Refugee children and resilience;

Empowerment, participation and subjective wellbeing

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Abstract

The intentions of this study was to learn what is promoting subjective wellbeing, resilience and mental health in refugee children, and how important participation and empowerment is in this process. There is a need to localize the power in children to find how to use it for navigating towards resilience which is valued by the children as well as the community.

This paper is presenting theory and literature which enhance the importance of participation and empowerment for the feeling of subjective wellbeing, mental health and resilience. Traditional resilience research is based upon multisystems theoretical approach, and is focusing on outcome based behaviour and interviews. However it is considered important to understand how children themselves describe their experience of wellbeing and resilience, to intervene and support them in their negotiation and navigation towards resilience. Thus the point of departure for this phenomenological study is a constructionist approach and in-depth interviews with five refugee children, three boys and two girls, in Norway.

All the children had different backgrounds; they came from different countries, were between 16 and 18 years old, and three of them were unaccompanied refugee minors. Four of the children had participated in changing their situation by organizing an action group, and had succeeded, and one had participated in trying to take a grasp of her life outside this group.

Their stories from Norway describe lives in a difficult and stressing environment.. The children explain how they negotiate and navigate in this environment to promote mental health, subjective wellbeing and resilience. They emphasize what have helped them in this process, and a crucial feature has been the genuine concern from one or two important adults. They also emphasize the importance of being spoken to and about in friendly terms and being met with a friendly attitude.

According to the children's explanations one of the most important needs to feel well seemed to be wedded to health promotion ideas and the Ottawa Charter; to achieve peace and security to be able to flourish and to be what Maslow called "all you can be".

The children's descriptions in this study was compared to theory and related studies, and there were not fond clear contradictions between this study and others mentioned in this paper. Rather on the contrary; the related studies confirmed the present findings, concluding that empowerment and participation is important for the development of subjective wellbeing. However this study highlighted that the need to be cared for and appreciated seemed to be more important than the participation. When the sense of coherence and the perceived locus of control were low, the children got psychosocial problems which for some time also were quite serious concerning their mental health, and they were not able to participate. When finding a few important adults who they trusted and they felt were supporting them and cared for them, they managed to reduce entropy and change their perceptions about a situation where it was futile to act, to a situation which became less chaotic and more meaningful.

Tones and Green claim that

> *empowerment does not just happen; there is a reciprocal relationship between individuals and their environment. Not only must individuals be "strengthened" in some way, but their socio- economic, physical and cultural environments must be conducive to their making empowered choices* (Tones and Green, 2004: 3).

Based on the findings in this study this paper also enhance that there are good reasons to keep the focus on critical health promotion, and call for health professionals to take political action to challenge adverse environmental circumstances (Tones and Green, 2004; Prilleltensky and Prilleltensky, 2005; Freire, 2002).

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PREFACE

The first time I met Abebe was shortly after her arrival to Norway, having crossed several continents all by herself from her home country Ethiopia. She was 16 years old, and was suffering from a serious lung disease. She was fragile and weak, and pregnant after she had been raped on her run for a safe life. Her mother had died when giving birth to her, and she had grown up with her grandmother whom she had nursed for years until she died from tuberculosis when the girl was 12 years old. Abebe had fought poverty and starvation. She was isolated as a consequence of her grandmother's disease, and the skinny girl had to bury her grandmother all by her self as nobody in her community dared to help because of fright for the infection. She fled her village and started her long journey towards what she hoped could bring her happiness.

After coming to Norway it took her and her little son more then three years before they got a permission to stay in the country. Ten years later she was apparently doing very well, and one day she came to my office with her son just to have a chat. When I told her about my admiration for her strength and the way she managed her life so smoothly after all she had been through, she raised her head, fixed her serious brown eyes at me and said quietly,

> *They say I am doing fine, but nobody can see the pain in my heart, my loneliness day after day, my tears, the nightmares and my constant lack of sleep.*

Her words open up for an important question: Who has the right to define whether one is resilient or not and why is there so little research about how children

themselves describe their state of welfare? Health and resilience have traditionally been defined by authorities and is tied to normative judgements related to particular outcomes in western societies.

During many years of work with refugee children and their psychosocial health and with unaccompanied refugee minors in particular, I have never stopped wondering how so many apparently develop well in spite of their adversities. During my search for understanding I was introduced to the concept of resilience. Michael Rutter (2002) defines "resilience" as relative good outcome despite the experience of situations that have been shown to carry a major risk for the development of psychopathology. Though there is much research available describing western identified risk factors and resilience, there is little research done on the actual health situation of refugee children in the western world (Borge, 2003; CMRD , 2003), and studies about how refugee children themselves describe their well-being are absent. This absence along with reflections about unaccompanied refugee children's adversities and risk factors concerning their mental health are the point of departure for this study.

1.0 INTRODUCTION

The number of separated refugee children in Western countries is rising significantly because of war and armed conflicts, and at any time there may be up to 100 000 separated children in West Europe (Fazel and Stein, 2002). According to information provided by United Nations' High Commissioner for Refugees (UNHCR) approximately 16100 unaccompanied minors applied for asylum in 26 countries during the year 2000. 27% of these children were girls. However UNHCR claims that it is difficult to estimate exactly how many separated children are entering European Countries, as they are not being registered in any country, and are very often prevented by the host countries from applying for asylum. This is also stated by Committee on Migration, Refugees and Demography, established by the European Parliament (CMRD, 2003). UNHCR's definition (1994) of unaccompanied minor refugees, are:

> *those who are separated from both parents and are not being cared for by an adult who, by law or custom, is responsible to do so* (Ingebrigtsen et al, 2004).

The events of 11th of September 2001 have increased the pre-existing trend of European governments to focus the migration debate on border security issues, and the living conditions for refugees in western countries have grown more difficult. Much of the information about refugees and migrants reaching the public is about refugees as potential terrorists and criminals, and it is influencing the communities to become more hostile towards refugees. Studies in Europe and USA show that hostile refugee policy is making the mental health situation for refugees in general and refugee children in particular very difficult (Fazel and Stein, 2002; Williams, 1991; Wolff and Fesseha, 1999; Ecker, 1998; Borge, 2003; Tunstrøm et al, 2004;

Ingebrigtsen et al , 2004; CMRD, 2003; ECRE, 2004; Mignard, 2005). A European Commission Report about "The State of Mental Health in the European Union" is concluding that being a refugee is a risk indicator for developing mental illness, and that as much as two thirds of refugees experience anxiety and/ or depression. The report also claims that a long asylum procedure is associated with psychiatric disorders and indicates that both policy makers and mental health workers should take note of this finding (European Communities, 2004).

