsed by Syrian refugees towards mental health services (Hassan et al., 2016). On the other hand, James et al. (2014) showed that refugee youth were reluctant to disclose their own traumatic experiences and related symptoms in an attempt to protect their own parents. At the first glance, this behavior may be viewed as an expression of convoluted psychological mechanisms that had the potential to hinder refugee youth's well-being. On the other hand, refugee youth's urge to protect their parents might have been associated with challenges related to the immigration process, such as asylum interviews and applications. Overall, it seems that in the displacement context, mental health stigma can contribute to refugee youth's difficulties in accessing and receiving adequate aid. Importantly, the current findings cannot be easily extrapolated to all refugee youth who

come from Middle Eastern backgrounds because there is great cultural diversity within this ethnicity.

## **Implications for School Psychologists**

### ***Intervention and Treatment***

Notwithstanding the shortage of evidence-based interventions for refugee youth, school psychologists should aim to mitigate negative outcomes of adverse experiences on these youth's psychological well-being and academic performance because during the migration stage. Schools are often a setting where the psychosocial and educational interventions can be delivered to address the mental health needs of refugee children (Tyrer & Fazel, 2014). Therapeutic methods that allow a client to verbally process traumatic events are effective in addressing multiple and complex trauma-related problems such as emotion regulation (Barrett et al., 2003) or traumatic grief (Kalantari et al., 2012). For example, Cognitive Behavioral Therapy (CBT) can be implemented in schools on a group level to help to reduce PTSD, depression (Barrett et al., 2012), and anxiety symptoms among refugee children and youth (Ehnholt & Yule, 2006). To be sensitive to the cultural norms of Muslim Arab clients, Dwairy (2009) recommended to first focus on a person's relation to their family instead of personality, intrapsychic feelings, attitudes, and thoughts. Therefore, school psychologists may encourage refugee youth to describe their family well-being, and their relationships with particular family members first. Psychotherapies can be supplemented with creative arts that are evidenced to foster refugee youth's well-being and address emotional and relational problems (Ager et al., 2011). Besides that, school psychologists can facilitate these youth's enrollment in extra-curricular activities to bolster their resilience. Marsh (2016) discussed that music and dance as activities fostered self-advocacy, encouraged creative expression, facilitated cross-cultural communication, and supported the



development of bicultural identity among refugee and newly arrived voluntary migrant children and youth in both formal school and informal out of school settings. Additionally, school psychologists should consider incorporating story-telling in support provided to refugee youth who come from African and Middle Eastern cultures (e.g., picture sequences that encourage child's free expression). Noteworthy, based on El-Khani and their colleagues' (2016) recommendations on supporting Syrian refugee families during displacement, school psychologists can offer interventions that foster a sense of control and self-efficacy, teach coping skills and positive communication strategies.

To adhere to the National Association of School Psychologists ([NASP], 2019), all therapeutic activities should be conducted with the assistance of an interpreter, and any deliverables such as pamphlets should be translated in the native languages of refugee students. Importantly, given that refugee youth tend to take on age-inappropriate roles in their families throughout their displacement, it is paramount that school psychologists do not engage refugee youth's siblings or friends as interpreters (NASP, 2019).

### ***Culturally Responsive Assessments and Screening***

School psychologists should use screening tools that incorporate child-friendly methods of gathering information (e.g., doll-plays) and are linguistically inclusive (Gadeberg et al., 2017). For example, the Child Behavior Checklist ([CBCL], Achenbach & Rescorla, 2000) that includes the Youth Self Report Form (YSR), and the Child Post-traumatic Stress Disorder Symptom Scale Interview (CPSS-I) have been translated into Somali (Hall et al., 2014). Additionally, the CBCL and CPSS-I include terms accepted by the community members to describe symptoms of traumatic stress such as thinking over too much or being surprised and shocked (Hall et al., 2014). Panter-Brick and their colleagues (2017) developed the 21-Item Trauma Checklist for

Syrian refugee youth that has been widely used in the humanitarian setting as well. Another example of the culturally adjusted screener is the Reaction of Adolescents to Traumatic Stress Questionnaire ([RATS], Bean et al., 2007) that is designed to measure PTSD symptoms in refugee youth and also includes a bilingual form (i.e., Dutch and a foreign language).

Furthermore, school psychologists should choose assessment tools that consider refugee children's literacy skills. For example, in RATS, the Likert scale was paired with colored balls of increasing sizes to clarify the quantity of reported feelings (Bean et al., 2007). Apart from exploring refugee youth's mental health problems, school psychologists can look at their resilience by using, for example, the Child and Youth Resilience Measure (CYRM-R) that was normed on many culturally diverse populations including refugees (Ungar et al., 2008b).

