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Refugee Children and Families

Psychological Health, Brief Family Intervention and Ethical Aspects

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There can be no keener revelation of a society’s soul than the way in which it treats its children.

Nelson Mandela

CONTENTS

ABSTRACT

Background: There are more than 45 million refugees and displaced people in the world. Children constitute almost half of the refugee population. It is an enormous challenge and a complex situation for refugee children and families escaping from their home country, to a new system of society to which they have to adapt and where they have to recapture a sense of coherence. This thesis focuses on the psychological health of younger refugee children before and after an intervention with family therapy sessions. The experiences and perceptions of refugee families who fled to Sweden as a result of the war in Bosnia and Herzegovina from 1992 to 1995 and who have permanent residence permits were explored. The ethical aspects of treatment of traumatized refugee children and families were also analysed.

Aims: To investigate parent-child agreement on the psychological symptoms of the refugee children; to explore refugee children's well-being before and after three sessions of family therapy; to explore, in more detail, the complexity of various family members' experiences and perceptions of their life before the war, during the war and their escape, and in their new life in Sweden; and also to highlight ethical issues and conduct ethical analyses using basic ethical principles that take into account the varying perspectives of the actors involved with regard to the psychological treatment of refugee children and families.

Methods: Data was collected using parental interviews and psychological assessments of children aged five to twelve years. In the first study, 13 children were assessed using the Erica Method and compared with a Swedish reference group consisting of 80 children. In the second study, the Erica Method assessments from before and after an intervention with brief family therapy were compared for ten out of those 13 children, complemented by parental interviews. Family therapy sessions were videotaped, and in the third study, the verbatim transcripts of nine family therapy sessions were analysed using a qualitative method with directed content analysis. Finally, the basic ethical principles in two case studies of teenage refugee children concerning psychological treatment were analysed taking into account the varying perspectives of the actors involved in the treatment.

Results: Parents' assessments of their children's psychological health according to the Symptom and Behaviour Interview did not correlate with the findings of the psychological assessments of children using the Erica Method. The majority of the parents were unaware of their children's psychological problems, as identified in the psychological assessments. There was a higher rate of not-normal sandboxes (Erica Method) in this group of refugee children, compared to the Swedish reference group. A statistically significant number of cases had improved after a brief family therapy intervention when evaluated with Erica Method. Three main categories emerged from the analysis of the family therapy sessions: "Everyday life at home", "Influence of war on everyday life", and "The new life". The three main categories were comprised of a total of ten subcategories: the family, work and school/preschool, the war, the escape, reflections, employment, health, relatives and friends, a limited future, and transition to the new life. A structured ethical analysis concerning the principles of autonomy, beneficence, non-maleficence, and justice is feasible and valuable when dealing with refugee children and families in clinical practice as well as in research.

Conclusion: The findings from these studies show the importance of highlighting individual perspectives from the point of view of children, parents, and siblings in order to better understand the complexity of family systems. Family interventions could be beneficial for refugee children and families, even if the children do not present with overt psychological problems. Salutogenic perspectives facilitate the provision of support to refugee families. Such support helps refugee families to adapt to a new system of society and recapture a sense of coherence. In research as well as in treatment sessions, basic ethical principles, from the point of view of all actors involved, is recommended to be taken into consideration.

SUMMERY IN SWEDISH

Bakgrund: Det finns mer är 45 millioner flyktingar och fördrivna människor i världen varav nästan hälften är barn. För flyktingbarn och familjer är det en enorm utmaning och en komplex situation att fly från sitt hemland, till ett nytt samhällssystem där de måste anpassa sig och återfå en känsla av sammanhang. Denna avhandling fokuserar på yngre barns psykiska hälsa före och efter en intervention med familjeterapisessioner. Erfarenheter och uppfattningar från flyktingfamiljer med permanent uppehållstillstånd i Sverige, som kom från kriget i Bosnien och Hercegovina 1992 till 1995, utforskades. Etiska aspekter vid behandling av traumatiserade flyktingbarn och familjer analyserades.

Syften: Att undersöka föräldrar och barns samstämmighet gällande flyktingbarns symptom; att analysera flyktingbarns psykiska hälsa före och efter en intervention med familjeterapi; att utforska komplexiteten hos olika familjemedlemmars erfarenheter och uppfattningar gällande livet före kriget, under kriget och flykten, och det nya livet i Sverige; samt att betona etiska aspekter och genomföra etiska analyser med hjälp av grundläggande etiska principer utifrån olika aktörers perspektiv vid psykologisk behandling av flyktingbarn och familjer.

Metoder: Data samlades in genom intervjuer med föräldrar och psykologisk testning av barn som var mellan fem och tolv år. I den första studien undersöktes 13 barn med Ericametoden och jämfördes med en svensk referensgrupp bestående av 80 barn. I den andra studien gjordes en jämförelse av Ericamaterialet från tio av de 13 barnen före och efter en intervention med familjeterapi, kompletterat med intervjuer av föräldrarna. Familjeterapierna videoinspelades och i den tredje studien transkriberades nio av dessa sessioner och analyserades med riktad innehållsanalys, en kvalitativ vetenskaplig metod. Slutligen studerades två analyser av grundläggande etiska principer utifrån olika aktörer inblandade i psykologisk behandling av flyktingbarn i tonåren.

Resultat: Föräldrars skattning av sina barns psykologiska hälsa utifrån intervju gällande symptom och beteende korrelerade inte med fynden i de psykologiska testningarna med Ericametoden. Majoriteten av föräldrarna var omedvetna om de psykologiska problem som visade sig i psykologbedömningarna. Det var högre frekvens icke-normala sandlådor (Ericametoden) i denna grupp flyktingbarn än i den svenska referensgruppen. Statistiskt signifikant antal av barnen hade förbättrats efter familjeterapisessionerna vid bedömningen enligt Ericametoden. Tre huvudkategorier framkom i analysen av de familjeterapeutiska samtalen: ”Vardagslivet hemma”, ”Krigets påverkan på vardagslivet” och ”Det nya livet.” De tre huvudkategorierna innefattade tio underkategorier: Familjen, arbete och skola/förskola, kriget, flykten, reflektioner, sysselsättning, hälsa, släktingar och vänner, en begränsad framtid och övergång till det nya livet. Strukturerade etiska analyser gällande principerna autonomi, göra gott, icke skada, och rättvisa underlättar hanterande av flyktingbarn och familjer i klinisk verksamhet så väl som i forskning.

Konklusion: Fynden i dessa studier visar betydelsen av att lyfta fram och synliggöra barns, föräldrars och syskons individuella perspektiv för att bättre förstå komplexiteten i familjesystem. Familjeinterventioner är av värde för flyktingbarn och familjer, även om barnen inte uppvisar psykologiska problem. Salutogena perspektiv underlättar beslut och tillhandahållande av stöd till flyktingfamiljer. Sådant stöd har som syfte att hjälpa flyktingfamiljer att anpassa sig till ett nytt samhällssystem och återfå en känsla av sammanhang. I forskning liksom i klinisk verksamhet rekommenderas grundläggande etiska principer från olika aktörers synvinklar tas i beaktande.

LIST OF PAPERS

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals.

Paper I
Jarkman Björn, G., Bodén, C., Sydsjö, G., & Gustafsson P.A. (2011). Psychological evaluation of refugee children: Contrasting results from play diagnosis and parental interviews. *Clinical Child Psychology and Psychiatry*, *16,* 517-534.

Paper II
Jarkman Björn, G., Bodén, C., Sydsjö, G., & Gustafsson, P.A. (2013) Brief family therapy for refugee children. *The Family Journal, 21,* 272-278. doi: 10.1177/1066480713476830

Paper III
Jarkman Björn, G., Gustafsson, P.A., Sydsjö, G., & Berterö, C. (2013). Family therapy sessions with refugee families; a qualitative study. *Conflict and Health 7,* 1-9. doi: 10.1186/1752-1505-7-7

Paper IV
Jarkman Björn G., & Björn Å. (2004). Ethical aspects when treating traumatized children and their families. *Nord J Psychiatry*, *58*, 193-198.

Paper V
Jarkman Björn, G. (2005). Ethics and interpreting in psychotherapy with refugee children and families. *Nord J Psychiatry*, *59,* 516-521.

INTRODUCTION

There are more than 45 million refugees and displaced people in the world (United Nations High Commissioner for Refugees UNHCR, 2012). Children constitute almost half of the refugee population. Many of the children are severely affected by different forms of organized violence, which influences their psychological health. It is a challenge to develop interventions meeting the needs of refugee children and their families in host countries.

Refugee families are affected by various types of stressors before the flight, during the flight, during the resettlement, and during the integration processes. The effects are divergent and have different time scales for the parents compared to those of the children (Angel & Hjern, 2008), for example, when parents are relieved after having escaped from a war zone area, a child might feel upset because he or she has been forced to leave friends and toys behind in the home country. Refugee children are often very resilient and resourceful despite the many adversities they face (for an overview see Rutter, 2003). However, many young refugees experience mental health difficulties. Thus, developing awareness on the part of society and clinicians concerning relevant risks and protective factors is important (Ehntholt & Yule, 2006).

Professionals in the host country who are not knowledgeable could aggravate the situation, even if acting with the best of intentions. The application of ethical principles is therefore especially important in the meetings with and treatment of refugee children and families. Increased awareness of ethical values in dealing with refugee children is in line with the growing interest in child perspectives stimulated by the Convention on the Rights of the Child (United Nations General Assembly, 1989, 2011). Basic ethical principles like autonomy, non-maleficence, beneficence, and justice (Beauchamp & Childress, 2009) is feasible to be taken into consideration in clinical practice and these principles may be considered from the point of view of each of the actors involved.

It is a big challenge and a complex situation for refugee children and families to escape from a home country where they had a sense of coherence (Antonovsky, 1987) in their lives and to adapt to a new society and recapture a sense of coherence in their new host country. Meeting and working with refugee families in an adequate and ethical way is a complex situation for professionals in the host country. Those who work with refugee and immigrant children agree on the importance of interpreters, but there is a need of appropriate training programs for interpreters and health-care professionals involved in child mental health care (Rousseau, Measham, & Moro, 2011) and training for researchers and clinicians in cultural psychiatry (Kirmayer, Rousseau, Corin & Groleau, 2008; .Kirmayer, Rousseau, Guzder, & Jarvis, 2008).

The research leading to this thesis was based on two tracks:

- A study of the psychological health of younger refugee children before and after an intervention with family therapy sessions and of the experiences and perceptions of refugee families coming to Sweden from the war in Bosnia and Herzegovina.
- Consideration of ethical aspects when working with refugee children and families.

This thesis must be put in a background context of refugees in an international perspective, refugees in Sweden, trauma, integration process, ethical aspects, psychological health, and previous intervention studies. Each topic is dealt with in sequence.

Refugees in an international perspective

There are international laws dealing with the rights and protection of refugees. One of them United Nations Convention relating to the Status of Refugees (United Nations, 1951) and with updating Protocol adopted in 1967 (United Nations, 1967), is the central feature of international regime of refugee protection. Through that law a refugee can get a permanent residence permit if he or she has a 'well-founded fear of being persecuted'.

The definition of a refugee according to the 1951 Geneva Convention together with the 1967 Protocol is a person who 'owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country: or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it'.

Children below 18 years of age constituted forty-six per cent of the refugees in 2012 (UNHCR, 2012). By the end of 2012, 45.2 million people were forcibly displaced worldwide as a result of persecution, conflict, generalized violence and human rights violations. Of these, 15.4 million people were refugees. The overall figure included 937,000 asylum seekers and 28.8 million internally displaced persons. Developing countries hosted over four-fifths of the world's refugees. Pakistan hosted the largest number of refugees in relation to its economic capacity. More than half (55%) of all refugees came from five countries: Afghanistan, Somalia, Iraq, the Syrian Arab Republic, and Sudan. Some 21,300 asylum applications were lodged by unaccompanied or separated children in 72 countries in 2012, mostly by Afghan and Somali children. It was the highest number since UNHCR started to collect such data in 2006 (UNHCR, 2012).

The thesis concerns people who came to Sweden from Bosnia and Herzegovina in the 1990s. From World War I until the end of the Cold War, Bosnia and Herzegovina was part of Yugoslavia. Bosnia and Herzegovina historically has been a multi-ethnic country consisting of predominantly Bosniaks (also named Muslims), Croats (Catholics), and Serbs (Orthodox). Bosnia and Herzegovina declared independence after a referendum and the war started shortly afterwards in March 1992. The estimated number of war-related casualties in Bosnia and Herzegovina varies between 102,000 to 300,000 (Blum, Stanton, Sagi, & Richter, 2007; Hayden, 2007; Ljubic, 1996; Richter & Stanton, 2008).

Because of the armed conflicts that took place between March 1992 and December 1995 in Bosnia and Herzegovina many surviving families and individuals escaped to other countries.

Refugees in Sweden

In Sweden there are additional reasons for granting asylum besides a 'well-founded fear of being persecuted', as documented in the international law in the 1951 United Nations Convention relating to the status of the refugee. These additional reasons are:

- Well-founded fear of capital punishment, corporal punishment, torture, or other inhuman or degrading treatment or punishment.
- Protection because of an armed conflict or an environmental disaster.

- Well-founded fear of persecution because of their gender or homosexuality.

During the first decades after the Second World War, most of the immigrants coming to Sweden were work labour for Swedish industries, but beginning in the 1980s an increasing number of refugees were coming from different conflict and war areas.

Before 1986, children were not included in the Swedish immigrant statistics. About 60,000 refugee children received permanent residence permits in Sweden between 1988 and 1995 (Swedish Immigration Board, 1996). In June 1993 the Swedish government took a decision of permanent residence permit for a family from Bosnia and Herzegovina, which was precedential for the around 40,000 Bosnians who had applied for asylum in Sweden (Swedish Ministry of Employment, 1995).

During the period 1992 to 1995, about 50,000 persons from Bosnia and Herzegovina were granted permanent residence permits in Sweden (Swedish Migration Board, 2013a, Table 1).

Table 1. Residence permits granted during 1992–1996 in Sweden

Citizenship	**1992**	**1993**	**1994**	**1995**	**1996**
Europe	2,134	30,718	36,969	2,556	898
of which Former Yugoslavia	1,080	30,313	36,183	2,370	753
thereof Bosnia and Herzegovina	598	28,703	18,495	1,547	392

Source: Statistics from the Swedish Migration Board (overview/time series) 1980-2012 (revised form).