In April 2005 a Norwegian newspaper presented an article about some refugee children and adolescents who had been living in asylum centres in Norway for more than 4 years. The children had decided to do something about this situation; they organized an action group, and started a campaign to change their conditions through democratic and advocatory processes. They succeeded in their attempt, and were determined to keep on working to try to change even more. The members of the action group lived with at least one family member in an asylum centre, and had opened up for some unaccompanied refugee children who were living in the centre as well. This encouraged the separated children to try to change their situation in the same way as the original group.

This article was the inspiration to study the way refugee children described how participating in their own lives had influenced their feeling of subjective wellbeing and mental health. Another related aspect was to explore how participation might enhance the children's sense of control, a key component of resilience and mental health (Prilleltensky and Prilleltensky, 2005). Four adolescents from the above mentioned group and a girl, who had no connections to theses adolescents except

from being an unaccompanied refugee minor, were interested in participating in such a study.

This following section will present the problem statement and research questions and describe the purpose of this study and definitions of terms used in this paper. After the introduction there will be a presentation of related studies, and relevant theories that are needed as a foundation for the study. Before closing up this section, there will be a presentation of methodology used in the paper, and finally the participants will be introduced before the results are presented.

1.1 Problem statement

Following research *problem* was designed:

> *What is promoting subjective wellbeing, resilience and mental health in refugee children, and how important is participation and empowerment in this process?*

The focus should be on a defined group of five minor refugees and their subjective experiences. Helpers or other persons in the children's lives were not interviewed as it was the children's own voices that should be heard; There are reasons to believe that nobody can describe the children's subjective wellbeing better than the children themselves as this is a matter of individual feelings and experiences. As four of the participants where members of the above mentioned action group, a reasonable question was if this was sufficient to give valid, reliable and generalizable results. However the decision to keep in mind the effect of group processes in the analysis was made and this could also be an interesting perspective of the study. Another aspect was how the low number of participants might affect the study; however Silverman

(2000) states that if a study is wedded to other studies which share the theoretical orientation, it may be generalizable. In addition according to Silverman

> *one single police station may provide enough data to develop all generalizations you want about police stations"* (Silverman, 2000:107).

Based on these reflections following research questions were designed to get closer to the problem.

1.2 Research questions

1. How do refugee children describe what is promoting subjective well being and mental health in their lives?

    a. How do they attribute causes for their level of psychological wellbeing

2. What or whom have been important in the children's pathways towards resilience and subjective wellbeing?

3. How do the adolescents articulate the connection of participation and empowerment to subjective wellbeing and resilience related phenomena?

4. In what way may important adults, like health and social welfare personnel, staff in reception centre, politicians and migrant authorities and guardians, support refugee children, and unaccompanied refugee minors in particular, in the process towards resilience?

1.3 The purpose of the study and research approach

It is considered important to find what is promoting resilience; if we know this, it may be possible to use this knowledge to intervene and turn negative development into positive (Ungar, 2005; Rutter , 2000). The purpose of this study was to learn how refugee children perceived their level of health and subjective well being, and how they managed to achieve resilient related phenomena. Michael Ungar is

explaining resilience as an outcome influenced by personal capacities as well as social, cultural and political aspects. He also claims that this outcome is a product of children's negotiations between the environment and themselves, and the way they navigate to achieve subjective wellbeing (Ungar, 2005). To gain more knowledge about this might open up for better ways to support refugee children in their effort to achieve subjective wellbeing and mental health. Therefore a socially constructed knowledge claim was chosen as a fundament for this study; that is how individuals construct meaning and understanding of the world in which they live based on their historical and social perspective (Creswell, 2003). A phenomenological approach was also chosen as it aims to identify the "essence" of the children's experiences of being refugees in Norway, based on their descriptions (Creswell, 2003). Besides, the research was also meant to be a contribution to advocate with refugee children, in particular unaccompanied refugee children, for a more caring and just society for them. According to Prilleltensky and Prilleltensky (2005) the children's own participation, along with community workers in challenging injustice can do much to enhance resilience. Therefore the advocacy / participatory knowledge claim and critical theory (Creswell, 2003) was added to the foundation for this study, hoping to visualize the refugee children's needs in the Norwegian society.

Sourander (1998) found in his study about refugee children that younger children seemed to be particularly vulnerable to emotionally distress; the interview situation might be experienced as emotionally stressing for smaller refugee children, and it was quite uncertain if there would be anyone available to follow them up if they got emotional problems after the interviews. A special permission from the Regional Committee for Medical Research Ethics would also be needed if the children were

below 16 years of age, and as the reception centre was about to close within a few days, there was no time to get that permission. Therefore the study was based on in depth interviews with 5 refugee adolescents between 16 and 18 years of age.

1.4 Definitions of terms

a) Because this study focus on the participants' experiences from the time when they were younger and up till the time of the interview, they are in the further descriptions referred to as "children" even though they were adolescents when the interviews took place.

b) Some people are expected to support children, like guardians, health and social personnel, teachers, staff at refugee centres, coaches etc. In this paper the term "helper" is used when referring to such people

c) UDI: The Norwegian Directorate of Immigration (Utlendingsdirektoratet)

d) UNHCR :   United Nations High Commissioner for Refugees

e) ECRE: The European Council on Refugees and Exiles

f) CMRD: The Committee on Migration, Refugees and Demography

g) WHO: The World Health Organisation

2.0 REVIEW OF RELATED STUDIES

Traditionally we are used to look through a pathogenic lens, at risk factors and circumstances that make people sick. Considering the difficulties refugee children have, they are all in a risk zone for developing psychosocial problems (Fazel and Stein, 2002; Williams, 1991; Wolff and Fesseha, 1999; Ecker, 1998). However, several studies establish the fact that some children develop well in spite of their extreme situation, and a few even seem to be strengthened by their adverse experiences (Rutter, 2000; Masten, 2001; Borge, 2003; Ungar, 2005). It might be

interesting to find why, for the purpose of mental health promotion. Ann Masten is defining resilience as:

> *.. a class of phenomena characterized by good outcomes in spite of serious threats to adaptation or development* (Masten, 2001).

Michael Rutter also emphasize that there are individual differences and that "*it is almost certainly misleading to seek a general answer on resilience*" (Rutter, 2000: 655). He is pointing to evidence that disturbed parent-child relationship do constitute an important risk factor for psychopathology. He also refers to important well known factors for health promotion, like locus of control, sense of coherence, close relations to others, attachment and self efficacy (Rutter, 2000). Werner and Smith's classic, longitudinal study of children in Kauai, Hawaii also concludes that it is of great importance for the development of resilience to have good social relations (Rutter, 2000; Borge, 2003).