### ***Collaboration With Relief Agencies***

School psychologists can utilize their academic and clinical background to liaise with humanitarian organizations and provide training that aims to enhance humanitarian workers' competencies including mental health literacy and promote positive coping strategies that can further bolster humanitarian workers' resilience. Due to geographical limitations, school psychologists can collaborate with these organizations remotely. If school psychologists work in the countries where humanitarian aid is delivered, it would be important to strengthen the support network through providing in-person or remote supervision and consultation to humanitarian workers especially those who are in remote areas, joining understaffed psychosocial teams, and training humanitarian workers including volunteers so that they can continue implementing trauma-informed interventions on-site. This recommendation aligns with the holistic approach pursued in some schools in Australia where schools partnered with welfare, and relief agencies to better support refugee students (Taylor & Sidhu, 2012).

Crossouard and Dunne (2020) strongly recommended that the international community should focus on strengthening humanitarian sustainability, instead of providing immediate relief only. I foresee two roles that school psychologists can play in this goal. First, school psychologists should aim to foster refugee youth's autonomy and leadership, for example, by encouraging refugee students to share their talents with other students (e.g., speaking foreign languages). To strengthen refugee youth's self-awareness and action initiatives, school psychologists can advocate for and participate in developing refugee students' radio broadcast, newspapers, posters, or drama groups, which have been the strategies widely used in the humanitarian sector (Save the Children, 2013). Second, school psychologists can engage in developing and implementing training that aims to deepen humanitarian workers' understanding of mental health-related topics such as psychosomatic and internalizing symptoms related to trauma. Furthermore, given massive difficulties in tracking the ages of refugee youth, school psychologists' robust training allows them to offer assistance in conducting comprehensive age assessment including the informed consent process or even developing brief screeners. In fact, the Association of Directors of Children's Services (ADCS) (2015) in England recommended comprehensive assessment tools for evaluating the age of unaccompanied children seeking asylum in the United Kingdom.

### ***Fostering School-Refugee Family Collaboration***

More displaced youth enroll in public schools (UNICEF, 2020), at the same time, facing new challenges, such as the adjustment to a new school culture including behavioral norms and expectations, dress codes, lunch routines, religious rituals (Makarova & Briman, 2016). School psychologists can facilitate refugee students' transition to school by familiarizing them with the new environment. It may be that school psychologists advocate for and deliver school orientation

sessions also for refugee parents who may endorse worries or biases related to public education, law, and policies in a host country (Lewig et al., 2010). For example, some schools in Australia that had students from refugee communities promoted interagency collaborations, and thus, involved interpreters, liaised with parents and the broader community (Taylor & Sidhu, 2011). Concretely, these schools organized a mothers' club in the school and created a kit and DVD on "Primary school in Australia". In France, there was a program called "Open the school to parents" which aimed to boost parents' French language skills in order to enhance their ability to support their children. In Northern Ireland, parents who came from migrant backgrounds received an overview of the content covered in each curriculum domain so that the parents could assist their children in making progress in schools (i.e., "Toolkit for diversity") (European Commission/EACEA/Eurydice, 2019). However, if there are no such resources available, school psychologists can work with the school staff to prepare summaries of the curricula with learning objectives and recommendations for the parents on how to find and access further information, and support their children's learning at home. Importantly, Block et al. (2014) found out that parental engagement in Australian schools was affected by the presence of interpreters. To enhance school-family collaboration, school psychologists can use on-site or telephone interpreters to adequately meet the families' needs. Recognizing numerous risk factors that refugee families face during displacement, school psychologists should strive to create inclusive and safe school environments, where especially, Muslim refugee girls do not feel threatened. For example, school psychologists can collaborate with the parents in order to address their potential worries and concerns pertaining to their daughters' safety.

While providing services to refugee families, school psychologists should be mindful of daily challenges that these families face, such as no access to daycare for young children, limited

or no transportation from a refugee camp to school. Therefore, if feasible, refugee families should be allowed to visit schools with their other children who otherwise could have been left unsupervised. Alternatively, school psychologists can liaison with humanitarian agencies and deliver orientation sessions on-site in a refugee camp.

### ***Collaboration With Teachers***

Given school psychologists' training in consultation, they can challenge teachers' harmful beliefs and support social justice efforts. Previous research studies highlighted that teachers' perspectives of acculturation were intertwined with their ability to assess and support diverse students which yielded a higher likelihood of using punitive strategies (Makarova & Herzog, 2013). Therefore, school psychologists can foster teachers' understanding of acculturative processes. Additionally, Dunn et al. (2014) suggested that an open dialogue about power dynamics and privilege was a pressing issue in the training of teachers. Given the presence of potential biases in obtained results, school psychologists may also want to promote cultural humility (Goforth et al., 2016) among humanitarian workers so that they become aware of the internal factors that drive their perception of gender-specific norms endorsed by some Muslim families.