In 2012 more than 40,000 people asked for asylum in Sweden. Most asylum seekers came from Syria, Somalia, Afghanistan, and Eritrea in the beginning of 2013 (Swedish Migration Board, 2013b).

This thesis is focused on refugee children’s psychological health and well-being. These subjects became a significant issue in Sweden after publication of a study of refugee children arriving in Lycksele (Gustavsson, Lindqvist, Nordenstam, & Nordström, 1987) and after a publication about children in war (Gustavsson, Lindqvist & Böhm, 1987). Several investigations of the mental health of refugee children were also conducted (Almqvist & Brandell-

Forsberg, 1989; Hjern, Angel, & Höjer, 1991; Ljungberg-Miklos & Cederblad, 1989; Thybell & Kock, 1988), which showed a high prevalence of mental health problems and a decline in emotional well-being in these children. A study of divorced parents concerning 17 children from refugee families, 27 immigrant children, and 113 Swedish children demonstrated that the refugee children had more symptoms than the Swedish-born children (Svedin, Back, & Wadsby, 1994).

Näreskog (1997) carried out an overview of refugee children and their situation in Sweden in the 1990s. Several projects focused on screening refugee children and families within the health care and the social welfare systems (Angel-Poblete, Lundin, Hjern, & Lekberg, 2002; Bäckström, Nilsson, & Nordenskjöld, 1993, Goetzinger-Falk, Mjönäs, & Stadin, 1992; Goldin, Levin, Persson, & Hägglöf, 2003; Lannemyr, 1995). A number of different treatment methods were developed—adjusted for traumatized refugee children—such as picture therapy group method (Angel-Poblete, 1995; Brandell-Forsberg & Almqvist, 1997), short-term psychotherapeutic intervention (Hessle & Levin, 1995), family-oriented psychotherapy (Påhlsson, Hjern, & Envall Ryman, 1995), and individual child psychotherapy (Lööf, 1995). Investigations were made on the national level to improve the reception system and to improve coordination among local authorities in communities supporting refugee children and families (The National Board of Health and Welfare, 1991).

In summary, projects and investigations made in the 1990s, when the refugees arrived in Sweden from the Balkan wars, showed that refugee children had a high prevalence of mental health problems, and that different treatment methods were developed for traumatized children and families.

Trauma

Refugee children and adolescents are vulnerable to the effects of pre-migration events, most notably exposure to trauma (Thomas & Lau, 2002). Refugees' traumatic experiences in their home countries are well documented. One study showed that negative health consequences are especially high when relocation is forced because of severe conflicts in the home country, conflicts associated with violence and trauma (Palmer & Ward, 2007).

Exposure to severe traumatic events in the refugees' home country, and the medical and psychological effects of this exposure, is known to influence critically the possibilities for resettlement and integration in a new country (Mollica et al., 1993).

Research has shown that organized violence can lead to different transient mental symptoms but also to long lasting effects like Post Traumatic Stress Disorder, PTSD, (Almqvist, 1997; Sack, Clarke, & Seeley, 1996; Macksoud & Aber, 1996; Macksoud, Dyregrov, & Raundalen, 1993). For a diagnosis of PTSD to be made, the following criteria must be met as specified in the Diagnostic and Statistical Manual of Mental Disorders IV (American Psychiatric Association, 1994): (a) exposure to a traumatic event, (b) persistent re-experiencing, such as flashbacks, recurring distressing dreams, subjective re-experiencing of the traumatic event(s), or intense negative psychological or physiological response to any objective or subjective reminder of the traumatic event(s), (c) persistent avoidance and emotional numbing, (d) persistent symptoms of increased arousal not present before the trauma, (e) duration of symptoms for more than one month, and (f) significant impairment in social, occupational, or other important area of functioning.

In adolescents, the subsequent levels of PTSD reactions are significantly associated with factors describing peritraumatic reactions: intense emotional reactions, physiological arousal, dissociation, and thoughts of intervening for example fantasies of altering the precipitating event (Dyb, 2005). In one study (Dalianis-Karambatzakis, 1994), children whose partisan mothers were imprisoned before, during, and after the Greek civil war were followed to assess their development and adult adaptation in relation to early maternal separation and war trauma. A majority of the children had achieved adequate psychosocial adaptation. Ahmad (1999) showed in his thesis based on interviews with children 6-18 years from three different socio-cultural backgrounds that developmentally based child characteristics have a determinant role as protective or vulnerability factors in childhood trauma and PTSD, even if socio-cultural factors also play a role. For children who have experiences from repeated physical and sexual trauma within families, van der Kolk (2007) has documented the importance of treatments that focus promotion of their development. The intensity and duration of response to trauma in children is dependent on many different factors. One of the most important factors seems to be the availability of a healthy and responsive caretaker to support the child following the child’s experience of trauma (Nilsson, 2007).

In summary, exposure to traumatic events influences the psychological health of children and families. A positive integration process is important in promoting the health of refugees and in helping them to achieve a positive psychological development.

Integration process

Stress may result in different emotional or psychological states (Lazarus, DeLongis, Folkman, & Gruen 1985). A psychological crisis can be described as a process comprising some or all of the following stages: shock, reaction, working through, and reorientation (Cullberg, 1980). A migration crisis also can be described as a process with different stages (Bustos & Ramos-Ruggiero, 1984; Enesten & Larsson, 1992; Sluzki, 1979; Söderlind, 1984). The model from Bustos and Ramos-Ruggiero (1984) is summarized, and some more aspects of the connection between the migration crisis of the grown-ups and children are added (Angel & Hjern, 2008).

When arriving in a new country, adult refugees generally feel relieved, according to many descriptions (Angel & Hjern, 2008; Bustos & Ramos-Ruggiero, 1984). The adults have made a decision to leave a country—that is, a war situation—and they feel reassured about being safe. The children might not have been informed, to prevent them from disclosing the escape plans, and as a result they can react with anger and intense sadness when they learn what is happening. The reactions from the children can give the parents guilt feelings. After some time in the new country, the adults usually go through a process of 'awakening' as they are confronted with demands from society and they may have new and different feelings like helplessness or aggressiveness. At the same time, the children often adapt more rapidly, learn the new language faster, and get acquainted with new peers. The adults can be disillusioned when they cannot express themselves adequately or when they only have the ability to use the language more like a child would use it. Native people might talk to them in a childish way, which can make them feel hopeless and incapable. Many refugees accept the difficulties, handle them, and engage in society, while others glorify the past and neglect their new reality. They may develop a 'nostalgic fixation' (Zwingman, 1973).

After some time in the new country, refugees can come to love their new country without losing their affection for their native country. It is important for refugees to develop strategies that take into account whether or how to maintain their native culture and at the same time adapt to the cultural practices of the host country (Berry, 1988; Marsella, 1994). Berry (1988) has used the term acculturation and described four different strategies towards acculturation: (1) assimilation, relinquishing one's cultural identity, and moving into the larger society; (2) integration, maintaining some cultural identity as well as becoming part of the cultural majority in the host country; (3) separation, maintaining traditional cultural identity without taking part in the cultural values of the host country; and (4) marginalization, relinquishing one's cultural identity and not taking part in the cultural values of the host country.

More recently, the concept of diaspora has been used in theories of how migrants reconstruct their lives. The diaspora theory is structured around three principal actors: (1) homeland; (2) diaspora group and (3) host, all of whom interact in a multi-faceted, changing set of relationships (Shuval, 2000). Migrants from the 1990s onwards have been less contained inside the physical and cultural boundaries of their host country than earlier because it is easier to travel and because the Internet makes possible ongoing communication with family and friends who remained in the home countries. The family dynamics can be influenced when different values from the native culture clash with the cultural values of the host country.

Parental roles may be different in different cultures and therefore could influence the parent-child interactions and cause conflicts and stress reactions that increase the gaps between generations (Skytte, 1997). Analysis of some interviews with immigrants in Sweden suggested that domestic disputes and intergenerational conflicts could be particularly stressful because they are often amplified by incompatible Western and non-Western representations (Tinghög, Richt, Eriksson, & Nordenfelt, 2009).

A national school survey of 15-year-olds in Sweden (Hjern, Rajmil, Bergström, Berlin, Gustafsson, & Modin, 2013) showed that pupils born in Africa or Asia are at high risk for being bullied and suffering from impaired well-being in schools that have few other migrant children. The conclusion of that study was that peer relations have to be improved and that school interventions have to be developed to prevent bullying and to help to promote well-being in non-European migrant children.

World Values Surveys are designed to provide a comprehensive measurement of all major areas of human concern, from religion to politics to economic and social life (Inglehart & Welzel, 2005). Two dimensions, Traditional/Secular-rational and Survival/Self-expression values, explained more than 70 percent of the cross-national variance in a factor analysis of ten indicators. In the 'Cultural Map of the World', countries are positioned according to people's values and not geographical position.

In 1995 the nation-level mean scores of Traditional/Secular-rational for Sweden were 1.49 and for Bosnia and Herzegovina 0.09; Survival/Self-expression values for Sweden were 1.99 and for Bosnia and Herzegovina -0.56, which means that Sweden and Bosnia and Herzegovina were manifestly different in cultural values at the time when the refugee families in this thesis escaped to Sweden.

The Traditional/Secular-rational values dimension reflects the contrast between societies in which religion is very important and those in which it is not. Societies near the traditional pole emphasize the importance of parent-child ties and positive respect for authority, along with absolute standards and traditional family values. The second major dimension of cross-cultural variation, the Survival/Self-expression values, is linked with the transition from an industrial society to post-industrial societies—which brings a polarization between Survival and Self-expression values. Priorities have shifted from an emphasis on economic and physical security towards an increasing emphasis on subjective well-being, self-expression, and quality of life. Inglehart and Baker (2000) found evidence that orientations have shifted from Traditional toward Secular-rational values in almost all industrial societies. When a society has completed industrialization and starts becoming a knowledge society, it moves in a new direction, from Survival values towards increasing emphasis on Self-expression values (Inglehart & Welzel, 2010).

However, even though persons coming from Bosnia and Herzegovina have different values than people born in Sweden according to the World Values Surveys from 1995, many of the refugees subsequently became well integrated in the Swedish society. In 1997 more than 70% of men coming from Bosnia and Herzegovina during the period 1993–94 had jobs in one area in Sweden (Gnosjö-Gislaved) in comparison to 20% of all working-age Bosnians in all of Sweden that year (Ekberg & Ohlson, 2000).

Children who come as refugees and present mental health problems are challenging for health care professionals. Problems during the integration process in combination with often traumatic experiences make them vulnerable and exposed. Professionals in health care face high demands in the context of assessment and treatment where ethical aspects are important. One model for bioethics to be used in working with these children and families is presented below.

Ethical aspects

Professionals working with children should always strive to take ethical guidelines into consideration in making decisions affecting these children. There are many different models for ethical decision making. The model from Beauchamp and Childress (2009) is one of the major systematic and well-argued models in the field of bioethics (Beauchamp & DeGrazia, 2004).

The basic ethical principles in the model of Beauchamp and Childress are autonomy, beneficence, non-maleficence and justice. Autonomy means the obligation to respect the decision-making capacities of autonomous persons. Beneficence means the obligation to provide benefits and balance benefits against risks. Non-maleficence stands for the obligation to avoid the causation of harm. Justice specifies obligations of fairness in the distribution of benefits and risks.

These four principles can be applied in clinical settings independently of the individual professional's personal philosophy, politics, religion, moral theory, or life stance. These basic principles are not and never can be all encompassing, but they offer a transcultural framework and a common language for ethical analysis (Gillon, 1994). In the Declaration of Helsinki (World Medical Association, 2004) there are statements of ethical principles relating to medical research involving humans. Children's ages and especially their maturity are important factors affecting their own decision making. Their competence in decision making gradually increases with age (Graham, 1994). Children's knowledge and understanding of somatic medical treatment has been reviewed by Eiser (1985). It is important to the well-being of children for health-care providers to be aware of ethical principles when handling parents and children. It is also important for the provider to feel secure in his or her professional behaviour, to be led by the guiding principles, to be able to be flexible in individual cases, and to take more time to listen to the views of the children and their parents (Graham, 1994). Ethical aspects can be evaluated from different points of view of the actors involved, which include not only the therapist, the patient, and patient’s family, but also the interpreter. When therapists work with interpreters, the nature of their work and the relationships that are formed with their clients are part of a complex set of interactions that influence the therapeutic efficacy of the particular system being employed (Raval, 1996).

Ethical issues are important in any kind of research. Research should be conducted with respect for human dignity and for the dignity of identity as explicated by Nordenfelt (2004, 2009). Ethics in qualitative research have been written about by, for example, Orb, Eisenhauer, and Wynaden (2000), who focused on the principles of autonomy, beneficence, and justice. They concluded that ‘ethical principles can be used to guide the research in addressing the initial and ongoing issues arising from qualitative research in order to meet the goals of the research, as well as to maintain the rights of the research participant’. They also pointed out that researchers should report incidents and ethical issues encountered in their studies to ensure discussion, analysis, and prevention of future mistakes.

Ethical issues are of special importance for vulnerable and exposed groups, like the refugee children and families in this thesis.

Psychological health of refugee children

An overview of research concerning the psychological health of refugee children is presented below because this research is of significance in dealing with the issues in this thesis.

The experience of war and violence increases the risk for psychological distress and the development of psychiatric disorders in children (Rousseau, 1995). Freud and Burlington (1943) described reactions of children from World War II. They emphasised the importance of the need for the child to stay with parents instead of being sent away to escape from bombing. Studies have demonstrated the need to take social context and the meaning of events into account when examining the impact of war exposure on psychological well-being (Jones & Kafetsios, 2005; Schweitzer, Greenslade & Kagee, 2007). A review of 22 studies of refugee children found substantial variation in the definitions used and measurements made of the children’s problems and reported levels of post-traumatic stress disorder, ranging from 19% to 54% (Bronstein & Montgomery, 2011). Some risk factors that have been shown to increase the probability of children developing PTSD, including symptoms of re-experiencing and avoidance of stimuli associated with the trauma (American Psychiatric Association, 1994), are severity of the traumatic event and the temporal proximity to the traumatic event (National Centre for PTSD, 2012). Peritraumatic reactions are also important predictors for who will develop PTSD (Bui et. al., 2010; Dyb, 2005)

Reports on the prevalence of psychological symptoms among refugee children have been published by several researchers (e.g. Ajdukovic & Ajdukovic, 1993; Ekblad, 1993; Fazel, Reed, Panter-Brick, & Stein, 2012; Kinzie, Sack, Angell, Clarke, & Ben, 1989; Kinzie, Sack, Angell, Manson, & Rath, 1986). For example, five surveys of 260 refugee children from three countries showed an average prevalence of 11% (range 7–17%) for post-traumatic stress disorder (Fazel, Wheeler, & Danesh, 2005).