Though there are not many studies about separated refugee children available, there are more showing that refugee children in general are at risk for developing mental health problems. How severe the problems can become, is illustrated in a Swedish study by Tunström et al (2004); After a national mental conference in Sweden where several professionals drew attention to their concern for refugee children, it was decided to send questionnaires to all 21 counties in Sweden and their 32 psychiatric policlinics, to find out how extensive the problem was. 28 policlinics responded to the questionnaires, and the result was scaring; 162 children coming from more than 20 different countries had so severe problems that they had to be hospitalized. These children were so depressed that they no longer managed to get out of their beds; they were devitalized, and suffered from a general "giving up" syndrome. There were no physical explanations to their

psychological and somatic problems, and Tunstrøm et al claimed that it seemed as the only treatment was to get permission to stay in Sweden. The report stated that the children's symptoms were accelerated passivity, lack of contact, functions disappearing, and different sorts of avoidance. Many of the children did not eat, and had to be fed through a tube. These children had come with their families to Sweden, and it was discussed whether the caregivers' depressions and lack of hope was transferred to the children. As a result of this study the Swedish Government appointed in 2004 a national coordinator instructed to examine the

> *new and serious problem that has been observed among asylum-seeking*
> *children in Sweden. The problem concerns asylum-seeking children who*
> *develop serious loss of function (*SOU, UD 2004:06).

Based on Tunstrøm's report this new coordinator designed a study in two stages; Stage one was a survey and status report, and stage two was an in-depth study. The results confirmed the problems described by Tunstrøm. In addition it visualized that the condition was not common in other countries, and possible reasons for this were discussed in the report. No general explanations were found offered for the emergence of the phenomenon, but an important factor mentioned was the asylum-seeking process and Sweden's *"ambiguous attitude when processing decisions to reject application in asylum cases"* (SOU, 2006). Other possible causes mentioned was individual cases of children with severe withdrawal behaviour, traumatic or stressful events in the country of origin and in other countries of asylum and in Sweden, the child's previous state of mental health, the parents' capacity to care for the child and cultural patterns of thought and behaviour. The study also described the phenomenon "learned helplessness" and lack of empowerment as an important issue, and that most of the children recovered after residence permit was granted; some directly following the granting of the permit (from one day to a few weeks) and some up to several months after (SOU, 2006).

Tones and Green (2004) describe "learned helplessness" to be a condition where you learn that responding to an uncontrollable event is futile, and by quoting Martin Seligman they claim that it may lead to anxiety and depression (Tones and Green ,2004:92). In May 2006 the Swedish report was followed up by a work shop, which lined up an action plan to handle the problem *(*SOU, UD, 2006).

Another study was carried out by Sourander (1998) who interviewed 46 unaccompanied refugee children at an asylum centre in Pernio in Finland 4-6 months after arrival. 20 minors were between 6-14 years, and 26 between 14-17 years. 80% were from Somalia, and the rest from 9 other countries in Africa and Asia. He used the Child behaviour Checklist (CBCL) in his research. He found that about half of the refugee children had behaviour symptoms in the clinical or borderline range. The most common symptoms were consistent with the Post Traumatic Stress Disorder (PTSD). Most of the children reported somatic complaints, uncertainty about their future, and some expressed suicidal thoughts. He concluded that the study indicates that unaccompanied refugee minors are in a highly vulnerable situation; high levels of emotional and behavioural problems were often present, and post- migratory stress faced by unaccompanied asylum-seekers might interact and exacerbate their emotional symptoms. He connected the problems to the asylum politics in Finland (Sourander, 1998:725). Such connections are also described by researchers in the USA and Great Britain (Williams, 1991; Ben-Porath, 1991; Afro American Newswire, 2004; Fazel and Stein, 2002*)*. In addition severe psycho-social symptoms among refugee children is also reported by Wolff and Fesseha (1999), Netland (1997), Dyregrov (2000) ,Raundalen (2000), Kidane (2001), Ben-Porath (1991), Garcia-Peltoniemi (1991).

Save the Children, Norway (Ingebrigtsen et al, 2004), carried in 2003-2004 out a supervision project on assignment for the Norwegian Directorate of Immigration. The purpose of the project was to develop a methodology for individual supervision of unaccompanied refugee children living in asylum centres in Norway. The project team interviewed 97 unaccompanied, asylum-seeking children between the ages of 5 and 18 years in five different asylum centres. They visited the centres 3 times, and each visit lasted for 5 days. In addition to interviews they were observing the children in their environment. They also interviewed the staff at the centres, teachers, health personal and guardians. Based on their interviews and observations they concluded that the number of staff was irresponsible low, and that the employees had little, if any, competence to give these children the necessary psychological care. The report describes a range of psychosocial problems among the children, and pointed to the need for professional treatment from mental health services as well as to the difficulties of accessing services. It also pointed to the children's low income and problems of poverty. The researchers claimed that although the UN's convention of the human rights of children have stated that they are to have the same rights for health and social care as native children in Norway, this was far from being a reality (Ingebrigtsen et al, 2004:63). They recommended that the responsibility for the care of unaccompanied refugee children must be given a formal foundation, and that this responsibility must rest within the child welfare program in stead of the present organising within the Directorate of Migration (UDI). In the end of 2006 the government decided that from October 2007 the responsibility for separated refugee children less than 15 years of age should be placed under the child care department.

Wolff and Fesseha's five year follow up study of unaccompanied refugee children and orphans in Eritrea shows the importance of safe adults as workers (Wolff and Fesseha, 1999). In the initial assessment 72 children at 4-7 year old, orphaned by the war, were examined while living in an institution during the war between Eritrea and Ethiopia. They were compared to a group of refugee children who lived with one or two parents in a nearby asylum centre, but were exposed to the same physical hardships of bombing and war. The children were examined by a Behavioural Symptom Questionnaire (BSQ), and of culture fair measures of cognitive performance. The orphans exhibited significantly more behavioural symptoms than the refugee children, but performed cognitive tests at a more advanced level. Five years later the children in the comparison group had all returned to their villages, and could not be traced, and the war had ended four years earlier. In the follow up study the orphans were therefore instead re-examined and compared to 9-12 years old children living at settings that differed qualitatively in their social climate, principles of child care and staff- child interactions, but had not experienced the threat of war and bombing. The orphans had still many symptoms of emotional distress, but less severe than before. However, they performed the cognitive tests as well as or even better than the unaccompanied children who had been protected from war and terror. The study indicated that a setting that respects the individuality of children and promotes their close personal ties with at least one staff member can improve many of the more serious psychological sequelae of having lost both parents and being exposed to the physical danger of war. Williams (1991) is supporting the need of safe adults, and claims that the lack of competence

and unpredictability of camp authorities added the youth's mistrust of authority after getting out of the camps.