## **Limitations and Future Directions**

### ***Limitations***

There were at least five potential limitations concerning the results of this study. A first limitation referred to cross-cultural factors and biases. Namely, all data was gathered in English while only 50% of participants were native English speakers. Ideally, interviews would have been conducted in languages preferred by the humanitarian workers; in this research, that accommodation was not feasible due to limited access to multilingual qualitative data analysis

software and research assistants who would be proficient in these languages. A second potential limitation was that only some interviews were conducted in person. It remained unclear how this part of method design contributed to the obtained results, however, I speculate that the depth of information that participants disclosed was somewhat associated with the format of the interview. A third limitation pertained to a vast range of refugee youth's ages discussed in this research study, which yielded challenges in the generalization of the findings. Fourth, this investigation focused on perspectives endorsed by humanitarian workers who have supported refugee youth in Southeastern Europe, therefore, these findings cannot be directly translated to all contexts, such as displacement in South American countries due to sociopolitical, cultural, and geographical factors that contribute to the lived experiences of refugee youth. Lastly, this research study explored refugee youth's mental health and resilience through humanitarian workers' testimonies only; therefore, a note of caution is due here since these results were likely to be infused by participants' individual biases. On this note, the sociodemographic survey did not collect data on participants' religious backgrounds; this information was explored only when individual disclosure occurred during the interview. Noteworthy, in the displacement context, it is incredibly challenging to conduct field research that investigates refugee youth's individual behavior due to safety, confidentiality, and logistics concerns as well as the urgent needs of these youth that must be secured first.

Overall, notwithstanding the present study has enhanced our understanding of humanitarian workers' role in fostering refugee youth's mental health, and humanitarian workers' perspectives of displacement-related challenges that these youth faced including barriers to accessing school-based supports.

### ***Future Research, Practice, and Advocacy***

Due to an increasingly unstable geopolitical context, but also emerging global challenges related to climate change, there is a pressing need to advance research focusing on refugee youth's mental health (Ivanovic & Malavisi, 2019). Thus, rapidly unfolding humanitarian crises require the pursuit of interdisciplinary scholastic efforts, such as a collaboration between practitioners who deliver aid to forcibly displaced youth across sectors, including school psychologists, and humanitarian workers. Even though schools have a key role in facilitating the transition and settlement of refugee youth, until recently, the literature on school psychology has ignored the phenomenon of forced migration and has failed to investigate experiences of refugee youth as distinct from other migrants and cultural minorities (Matthews, 2008). NASP (2019) issued position statements focused on the ways how to support forcibly displaced students' the US school settings, however, these guidelines are urgently needed in many other countries en route where school enrollment for newly arriving refugees is permitted (e.g., Greece) (UNICEF, 2020a). Therefore, I hope that the current research will stimulate further investigation of the well-being of refugee youth in transit, the development of evidence-based interventions, and further explore the opportunities for school psychologists to collaborate with refugee communities and relief agencies.

Given the healing aspect of storytelling (Moore, 2017), researchers should strive to carry scientific investigations that also encourage these youth's autonomy, for instance, by respecting and hearing their tales and stories of their lived experiences. On this note, the cultural diversity of the refugee youth population yields the importance of employing culturally responsive methods which would consider these youth's involvement in research as a collaboration rather than mere participation. In school psychology, these methodologies are underrepresented,

however, researchers may outsource and adjust concepts discussed in the field of indigenous research (Lin et al., 2020). Importantly, to conduct culturally responsive and community-based research allotted to the well-being of diverse refugee youth, scholars need to practice caution and recognize the Eurocentric prism that has been favored in the literature for decades (Crossouard & Dunne, 2020).

Lastly, given sociopolitical challenges, including anti-migrant sentiments worldwide (e.g., perceiving refugees as a burden), it is critical that scholars should practice sensitivity to how they communicate research findings focused on refugees in general so that this population is also discussed in terms of assets to a host community (Salehyan, 2018).



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## Appendices

### Appendix 1. Email Invitation to Participation in the Study

Dear Sir/Madame,

I would like to invite you to participate in the research study that explores humanitarian aid workers' views of refugee children's well-being. The study has two parts:

On online sociodemographic survey (10 minutes)

An in-person/ on-phone interview (no longer than an hour)

Both parts of the study are conducted in English. Your responses will be voluntary and confidential.

Given how important role you play in refugee children's life, I would like to support you. Your contribution will help me to gain a better understanding of the refugee children's needs. This knowledge will allow me to develop future training for humanitarian aid workers on how to foster resilience to decrease the risk of refugee children experiencing trauma-related mental disorders.

If you are willing to participate in this study, I would highly appreciate your taking the time to answer the questions in this online survey:

[\[LINK\]](#)

Finally, if you know other humanitarian aid workers who have supported refugee children and who might be interested in participating in this study, I would appreciate if you could share their contact information with me.