Concerning pre-migration factors Rousseau and Drapeau (1998a) showed that the children's emotional problems, as perceived by the parents, were influenced by the family history of traumas connected with the socio-political situation. Thomas and Lau (2002) concluded that refugee children and adolescents are vulnerable to the effects of pre-migration events, most notably exposure to trauma. Factors of importance for the psychological health of children and teenagers include family cohesion, family support and parental psychological health; individual dispositional factors such as adaptability, temperament and positive esteem; and environmental factors such as peer and community support.

Post-migration factors such as language barriers (Mollica, 1987), loss of culture and support (Steel, Silove, Bird, McGorry, & Mohan, 1999), and a prolonged asylum process (Richman, 1998) have been found to have a negative impact on psychological well-being. Post-migration stresses among Southeast Asian refugee youth coming to Canada included stressors related to school adjustment, parent-child relationships, and intra-personal conflict (Hyman, Vu, & Beiser, 2000). Some identifiable groups are at higher psychological risk than the general risk level for others: for example, those still in the process of seeking asylum constitute such a high-risk group. Other groups at higher risk are unaccompanied minors and former child soldiers.

Studies with adult refugees have shown the importance of post-migration factors. In one study of war-wounded adult refugees exposed to severe traumas in their home countries, the results indicated that life circumstances and events related to the present situation, the 'here and now', were more important than background factors for their well-being and social integration (Hermansson, 1996). A study of adult Bosnian war prisoners who came to Sweden concluded that the most important factor for their well-being during the first period in exile was whether or not the family and other relatives were reunited and if they knew what had happened to other members of their family (Björn & Eriksson, 1993). A study of traumatized Bosnian adult refugees in Sweden (Kivling-Bodén, 2002) showed an association between the level of post-traumatic symptoms and the life situation in the recipient country. Refugees with a higher level of symptoms had more passive and socially isolated life situations.

Traumatic experience before arrival is the most important factor determining the short-term reaction of the children, while stressful life in exile seems to be the most important factor affecting the children's ability to recover from early traumatisation, according to Montgomery (2011), who also points out that the quality of family life seems to be important for both short- and long-term mental health.

According to several researchers, symptoms such as depression and anxiety can be expected in children in refugee families (Felsman, Leong, Johnson, & Felsman, 1990; Mghir, Freed, Raskin, & Katon, 1995; Servan-Schreibert, Lin, & Birmaher, 1998; Thabet, Abed, & Vostanis, 2004; Ziaian, Anstiss, Antoniou, Baghurst, & Sawyer, 2012). In one study, 47% of Bosnian refugee children reported symptoms of depression and 23% reported anxiety (Papageorgiou et al., 2000). Co-morbidity with PTSD is frequently reported (Heptinstall, Sethna, & Taylor, 2004; Kinzie et al., 1986; Sack et al., 1994; Thabet, Abed, & Vostanis, 2004). In one study of 99 school-aged Bosnian refugees in Sweden, 36% of the children were reported to be suffering from hypervigilance/startle reactions or from conditioned fear (Angel, Hjern, & Ingleby, 2001). Other commonly reported problems in refugee children include somatic symptoms, sleep disturbances, social withdrawal, attention problems, irritability, and difficulties in peer relationships (Almqvist & Brandell-Forsberg, 1997; Mollica, Poole, Son, Murray, & Tor, 1997; Montgomery, 1998; Tousignant et al., 1999). A number of the children's disorders could be handled directly: for example, depression and common sleep problems for which psychotherapeutic treatments and medication are available (Fazel & Stein, 2002; Pynoos, Kinzie, & Gordon, 2001; Yule, 2000). There are, however, difficulties in capturing an accurate picture of trauma in children who have experienced war. Thus it is important to get information from the children themselves and give adequate support and treatment considering also basic ethical principles.

Capturing psychological problems by different methods

Evaluation of symptoms based on parent interviews and on information from the refugee children themselves varied considerably in a study by Rousseau and Drapeau (1998b). In addition, the degree of agreement varied considerably depending on the sex and ethnic origin of the informants. The study also showed that data on multiple informants gathered from Western samples are not universally valid for comparison with non-Western samples. Goldin, Levin, Persson, and Hägglöf (2003) showed that parent and teenager assessments of total war exposure correlated strongly, but assessments of specific events diverged markedly. Primary school children systematically offered a less-detailed account of their own war exposure compared with older children. Jones and Kafetsios (2002) have stated that self-report checklists may be useful as a public health measure to assess the prevalence of psychological distress in areas affected by war, but they are not sufficient for clinical screening.

Robertson and Duckett (2007) studied displaced Bosnian mothers' experiences of caring for their children during and immediately after the war (1992–1995). They concluded that although families need to move forward, they also may need to look back, at least from time to time.

Al-Baldawi (2002) pointed out the importance distinguishing psychosomatic manifestations due to stress from pathological symptoms developed as a result of psychiatric or somatic diseases. This distinction reduces the risk of over- or under-diagnosing the patient's problems, and helps the provider choose the most suitable treatment to promote better and quicker integration. One qualitative study where refugees aged from 12 to 49 years with chronic somatic conditions were interviewed about their experiences with the Swedish health-care system showed that care providers' conversations about daily life were seen as a sign of commitment, knowledge and professional skill (Razawi, Falk, Björn, & Wilhelmsson, 2011).

Another study has shown that second-generation immigrant children did not differ from non-immigrant children in their own presentation of mental health at the age of 12 (de Keyser, Svedin, Agnafors, & Sydsjö, 2011).

Even if refugee children have gone through traumatic experiences there are several protective factors that can help them and safeguard their emotional well-being.

Protective factors

Reactions to stress may be mediated by coping strategies, belief systems, and social relations (Lustig et al., 2004). Adequate emotional expression, supportive family relations, good peer relations, and prosociality constituted the main indicators of resilience among refugee children in the study by Daud, Klinteberg and Rydelius (2008).

When refugee families leave their country of origin, they also leave their cultural context and accustomed support systems. Their abilities to overcome the emerging adversities still remain (Voulgaridou, Papadoupoulos, & Tomaras, 2006). Adaptability and cohesion within families seem to protect the emotional well-being of very young children following traumatic exposure (Laor et al., 1996). In a study of Cambodian refugee families in the United States the authors stressed that because the family is the centre of life for these families, healing must occur within this family context (Wycoff, Tinagon, & Dickson, 2011). In another study of Cambodian refugees, Frye and D'Avanzo (1994) identified themes in the family management of culturally defined illness.

The majority of refugee children appear to recover from symptoms and adapt fairly well to their host society (Kinzie et al., 1989; Krupinski & Burrows, 1986; Räsänen, 1992). This is explained as a result of the refugee children's ability to cope with the situation if given adequate support from parents and society. Garbarino (1991) claimed that young children will continue to cope with difficult situations as long as their parents are not pushed beyond their stress-absorption capacity. Also, parents are influenced by their children's coping success or failure (Almqvist & Hwang, 1999).

Most children, particularly younger ones, cope with the separation from their home countries more easily than the parents, and they experience fewer barriers to social network rebuilding (Morantz, Rousseau, & Heymann, 2012).
A study examining the functioning of the family and the child's psychological adaptation while staying in a refugee camp in Sweden concluded that family members should not be separated during the asylum period, and that a follow-up process is desirable when they have obtained residence permits (Ekblad, 1993). Hope may be a protective factor. Hopes regarding education

and family reunion were central in the resettlement of West African adult refugees in Sweden (Anjum, Nordqvist, & Timpka, 2012). In one study evaluating mental health and social adjustment of Iranian children 3.5 years after arrival in Sweden, the conclusion was that current life circumstances in receiving host countries, such as peer relationships and exposure to bullying, are of equal or of greater importance than previous exposure to organized violence (Almqvist & Broberg, 1999). Another study showed that extended family and, in particular, parental siblings play important roles in the acculturation experience and family functioning of Vietnamese refugee families in Norway (Tingvold, Middelthon, Allen, & Hauff, 2012).

Goldin (2008), who studied 90 Bosnian-Serbian-Croatian refugee children and their families, showed that nearly half the group were identified in clinicians' interviews as having one or more mental health problem 'demanding further attention'. Teacher reports showed cognitive-social capability in the vast majority of that group of children. One conclusion in that study was that a warm family climate and above all a family sense of hope for the future were associated with protection of the refugee children's psychological health.

Intervention studies

A literature review (Peltonen & Punamaki, 2010) showed that increasing research is available on the preconditions for improving the mental health of traumatized children, but less is known about how to translate these findings into effective interventions. The authors concluded on the basis of their literature review that substantial additional work needs to be done to develop effective preventive interventions and treatments for children traumatized by exposure to armed conflict. Ehntholt and Yule (2006) concluded that there are as yet relatively few publications on interventions for war-affected children under eight years of age.

A holistic approach taking into account family, emotional, social, financial and political situation is necessary for intervention programs with young refugees (Ehntholt & Yule, 2006; Papadopoulos, 1999). Ethical values also need to be considered in a holistic approach. Checklists used in combination with qualitative approaches make it possible to identify those children in need of treatment and avoid pathologizing those who do not have significant symptoms (Jones & Kafetsios, 2002). The effect that different traumas and negative life events may have on families, may give rise to changes in attachment patterns between children and their parents which may have negative consequences for child development. Culturally appropriate counselling theories and their respective interventions can be helpful (Stauffer, 2008).

In one study, different patterns regarding the referral process, problem presentation, and expectations regarding therapeutic conversations were outlined (Sveaass & Reichelt, 2001). One study analysing therapy with refugee families addressed the question of what is a 'good' conversation by analysing 'poor' conversations and learning how to improve the therapeutic process (Reichelt & Sveaass, 2004).

A phased model of intervention with stages such as first establishing safety and trust, and then including trauma-focused therapy and reintegration, is often useful, as Ehntholt and Yule (2006) noted in a summary of assessments and treatment of refugee children and adolescents who have experienced war-related trauma. Bernardon and Pernice-Duca (2010) have pointed out the need for a systemic family perspective, including a narrative therapy approach, when considering the development, maintenance, prevention, and resolution of PTSD in children and adolescents. Several surveys have focused on the importance of the parental role and on considering the whole family system in supporting children and youth. A study with a brief, community-based parenting intervention for Vietnamese American immigrant parents showed that after the intervention the participants reported a greater intention to show expressive love to their children as well as increased parental empathy (Wong et al., 2011).

Another psychosocial intervention programme, a randomized controlled trial, evaluated the effects on small children, five-year-olds in Bosnia and Herzegovina (Dybdahl, 2001). The programme consisted of weekly support group meetings for mothers over a five month period. The intervention programme had positive effects both on the mothers' and the children's mental health. A psychosocial treatment programme in a study of Kosovar refugees with a mean age of 13.3 years consisting of individual, family, and group sessions resulted in improvement in overall psychosocial functions for all but those in a subgroup of severely traumatized patients with complex psychiatric disturbances (Möhlen, Parzer, & Brunner, 2005). In a Swedish study of family treatment sessions in the homes of eight refugee families from Bosnia and Herzegovina, the refugees themselves reported positive effects resulting from these family sessions (Alinder, Ralphsson, Bjar, Wessman, & Lindfors, 1998).

A Norwegian study of clinical intervention for youth with stressful background experiences showed insight into how positive chain reactions could evolve (Waaktaar, Christie, Borge, & Torgersen, 2004). Four main therapeutic principles facilitated positive chain reactions in the participants: a focus on group work with same-age peers; organizing group work around activities that the participants were motivated to learn more about; facilitating playful exploration and individual symbolic expression within the chosen activity; and encouraging youths to make meaningful connections between different aspects of their past, present, and future lives.

Interventions according to a cognitive model of post-traumatic stress disorder have been applied successfully to refugee children (Ehlers & Clark, 2000) and have been described in two case vignettes (Vickers, 2005). A controlled study (N=26) with child refugees aged 11-15 years from different countries who had experienced war-related trauma showed that group cognitive-behavioural treatment (CBT) was effective in reducing PTSD symptoms, as well as behavioural difficulties and emotional symptoms. Follow-up data from eight children at two months after treatment failed to discover any significant changes in self-reported symptom scores compared with pre-treatment (Ehntholt, Smith, & Yule, 2005).

Both child-centred play therapy (CCPT) and trauma-focused cognitive-behavioural therapy (TF-CBT) were effective in reducing symptoms of traumatized refugee children in the United States according to reports from both children and parents in a randomized, controlled trial (Schottelkorb, Doumas, & Garcia, 2012).

The short-term impact of a group crisis intervention for children aged 9–15 years during ongoing war conflict was evaluated by Thabet, Vostanis, and Karim (2005). No significant impact of the group intervention on children's post-traumatic or depressive symptoms could be established. One possible explanation discussed in that study was the continuing exposure to trauma.

An overview of school-based interventions for minors in war-exposed countries showed that although studies reported changes in symptoms associated with interventions, most studies did not report the degree of functional impairment (Persson & Rousseau, 2009).

Play therapy is a significant, effective method for children and especially smaller children because it is a nonverbal method and can be used independently of language and skills. A meta-analysis of 93 controlled studies with play therapy for children published during the period 1953–2000 showed the overall treatment effect size was 0.80 (Bratton, Ray, Rhine, & Jones, 2005). That meta-analysis study found that using parents in play therapy produced the greatest effects. In one case study with sessions of non-directive play therapy, arguments were presented that the method both provided a child's developmental status, wishes, or feelings as well as facilitated therapeutic change (Ryan & Wilson, 2000). In a qualitative study concerning psychotherapy with smaller children, Svendsen (2007) showed the importance of communication through play and also that mentalization and narratives are perceived as important therapeutic phenomena that enable relationship development. Development of the technique of child play psychotherapy was shown in a study treating disruptive behaviour in Swedish children (Eresund, 2002).

One study in Canada comparing a community and clinical sample of children who had experienced war showed that creative play appeared linked to a family feeling of safety to discuss their experiences and their manner of transmitting information so that the children could process it (Measham & Rousseau, 2010). Another study with immigrant preschoolers evaluated a sandplay program in a multiethnic neighbourhood. Some evidence was found that small children who have experienced adversity before migration can benefit from creative expression workshops (Rousseau, Benoit, Lacroix, & Gauthier, 2009). A school drama therapy program for immigrant and refugee adolescents showed lower mean levels of impairment by symptoms and increased performance in mathematics than those in the control group (Rousseau et al., 2007).