3.0 THEORETICAL FRAMEWORK AND RELEVANT LITERATURE

Equity concerning all children's rights to achieve a good life should be a matter of course. It is also one of the important features in health promotion, which is aiming to achieve positive health and well-being of individuals, groups and communities (Naidoo and Wills, 2000). Tones and Green (2004) consider empowerment and beliefs about locus of power important to health promotion. Borge (2003) states that there is only limited research about resilience promoting processes and immigrant children in Norway, and the European Council on Refugees and Exiles (ECRE,2004) and the Committee on Migration, Refugees and Demography (CMRD, 2004) claim that there is a great need of research of refugee children's living and health conditions all over Europe.

Traditionally three dimensions are considered important to develop resilience: Individual factors, like experiences and characteristics of the child, relational factors, like qualities in close relationship, interpersonal interactions over time and characteristics in the social environment (Rutter, 2000; Masten, 2001; Fraser, 2004; Borge, 2003; Waaktaar and Christie, 2000; Dyregrov, 2000; Raundalen, 2000; Luthar and Cicchetti, 2000; Ecker, 1998). In addition there is also a growing interest for the idea that biological processes caused by access to love and care are of great importance for the development of health and wellbeing (Cloninger, 2004; Gerhardt 2004; Lewis et al, 2001). The traditional approach to resilience is based on systems theory and is emphasizing predictable relationships between risk and protective

factors, circular causality, and transactional processes. However this approach seems insufficient to account for people's own experiences of resilience.

The discussions about who is to define whether a person is resilient or not is interesting; is it the community, the health service authorities, politicians, or is it the individual itself? Is a child or adolescent considered resilient because of his or her behaviour observed by others, and defined healthy even though he or she is struggling with severe internal psychological pain, like Abebe in the preface of this paper? Ungar is enhancing the importance of listening to the children's voice, and the children's own explanation of how they are feeling and what is helping them to overcome adversities (Ungar, 2005; Ungar, 2004). He is claiming that resilience is more than internal capacities or behaviour (Ungar, 2005). He is also pointing to the growing evidence that resilience is as much depending on the structural conditions, relationships and access to social justice that children experience as it is on any individual capacities. These ideas are also in accordance with the Ottawa charter's description of health:

> *Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members* (OttawaCharter,1986).

3.1. Resilience as a health promotion issue

Boyden and Mann (2005) are drawing a historical sketch on the development of resilience as a term. The term "resilience" has historically entered from applied physics and engineering, where it refers to the ability of materials to "bounce back"

from stress and resume their original shape or condition, like for example a rubber ball. The term developed to medicine, to characterize the recovery of patients from physical traumas such as surgery or accidents. Later it was adapted to psychology through study of children of mentally ill mothers. Resilience is recognized as depending on both individual and group strengths and is highly influenced by supportive elements in the wider environment. Although it is understood that risk and resilience are not constructed the same way in all societies, it is generally accepted that the interaction of risk and protective factors play an important role in the social and psychological development of boys and girls in all contexts. The concepts of risk, resilience, and protective factors have come to form the bedrock of research on children who live with adversity, although the concepts are not without problems and limitations.

An outlook of resilience research is Fraser's "multisystems, transactional perspective of the ecology of childhood" (Fraser, 2004). He claims that services can and must better address the individual, family, neighbourhood, and broader contextual conditions that produce childhood problems. He is highlighting two familiar angles; the ecological and the systems. Ecological theory includes risk and resilience perspectives, and the theory focuses both on the individual and on the context. The ecological theory in a multisystems, transactional perspective posits that

> *children develop and adapt through transactions with parents, siblings, peers, teachers, coaches, religious leaders, and the variety of others, sometimes for better sometimes for worse, people in their lives* (Fraser, 2004:6)

Fraser claims that theory from transaction analysis and the attachment theory are important in this perspective (Fraser, 2004). He also argues together with other authors in his book that the central systems in children's life make up the ecology of childhood. The theory does not fully invoke the typology of general systems theory, but simply identify risk and protective conditions that affect children across the systems-related domains.

Ungar (2005; 2004) is critically reviewing research findings that support an ecological perspective. He claims that a major limitation of the concept of resilience is that it is tied to the normative judgements related to particular outcomes. This means that the child in a way negotiate with itself and the environment to reach the normative definitions of resilience because they consider their lives less problematic if they are accepted by the public. Health authorities have traditionally defined what good health is, and which behaviour is the best to achieve that. The way I understand Ungar is that he claims that traditional resilience researchers have based their conclusions about resilience as an outcome on observations of behaviour and interviews. In this way the behaviour of the children does not necessarily express the resilience in children, but visualize a learnt behaviour used to achieve benefits like acceptation from the environment to feel good.

Ungar is therefore claiming that an ecological approach based on systems theory and the emphasis of predictable relationships between risk and protective factors is inadequate to account for the diversity of people's experiences of resilience. It is only working in connection with people's adaptations to social environment and to describe individuals' personalities and what is characteristic for "resilient people" in

that connection. A constructionist's approach of resilience is focusing on the individuals' own experience and their feeling of subjective wellbeing as this is the only way to measure it. The questions are: Do they *feel* healthy? Happy? Satisfied? Secure? How do they actually describe the reasons for what they feel? What are their experiences of quality of life? Nevertheless when following these discussions systems theory and ecological approach might still be used, when connected to the individual and its context; there is still a chain reaction, but within each person's experiences, their particular community, their relations, cultural contexts; "everything is still connected to everything".

The big challenge for researchers is to determine what is enhancing these subjective feelings as there is emerging evidence that children do not share the same understanding of risk and adversity as adults (Boyden and Mann, 2005). Boyden and Mann (2005) also maintain that for adults to better understand children's perspectives adult expertise must be tempered with some humility and children must be allowed to explain and interpret their childhood. It implies the need for research methods and methodologies that are participatory and child centred and gives proper scope for children's testimony.

Ungar (2005a) discusses resilience in different cultural contexts. He claims that children negotiate between themselves and their environment, and navigate to experience resilience. He makes thus a point that children may not seek to criminal gangs to rob and steal, but rather to get the access to friendship, belonging and respect, that they do not get elsewhere. Although he attacks traditional resilience research to be insufficient as children's interpretations vary, he is also in accordance

with Boyden and Mann (2005) and Lewis et al (2001) who claim that some principles seem to be universal, for instance to be valued and appreciated (Ungar, 2005a). However there may be variations in which pathways children use to reach these standards. The most common one that we as social community define as resilient might not be the one which is seen as positive by the child. There is a need to localize the power in children to find how to use it for navigating towards a resilience which is also valued by the community. The question is not to put one theory above another, but to use the best of them all in order to reach the common aim: To find out how children navigate towards a healthy life for themselves, and to support them to get a better quality of life based on their own perspectives. Of course it is of importance to make people feel that they belong to a supporting community, but how a supporting community is defined may be discussed in different cultural contexts.