Please contact me if you have any questions.

Thank you,

Diana Diaków, M.A.

Ph.D. School Psychology student

Department of Psychology

University of Montana

*CRESP Research Lab*

<http://hs.umt.edu/psychology/goforth/default.php>



## Appendix 2. Online Consent Form for an Online Sociodemographic Survey

Dear Participant:

I am a second year School Psychology Ph.D. student in the Department of Psychology at University of Montana and I work under the supervision of Dr. Anisa Goforth. I am asking you to complete a survey being given to individuals who have worked with refugee children. The purpose of this survey is to learn about your background and experiences in delivering aid to refugee children.

The survey will ask questions about your language skills, length of work experience, as well as training in mental health. If you decide to participate, please complete the following survey.

Data will be collected using the Internet; no guarantee can be made regarding the interception of data sent via the Internet by any third party. Confidentiality will be maintained to the degree permitted by the technology used. Any reportage of research results will be in the aggregate, and your information will not be identifiable.

Participation is completely voluntary and you may withdraw at any time without penalty. There is no reward for participating or consequence for not participating. Any risks associated with this research do not exceed those of daily life. The survey should take about 10 minutes to complete.

Your completion of this survey indicated your consent to participate in the second part of this research study. The second part of this research study is an individual in-person or on phone interview with the primary investigator. During this interview, you will be asked questions about refugee children's struggles, the ways they cope with them, and your role in helping them to overcome the difficult circumstances.

For further information regarding this research please contact me at:

diana.diakow@umontana.edu, or Dr. Anisa Goforth at: [anisa.goforth@umontana.edu](mailto:anisa.goforth@umontana.edu)

Thank you for your time.

Sincerely, Diana Diaków, M.A.  
Ph.D. School Psychology student

Department of Psychology  
University of Montana  
diana.diakow@umontana.edu

CRESP Research Lab  
<http://hs.umt.edu/psychology/goforth/default.php>

With my signature below, I confirm that I have read this form and decided that I will participate in the project described above. Its general purpose, and possible risks and inconveniences have been explained to my satisfaction. I understand that I can discontinue participation at any time. My consent also indicates that I am at least 18 years of age. [Please feel free to print a copy of this consent form]

I agree to participate

*Signature*

**Appendix 3. A Thank-you Note for the Participant who Completed an Online  
Sociodemographic Survey.**

Dear Participant,

Thank you for taking your time to complete this survey. We truly value the information you have provided. Your responses will contribute to a better understanding of humanitarian aid workers' views of refugee children's mental health and their needs.

If you would like to receive a follow-up with the summary of the research findings, please contact me at [diana.diakow@umontana.edu](mailto:diana.diakow@umontana.edu) after December, 2019.

Thank you for your time.

Sincerely,

Diana Diaków, M.A.

Ph.D. School Psychology student

Department of Psychology

University of Montana CRES Research Lab <http://hs.umt.edu/psychology/goforth/default.php>

#### Appendix 4. Paper Consent Form for an in-person Interview

Dear Participant:

I am a second year School Psychology Ph.D. student in the Department of Psychology at University of Montana and I work under the supervision of Dr. Anisa Goforth. I am asking you to participate in an in-person interview being administered to individuals who have worked with refugee children. The purpose of this interview is to learn about your perspectives of refugee children's mental health.

The interview will last no longer than an hour, and I will ask you about your views on refugee children's mental health, what makes them overcome the difficulties, and what factors exacerbate their mental health problems. I will also ask about the ways you have addressed these children's needs as well as your reflections of how you can facilitate their recovery from trauma.

It is important that during the interview you withhold from using real names of children, persons and agencies you have worked with. If you accidentally share with me any of these, I will delete this information from the transcript of our interview.

I will be audio-recording our interview, and I will be taking notes, too. The audio-file will be encrypted and uploaded to my university data storage; no guarantee can be made regarding the interception of data sent via the Internet by any third party. Confidentiality will be maintained to the degree permitted by the technology used. Any reportage of research results will be in the aggregate, and your information will not be identifiable.

Participation is completely voluntary and you may withdraw at any time without penalty. There is no reward for participating or consequence for not participating. Any risks associated with this research do not exceed those of daily life.

For further information regarding this research please contact me at:

diana.diakow@umontana.edu, or Dr. Anisa Goforth at: [anisa.goforth@umontana.edu](mailto:anisa.goforth@umontana.edu)

Thank you for your time.

Sincerely, Diana Diaków, M.A.

Ph.D. School Psychology student

Department of Psychology

University of Montana

diana.diakow@umontana.edu

CRESP Research Lab

<http://hs.umt.edu/psychology/goforth/default.php>

With my signature below, I confirm that I have read this form and decided that I will participate in the project described above. Its general purpose, and possible risks and inconveniences have been explained to my satisfaction. I understand that I can discontinue participation at any time. My consent also indicates that I am at least 21 years of age.