Different treatment methods were adjusted to the needs of traumatized refugee children during the 1990s, when the refugees from the Balkan wars, the group that was the subject of this research, arrived in Sweden. Picture therapy groups allowed children the possibility to express their experiences—for example, when painting something from the war or 'that time when I was very, very scared'. Evaluation sessions with parents showed that the parents had noted positive changes after their children completed picture therapy. The children played normally and acted out fantasies about things other than the war (Angel & Hjern, 2008). In another project that used picture therapy groups with refugee children, 91% of the children said that they felt very positive about working with pictures and talking with other refugee children (Brandell-Forsberg & Almqvist, 1997). Short-term psychotherapeutic interventions were conducted that stressed early treatment and the importance of asking the children what they had experienced (Hessle & Levin, 1995). Through family-oriented psychotherapy, refugee families were given opportunities to develop new life strategies to develop better-functioning life situations (Påhlsson, Hjern, & Envall Ryman, 1995). Individual child psychotherapy (Lööf, 1995) was also conducted.

There are divergent opinions about the extent to which children are able to decide for themselves about participation in research projects. Findings from a study of 2,500 families in Sweden showed that parents were generally positive about supplying their child with individual information and assuring the child's consent/assent to participate. About half of the sample was opposed to the children's right to decide about the use and storage of biological samples and natural history data (Swartling, Helgesson, Hansson, & Ludvigsson, 2008). In another study with 4,000 families, child autonomy and decision-making were ranked lowest when parents were asked which interests they considered most important in paediatric research (Swartling, Helgesson, Hansson, & Ludvigsson, 2009). Participation in research studies of traumatized or bereaved populations can have beneficial effects on the families taking part in the research. Dyregrov, Dyregrov and Raundalen (2000) found that Bosnian refugees, both parents and children, experienced participation in a research project as positive.

Qualitative family research is useful for understanding refugee families and spreading knowledge about the findings that can help the families through family-oriented mental health services (Weine et al., 2004). Using qualitative research that aims to explore issues and to understand different phenomena and ethical aspects can give a broader and deeper perspective of complex situations.

Thus research on refugee children and families can be helpful in understanding psychological health and traumatic experiences and can be helpful in developing adequate treatment methods. The integration process is very important and the more professionals have experience and knowledge and know about cultural aspects, the easier they can adequately support refugee children and families.

A summary of the literature review of research concerning refugee children and families shows increasing research has been done on the preconditions for improving the psychological health of traumatized children. Less is known, however, about adequate interventions for children and especially smaller children exposed to war situations. Thus there is a knowledge gap that led to the research for this thesis about the psychological health of refugee children and interventions with family sessions. An adequate ethical approach is always important, but especially crucial when meeting persons who are vulnerable and exposed. Therefore, a structured analysis of case studies with refugee children, analysing basic ethical principles with assessments made from different actors involved in the treatment, is included in this thesis.

PRESENT INVESTIGATION

This thesis is based on research following two tracks concerning refugee children and families:

- Studies of families from Bosnia and Herzegovina who had escaped from the war, who had received permanent residence permits in Sweden and had at least one child between five and twelve years old. The psychological health of the refugee children was studied before and after an intervention with brief family therapy. Also explored were experiences and perceptions of refugee families from their life before the war, during the war and the escape, and during their new life in Sweden.
- Case studies of older children coming from Africa and the Balkans concerning psychological treatment, analysing basic ethical principles with assessments made from different actors involved in the treatment.

Aims

The main aims were

- to investigate parent-child agreement on the psychological symptoms of the refugee children (Paper I).
- to explore refugee children's well-being before and after three sessions of family therapy (Paper II).
- to explore, in more detail, the complexity of various members' experiences and perceptions of their life before the war, during the war and their escape, and in their new life in Sweden (Paper III).
- to highlight ethical issues and conduct ethical analyses using basic ethical principles that take into account the varying perspectives of the actors involved with regard to the psychological treatment of refugee children and families (Papers IV-V).

Methods

Empirical study group (Papers I-III)

Families were asked to participate in this study by a nurse in a medical health care centre or by social workers in the communities where the families lived. The families received written information about the project in Swedish as well as in translations to their native language. The exact number of refugee families who got the request to participate in the study is unknown. Initially 27 families participated, 14 were interviewed to take part in psychological assessments and brief family therapy. Thirteen were placed in a control group without any intervention, given the possibility of getting an intervention with family therapy later. The families were randomly assigned to these groups. Unfortunately there were too few left in the control group (eight), since four families did not want to continue participating in the research project and one dropped out for somatic reasons, which made comparisons un-reliable. The studies reported in this thesis concern the group of 14 families who were offered family therapy sessions. The families had arrived in Sweden between 1992 and 1995. Thirteen families had arrived from different cities in Bosnia and Herzegovina; one family was from the countryside. All parents had jobs except for one person who was studying. Eight families were Muslims, two Catholics, one Orthodox, and in two families the parents had different religions, Catholic and Orthodox. No religion was noted for one family.

The families had been in Sweden for an average of five years (range two to eight years) before they were included in the research project. The inclusion criteria were that the family came from Bosnia and Herzegovina, had escaped from the war, had received permanent residence permits in Sweden and had at least one child between five and twelve years. The age of the 13 children who participated in the psychological assessments (index children) were ranging from five to twelve years with a median of 7.5 years. Psychological projective methods were chosen suitable for the age group. One reason for using projective methods was to obtain more information from young children themselves than is usually obtained by simply interviewing them. The asylum process was not studied in this thesis. The choice was to concentrate on the psychological health and an intervention with refugee children and families after the families had received permanent residence permits.

Parents in one family participated only in the baseline interview, two families did not participate in the family therapy sessions, and one family did not attend the evaluation session after the intervention. Thus it was possible to analyse assessments with Erica Method for 13 children, seven boys and six girls, and to evaluate follow-up data with Erica Method from ten children, five boys and five girls. The ten children had between zero and three siblings at the baseline interview. In five cases they had one sibling. These ten families had been in Sweden an average of four years (range two to seven years) when baseline data were collected. The average age and also the median of the ten index children on arrival in Sweden was 4.5 years (range half-a-year to nine years).

The samples of as well as the methods used for Studies I–III will be described below; see also Table 2. Descriptions of the respective measures will follow on page 40-45.

Sample (I)

The sample in Study I consisted of 14 children, seven boys and seven girls, whose parents were asked in a semi-structured interview about the background and their children's symptoms. One of the families with one of the girls interrupted their participation during the study and did not complete it.

Thus, thirteen children participated in the Erica-play diagnostic sessions, each with three sandboxes, for a total of 39 sandboxes. The ages of the 13 children were: five (one child), six (one child), six-and-a-half (one child), seven (three children), seven-and-a-half (one child), eight (one child), nine-and-a-half (one child), ten (one child), and twelve (three children).

The assessments were compared with a reference group, a Swedish non-clinical sample (Olsson, 2006) consisting of 80 children, of which 40 were six years old and 40 were nine years old. There were 239 sandboxes altogether in the reference group. Information was lacking from the third sandbox for one nine-year-old boy.

Sample (II)

Eleven refugee children participated with their families and received a brief family therapy intervention (see page 38). The ages of the ten children were: five (one child), six (one child), seven (three children), seven-and-a-half (one child), nine-and-a-half (one child), ten (one child), and twelve (two children).

Parents were also asked in a semi-structured interview about the background and their children's symptoms. Erica play-diagnostic sessions before and after the intervention could be evaluated in ten cases. Of these ten children, nine had been together with one or both parents during the war experience. Two children had not been close to the war zone area.

Sample (III)

Family therapy sessions with three families were evaluated in this part of the study. They were selected because of the rich descriptions given in the therapy transcripts. The data corpus consists of three sessions from each family, i.e. a total of nine family therapy sessions.

The families consisted of both mother and father. Two of the families had one child each, and the third family had two children. The ages of the children were: four (one child), seven (two children), and twelve (one child) at the start of the first family session. At the start of the first family session the three families had been in Sweden for about two years, four years and six-and-a-half years, respectively.

Table 2. Samples and measures

	Study 1	Study II	Study III	Reference study
Number of children	14	10 out of 14 from Study I	3 out of 10 from Study II	80
Measures (n)	Parental interview (14) Symptom and Behaviour Interview (14) Erica Method (13) Machover (13) Children Apperception Test (11)	Parental interview (10) Symptom and Behaviour Interview (10) Erica Method (10) Machover (10) Children Apperception Test (10)	Qualitative Directed content analysis (3)	Erica Method
Intervention	None	Brief family therapy	Brief family therapy	None

Procedure

Refugee families from Bosnia and Herzegovina were asked to participate in this study by a nurse at a medical health centre or through contacts with social workers in the communities where the families lived. For an overview of the procedure and methods, see Figure 1.

Baseline evaluation

Parents:
Interview about background and present situation
Symptom and Behaviour Interview

Index children:
Erica assessment with three sandboxes
Machover test
Children's Apperception Test

↓

Intervention

Index children, parents and siblings:
Three family therapy sessions

↓

Follow up evaluation

Index children:
Erica assessment with one sandbox

Parents:
Interview about experiences of family therapy
Symptom and Behaviour Interview

Figure 1. Overview of the procedure and the methods

Baseline evaluation

Interview about background and Symptom and Behaviour Interview

Parents in all families were interviewed by the same interviewer (designated here as Interviewer 1) about background factors, their present situation, as well as a Symptom and Behaviour Interview (Cederblad & Höök, 1986) regarding the index children at baseline. The interviews were conducted between 1995 and 2000. In six of the 14 families, both parents were present at the interview.

Psychological assessments

On another occasion after the interview, the index children participated in the Erica Method (Sjolund, 1981; Danielsson, 1986) with three observations carried out by Psychologist A.

Additional psychological tests done were the Machover test (Blomberg & Cleve, 1997) and Children's Apperception Test (Bellak & Bellak, 1949).

Intervention

The intervention in this study was three sessions of family therapy in which the children participated with their parents and siblings. The purpose of these sessions was to give everyone the possibility to be involved, to share experiences and thoughts with each other, to tie together a family narrative with the aim of supporting the whole family. The sessions were offered with an average interval of one month between sessions (range between two weeks and three months). All sessions lasted about one hour, never longer.

The family therapy was influenced by a systemic and narrative approach with crisis and salutogenic theory as the framework (White & Epston, 1990; Cullberg, 1980; Antonovsky, 1987). It was decided beforehand that the following themes should be covered during the sessions: life situation before the war, the war, the escape from the home country from each family member's point of view, the present situation in regard to role changes, networks, thoughts about the future, and coping strategies in the family.

All family members, including the children, were involved in talking during the sessions. An interpreter participated in all sessions except one (the absence was because of sick leave).

Follow-up evaluation

The children completed a follow-up sandbox observation (the fourth sandbox) with the Erica Method, which was carried out by Psychologist A at between three months and 18 months (mean time eleven months), after the third family session.

The parents were interviewed by an independent interviewer (not part of the research team), about the parents' evaluation of the symptoms of the index children using the same Symptom and Behaviour Interview (Cederblad & Höök, 1986) as at baseline.

The parents were asked questions about how they experienced the family therapy sessions, how they experienced talking about the escape with their children in the sessions, whether they or their children had any problems that had deteriorated or improved. They were asked questions about how the family therapy sessions had affected them, whether the number of sessions were too many, enough, or too few and how it felt to converse through an interpreter.

Interpreter

A professional interpreter was involved during the interviews with the parents, in the diagnostic sessions and in the family therapy sessions. The same interpreter participated in nearly all sessions. All children spoke Swedish. During the Erica assessments, the interpreter was sitting in the room and interpreted when the children did not know specific words in Swedish, which happened only a few times.

Ethical considerations (I-III)

The model for structured ethical decisions considering the ethical principles of autonomy, non-maleficence, beneficence, and justice as described by Beauchamp and Childress (2009) was chosen in this thesis. To establish autonomy, the families had been asked to participate in the study by persons outside the organization, not involved in the research project. They received written information in Swedish and in their native language, had time to consider whether to participate or not, and they knew they could end their involvement at any time. When considered the ethical principle of non-maleficence, one dilemma was that talking about negative experiences might remind them of hard times and thus might worsen their current mental condition. An additional aspect considered was the possible sensitivity of talking about war, traumatic experiences, and escape from the home country. Special care and considerations have to be taken when talking about sensitive topics (Raymond, 1993). Hydén (2008) has stated that whether a topic is sensitive or not depends mainly on the relationship between the teller and the listener as well as the personal, cultural, and contextual nature of that relationship. Even if it is difficult to talk about sensitive topics, children want the opportunity to tell their stories (Eriksson & Näsman, 2012). The purpose of brief family intervention was to help the family members, including the children, leave negative experiences behind and continue their new life. Therefore, the principle of beneficence involved a possible gain in processing traumatic memories. As for justice concerns, the work with the family therapy sessions was done without taking account of gender, social or economic status, ethnicity, or any other factor.

The study was approved by the Ethics Committee of the University of Linköping (D-nr 93092).

Measures

Parental interview

The interviews with the parents before the intervention with family therapy sessions were conducted by interviewer 1, a trained social worker who also was the co-therapist in the family therapy sessions. In six cases both parents attended the interview; in five cases, only the mother; and in three cases, only the father. The parents were asked questions about their family composition, proximity to the war and how they escaped from the war, religion, language, when they left their home country and arrived in Sweden, whether the family members arrived together or separately, whether the parents had told the children about the escape in advance, whether the parents themselves had had traumatic experiences, whether they were separated from persons close to them, and whether the children's belongings had been left in the home country.

Symptom and Behaviour Interview

Any psychological symptoms of the index child (aged five to twelve years) in each family were assessed using a semi-structured interview with the parents according to the Symptom and Behaviour Interview, developed by Mc Farlane, Allen and Honzik (1954) and revised by Jonsson and Kälvesten (1964) and Cederblad and Höök (1986). The parents were asked about the presence of 33 different symptoms including sleeping problems, somatic disturbances, anxiety and aggressiveness in their children. Each symptom was scored as being normal or abnormal according to an operational scale. The cut-off score on that scale for having clinical symptoms is 300.