James Garbarino finds it important to emphasize that resilience is not unlimited, automatic or universal. He claims that under conditions of numerous serious threats experienced in hostile environments no child may escape unscathed no matter how well equipped the child may be temperamentally (Garbarino, 2005). This statement emphasize the importance of doing the utmost to make the children's surroundings as smooth as possible, and avoid a relaxing attitude trusting that resilience will emerge if the individual child is strong enough, no matter what life conditions the child lives in.

An interesting perspective related to resilience is the research of "what works in therapy", by Scott Miller et al (2006). They state that it is evident that the

individuals' own experience, their participation in cooperation with the therapist, and the relationship, or "alliance" between the therapist and the client, is what is really helping the client above all. They enhance the client's capacity or resilience as crucial for recovering from mental disease. It is natural to transfer these findings to mental health promotion, resilience research and refugee children; the different theories underscores the importance of the relationships, and whatever is initiated may cause chain reactions in one's life.

3.2. Theoretical framework

The concept of resilience is related to positive psychology, which is based on Aron Antonovsky's term "salutogenesis" (Antonovsky, 1996). This is a key concept, which focuses on the salutary or "health - enhancing" rather than the pathogenic, which is disease -causing aspects of health (Tones and Green, 2004). Positive psychology is building a new psychology of human strength. It is focusing on the positive subjective experience of the past, the present and the future. In research the focus is on positive individual characteristics like the strength and the virtues and the study of positive institutions and positive communities asking, "*What are the institutions that take human beings above zero?*" (Seligman, 2003:xvii).

There are different kinds of challenges in positive psychology, and Ryff and Singer (2003) claim that some people get even stronger and manage to get a better life after having been through a crisis or trauma. It would be interesting to find what the power in these people is. Ryff and Singer mention increased self knowledge and self reliance, heightened awareness of personal vulnerabilities, greater emotional expressiveness and disclosure to others, increased compassion for others and deeper level of spirituality. They also enhance the need to promote the tools that strengthen

resilience, in the level of public education and community intervention programs to promote the greatest possible good for the largest possible society (Ryff and Singer, 2003).

An interesting aspect within positive psychology is the research about the effect of "good" and "bad" experiences of human's experience of wellbeing. Reis and Gable (2003) claim that in children as well as adults the emotional impact on social rejection is greater than the emotional impact of social acceptance. They refer to several studies that conclude that conflicts had significantly stronger effects on individual wellbeing than did support. They claim that negative events appear to elicit more physiological, affective, cognitive and behavioural activity and prompt more cognitive analysis than neutral or positive events. They also refer to research concluding that "one zinger will erase twenty acts of kindness" and that it takes one put-down to undo hours of kindness (Reis and Gable, 2003). This may indicate that refugee children with histories of war and conflicts probably need more and stronger positive stimuli to balance for the bad in order to give them a general impression of good experiences.

Positive psychology could be described as an effort to revive some of the agenda that had mobilized humanistic psychologists in the middle of the 20th century. At he same time it does not share Maslow's and Rogers' suspicion of abstraction and quantification. In stead it tries to extent the scientific method to deal with certain aspects of experiences (Csikszentmihalyi, 2006:4). Carl R. Rogers' approach to humanistic psychology is enhancing that every human being is unique with almost unlimited possibilities if given the right conditions, like a caring and understanding

environment. He is also enhancing the importance of congruent communication and unconditional positive regard to make people feel well (Rogers, 1980). The theory of humanistic psychology is enhancing subjects like "the experiencing person" and the person's capability of self actualisation, and exceeds choice, responsibility, and creativity (Pervin and John, 2001). Like Rogers, Abraham Maslow argues for the importance of being appreciated and loved to reach the level of self actualisation:

> *It's amazing how little the empirical sciences have to offer on the subject of love. Particularly strange is the silence of psychologists, for one might think this to be their particular obligation* (Maslow, 1970:181).

Seen in the light of a humanistic approach and the importance of unconditional positive regard, it may also be appropriate to mention how Event Counter Transference Reactions (CTRs) in professionals, may affect them when working with traumatized children, and in its turn affect the children (Danieli, 1994; Lindy and Wilson 1994; Dalenberg, 2000; Bang, 2003). CTRs are in this connection defined as dysphoric and excessive affects that influence the core of the helper. Those affects may create defences that may cause distance or spur over-involvement characterized by withdrawal, regression, disequilibrium, or over-identification tendencies. Many health and other professionals are at risk concerning developing strong empathic strains, and Lindy and Wilson mention in particular

> *psychologists, nurses, social workers, physicians, paramedics, police officers, research interviewers, fire-fighters, trauma counsellors, teachers and members of the victim's significant others* (Lindy and Wilson, 1994:32).

When such reactions occur in professionals it may disturb the professional work (Lindy and Wilson, 1994; Dalenberg, 2000; Bang, 2003), and the helpers' behaviour may be experienced harmful by those who need their support. In this way

it may be an obstacle for the promotion of mental health and resilience related phenomena. Evidence has proved that by being aware of one's own feelings and by identifying them, helpers are better fit to avoid the special destructive behaviour following these feelings, and this may limit the extent of unconscious communication and thus make less damage (Bang, 2003; Dalenberg, 2000; Wilson and Lindy, 1994; Satir, 1993).

3.3 Health promotion and empowerment

The close connection between the ideas above and the theory of empowerment has greatly influenced this study. According to the Cornell University Empowerment group empowerment is an

> *Intentional ongoing process catered in the local community, involving mental respect, critical reflection, caring and group participation, through which people lacking an equal share of valued resources gain greater access to and control over these resources* (Wiley and Rappaport, 2000).

Maslow's work has considerable relevance for the empowerment imperative of health promotion (Tones and Green, 2004), and Varvin (2003) is claiming that human beings have a basic need for meaning and coherence in life. He draws attention to the notion of "the symbolic mind", and describes how human beings strive to find explanations of whatever is happening in life. The attribution made by a person is considered to influence important consequences; for instance is attribution of lack of control to internal factors seen to influence a greater loss of self esteem than attributions to external factors (Pervin and John, 2001). Tones and Green (2004) are also stating the importance of Antonovsky's theory about "sense of coherence" for health promotion. Antonovsky is defining sense of coherence as:

A global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected (Antonovsky ,1979:123).

A major task of health promotion is to reduce entropy (disorder within systems) by changing the situation so it becomes less chaotic, and change people's perceptions and beliefs about the situation so it becomes more meaningful. In this way we can generate a sense of coherence. Tones and Green (2004) mention the two approaches of health promotion; the one that is a "positive" approach to conceptualizing health and the other which is a disease focused definition. They enhance that in both perspectives self actualization, coherence, and above all, empowerment are central.