I agree to participate

*Signature*

## Appendix 5. Online Consent Form for an on-phone Interview

Dear Participant:

I am a second year School Psychology Ph.D. student in the Department of Psychology at University of Montana and I work under the supervision of Dr. Anisa Goforth. I am asking you to participate in on-phone interview being administered to individuals who have worked with refugee children. The purpose of this interview is to learn about your perspectives of refugee children's mental health.

The interview will last no longer than an hour, and I will ask you about your views on refugee children's mental health, what makes them overcome the difficulties, and what factors exacerbate their mental health problems. I will also ask about the ways you have addressed these children's needs as well as your reflections of how you can facilitate their recovery from trauma. It is important that during the interview you withhold from using real names of children, persons and agencies you have worked with. If you accidentally share with me any of these, I will delete this information from the transcript of our interview. I will be audio-recording our interview, and I will be taking notes, too. The audio-file will be encrypted and uploaded to my university data storage; no guarantee can be made regarding the interception of data sent via the Internet by any third party. Confidentiality will be maintained to the degree permitted by the technology used. Any reportage of research results will be in the aggregate, and your information will not be identifiable.

Participation is completely voluntary and you may withdraw at any time without penalty. There is no reward for participating or consequence for not participating. Any risks associated with this research do not exceed those of daily life.

For further information regarding this research please contact me at:

diana.diakow@umontana.edu, or Dr. Anisa Goforth at: [anisa.goforth@umontana.edu](mailto:anisa.goforth@umontana.edu)

Thank you for your time.

Sincerely, Diana Diaków, M.A.

Ph.D. School Psychology student

Department of Psychology

University of Montana

[diana.diakow@umontana.edu](mailto:diana.diakow@umontana.edu)

CRESP Research Lab

<http://hs.umt.edu/psychology/goforth/default.php>

With my signature below, I confirm that I have read this form and decided that I will participate in the project described above. Its general purpose, and possible risks and inconveniences have been explained to my satisfaction. I understand that I can discontinue participation at any time. My consent also indicates that I am at least 21 years of age.

I agree to participate

*Signature*

## Appendix 6. Online Sociodemographic Survey and Consent Form

### Survey for Humanitarian Aid Workers

#### Block: Default Question Block (22 Questions)

Dear Participant:

I am a second year School Psychology Ph.D. student in the Department of Psychology at University of Montana and I work under the supervision of Dr. Anisa Goforth. I am asking you to complete a survey being given to individuals who have worked with refugee children. The purpose of this survey is to learn about your background and experiences in delivering aid to refugee children.

The survey will ask questions about your language skills, length of work experience, as well as training in mental health. If you decide to participate, please complete the following survey.

Data will be collected using the Internet; no guarantee can be made regarding the interception of data sent via the Internet by any third party. Confidentiality will be maintained to the degree permitted by the technology used. Any reportage of research results will be in the aggregate, and your information will not be identifiable.

Participation is completely voluntary and you may withdraw at any time without penalty. There is no reward for participating or consequence for not participating. Any risks associated with this research do not exceed those of daily life. The survey should take about 10 minutes to complete. If the primary investigator decides that you meet inclusion criteria, you may be contacted again and invited to participate in the second part of this research study which includes an individual in-person or on phone interview with the primary investigator. During this interview, you will be asked questions about refugee children's struggles, the ways they cope with them, and your role in helping them to overcome the difficult circumstances.

For further information regarding this research please contact me at:  
diana.diakow@umontana.edu, or Dr. Anisa Goforth at: [anisa.goforth@umontana.edu](mailto:anisa.goforth@umontana.edu)  
Thank you for your time. Sincerely, Diana Diaków, M.A.

Ph.D. School Psychology student

Department of Psychology

University of Montana

diana.diakow@umontana.edu

CRESP Research Lab

<http://hs.umt.edu/psychology/goforth/default.php>

With my signature below, I confirm that I have read this form and decided that I will participate in the project described above. Its general purpose, and possible risks and inconveniences have been explained to my satisfaction. I understand that I can discontinue participation at any time. My consent also indicates that I am at least 18 years of age. [Please feel free to print a copy of this consent form]

I agree to participate

*Signature*

☐ Yes (1)

☐ No (2)

*Skip To: End of Survey If Q52 = 2*

Page \_\_\_\_\_  
Break

Q1

## DEMOGRAPHICS

In this section, you will be asked questions about your background and work experiences with refugee children.

Q2 What is your area of expertise in the refugee camp?