Erica Method (I and II)

The Erica Method is used for psychological projective diagnostics (Harding, 1969; Danielsson, 1986; Sjolund, 1981). Psychological projective methods are valuable in gathering information about thoughts and feelings, especially for young children. Many projective methods can be used meaningfully with children from early age and may be the only means of obtaining test data for personality constructs (see e.g., Graybill & Blackwood, 1996; O'Donnell & Curley, 1985). One reason for using a projective method was to obtain more information from the children themselves than is often obtained by simply interviewing them. The Erica Method is both a play-diagnostic and a play-therapy method. This method has its roots in the World-Technique, which uses standardized material (Lowenfeld, 1950). The Erica Method uses similar methods and tools as in the World Technique of Lowenfeld, with the difference that diagnostic and therapeutic applications are clearly distinguishable (Mattson & Veldorale-Brogan, 2010).

In this play-diagnostic method there are 360 miniature toys each assigned to one of ten different categories: soldiers, cowboys and Indians; people; wild animals; domestic animals; vehicles; war objects; buildings; fences and traffic signs; trees; and interior objects like furniture and telephones.

The children are asked to build whatever they want in a sandbox. The final sandbox scene is photographed, and what has been built is assessed from a construction point of view. Observations are made concerning points at which the type of construction and type of play are repeated, when activity intensifies or slackens, when regressions occur, and the control mechanism being destroyed or strengthened. When the sandbox scene gradually improves in structure or when the sand is played with in a more constructive way each time, it can be seen as a sign of improvement. The psychologist's observational attitude should be as free as possible from influencing the child, thereby eliminating the risk that external suggestions and stimuli could distract the child's attention from the material. Explicit comments and interpretations from the psychologist to the child that can release tendencies to display aggressive or regressive impulses or to turn unconscious wishes and problems into conscious ones have been completely omitted from the Erica Method at the diagnostic stage (Danielsson, 1998).

The formal elements of the Erica Method include noting behaviour during the sessions and observations how the children play (Danielsson, 1998, see Figure 2).

Information relevant to the whole observation

Formal aspects	**Description**
Choice of sand	Dry or wet
Treatment of the sand	Scooping, sprinkling Patting, smoothing Digging, excavating Shaping plastic construction Marking Imprints, patterns Hiding in the sand Adding water, more sand or other
Type of play	Explorative play Functional play Role play, fiction play
Changes and corrections	Frequency
Timing	Latency Building time

Information relevant to the final sandbox scene

Building surface	Half or less The whole surface More than one sandbox Outside of sandbox
Compositions in a progressive development	Indifferent placement Sorting Configuration Simple combination Juxtaposing Conventional grouping Coherent world
Special compositions	Chaotic world Bizarre grouping Enclosed world

Figure 2. Erica Method, assessment form

Notes are made on changes and corrections and timing (latency and building time). Information relevant to describing the final sandbox scene includes extent of the building surface and compositions in a progressive development. Special compositions and groupings also are recorded: chaotic world, bizarre grouping, and enclosed world. The number of objects left in the sandbox after each of the three sessions is recorded. Conflicts and relations are analysed. A conflict is defined as a negatively charged relation between something in the sandbox; it could be between objects, animals or human beings. A relation is defined as a positively charged or neutral relation, a scene in the sandbox where at least two persons, animals, or objects have something to do with each other.

The Erica play method was standardized by Olsson (2006). The Swedish non-clinical sample was used as a reference for the refugee children group.

The assessment of the sandboxes was categorized into two different categories: 'normal world' (N) and 'not normal world/clinical world' (C). In a clinical world, the content and configuration are considered to indicate psychological disturbances according to the Lowenfeld World Technique (Lowenfeld, 1950) and the Erica Method (Danielsson, 1986). 'Re-enactment boxes' were treated as being equivalent to the 'clinical world' in this study. The criteria for the re-enactment boxes used in this study were the same as in the research study by Almqvist and Brandell-Forsberg (1995). At least three of the following criteria have to be fulfilled for the box to be named a re-enacting box: the child acts and dramatizes one or several events instead of building a world in accordance with the given instructions; the child repeats acts of violence several times; the child performs the dramatizations in an obvious state of increased arousal; and the child shows expressiveness when sharing his or her inner world. Almqvist (1997) stated that all the children who participated in her study who dramatized acts of organized violence with the Erica Method had experienced the incidents they dramatized, according to their parents. The validity of the children's descriptions was verified by information from interviews with their parents. These interviews were made independent of the assessments of the children. According to Buhler, Lumry and Carrol (1951), worlds with aggressive themes were not considered signs of emotional disorder if they were not chaotic or rigid. A normal world is any world that is developmentally adequate in configuration according to the standardization (Danielsson, 1986).

In the study, Psychologist A, who had evaluated the Erica Method before and after the intervention with family therapy, was blind to the background and symptoms of the children and had no information from the baseline data. The photographs of the sandboxes, the written notes about the activities of the children, and what the children said during the assessments were also assessed by an independent Psychologist B, who was blind to the background and symptoms of the child, as well as to the order of the four sandboxes created by each child. The assessments made by the independent Psychologist B are less reliable because the Erica Method includes objective assessments of the sandboxes together with an assessment of the child's acting during the play session, where expressions and feelings are observed, assessments that cannot be fully written down in notes. Both psychologists were trained in the procedures of the Erica Method at the Erica Foundation, Stockholm. An overview of clinically based research at the Erica Foundation was written by Carlberg (2008).

Inter-rater reliability (I and II)

Concerning inter-rater reliability, the assessments of Psychologist A and Psychologist B were in accordance for 80% of the assessments before the intervention and for 78% when all assessments were included. For first observations, phi = 0.62, $p < 0.026$; second observations, phi = 0.72, $p < 0.009$; third observations, phi = 0.73, $p < 0.008$; and fourth observations, phi = 0.41, $p = 0.197$. The assessments by the two psychologists differed for nine out of 40 sandboxes; Psychologist B rated the nine sandboxes as not normal while Psychologist A rated them as normal.

If at least one sandbox out of the series of three sandboxes was a 'clinical world', this child's series was assessed as 'not normal'. An index was created to include the Erica assessments from both psychologists, giving a value of '0' for a normal sandbox and '1' for a clinical sandbox. When their assessments differed, the value given was '0.5'; thus a child could be given a rating of 0, 0.5 or 1.

Machover test

The refugee children in Studies I–III were assessed with the Machover test, a 'draw a person test' (Blomberg & Cleve, 1997). This test is considered to be a valuable test for assessing personality. The child is assumed to be projecting his or her inner dynamics in the drawings and answers to the questions. There are two parts in the Machover test. In the first one, the drawings are less structured, while the other one with questions is more structured. Distortions of figures are interpreted as symbolic inadequacies of their self-images. The children are told to draw a person. If the child draws a male figure first, he or she then is asked to draw a female figure. The first figure is seen as a projection of the self-image of the child. The second figure is interpreted as revealing something about the child's view of other key people who have influenced the child's picture of an ideal of an ego.

Children's Apperception Test

The refugee children in Studies I–III were assessed with a Children's Apperception Test (CAT). CAT is a projective psychological test that assesses personality and level of maturity. The test consists of ten pictures portraying animals in various situations. The theory is that children's responses to drawings of animals and humans in different situations reveal significant aspects of their personality (Bellak & Bellak 1949).

Analysis

In this thesis quantitative, qualitative, and ethical methods have been used. The purpose of using different methods was to get a broader and deeper perspective of the psychological health of refugee children and families before and after an intervention with brief family therapy and also to use ethical analysis concerning psychological treatment from different participants' points of view. These different methods were also used to highlight both individual perspectives as well as the complexity of family perspectives and family systems.

Statistical analysis (I and II)

The statistical tests were performed with SPSS-version 14.0. Chi-test and t test (two-sided) were used. Inter-rater reliability of the assessments of the sandboxes was calculated with the phi-statistic. Comparisons of the situation before and after intervention were analysed with Wilcoxon signed-rank test (two-tailed).

Qualitative analysis (III)

In Study III the focus was on the complexity of various members' of refugee families' experiences and perceptions from their life before the war, during the war and the escape, and during their new life in Sweden. The research plan was originally to analyse spontaneous communications in the family sessions using conventional content analysis. This was changed to directed content analysis due to the way the sessions were performed – talking about given themes. Directed content analysis seemed more appropriate for analysing the data, and could give a deeper knowledge of refugee families.

Directed content analysis is a method of analysing verbal or written communication in a systematic way (Krippendorf, 2004). Directed content analysis is used to interpret meaning from the content of text data (Hsieh & Shannon, 2005).

Nine family therapy sessions from three refugee families were analysed. The sessions were selected because of the rich descriptions that appeared in the transcripts. All family therapy sessions were videotaped. Verbatim transcripts were made from the videotapes. Interactions between the family members were noted. The author was in charge of the family therapy sessions together with a social worker; both were trained in family therapy.

Material from all three sessions with each of the three families was in this study analysed with the directed content method, starting with an analysis of the different themes that were focused on in the family therapy sessions. The themes were: former life situation before the war, the war, the escape from the home country, and present situation including thoughts about the future. Transcripts from each session were read several times. First the text was read so that the different themes could be identified in the family therapy sessions. The next step was to collect the text material belonging to each theme from the nine different family therapy sessions. The text was re-read several times and meaning units assigned to a single topic were sorted into three categories. The three main categories were subdivided into ten subcategories. The categories and subcategories were validated through a systematic analysis of the material, and the analysis and findings were discussed with an experienced and skilled qualitative researcher.

Ethical analysis (IV and V)

A structured scheme was used to analyse ethical dilemmas regarding refugee children and families in mental health settings. One case concerned whether to admit a traumatized patient for inpatient treatment or not. The other case was whether to use a certain interpreter in the therapeutic work or not.

The analyses presented were based on the model from Beauchamp and Childress (2009). An assessment was made of every actor as concerned the four ethical principles of autonomy, beneficence, non-maleficence, and justice. The model can be used when considering both somatic (Enskär, 1995) and psychological or psychiatric interventions (Björn & Björn, 2004).

Evaluations were made using the operational definitions below:

Not applicable = the principle does not involve the actor
+ Known gain = there is gain for the actor on the principle; the known gains are graded from + (relatively small gain) to +++ (very high gain)
(+) Possible gain = there is uncertainty whether there really is a gain
- Known cost = there is a cost for the actor on the principle, the known costs are graded from - (relatively small cost) to --- (very high cost)
(-) Possible cost = there is uncertainty whether there is a cost.

The analysis and findings were discussed with an experienced and skilled researcher in ethics (Nordenfelt, 1993). Papers IV and V in this thesis about ethical aspects were written as part of the European Biomedical Ethics Practitioner Education (EBEPE) project (Dickenson & Parker, 1999) called 'Ethical Issues in Child Psychiatry', originally presented at the Psychoanalytic Institute for Social Research in Rome, Italy, in March and October 1997.

Results

Paper I-Psychological evaluation of refugee children: Contrasting results from play diagnosis and parental interviews

The aim of this study was to evaluate the degree of parent-child agreement on the psychological symptoms of the refugee children. The two methods used were

- a semi-structured interview (Symptom and Behaviour Interview) with one parent or both parents in each family, asking about symptoms of one child aged five to twelve years in the family
- the Erica Method to study inner thoughts and feelings of the children.

Results from the Erica play-diagnosis method were compared with findings from Erica play-diagnosis in a Swedish non-clinical reference group.
Results from the parental interviews showed that 13 of the 14 children had few or no overt psychological symptoms according to the parents' ratings. Among symptoms described were aggressive problem behaviour and stomach-ache.

In summary, results from the Erica play-diagnosis in the study group showed that out of the assessments of 39 sandboxes, 17 (44%) were not-normal sandboxes (Table 3). According to the assessments of the independent psychologist there were 24 not-normal sandboxes (62%). In the Swedish reference group (R-group) 18/239 sandboxes (8%) were not normal ($p < .001$).

Table 3. Observations of sandboxes for 13 children (N = normal world, R = re-enacting world, and C = clinical world; R & C are considered not normal)

Observation 1	Observation 2	Observation 3
N	R	N
N	C	R
N	N	N*
N	N	C
R	C	N
N	N	N*
N	N	N*
N	N	N*
R	C	C°
R	R	R°
N	N	N*
C	C	C°
N	R	R

* 5 of 13 (38%) children with three normal sandboxes,
° 3 of 13 (23%) with three not-normal sandboxes.

In comparison with the Swedish reference group (R-group) this study of refugee children showed

- building time was statistically significantly shorter ($p < .05$ observation 1; $p < .01$ observation 2; $p < .001$ observation 3) in all three observations
- higher frequencies of building in dry sandboxes were noted in observation 2 ($p < .05$)
- building with fewer toys on the average was noted in observations 1 and 2 ($p < .01$)
- fewer made imprints in observations 2 and 3 ($p < .05$)
- no children made frequent rearrangements, and this was significantly different in observation 1 ($p < .05$)
- fewer indicated play on the whole in observation 3 ($p < .05$)
- fewer were patting and smoothing in observation 2 ($p < .05$)
- fewer had latency less than one minute in observation 1 ($p < .05$)
- fewer shaped conflicts in observation 1 ($p < .05$).

Thus, the main finding in this study was that there were differences between the results from parental interviews using a symptom scale and from child assessments. In contrast with the results from Symptom and Behaviour Interview data gathered from parental interviews, results from the children's play in the Erica setting indicated that a high percentage of the refugee children had non-optimal psychological health.

Paper II-Family therapy with refugee children

The aim of this study was to explore refugee children's well-being before and after brief family therapy.
The findings in this study:

- Four of ten children, on the basis of assessments of the Erica Method completed after intervention with brief family therapy, had normal sandboxes in all three observations before the intervention. After the intervention, nine out of ten children built a normal sandbox. The improvement was statistically significant even if counting the combined ratings of the two psychologists ($p = 0.046$)
- More children shaped a conflict during the sandbox diagnostic sessions after the intervention than before
- Fewer children shaped a positive relation after the intervention than before. The percentage who could create a positive relation after the intervention was about the same as in the Swedish reference group (Olsson, 2006)
- The majority of the children showed few if any overt psychological or psychiatric symptoms evaluated by parents before the intervention with brief family therapy sessions. The most common symptoms were aggressive symptoms and stomach problems. There was a tendency towards improvement after family therapy as seen in even lower symptom scores reported by the parents after the intervention, but this tendency was not statistically significant.

In summary, the main results in this intervention study were: significantly more normal sandboxes after the intervention than before, more conflicts and fewer positive relations created after the intervention than before, and no significant changes observed concerning symptoms evaluated by parents.

Paper III-Family therapy sessions with refugee families; a qualitative study

The aim of this qualitative study was to explore, in more detail, the complexity of various members' experiences and perceptions from their life before the war, during the war and the escape, and during their new life in Sweden. The directed content method of analysis was used. The findings in this study were organized into three main categories and ten subcategories (Figure 3).