Tones and Green warn against victim blaming tendency when discussing the importance of empowerment. Victim blaming occurs when the environmental factors that impact on the individual are ignored (Tones and Green, 2004). They argue that:

empowerment does not just happen; there is a reciprocal relationship between individuals and their environment. Not only must individuals be "strengthened" in some way, but their socio- economic, physical and cultural environments must be conducive to their making empowered choices (Tones and Green, 2004: 3).

This is also related to James Garbarino's statements about resilience above.

Another important aspect is that there is a need for critical health promotion, where those who are working in medical and social services should be prepared to support individual empowerment and take political action to challenge adverse

environmental circumstances (Tones and Green, 2004; Prilleltensky and Prilleltensky, 2005; Freire, 2002). This perspective has influenced this study based on the constructionist approach and participatory / advocacy claim, along with Paolo Freire's *critical consciousness raising theory* (Freire, 2001; Creswell, 2003). The complete Freiran philosophy chimes with the ideological commitments of health promotion, as formulated in the Ottawa Charter, and distilled in the empowerment model (Tones and Green, 2004). Freire's humanistic approach are also essentially similar to Carl Roger's "unconditional positive regard" (Tones and Green, 2004; Rogers, 1980) and the critical consciousness raising theory refers to learn how to perceive social, political, and economic contradictions and take actions against the oppressive elements of reality . These observations are also leading to transactional analysis' notion of healthy life positions (Harris and Harris, 1985; Tones and Green, 2004; Pervin and John, 2001). All the perspectives mentioned above appear to be related to the development of resilience. However a constructionist approach to resilience is based on interactions between oneself and the environment more than transactions.

Empowerment has to do with people acquiring a degree of power and control. Self empowerment is in this way defined as the extent to which individuals have power and control over their interactions with their physical and social environment (Tones and Green, 2004; Pervin and John, 2001). "Perceived locus of control" is considered important for the feeling of empowerment (Rotter, 1966). This is a condition that emphasizes the fact that it refers to a subjective probability rather than the actual degree of control possessed by the individual. When referring to internal locus of control, it describes a tendency to believe that one is in charge of

one's life. On the other side, the external locus of control describes the feeling of being general powerless. The person feels controlled by chance, luck, fate, or by powerful others. When such a lack of control is experienced, one might navigate into a stage of "learned helplessness".

Following the line of perceived locus of control, Bandura (1992) is going further in his presentation of the importance of self efficacy; the judgement of how well one can execute courses of action required dealing with prospective situations. Tones and Green (2004) claim that self efficacy is influenced by past experience of mastery, and health promotion is to influence the experiences of mastery. In this way it is related to participation and empowerment. Tones and Green (2004) is presenting empowerment as the connection between coherence, hardiness and resilience. Important to facilitate health actions is knowledge and skills. Empowerment techniques influence individuals' beliefs about self and their skills, and in this way it is an essential part of the empowering process; people may not feel that they are in control of their lives and health as long as there are remaining barriers, and the environment in which people live and work does not actively conspire "to make the healthy choice the easy choice" (Tones and Green, 2004).

In this paper the process of resilience and its connections to health promotion, may be explained by the Health Action Model (HAM), designed by Tones and Green (2004). This model may also be suitable to understand Ungar's constructionist approach to resilience (Ungar, 2004); the person negotiate between it's self, and the environment, skills and knowledge; he/ she has an intention on how to achieve health and is trying to reach it. The quality of all elements influencing the intentions

is of great importance. If children get the experience that they cannot navigate in the established normative systems of health service, then they adapt the knowledge of these experiences and negotiate with themselves and the environment to find other actions to reach it. These actions may in its turn feel healthy for the child, but may also be harmful for the community, the child's social welfare, and as I see it, it might also influence the level of self esteem. Normative systems describe the network of social pressures that might be brought to bear on an individual's intention to reject or adopt health actions (Tones and Green, 2004). Interpersonal influences are considered most effective concerning helping children and adolescents to "make the healthy choice the easy choice". Close friends, important adults, family, other alliances including trusted professionals are crucial in the process of guiding (Tones and Green, 2004; Miller, Duncan and Sparks, 2004; Bachelor and Horvath, 2006; Maslow, 1970). The environment is influencing the self, its beliefs and motivations, and a supportive environment is of special importance to what actions people choose. Tones and Green (2004) are claiming that self esteem is a motivating factor for all mentioned health promotion models. Abraham Maslow (1970) argues that maximum health status involves "being all that you can be". However when putting self actualisation on the top of his pyramid, he also emphasizes that physiological needs must be satisfied before higher order needs can be fully achieved. This is in accordance with the statements from World Health Organisation about the need for peace, safety and security and that these requirements must be satisfied before people consider adopting behaviour that will improve their health (The Mexico Conference, 2000).

4.0 METHODOLOGY

To explore children's experiences of empowerment and subjective well being qualitative research method seems to be most useful. Silverman (2004) and Kvale (2004) consider in depth interviews and literature review as qualified methods to study people's life histories and these methods are considered relevant to find answers to the research problem in this study.

Carolyn Williams (1991) states that the knowledge about refugees in the United States is quite poor, and reports from The European Parliament conclude that there is a big lack of research and data collection about refugees' mental health in Europe as well and particularly little about unaccompanied refugee minors (CRMD, 2003; ECRE,2004; Borge, 2004). I have searched for review articles and reports in several databases, like the web site of the European Union and ECRE and borrowed and bought books about relevant theories and literature. However there seem to be more research about wellbeing, health promotion and empowerment connected to other groups, mainly in the western world.

4.1 Strength and limitation of the research

This study was not meant to control and discuss all variables that contribute to define whether the participants have a resilient functioning or not. For such a purpose a longitudinal study is needed; a study perhaps with a mixed methods approach, including information from children, teachers, caregivers, significant family members, and taking into account factors like the psychosocial environment, cultural background, cultural identity, cultural explanation or meaning of the child's symptoms and behaviour. Ungar and Teram (2005) claim that qualitative research is

a way to achieve integration of the impact of disparities into mental health care because it thoroughly describes the lives of the children, and in particular the lives of those from culturally diverse backgrounds who may be doubly marginalized by age and address. Though qualitative research does not attempt to claim grand generalizations, it may be transferred to other groups by the way the reader may find it transferable to his or her context (Ungar and Teram, 2005). In this way the descriptions in this present study may enable the reader to decide whether or not it may be transferable to other contexts. The study is based on 1, 5 -2 hours interview of each child.

The goal of constructionist research is to rely as much as possible on the participants' view of the situation being studied, and thus this research is limited to an interpretation of resilience with a post-modern understanding of the construct that accounts for the cultural and contextual differences in how resilience is being expressed by individuals. Some might say that listening to the children's voices only is not giving a true picture of their situation. However, according to theories about perception and attribution "the truth" is a relative idea and what is "true" to one person may be untrue to another. Because of people's perceptions of reality, they look at the world from different perspectives (Kaufmann and Kaufmann, 1998; Røkenes and Hanssen, 2006). The interesting perspective here is how the children feel and think about their situation as this is actually their "truth" and experienced reality, and consequently also their point of departure for how they navigate towards resilience.