☐ Mental Health (psychologist, therapist, psychiatrist, counselor, etc.) (1)

☐ Education (teacher, tutor, etc.) (2)

☐ Social Work (social worker, family assistant, caregiver, etc.) (3)

☐ Health or Medicine (physician, nurse, etc.) (4)

☐ Other (5) \_\_\_\_\_

Q3 Have you ever worked with refugee children or assisted others who worked with them (for example by interpreting/translating)?

☐ Yes (1)

☐ No (2)

*Display This Question:*

*If Q3 = 1*

Q4 How long have you worked with refugee children?

☐ Less than 3 months (1)

☐ More than 3 months but less than 1 year (2)

☐ 1-3 years (3)

☐ 3-5 years (4)

☐ More than 5 years (5)

Q5 In which country/countries have you worked with refugee children? Please list all of them.

---

Page 

---

 Break

Q6 What are the nationalities of refugee children that you have worked with? Please list all of them.

---

Page 

---

 Break

Q7 What is your native language?

---

Page \_\_\_\_\_  
Break

Q8 What is your English language proficiency?

- ☐ A1 (Beginner) (1)
- ☐ A2 (Elementary) (2)
- ☐ B1 (Intermediate) (3)
- ☐ B2 (Upper-intermediate) (4)
- ☐ C1 (Advanced) (5)
- ☐ C2 (Proficiency) (6)
- ☐ English is my mother tongue (7)
- ☐ Bilingual/multilingual (English is one of my native languages) (8)
- ☐ Other (9) \_\_\_\_\_

Page \_\_\_\_\_  
Break

Q9 Have you ever worked with refugee children?

- ☐ Yes (1)
- ☐ No (2)

Page \_\_\_\_\_  
Break

Q10 Do you speak any Arabic dialect?



- ☐ Yes (1)
- ☐ No (2)
- ☐ I am learning it currently (3)

---

Page \_\_\_\_\_

Break

Display This Question:

*If Q10 = 1*

Q11 What Arabic dialect do you speak?

---

---

*Display This Question:*

*If Q10 = 1*

*And Q8 = 3*

Q12 What is your Arabic dialect proficiency?

- ☐ A1 (Beginner) (1)
  - ☐ A2 (Elementary) (2)
  - ☐ B1 (Intermediate) (3)
  - ☐ B2 (Upper-intermediate) (4)
  - ☐ C1 (Advanced) (5)
  - ☐ C2 (Proficient) (6)
  - ☐ This Arabic dialect is my mother tongue (7)
  - ☐ Bilingual/multilingual (this Arabic dialect is one of my native languages) (8)
  - ☐ Other (9) \_\_\_\_\_
- 

Page \_\_\_\_\_  
Break

Q13 Do you speak Modern Standard Arabic (MSA)?

- ☐ Yes (1)
  - ☐ No (2)
  - ☐ I am learning it currently (3)
-

*Display This Question:*

*If Q13 = 1*

*And Q13 = 3*

Q14 What is your Modern Standard Arabic (MSA) proficiency?

- ☐ A1 (Beginner) (1)
- ☐ A2 (Elementary) (2)
- ☐ B1 (Intermediate) (3)
- ☐ B2 (Upper-intermediate) (4)
- ☐ C1 (Advanced) (5)
- ☐ C2 (Proficient) (6)
- ☐ MSA is my mother tongue (7)
- ☐ Bilingual/multilingual (MSA is one of my native languages) (8)
- ☐ Other (9) \_\_\_\_\_

Page \_\_\_\_\_  
Break

Q15 How old are you?

- ☐ Less than 21 (1)
- ☐ 21 or older (2)

Q16 Are you currently employed by a relief agency (nonprofit organization that delivers support to refugee children, or other institution that serves the same same role)?

- ☐ Yes (1)
- ☐ No (2)

*Display This Question:*

*If Q16 = 2*

Q17 Are you currently a volunteer in a relief agency (nonprofit organization that delivers support to refugee children, or other institution that serves the same role)?

☐ Yes (1)

☐ No (2)

*Display This Question:*

*If Q17 = 2*

Q18 Have you ever worked for a relief agency (nonprofit organization that delivers support to refugee children, or other institution that serves the same role)?

☐ Yes (1)

☐ No (2)

*Display This Question:*

*If Q18 = 2*

Q19 Have you ever been a volunteer in a relief agency (nonprofit organization that delivers support to refugee children, or other institution that serves the same role)?

☐ Yes (1)

☐ No (2)

Q20 What is the highest academic degree you have?

Q21 In what field of study did you receive your academic degree?

## Q22

Thank you for taking your time to complete this survey. We truly value the information you have provided. Your responses will contribute to a better understanding of the refugee children's mental health and their needs.

If you would like to receive a follow-up with the summary of the research findings, please click on the link below.