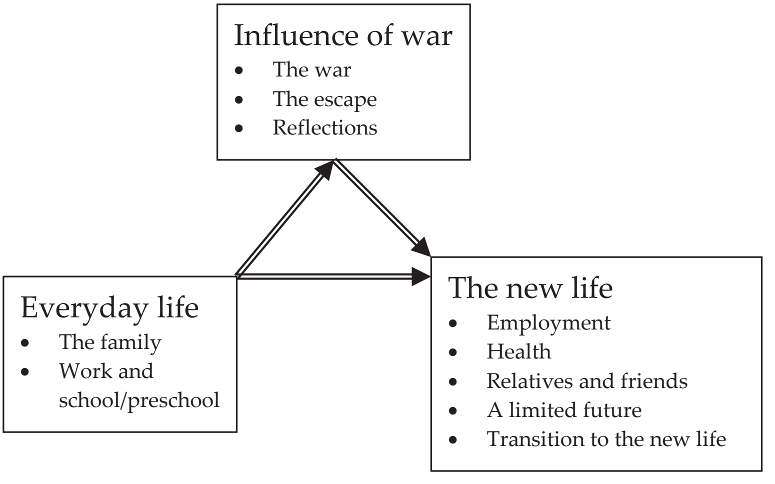

Figure 3. The main categories and subcategories illustrating the time process

- Everyday life at home, with two subcategories: The family, work and school/preschool

Everyday life at home was the main category that emerged from the analysis of the material from the sessions focusing on life before the war. Narratives came up about family members who still live in Bosnia and Herzegovina and whom the informants missed very much. Besides family, work and school/preschool were important. The parents had done well at their jobs in Bosnia and Herzegovina and their relatives helped them. Family life functioned well economically. Overall, the informants had a sense of coherence in their home country and highlighted mostly the positive aspects of life before the war.

- The influence of war on everyday life, with three subcategories: the war, the escape, and reflections

Life changed dramatically because of the war when the families began to experience bombings and shooting. The informants escaped from their home country in different ways, with part of or the whole family together. Each of the family members had different experiences from the war and escape.

Informants described feelings (crying, fear), somatic complaints (for example vomiting), and depressive symptoms. They brought up uncertainty about where to escape to and how to do it.

Family members reflected on changes and difficulties associated with the war and the escape. Parents in mixed marriages in which the spouses came from different ethnic groups reported difficulties arising from this situation. Someone said that it was better to forget about the past and move on in life. Parents mentioned things that were important for their children in their home country but were left behind, for example, toys.

- The new life, with five subcategories: employment, health, relatives and friends, limited future, and transition to the new life

The third main category was the new life. Informants described different ways of adapting to a new society and finding a sense of coherence under the five subcategories related to this main category. They brought up the process of finding jobs and learning a new language. In their new life, some dealt with health conditions linked to the war and to traumatic experiences, but also experienced ordinary health problems such as colds and infections. Much effort was put into keeping the family together and making new friends. Much of the conversation was about here and now, with expressions of feelings of a limited future. The subcategory of the limited future was named to capture the difficulties the grown-up informants described in thinking far ahead about the future. It also appeared that not all difficulties were linked to cultural differences arising from living in different countries, but instead arose because persons had different personalities, so that experiences, at least to some extent, depended more on personality differences than on cultural differences. Even if the parents thought that they had a limited future, they had hopes of getting jobs and taking care of themselves and their families. Thoughts of not getting stuck in the past came up. The children could see an unlimited future.

Dilemmas regarding making different aspects of life work together were highlighted; for example, when a person had got a job but had to go there by car, there was a delay starting the job because of the need to get a driver's license first.

The new life was accompanied by health problems linked to cultural differences and traumatic experiences, as well as by ordinary health problems that children face, for example repeated colds and infections. War injuries were discussed, and various operations and forms of bodily harm resulting from these were mentioned. Traumatic memories and nightmares were mentioned and also sleeping problems and depressive symptoms.

Concerning the subcategory of relatives and friends, the importance of having relatives was mentioned. Difficulties in socializing and making friends were also mentioned.

The qualitative analysis showed that the families had lived normal lives in their country of origin, similar to others around them and with a sense of coherence. After experiencing a war situation their lives changed when they escaped to a new country and started a new life where they had to try to find a new coherence of comprehensibility, manageability and meaningfulness.

Additional results (Papers I–III)

Psychological testing

A summary of 13 Machover tests with refugee children in Studies I–III showed that ten children had good object relations and good self-images interpreted as having good relations to other people.

Four children did not make age-appropriate drawings. Two of these children did not make normal sandboxes in Erica Method. These two children also showed negative self-images.

A summary of the Children's Apperception Test assessments of 11 children showed that they could tell stories and that they told age-appropriate stories in relation to the ten different pictures.

The results of CAT and Machover test have not been published in the articles referred to in this thesis. Summarizing, the results of CAT and Machover test showed that they complemented the Erica Method as a whole and supported the findings in that test.

Follow - up interview

Seven out of eleven families who had been given brief family therapy were interviewed at a follow-up with the parents within 16 months after the last family therapy session.

All seven answered that the response during the research process was good or very good and the majority of them said that they had felt that they had been understood. One parent answered, ‘Nobody that has not been in a war situation and escape can understand all experiences, but empathy they can feel’.

Most parents were positive when answering about their experiences from the family therapy sessions. One parent said, ‘It is much easier to talk and have conversations with persons that you are not linked to directly, who are neutral and independent’.

Some doubts were expressed by one of the parents in one family about talking with children about traumatic experiences. This parent said that it would be better for the children if they forgot about what had happened.

Most parents did not think that any problems their children displayed before therapy had changed after the therapy sessions. Some of them thought that their own problems had not changed either. One parent said that the sessions were good because it was important to tell someone about their experiences. The majority of the parents thought three sessions were enough.

Paper IV- Ethical aspects when treating traumatized children and their families

This paper focused on three issues—traumatic life events, hierarchy, and repatriation—where potential ethical conflicts might arise for healthcare professionals in treating refugees with different cultural backgrounds. An ethical analysis of the decision to admit a traumatized teenage refugee to a child psychiatric in-patient ward was discussed with respect to the ethical principles of autonomy, non-maleficence, beneficence, and justice. There were both gains and losses, which were valued differently depending on the actors involved (Table 4).

Ethical analysis concerning autonomy in this case:

The teenage girl was old enough to say what treatment she accepted. However, she was self-destructive and had to be stopped from harming herself and others. The staff had to hold her. It was more important to prevent her from harming herself than to keep strongly to the principle of autonomy. Therefore, there was a known cost concerning the principle of autonomy. The father was not involved in the emergency situation and had no influence on the decision; therefore, there was a known cost here. The foster parents could participate in the decision with the professionals, and this participation was a known gain for them. Professionals should be open to considering the autonomy of the siblings, even if their autonomy is not comparable with the autonomy of parents. In this case, the siblings did not participate in the decision, and there was therefore a known cost concerning autonomy.

In this case, the best solution for the teenage refugee found in the emergency situation was the admittance to a child psychiatric in-patient ward.

Table 4. Ethical Costs and Gains (case example)

Actors	**Autonomy**	**Non-maleficence**	**Beneficence**	**Justice**
Child	--	(-)	+	(+)
Father	---	(+)	(+)	+
Foster parents	+	++	+++	+++
Sibling	---	(+)	(+)	+

+ Known gain = there is gain for the actor on the principle, the known gains are graded from + (relatively small gain) to +++ (very high gain);
(+) Possible gain = there is uncertainty whether there really is a gain;
- Known cost = there is a cost for the actor on the principle, the known costs are graded from - (relatively small cost) to --- (very high cost).
(-) Possible cost = there is uncertainty whether there is a cost;

Basic ethical principles can be analysed structurally step-by-step when dealing with refugee children and their families. The feasibility and value of such ethical discussions and reflections in the clinical practice was pointed out in Paper IV.

Paper V-Ethics and interpreting in psychotherapy with refugee children and families

The aim of this paper was to focus on the role of the interpreter and on different aspects to be considered by the therapist when working with interpreters in the psychotherapeutic treatment of refugee children and families. An ethical analysis of a case was made; in this case a teenage refugee received therapeutic treatment using an interpreter who had gone through a migration crisis several years ago and had a daughter of about the same age as the patient. The basic ethical principles used were autonomy, non-maleficence, beneficence, and justice (Table 5)

Ethical analysis concerning autonomy in this case:

The autonomy of a child depends on, among other things, the child's age and psychological developmental stage. An adolescent has a level of autonomy more similar to an adult's than a small child does. A 16-year-old teenager has a recognized autonomy in most situations, and should normally be treated in a manner similar to an adult.

The girl in this case knew Swedish fairly well, but she needed an interpreter to help her to understand special words. She was old enough to decide whether to accept the treatment offered. However, she was depressed and in a mental state where it was difficult for her to make decisions. She had been persuaded by her mother to come for treatment. Her mother displayed a caring function as a parent and wanted the best possible treatment offered by professionals. There was some loss of autonomy with regard to the treatment because her mother's persuasion to come to therapy. She also had been forced to accept the use of the interpreter. The interpreter was secure in her professional role and she was in that sense independent of the patient. She followed the rules she had learned during her training as an interpreter. She did not have control over deciding the exact length of the therapy session, nor could she control how many words the therapist might say before letting her interpret, and so forth, but from an ethical point of view, this was not considered a cost of autonomy. She was free to reject the assignment. On the other hand the interpreter cannot freely choose the patient. The interpreter will have to hear things that she does not want to hear. Summarizing, there was a predominantly gain as concerned autonomy from the point of view of the interpreter.

There were both gains and losses when evaluating and analysing different aspects in this case. There was a possible cost associated with autonomy for the teenager and a small gain concerning non-maleficence. For beneficence, there was a known gain. Summarizing, there were more gains than losses for the patient. The conclusion was that it was better to use this interpreter than not to use an interpreter. The ethical analysis had been treated in a parallel way concerning the patient and the interpreter, but the ethical considerations concerning the patient had priority in relation to those of the interpreter.

Table 5. Ethical costs and gains (case example)

Actors	Autonomy	Non-maleficence	Beneficence	Justice
Teenage refugee	-	+	++	Not applicable
Interpreter	++	-	(+)	Not applicable

Not applicable = the principle does not involve the actor;
+ Known gain = there is gain for the actor on the principle; the known gains are graded from + (relatively small gain) to +++ (very high gain);
(+) Possible gain = there is uncertainty whether there really is a gain;
(-) Possible cost = there is uncertainty whether there is a cost;
- Known cost = there is a cost for the actor on the principle, the known costs are graded from - (relatively small cost) to --- (very high cost).

Reflective summary of findings in Papers I–V

The findings from the psychological assessments showed that a statistically significant number of refugee children had psychological problems in comparison to a Swedish reference group. According to the Symptom and Behaviour Interview with their parents, however, the majority did not show overt psychological problems. Thus it is important to focus on the child in order to find out more about the child's psychological health situation than can be learned by only talking with the parents. Internalized symptoms—for example, anxiety—are more difficult for parents to detect than externalized symptoms such as aggressiveness. Non-verbal methods like the Erica Method can be useful for younger children when interviewing is difficult. A statistically significant number of cases improved in their psychological health after a brief family intervention when the results were evaluated with a projective method. A significant number of the refugee children showed more conflicts when playing in the sandbox after the intervention than before. One interpretation is that they showed more normal psychological feelings after the intervention. They felt that they had been allowed to express negative as well as positive feelings.

The findings from the qualitative analysis of family therapy sessions showed that the families involved had lived normal lives in their home country, similar to others around them. Life changed because of the war situation. The families had a sense of coherence in their home country before the war. After the escape to Sweden they started a new life, trying to find a new coherence in their new country. One conclusion in the study was that it is important to listen to each person's point of view to understand the complexity of the family system and tie together the family narrative. The intention of the brief family therapy was to focus on each individual person, including the children. However, the analysis showed that less space was allocated to the statements made by the children. One interpretation could be that this arises because there is a tradition that adults talk more with each other than with children.

Two cases were analysed and discussed with respect for the ethical principles autonomy, non-maleficence, beneficence, and justice to illustrate the importance and feasibility of evaluating gains and losses made from the perspectives of the different persons or actors involved. It is important to analyse ethical aspects in a systematic way, when meeting and treating refugee children and families.

The findings from these studies show the importance of highlighting individual perspectives from the point of view of children, parents, and siblings in order to better understand the complexity of family systems.

DISCUSSION

This thesis has two tracks. In the first track (Studies I–III), the focus was on the psychological health of refugee children coming from Bosnia and Herzegovina to Sweden during the war situation in the 1990s. The other track, (Studies IV–V) focused on ethical aspects when treating traumatized refugee children and families, as well as other aspects to consider when using interpreters.

A common thread throughout the thesis is the importance of ethical considerations when handling refugee children and their families.

The main aim of Study I was to find out degree of parent-child agreement on the psychological symptoms of the refugee children. The parental interview using the Symptom and Behaviour Interview indicated a low level of psychological symptoms in all but one child in this study. This child also built non-normal sandboxes and had a high anxiety level. In contrast with results from the parental interviews, results from the children's play in the Erica setting indicated to a great extent that the children had psychological problems.

The main finding in this study was that there are differences between the results from parental interviews and from child assessments. Almqvist and Brandell-Forsberg (1997) reported a similar finding in a study of refugee children coming to Sweden from another country and culture. In another study by Rousseau and Drapeau (1998b) there was a considerable difference between evaluation from parental interviews and information from the child. Montgomery (2008) has found that self- and parental assessments of mental health problems yield a limited degree of cross-informant agreement in adolescent populations. Comer and Kendall (2004) examined parent–child agreement at the symptom level in the assessment of anxiety in youths. Parent–child agreement at the symptom level was stronger than agreement at the diagnostic level. Parent–child agreement was stronger for observable symptoms than for unobservable symptoms and weaker for school-based symptoms than for non-school-based symptoms. In another study investigating Bosnian refugee children (Goldin, Hägglöf, Levin, & Persson, 2008), parent, child, and clinician appraisals of primary-school children showed broad similarities. However, the evaluation of teenage youths showed greater disparity; teenagers labelled their own symptoms more often as posttraumatic stress reactions than the clinician did, whereas teachers identified few youths in need of attention.

The present study showed that information from the children themselves gave different information about their inner feelings and thoughts than interviews with parents evaluating their children with a symptom scale. In only one case was the assessment of symptoms based on the parents' interviews supported by the assessment that was made from not-normal sandbox observations of a child. That boy acted differently from the others during assessment with Erica Method. He did not play with toys in the sandboxes but played outside the sandbox. According to Erica Method, this could be interpreted as a sign of psychological distress, which he acted out in that situation.