Another perspective of the constructionist research is that although qualitative resilience research is considered suitable to judge contextual issues and youth's own accounts of their pathways to health, the essence of its methodology presents unique interpretive challenges (Ungar and Teram, 2005).The information given by the participants is thus to an extent shaped by our own experiences and background.

We might therefore experience our own cultural biases through our research and that we are imposing them on others by seeking explanation for people's experiences in terms that are relevant mostly to the outsiders conducting the study (Ungar and Teram, 2005). Besides, it should be emphasized that the researcher's own personal beliefs and feelings when listening to participants' painful stories in interviews should be taken in consideration, as there may be a danger that the focus of the purpose of the study might be unclear if these feelings are ignored (Lindy and Wilson, 1994; Dalenberg, 2000; Bang, 2003). Awareness of the danger of bias in the study because of these aspects is important, and it has been important with disciplined methods to systematize data to avoid such bias in this present study.

If it is accepted that qualitative resilience research is about individuals and personal agency in its many forms, it is possible to more effectively point out connections between the choices made by the youth and the contexts for making these choices. The point of the constructionist perspective of resilience research is to highlight these connections, and emphasize that unless they are changed, children and youth will continue to be resilient in ways that may not confirm to society's norms (Ungar and Teram, 2005). A challenge is therefore to come to terms with the contradiction between respecting youth's definition of resilience and health and our understanding of it; to gain full citizenship in a society some of these definitions

must shift towards common norms (Ungar and Teram, 2005). Ungar and Teram (2005) refer resilience to a child's state of wellbeing as well as to the characteristics and processes by which that wellbeing is achieved and sustained, and this understanding is also used in this paper. Problems may arise when researchers and practitioners attempt to agree on what constitutes significant risk and successive outcomes that are beyond predicted expectations. Because of the difficulties of different interpretations of terms, like "risk", "resilience", "vulnerability" and "outfits" resilience is difficult to measure in quantitative research (Ungar and Teram, 2005). Thus qualitative research, as I understand it, is most effective for contextualizing behaviours and process, but a mixed methods approach would perhaps have given a broader understanding of the process. However this present study did not aim to reach that dimension.

4.2 Sample population

The participants were purposively sampled, and were selected because they all had been active in trying to change their adverse situation. A thorough presentation of them will be given in chapter 5 below. The following table will briefly give an overlook of their civil status at the time of the interviews.

Sex	Age	Nationality	Civil Status	Address	Resident Permit	Action-group member
Boy	16 years	Middle East	Family member	Asylum centre	Yes	Yes
Boy	17 years	Middle East	Unaccompanied minor	Asylum centre	No	Yes
Girl	17 years	Ex Yugoslavia	Family member	Apartment with family	Yes	Yes
Girl	16 years	East Africa	Unaccompanied minor	Asylum centre	No	Yes
Girl	18 years	Central Africa	Unaccompanied minor	Apartment with friends	Yes	No

The way the action group was presented in media portrayed refugee children in a new positive and active role, and this was an interesting perspective connected to their experience of empowerment, participation and subjective well being.

4.3 Materials/ Instruments

The interview guide was designed to suit the demands for doing the phenomenological study based on the constructionist knowledge claim (Creswell, 2003). It was also based on important concepts of the theoretical framework, like participation, subjective wellbeing, empowerment, resilience, positive psychology, and a humanistic approach.

The interviews were flexible face to face in depth interviews. Observations during the interviews were an important part of the study, especially as some of the participants spoke Norwegian and some English, and some did not speak the used language fluently. Theories about communication, transactional analysis, and client centred therapy, dialogue and confluent supervision (Satir 1993; Rogers, 1980; Miller et al, 2005; Freire 2002; Harris and Harris, 1985; Tveiten, 1998; Bang, 2003) were crucial for the questionings as well as observations through the dialogues. Circular questioning techniques and repetitions of the participants' answers and statements were used to visualize for the children that they were listened to and to assure that they were understood correctly. The research was based on the participants' words only and I had no information about their life before the interviews took place except from the fact that they had participated in trying to change their conditions. An exception from that was the girl from Central Africa, whom I knew from 3 years earlier, but had not seen in between. An audio recorder was used during the interviews, and the interviews were transcribed afterwards. A reflection note over the interviews, the situation, the

atmosphere, the non verbal communications and observations done through the conversations, was written after finishing the interviews. Those field notes were later used to recall the interview situation as correctly as possible.

The interview guide operated as a guideline for the interviews. In this way some questions were never asked as the participants answered them anyway, and some questions were added to follow up some of the statements of the children. The duration of the interviews varied between one and a half and two hours.

4.4 Procedures

A written invitation to participate in the research was sent to the participants. The invitation included thorough information about the purpose of the study, and what kind of questions should be asked. The letter was presented for four of the participants by a gate keeper who had known the children for years, and whom they trusted. The fifth participant, the girl from Central Africa who was not part of the action group was recommended by a psychologist, and she immediately decided to participate as she considered this kind of study important.

Most of the interviews took place in a meeting room where four of the children used to gather for meetings together with other refugee children and helpers. This was regarded as a safe and familiar room for them, and was also used for positive activities like playing music. When interviewing the girl from Central Africa a private sitting room was used, and she expressed verbally and nonverbally that she was content with that solution. The questions were designed to achieve a trustworthy and relaxing atmosphere.

Three of the interviews were carried out in simple Norwegian, and they were translated into simple English after having been transcribed word by word. Two of the interviews were in English. A translation from relative poor Norwegian has been a challenge, but the children's expressions are rendered as accurate as possible. Another important consideration was that it has been some discussion the past years that health personnel were not considered trustworthy when describing the situation and health condition of refugees. Taking these debates in consideration the decision was taken to make extensive use of direct quotations when describing the results of the study. In this way speculations about what are the researcher's personal interpretations and what are the accurate words of the children might be avoided.

After transcribing the interviews there was a certain need to return to two of the participants to check out if their statements were cited correctly. However the asylum centre was closed up 3 days after the interviews had taken place, and as these children were difficult to trace, no further efforts were made to find them.

4.5 Ethical considerations

The Norwegian Social Science Data Services (Norsk Samfunnsvitenskapelig Datatjeneste) approved of the study. All participants were informed that participation was voluntary and the interviews were based on informed consent. Confidentiality and anonymity were assured, and the participants were also informed about their rights to withdraw from the study without explanation whenever they wanted to. These rights have been respected throughout the study. Coded information about respondents' identity and data sets were kept separately, and the criteria for the evaluation of research have been followed during the study (Silverman, 2004).