[https://umt.col.qualtrics.com/jfe/form/SV\\_5nWZeMX9lAlWq2h](https://umt.col.qualtrics.com/jfe/form/SV_5nWZeMX9lAlWq2h)

End of Block: Default Question Block

---

## Appendix 8. Guided Individual Interview Schedule

### Humanitarian Aid Workers' Perspectives on Refugee Children's Mental Health Guided Individual Interview Schedule

The following statements and questions reflect topical areas to be addressed by the interviewers. Due to the nature of conducting a semi-structured focus group, having guiding topics will offer the flexibility needed to pursue lines of discussion that emerge in the focus group. The focus group will commence with an initial statement, listed below, and then address the topical areas.

#### Beginning of Individual Interview Script:

Welcome. Thank you again for coming and taking time out of your day to speak with me. I know that you read and responded to the initial email regarding our interest in better understanding your knowledge of mental health of refugee children. Before we begin, you were emailed an invitation to a sociodemographic survey. I reviewed your answers and decided that you can participate in the second part of the study. I also sent you a consent form to review. Here is another copy for you to sign acknowledging that you have read and agreed to participate in this interview that will help me understand your views of refugee children's mental health.

For approximately the next 60 minutes, I will be asking you different questions to learn more about what you know and what you would like to know about refugee children's mental health, particularly related to trauma and resilience. The information we gather from this interview will help to inform the development of future training for humanitarian aid workers.

The information that you provide during the interview will be kept confidential. That is, I will make sure that I do not link your name with any information me and my research team share through publications or presentations. It is also important that you do not share what identifiable information of individuals who you work with such as real names of refugee children or names of relief agencies you worked for. I will also be audiotaping and taking notes to make an accurate record of what is said, including your comments. There is no right or wrong answer to the questions that will be raised in the group; the important thing is that you share your experiences and opinions.

The notes and the information you provide in the meeting will be kept confidential. Only those of us who are involved in the further analysis will have access to the information I collect. This information will be kept in a locked research lab on the University of Montana campus. No one else outside of the research team will see your responses.

Do you have any questions about the informed consent or how we will be spending the next 60 minutes?

#### Topical Areas for Questions:

Discussion of individual's beliefs and knowledge about mental health.

Knowledge of roles and responsibilities of humanitarian aid workers in delivering services to refugee children

Previous interactions with refugee children

Experience of how trauma influences refugee children's mental health

Understanding of protective factors that bolster refugee children's mental health

Role and responsibility of humanitarian aid workers to facilitate mental health needs of refugee children

#### Interview Warm-Up:

Have the participant signed the informed consent, they will be asked about their recent experience in humanitarian aid field.

Main Guiding Questions:

Tell me about your educational and work background. What is important for me to know?

Tell me, in a sentence or two, how you came to the decision to work with refugee children?

What does mental health mean to you?

What are the factors that contribute to refugee children's poor mental health?

When you hear trauma-related symptoms in refugee children, what comes to your mind?

Tell me about how you learned about refugee children's mental health?

Tell me about your experiences with refugee children who demonstrated mental health problems?

How did you respond to refugee children's mental health problems?

What are the things you could have done better in addressing their needs?

What are the factors that help refugee children cope with trauma?

How culture contributes to refugee children's mental health?

What is the role of humanitarian aid workers in supporting refugee children?

Are there any points that I missed or things you believe are important in understanding what you know about refugee children's mental health?

Ending the Interview:

Thank you again for taking the time to participate in this important research.

Finally, I want to remind you that your name will be kept confidential and separate from any of your answers in the interview recordings or notes. If at any point you have any questions or are concerned about your comments being used, please contact me (primary investigator, Diana Diakow), at the email address provided in the informed consent. Do you have any questions before we end? Thank you.

**Table 4***Participant Aggregated Sociodemographic Information.*

	<i>N</i>	%
Total Participants	12	
<b>Gender</b>		
Male	2	16.6
Female	10	83.4
<b>Cultural identity</b>		
U.S. American/White	2	16.6
Hellenic/Greek	2	26.6
British/White	1	8.3
Scottish/Australian/White	1	8.3
Irish	1	8.3
Syrian/Muslim/Arab	1	8.3
Kurdish/U.S. American/Muslim	1	8.3
Romanian/British/White	1	8.3
Citizen of Brussels	1	8.3
U.S. American/Jewish/White	1	8.3
<b>Work Affiliation</b>		
Mental Health	0	0
Education	5	41.7
Social Work	0	0
Health or Medicine	0	0
Protection	1	8.3
Language Assistance	1	8.3
Other	5	41.7
<b>Years of experience</b>		
>3 months	8	66.7
1-3 years	3	25.0
3-5 years	1	8.3
<b>Language Proficiency</b>		
B2	1	8.3
C1	1	8.3
C2	3	25.0
Bilingual English Native Speaker	1	8.3
English Native Speaker	6	50.0
<b>Proficiency in Arabic</b>		



Modern Standard Arabic or Arabic Dialect	8	66.6
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*Note:* B2, C1, and C2 are levels of English proficiency on the Common European Framework of Reference for Languages scale.