Five children (38%) created worlds in all three observations that were developmentally adequate according to standardization (Danielsson, 1986). The compositions were structured and well organized. There were 62% who built at least one sandbox which was not normal. These children described different traumatic experiences through building in the sandboxes. Garbarino and Todd (1996) have described how traumatic experiences often obstruct the child's ability to free play. The findings in the Erica Method were supplemented by two other tests: the Machover test and CAT. The findings in these tests supported the results from the Erica Method.

Preschool children often have difficulties in verbalizing a traumatic experience. Researchers claim that the parents underestimate or deny post-traumatic reactions in their children (Almqvist, 1997; Applebaum & Burns, 1991; Burke, Borus, Burns, Millstein, & Beasley, 1982; Earls, Smith, Reich, & Jung, 1988). There were both preschool and school-age children in the present study, but the findings could support the view that parents underestimate reactions in their children and are thus consistent with findings of the researchers cited.

A difficulty in working with refugee children who have been traumatized through war and political persecution is the family's silence and denial. The husband tries to protect his wife, the wife her husband, the parents their children, and the children their parents. Reluctance to talk openly about the traumatic event can be seen as a family survival strategy (Almquist & Broberg, 1997). Children appear to protect their parents from knowing how much the trauma has affected them (Yule, 1991; Yule & Williams, 1990). One interpretation of the results in this study could be that the children tried to protect their parents by not showing symptoms openly in the presence of their parents. Traumatized children are known to not tell what has happened until they are asked the right question, and they usually do not tell what had happened in the presence of parents (Pynoos & Eth, 1991). Research has shown that even very young children are able to talk about traumatic experiences under the right conditions, such as in play therapy, and they are able to re-create the traumatic event in play and enactment as reported in the literature (Pynoos & Eth, 1991; Schaefer, 1994; Terr, 1988) and as we have found in this study. One interpretation of the finding that most parents did not report symptoms in their children could be that the parents employ a strategy of normalizing the situation or that they employ this as a specific strategy for coping with family problems (see, e.g., Comer & Kendall, 2004; Frye & D'Avanzo, 1994; Goldin, Hägglöf, Levin, & Persson, 2008). As long as the parents manage to maintain their child's inner sense of security and their own sense of providing protection, psychic trauma may be avoided (Grubrich-Semitis, 1981). The finding that the children in this study built with fewer toys in the first two observations could also be compared with findings in another study by Helgeson (1995). In that study of 40 non-clinical children, researchers observed one sandbox at the age of 5 years and one at 9 years, showing that the average number of toys was 66 in comparison with 34 in this study. Building time was shorter in our study than in the standardized study (Olsson, 2006). To build in a shorter time could be interpreted as wanting to keep control of impulses aroused by the material. Another interpretation is that the child had a wish to adapt to the situation because the child thought that the adults expected rapid responses (Danielsson, 1986). Most of the children in this study built in the sandbox in a restrained way. One interpretation was that they were trying to keep their impulses under control. The results above, which differ from results in the standardized study, support this interpretation. Although there could be cultural differences in how they use the toys, these children acted as if they were quite familiar with the toys in the same way Swedish children did. However, one must be careful when comparing groups of children from different countries with different cultures.

The background to the children's building during the psychological assessments could be experiences from the war situation, experiences during the escape, and/or other events in their country of origin or in the new country. The children in this study had been in Sweden for several years before the assessments, which mean that experiences during the asylum period, in addition to events during wartime and the escape, could have influenced the results.

The refugee children are a risk group who need special support that is adapted to each individual and is independent of the cause of traumatic experiences. The finding that symptom rates according to the parents do not correlate with findings in the psychological assessment of the child emphasizes the importance of focusing on the child. This view is in accordance with the Convention on the Rights of the Child (United Nations General Assembly, 1989). Although the number of children in this study is small, our results indicate that additional information about the psychological health of the children could be retrieved from the children themselves. Information from the parents is also important to get a holistic view of the situation.

In Study II the main findings were that significantly more normal sandboxes, more conflicts, and fewer positive relations were shaped in the sandboxes after an intervention with short family therapy than before. There were no significant changes before and after the intervention concerning symptoms evaluated by parents. To some extent this was probably due to the few symptoms of the children the parents had listed before the intervention. Three sessions of family therapy were offered, none of which lasted longer than one hour, which means that the intervention was not especially time consuming. It might be valuable to offer all refugee families a few family therapy sessions and to focus in these sessions on common themes such as the family's present situation, their life situation before the war, their escape from the home country, role changes, and network and coping strategies in the family—all with the aim of supporting them in the new country to which they came in their escape from a war situation. Meetings with the families are an occasion to find out if someone has deeper psychological or psychiatric symptoms, which would give the possibility for individual treatment in addition to brief family therapy.

An interesting result was that more children shaped a conflict during the sandbox diagnostic sessions after the intervention than before, which was interpreted as a sign of improvement of their psychological health. One might infer from this that the children were no longer as reserved after the intervention as they had been before, so they could allow themselves to act out conflicts more easily than had been possible before. The family therapy sessions together with diagnostic sessions in the sandboxes may have challenged the use of denial as a family strategy and may have helped the children to become more open about their thoughts and feelings. There were fewer children who shaped a positive relation after the intervention than before. The percentage that could create a positive relation was about the same as in the Swedish reference group (Olsson, 2006). One possible explanation for the children showing more positive relations before the intervention and in comparison to the Swedish reference group could be that by trying to keep together and not letting emotions take over, the children found it easier to create positive relations than to create conflicts.

Working with immigrant and refugee families challenges us to move beyond the cultural norms and imperatives that we take for granted, so that we can learn about the strength, resilience, and richness of families from other cultures (Mirkin, Kamya, McGoldrick, & Hardy, 2008). Carr (2009) has presented evidence from meta-analyses, systemic literature reviews, and controlled trials indicating the effectiveness of systemic interventions for families of children and adolescents with various difficulties. Systemic interventions include both family therapy and other family-based approaches.

One may question whether it is ethical to offer families treatment with an intervention with family therapy sessions when the family members themselves have not asked for it, or whether, on the contrary, it is unethical not to offer some help or treatment when one knows that they have gone through traumatic experiences. In the research leading to this thesis, brief family intervention sessions were given to create a narrative together in the family, not with the intention that the fathers would talk in detail about their war experiences, but to tie together different experiences in the families. The complexity of family perspectives and family systems must be considered when handling psycho-social support for refugees. In family therapy, it is known that if one individual does not feel happy, this will influence the whole family. There is a risk that this phenomenon will be magnified in refugee situations, because the families' normal social networks usually have deteriorated. If everyone is heard, knowledge of different thoughts and feelings will be acknowledged; with support, it is possible to help the family on the whole to feel better. But this has to be done in an ethical way by taking into consideration basic ethical principles with assessments made from different actors involved.

In Study III, using a qualitative method, it was found that the parents had lived normal lives in their country of origin, similar to those of others around them. They described their lives as normal and good most of the time. They had a sense of coherence (Antonovsky, 1987). Life changed because of the war situation, and they were forced to start all over again. One conclusion in the study was that it is important to get an all-embracing and comprehensive picture of a family and listen to each person's point of view to understand the complexity of the family system and tie together the family narrative. The family members in this study had no pronounced psychiatric problems. The parents' thoughts about the years ahead showed that they had a limited scope of the future. When questioned about how they perceived life within five years, they had problems thinking that far ahead. They focused their efforts on more immediate and practical problems such as getting jobs and taking care of themselves economically. This finding of a limited view of the future is in accordance with other studies with adult refugees (Hermansson, 1996). The children did not worry or have problems when they talked about jobs. They seemed more certain that they would get jobs in the future.

Salutogenesis is important theoretically when meeting these families. Antonovsky (1987) developed the term 'salutogenesis'. The main concept in his theories is comprehended in the concept 'sense of coherence'. The need for coherence gives an explanation for the role of stress in human functioning. The importance of refugees and immigrants feeling secure was explored by Sundquist (1995). Not feeling secure in daily life was a strong risk indicator in that study for long-term illness and ill health. Another study with traumatized men coming from Bosnia and Herzegovina to Sweden showed that the more they had a feeling of coherence, the less pain they presented (Kock, 2006). Earlier research has shown the importance of the Antonovsky coherence concept in clinical settings when considering restructuring the meaning of illness; constructing coherence between experience, expression, and past and new illness meanings may be significant for patients' recovery (Bäärnhielm, 2003). The sense of coherence has three components: comprehensibility, manageability, and meaningfulness. These components seemed valuable in the present study when interpreting what the family members were talking about in the sessions about life before the war, during the war, the escape, and life in Sweden. Their statements, for example, about having close relations to family and relatives and their job situations in their home country showed the importance of coherence. The war interrupted their sense of coherence in all three respects of the concept. It seemed important for the families who had experienced a good sense of coherence in their home country also to achieve a sense of coherence in the new country. Several of the members stressed the importance of making friends and getting jobs in the new country and bringing comprehensibility, manageability, and meaningfulness into their lives again.

Nordenfelt's ideas of the concept of health and of using a holistic approach (Nordenfelt, 1995) are useful to consider in this context. He suggests that a person's health is "tantamount to a person's ability to reach vital goals given standard or accepted circumstances" (Nordenfelt, 2001). Most refugees have the ability to reach vital goals but there are obstacles in the opportunity to use this ability. They might be hindered by different rules or, for example, difficulties in getting jobs.

The war was mentioned in passing. In comparison to other themes, less time was spent talking about the war. There was an intention on the part of the therapists not to focus on traumatic experiences, but to keep the family story on track. This intention probably influenced the time used to talk about traumatic experiences. Another explanation could be that the family members did not want to be reminded of the war and handled the situation by neglecting that issue. Bronfenbrenner's ecological theory of human development (1979) is another theory that is worth considering when trying understanding refugee families who are considering their background and earlier experiences in their new life. He analysed different types of systems that aid in human development. Later Bronfenbrenner and Evans (2000) stated about the future of developmental psychology in general and social development in particular of being in a phase of growing chaos, in the lives not only of families but in all the day-to-day environments of people of all ages, and that re-creating social development is the principal challenge confronting contemporary societies. To understand a child's development and situation, it is important to look not only at the child, his or her family, and his or her immediate environment, but also at the interaction with the wider environment. When the families in this study talked about their new life not only the immediate environment influenced them but also the interaction with the wider environment, such as how society is constructed and what kind of culture, rules, and regulations there are in the new country. For the refugee children, the support of not only their families, but also of schoolteachers and their new friends was important. Their contacts with their extended family, perhaps living in another part of the world, also were described as significant.

In the attempt to generalize the findings from qualitative studies, it is necessary, as in all research, to consider whether the findings, based on the data presented, are transferable to other similar groups (Morse, 1991). The main categories found in this study seem reliable, but possibly could be different in other refugee groups. The subcategories would probably differ more, particularly if the families came from another cultural background. The investigated families had a good life, with no psychiatric problems, before the war and before the flight to Sweden. Because of the traumatic events they went through, they are vulnerable. Even if the children do not have psychiatric problems, information directly from the child is valuable in understanding the child's psychological condition (Study I). The UN Convention on the Rights of the Child (United Nations General Assembly, 1989) is important, among other things, for impacts on the interplay between government policy and practice and refugee children's welfare (Eastmond & Ascher, 2011). Refugee children constitute a vulnerable group in need of special care and attention (Almqvist, 1997); few studies to date, however, have focused on the children's assimilation in the new country viewed from a longer time perspective (The National Board of Health and Welfare, 2012).

The intention of this study was to focus on and listen to all members of the family, but the analysis of the transcripts detected that less space was allocated to the children's statements. One explanation could be that it was easier for the grown-ups to remember things about their home country than it was for the children, and the therapist continued to ask more questions about their memories. One of the children was less than one year old when arriving in Sweden and therefore could not express memories from the home country. Another explanation could be that this situation was due to the tradition that grown-ups talk more with each other than with children. Cortical and sub cortical components of the brain develop continuously during childhood and adolescence and could influence developmental changes in cognition and behaviour (Lenroot & Giedd, 2006) which could constitute a non-psychological explanation.

In Paper IV an ethical analysis of the decision to admit a traumatized teenage refugee to an in-patient psychiatric ward was discussed with respect for the ethical principles of autonomy, non-maleficence, beneficence, and justice, based on a model from Beauchamp and Childress (2009). Assessments were made from the perspective of different participants in the treatment. There were both gains and losses to admitting the refugee teenager to a child psychiatric ward. In this emergency situation, no better solutions were found. Different issues were pointed out where potential ethical conflicts might arise when treating refugee children and their families from a different cultural background: traumatic life events, hierarchy, and repatriation. There are other areas of potential conflict, but the intention was to focus on a few issues. The value of ethical discussions and reflections in the clinical practice were pointed out. Repeated structured analyses of a clinician's decisions will increase his or her ability to make relevant decisions for the good of the patient and his or her family members. Refugee children from many regions might not have the same experiences as children in the host country in meeting the health-care system from an early age. Non-refugee children are more used to the environment in health-care units. Having their own experiences from a young age probably facilitates the establishment of basic trust in situations in familiar health-care systems. Refugee children and families from countries with strong oral traditions experience problems when they encounter a health-care system with ingrained notions of giving messages in a written language. Normal situations in health-care might be extremely frightening and cause inexplicable reactions, creating flashbacks or involuntary remembrance of abuse and atrocities—for example, needle injections, gynaecology examinations, or magnetic resonance imaging (MRI) investigations. Health-care professionals must maintain an awareness of such reactions caused by earlier traumatic experiences. One must also balance potential differences in ways behaviour is defined by the culture. What is considered proper ethical behaviour in one culture could be defined as being unethical in another culture (Birman, 2005).

A professional relationship is traditionally supposed to be value-free. Doctors, psychotherapists, and other health-care professionals are used to not expressing personal responses or moral positions about such concerns as severe injury, severe disease, mental illness, or psychological reactions to severe trauma and social events. In situations beyond the range of usual human experiences, such as torture and other manmade traumas, it might be counterproductive in the treatment process not to take a moral position. At the same time, too much of a moral response may hinder the patient's communication. There is sometimes a delicate balance between the clinical and ethical issues a health-care professional has to consider when treating victims of torture and organized violence.