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**Table 5***Study Participants.*

Participant ID	Gender	Cultural identity	Work background	Years of direct experience with refugee youth	English Language Proficiency	Other languages spoken
1	Female	Brussels	CFS volunteer	3 months – 1 year	C2	French (mother tongue); Spanish; Portuguese; Levantine Arabic (A1)
2	Female	White	Elementary school teacher; CFS volunteer	3 months – 1 year	English is a mother tongue	Levantine Arabic (A2)
3	Female	Australian Scottish	Human rights specialist; CFS manager	1 – 3 years	English is a mother tongue	French; Levantine Arabic (not specified)
4	Female	Irish	Social worker	3 months – 1 year	Multilingual/English is one of the native languages	Irish, Levantine Arabic (A1)
5	Female	Kurdish American	preschool teacher; CFS volunteer	3 months – 1 year	English is a mother tongue	Kurdish is a second language
6	Male	Muslim Syrian	Interpreter	1 – 3 years	C1	Greek; Levantine Arabic (mother tongue)
7	Female	White Romanian	Play work specialist; researcher; CFS volunteer	3 months – 1 year	Multilingual/English is one of the native languages	Spanish; French
8	Female	Hellenic	Preschool teacher; CFS volunteer	1 – 3 years	B2	Greek (mother tongue)
9	Male	Hellenic	Yoga instructor	3 months – 1 year	C2	Greek (mother tongue)

10	Female	American Jewish White	Human rights specialist; CFS facilitator	3 months – 1 year	English is a mother tongue	None
11	Female	Caucasian	Kindergarten and elementary school teacher; CFS facilitator	3 months – 1 year	English is a mother tongue	French; American Sign Language
12	Female	White British	Leader of the play school in a refugee camp; elementary school teacher	More than 5 years	English is a mother tongue	Bulgarian; Levantine Arabic (not specified)

*Note:* B2, C1, and C2 are levels of English proficiency on the Common European Framework of Reference for Languages scale; CFS is an abbreviation of child friendly space; CFS facilitators, volunteers, and managers are psychosocial humanitarian aid workers.

**Table 6**

*Listing of Participants' Contributions to the Themes Associated With the Protective Factors That Fostered Refugee Youth's Well-Being during the Migration Stage.*

Themes of protective factors that fostered refugee youth's well-being during the migration stage	N of participants who contributed to this theme	% of participants who contributed to this theme
Theme 1: Refugee youth's engagement and creativity	8	66.7%
Theme 2: Refugee youth's psychological flexibility and openness to new cultural experiences	8	66.7%
Theme 3: Refugee youth's self-awareness and self-advocacy	6	50.0%
Theme 4: Refugee parents' sensitivity to children's needs	6	50.0%
Theme 5: Humanitarian workers' verbal and nonverbal communication strategies individualized to the refugee youth's needs	9	75.0%
Theme 6: Humanitarian workers' assistance in navigating cultural differences	8	66.7%
Theme 7: Nurturing spaces for refugee youth inside and outside of the refugee camp	12	100.0%
Theme 8: Humanitarian workers' self-awareness and positive attitudes towards refugee youth	11	91.7%
Theme 9: Humanitarian workers' positive coping strategies	12	100.0%
Theme 10: Cultural practices and customs	9	75.0%

**Table 7**

*Listing of Participants' Contributions to the Themes Associated With the Challenges that Impacted Refugee Youth's Well-Being during the Migration Stage.*

Themes of challenges that contributed to refugee youth's well-being during the migration stage	N of participants who contributed to this theme	% of participants who contributed to this theme
Theme 1: Continuous trauma and ongoing stressors	10	83.3%
Theme 2: Trauma-associated psychosomatic problems and sleep disturbance	8	66.7%
Theme 3: Youth's poor emotional regulation skills	12	100%
Theme 4: Parents' poor mental health	7	58.3%
Theme 5: Disrupted family life	12	100%
Theme 6: Unstable and interrupted social relationships	7	58.3%
Theme 7: Interrupted collaboration with families	6	50.0%
Theme 8: Language barrier between humanitarian workers and refugee youth	8	66.7%
Theme 9: Social exclusion and discrimination of refugee youth	8	66.7%
Theme 10: Humanitarian workers' high level of stress	8	66.7%
Theme 11: Hostile and unstable conditions of the refugee camps	12	100.0%

Themes of challenges that contributed to refugee youth's well-being during the migration stage	<i>N</i> of participants who contributed to this theme	% of participants who contributed to this theme
Theme 12: Gender differentiation	6	50.0%
Theme 13: Mental health stigma	3	25.0%