In Paper V there was an analysis with respect to the same ethical principles of autonomy, non-maleficence, beneficence, and justice in the case with an interpreter who had gone through a migration crisis several years before and who had a daughter of about the same age as the patient. There was some cost in autonomy for the teenager and a small gain concerning non-maleficence. For beneficence, there was a known gain. In other words, there were more gains than losses for the patient. The conclusion was that it was better to use that interpreter than not to use an interpreter at all. The focus in the paper was also on the role of the interpreter and on different aspects to be considered by the therapist when working with interpreters in psychotherapeutic treatment of refugee children and families.

Earlier studies have shown that patient-centred consultations influence patient satisfaction (Ruusuvuori, 2001; Steward, Brown, Donner, McWhinney, Oates, Weston et al., 2000). It is important that the interpreter and the therapist know each other's role, learn how to work together, and feel comfortable in what they do. It takes time to do this work in a professional, ethical way. If an interpreter is not professional and comfortable in his/her role, problems may arise.

In many refugee families, like the case in Study V, one or more of the children have a better grasp of the new language than does either parent. As a consequence, families frequently think it might be acceptable for a child to serve as interpreter. However, children should never be used as interpreters. Placing a child in this position poses a severe risk of destroying the normal hierarchy of the family. The child is put in a leading position and the parents in subordinate position in a situation exposing the parents' difficulties. No child should ever be exposed to a situation where they need to be responsible for explaining the parents' weaknesses and health problems or to explain a health professional's analysis and recommendations concerning the parents' health problems. Furthermore, the child ordinarily does not have deep knowledge of the language, and this will lead to misunderstandings, which may be blamed on the child. Studies have shown that the quality of communication outcome may be reduced when children translate because of a lack of language knowledge and impartiality (Fatahi, 2010; Gerrish, 2001; Jacobs, Kroll, Green, & David, 1995; Rosenberg, Seller, & Leanza, 2008).

In regard to psychiatric symptoms, the therapist and the patient may have disparate ideas about health and illness. The ideas held by each about why symptoms occur and about aspects of treatment may differ, and this may affect the meeting between an interpreter, a therapist and a patient. The interpreter knows both the cultures of the patient and of the therapist, which will be important and worthwhile when interpreting concepts. This will influence the therapeutic contact. The interpreter needs to balance between closeness and distance in relation to the patient and the health-care personnel, both emotionally and technically (Fatahi, Mattsson, & Hellström, 2012). Drennan (1999) highlighted the importance of equal communication and access in a study using interpreters.

Lidberg (2001) has called attention to the debate concerning the need for therapists' cultural competence. Empathic understanding is as important as cultural competence (Ticho, 1971). Language plays a major role in influencing expression and personal perception of psychopathological conditions (Kinzie et al., 1982). Medical and psychiatric terms can be difficult to translate into lay language (Berkanovic, 1980), especially if the patients do not understand psychological terms. Rates of misdiagnosis can be high without cross-cultural diagnostic methods (Boxer & Garvey, 1985). There are several psycholinguistic studies discussing the complexity of the task faced by the interpreter (Roe & Roe, 1991; Roy, 1992). Interviewing young traumatized children is difficult, not only because of children's recall deficiencies but more often because standard interviewing formats can be ineffective with children with a cultural background that is different from that of the therapist (Mordock, 2001). Problems arise if interpreters work with patients they know privately. It is an enormous challenge to maintain professionalism if there is an emotional dependence between patient and interpreter. In some languages there are few authorized interpreters available, and it therefore happens that the only interpreter available knows the patient.

Awareness of the concept of psychiatric and medical practice as a value-laden procedure as discussed by Fulford (1989) is important when treating refugees. Work with patients who do not speak the same language as the health professional and the presence of an interpreter as well influence three core tasks of a healing process: establishing a basic trust, understanding the patient's problems, and trying to make a difference (Bolton, 2002). If the interpreters have not worked through their own migration crisis, they may all too easily take over the grief of the patient.

Psychotherapy performed at multidisciplinary institutions will be influenced by the ongoing dynamics and inevitable group processes of the institution (Lindbom-Jakobson & Lindgren, 1997). To promote health is to perform a variety of actions, and most of these actions are of an interactive kind like those discussed by Nordenfelt (2000). Interpreters' competence and the confidence the patients have in the interpreters are essential for an adequate cross-cultural health communication. Knowledge of the patient's/client's mother tongue, rather than citizenship, should determine the interpreter assigned (Fatahi, 2010). The value of having a professional interpreter, as in this study, is in accordance with findings that it is hard to get valid and reliable communication without competent interpreters (Hunt & de Voogd, 2007; Karliner, Jacobs, Chen, & Mutha, 2007; Wadensjö, 1992). One study with pregnant women from Africa's Horn coming to Sweden showed that using interpreters was a prerequisite for optimal care and surveillance (Essén, 2001). Studies have shown that health outcome has been improved by using professional interpreters as compared to non-professional interpreters (Brach, Fraser, & Paez, 2005; Stolk, Ziguras, Saunders, Garlick, Stuart, & Coffey, 1998). There is a need to develop and evaluate appropriate training programs for interpreters and clinicians working with child mental health (Rousseau, Measham, & Moro, 2011).

Cost-effectiveness has become increasingly important in health organisations. In one study (Fatahi, 2010), interpreters experienced their work as an economic burden on the health-care system. However, studies have shown that in the long run, the use of professional interpreters is more economical than not using interpreters or having relatives translate communications (Jacobs, Sadowski, & Rathouz, 2007).

The findings from the studies in this thesis show the importance of having knowledge of individual perspectives from the view of children, parents and other adults involved. Knowledge of these individual perspectives independent of age and language skills is significant. A relationship that shares mutual information is important for health care professionals; the information must be suitable and understandable to both the minor(s) and the parent/guardian and should be provided in their first language (Mårtensson, 2009). Primary care institutions, including clinics, schools, and community organizations, are appropriate to help refugee children and families to establish a support network and with help from specialised child psychiatric consultants support the families to maintain the trauma narrative (Rousseau, Measham, & Nadeau, 2013).

To conclude, there were two tracks in this thesis: (1) the psychological health of refugee children before and after an intervention with family therapy sessions and experiences and perceptions of refugee families coming to Sweden from the war in Bosnia and Herzegovina and (2) ethical aspects when working with refugee children and families.

The ethical principles of autonomy, beneficence, non-maleficence, and justice were included as a raster in the whole research process with the refugee families in Studies I–III, which focused on all the different actors in the family: the index child, the parents, and the siblings. The same principles have been analysed in Studies IV–V with cases concerning refugee children and treatment from different actors involved.

Methodological considerations

Psychological projective methods are valuable in getting information about thoughts and feelings, especially from younger children, who are more difficult to interview than older children. Several investigations of refugee children have been limited to older children, who are easier to interview (Mollica, Poole, Son, Murray, & Tor, 1997; Kia-Keating & Ellis, 2007). One reason for using a projective method was to get more information from children who might not provide this in an interview. Projective methods can give information about unconscious thinking and emotional responses, information that cannot be subject to conscious biasing by controlling or filtering (Ganellen, 2007). There is a debate about the validity and reliability of projective tests. Negative critiques of projective tests have been published (e.g., Lilienfeld, Wood, & Garb, 2000) but validating these measures is ongoing (e.g., Hibbard, 2003).

In clinical work it can be valuable to get deeper psychological information from a child. The Erica play-diagnostic method was chosen as one technique that gives the children a better opportunity to express their feelings and experiences independent of language and skills.

Papers I–III focused on the psychological health of refugee children with a raster considering the ethical principles of autonomy, non-maleficence, beneficence, and justice. As for autonomy, the families had agreed to participate in the study, and they knew they could end their involvement at any time. The children were twelve years old or younger, which meant that their parents were asked about participation in the study. Nobody wanted to discontinue the study because the children did not want to participate. Non-maleficence was a dilemma considered regarding families and individuals talking about traumatic experiences and hard times; there was possibility of worsening their current mental condition. This same consideration was also a possible gain represented by the principle of beneficence. One purpose was to help the family members to leave traumatic experiences behind and continue their new life. The work with the family therapy sessions was done without taking into account gender, social or economic status, ethnicity, or any other factor.

The limitations in Studies I–II were the small sample size and the interviews with only the parents, and not the children themselves, about the children's symptoms. The representativeness of the sample might be influenced by the recruitment procedure. Nothing was known about the study group compared to the families who did not participate in this project. It could be possible that the families in this study functioned better and managed to allocate time and involvement in spite of all the other activities they had. Another possibility was that families who experienced their children's psychological problems wished to participate in this study. However, the children's low symptom scores in the parent ratings did not support this. Also, the psychological health of the parents was unknown. Ajdukovic and Ajdukovic (1993) found that mothers' emotional well-being best predicted emotional well-being and adaptation in children. Other studies have come to the same conclusion (Ekblad, 1993; Almqvist & Broberg, 1999). Furthermore, the children and their families had been in Sweden for a rather long time. Experiences after their migration to Sweden could have influenced their psychological well-being in both directions, depending on what kind of experiences they had gone through. The gender of the interviewed parent might have had a mediating effect on the amount or level of detail of the revealed information. Memories of life events differ between men and women in the inclusion of emotional and interpersonal information (Bloise & Johnson, 2007).

One objection to the results could be that Psychologist A made observations that were biased in some way. She did not have any information about the backgrounds or the symptom evaluations of the children from the parents' ratings. Still, she knew that they had escaped from a war and might have had thoughts that the children were traumatized and could have psychological problems. However, the results from the independent Psychologist B supported the finding that a greater percentage of the refugees created not-normal sandboxes than the reference group (Olsson, 2006). Psychologist B had an even higher percentage of assessments of not-normal sandboxes than the observations of Psychologist A.

The lack of a comparison group was a limitation in Study II. The study was designed initially to have a randomized comparison group with refugee children coming from Bosnia and Herzegovina with no intervention of family therapy sessions, but because of too many drop-outs in the control group, it was not possible to do a between-group comparison. On the other hand, it was difficult to find a comparison group because of too many uncertain parameters. Another possible limitation is that the length of time between the family intervention and the follow-up sessions varied from family to family, which could mean, for example, that experiences other than the short family therapy sessions could have influenced the outcome, especially for those with a longer time interval until follow-up. Another possible limitation was that only one evaluation of sandboxes using the Erica Method after the intervention with family therapy sessions was compared with three evaluations before the intervention.

The use of an interpreter potentially threatens validity at various points (Kapborg & Berterö, 2002). Methodological issues with respect to interpreters have received only limited attention in cross-cultural interview studies (Wallin & Ahlström, 2006). One study showed that only 6 out of 40 selected cross-language qualitative studies published in nursing and health science journals met all the criteria recommended by the literature on cross-language methods for the production of trustworthy results in cross-language qualitative studies (Squires, 2009).

In study III, a qualitative method was chosen to get a deeper knowledge of the lives and experiences of three families from Bosnia and Herzegovina. Several limitations of this study have to be considered. One is that only three cases were examined. But with the qualitative method used in the study, it is possible to get reliable information in spite of the condition that only a few cases were analysed. The families came from one part of Europe; the adults were well educated and had lived a life quite similar to other European people and might not be comparable to other refugee groups from other cultures. There were also some technical problems in the video-recording. Other limitations are the therapists' lack of linguistic skills and how interviews might be affected by an interpreter (Kapborg & Berterö, 2002). In all the sessions except one, there was an interpreter. All families had members who knew Swedish fairly well, and these members were able to evaluate the interpreter's translation as accurate. In some sessions, the interpreter attended but was silent throughout the session. One has to consider whether the interpreter had an effect on the communication, for example, whether interviewees would have said other things if an interpreter had not been involved. In order to limit the risks identified and reduce misunderstandings, the intention was to use the same interpreter in each family for all three sessions. The same interpreter was involved in all three sessions for two out of three families. The same structure and approach was kept in all family sessions.

Concerning Studies IV–V, having a structure is most important when analysing basic ethical principles with assessments made from different actors involved. The model with the principles autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 2009) was chosen because it is well known and used in the biomedical ethics field. However, evaluating known facts and different ethical principles in discussions with other professionals before a decision is made is of greater importance than the model itself in clinical practice.

Practical clinical implications

- It is an issue for all professionals coming in contact with refugee children to deepen their understanding and knowledge of background and psychological health of children, which is in accordance with the Convention on the Rights of the Child.

- It is of great importance to listen to and focus on the children themselves and also take into account the experiences of the parents.

- A family intervention in which the whole family assists in creating a shared family narrative can be helpful for all.

- To explore the background of the refugee family members could help them in a salutogenic way to adapt to a new system of society and recapture a sense of coherence.

- Basic ethical principles should be taken into consideration. These principles could be considered from the point of view of each of the actors involved. Time for reflection should be provided, and professionals must, as a matter of routine, take ethical aspects into consideration.

- It is important to develop appropriate training programs for health-care professionals involved in child mental health care for refugee children and families, to highlight the importance of using interpreters, and to implement continuous education on how to use interpreters, as well as support appropriate training programs for interpreters.

Future research

- The few studies on younger children previously carried out in this field indicate a need for more research work to be done in this area, especially research in handling and treating refugee families and refugee children.

- Intervention studies with a control group are to be encouraged considering the complexity from a scientific point of view. Such an approach could be a complement to existing studies.

- Attention should be given to relevant symptom measures suitable for refugee children, instruments constructed to be used by children as well as by parents.

- Follow-up studies after intervention of treatment methods for refugee children and families are needed.

- More ethical analyses in clinical cases are desirable, as are studies in how ethical principles are applied in different health-care organizations.

MAIN CONCLUSIONS

- Parents' assessments of their children's psychological health according to the Symptom and Behaviour Interview did not correlate with the findings from psychological assessments of children using the Erica Method. This finding emphasizes the importance of focusing on both measures from children and parents in evaluating the psychological health of younger children.

- There were higher frequencies of not-normal sandboxes (Erica Method) in this group of refugee children indicating non-optimal psychological health compared to those in a Swedish reference group.

- A statistically significant number of cases had improved after a brief family therapy intervention when evaluated with the Erica Method.

- Family interventions can benefit children and families and could be used more frequently even if the children and their parents do not present overt psychological problems.

- The findings from these studies show the importance of highlighting individual perspectives from the point of view of children, parents, and siblings in order to better understand the complexity of family systems.

- The salutogenic perspectives facilitate the provision of support to refugee families. This support helps refugee families to adapt to a new system of society and recapture a sense of coherence.

- In research as well as in therapy sessions, basic ethical principles such as autonomy, non-maleficence, beneficence, and justice is feasible and valuable when dealing with refugee children and families in clinical practice as well as in research. These principles are recommended to be considered from the point of view of each of the actors involved.

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