To be able to find ways to give the best support to unaccompanied refugee children, it is of great importance to study their functioning in daily life even when they live under adverse circumstances. However Wiley and Rappaport (2000) claim that it may be a risk to ask vulnerable persons to participate in a research study, as they might have psychological problems afterwards. They emphasize that it is important to have a state of readiness if this should happen (Wiley and Rappaport, 2000). For this reason the children were not encouraged to share particular sensitive information about their lives; the conversations emerged freely, and the participants decided what they wanted to tell. Two persons mentioned by the children as trustworthy caretakers, agreed to support if there should be any need for it. The considerations of the children's welfare, the awareness of the effect of transaction analysis, and that people influence each other through dialogue and communication influenced the choice of communication methods in the interviews (Maslow, 1970; Rogers, 1980; Harris and Harris, 1985; Satir 1993; Tveiten, 1998; Freire, 2002).

4.6. Data analysis

When searching in literature to find ways to analyse and structure the data, recommendations by John W.Creswell (2003) and David Silverman (2004) were the most useful. Creswell also presented six generic steps for analysis (Creswell, 2003: 190-195) which appeared to be practical.

Step one: Data was organized and prepared for analysis; each interview was transcribed word by word from the tapes, and the transcriptions of the interviews were the point of departure for the process of interpretation and analysis. The interviews were mapped anonymously in paper as well as electronic (Microsoft

Words). Interviews and notes from the interview sessions were organized in different categories and files. Notes were written in the margins, along with general thoughts after each interview transcriptions.

Step two: The complete data material was examined to get a sense of its general meanings, and what the children actually were saying. The analysis started already during the interviews and the writing of transcriptions to find what this was actually all about. The atmosphere in the rooms where the interviews took place was noticed; in addition to the children's verbal expressions the attention was also directed to their non verbal communications, like face expressions, body movements and their voices in order to try to understand their statements better.

Step three: Data was organized in different categories, and the categories were labelled with a term based on children's descriptions. In this way the process of coding the data had started. A list of all topics was written and similar topics were clustered together. The topics were arrayed as "major topics", "unique topics" and "left -overs". A scheme for children's negotiations and navigations to achieve subjective wellbeing from different topics was also designed. In addition the most descriptive wordings of the topics were identified and turned into categories; by using a computer and Microsoft Words program text segments from the transcriptions were selected, copied and placed on a note. As there were no more than five participants it was not practical to use a qualitative computer software program.

Step four: A description of the setting, the participants and themes was generated. The data was divided into 7 categories and themes were identified in each individual interview and labelled in different categories before they were shaped into a general description.

Step five: The further challenge was to decide how the description and themes should be represented. A narrative passage to convey the findings of the analysis was chosen and the description part was designed by quoting children's statements and organizing them under different categories.

Step six: Finally it was time to interpret what the children actually told about how they felt, their situation, their attributions and experiences and to look for answers to the research problem and research questions. According to Silverman a study may be generalizable if it is wedded to other studies which share the theoretical orientation (Silverman, 2000), so the statements of my participants were compared to literature and related studies looking for connections.

5.0 PRESENTATION OF PARTICIPANTS AND THEIR BACKGROUND

This chapter will present the children and their background as their stories may give a closer understanding of their strength before as well as during their life in Norway, and also to understand some of their statements in the next section better. All names of persons and places mentioned in this paper are fictive to protect the children's anonymity.

Aida, 17 years old from former Yugoslavia

When Aida was 11 years old, she arrived to Norway with her mother and siblings. Her father was already in the country. She had been living with her family in her home country, but they were all forced to leave because of war. They stayed in an asylum centre, but after some years their application for asylum in Norway was denied. They complained, but got new refusals, and during this time the family had increased with a little brother. It took six years before they got a residence permit,

and during that time Aida's parents had divorced, and her mother had become seriously ill from a psychiatric disease; she was suicidal, and was hospitalized twice for longer periods. The children were placed in orphans' home when their mother was hospitalized. Before getting a permission to stay, her father and her older brother were transferred back to their home country. Aida was responsible for taking care of her two and a half year old brother, and she was depressed, tired, and suffered from anxiety, concentration problems, sleeping disturbances, and head aches. She joined some other children in the asylum centre, and they founded an action group to try to change their life conditions. By the time of the interview she had recovered, lived in an apartment with her mother and siblings, and was doing apparently well.

Hassan 16 years, from The Middle East

Hassan came to Norway together with his mother when he was 10 years old. After having stayed for two years in an asylum centre their application for residence permit was refused. They complained, and after getting 3 or 4 more refusals his mother became seriously mentally ill and was hospitalized several times. The boy got problems to concentrate in school, and needed psychological health care. However he engaged in playing football, and was active in a music group. The music and the support from the leader of the music group helped him to divert his attention to something positive, feeling close to somebody he trusted, and to have fun. Together with Aida and other children at the asylum centre he was active in founding an action group to try to get a grasp on his own life. After nearly six years he got a permission to stay in Norway, as a direct result of the children's advocacy work in the group. When the interview took place six months later he was

apparently doing well. However even though he had a permission to stay in Norway, he was still living in the asylum centre with his mother, waiting for a decision about where he was going to settle down.

Mohammed 17 years old, from the Middle East

Mohammed came to Norway when he was 15 years old. He was alone and stayed in an asylum centre for unaccompanied refugee children. He had applied for asylum but had not got any answer from the migration authorities by the time of our interview. The interview took place in English; I had been told that his English was good, but at times it was difficult to understand him. More questions were added to make sure that I understood him correctly, and several times he told that it was difficult for him to explain what he meant. He did not tell anything about his life before coming to Norway. In the asylum centre he was supposed to make his food by himself and clean his room and clothes, but he told that nobody guided him in how to do this or how to learn about Norwegian culture and customs. He went to school, but had barely any friends. He told that he had asked for psychological help without getting access to it. The last months Mohammed had joined the action group to try to change his life conditions, and when the migration authorities decided to close up the centre where he lived, he refused to move. He participated in campaigns demonstrating against the transfer. He got support from the other members of the group, who had also joined him in the meetings with UDI. By the time of the interview Mohammed still lived in the asylum centre, but the centre was about to close up in few days, so he was scared and desperate.

Sana, 16 years old, from East Africa

Sana came to Norway alone when she was 14 years old. Her parents were killed when she was a baby, and Sana and her one year older sister grew up with an aunt and her children; they worked for her, and slept on the floor. 13 years old Sana's sister accepted her aunt's decision to marry an old, rich alcoholic in order to try to change the condition for herself and her sister. However Sana was not allowed to visit her, but she was often waiting outside the house, talking to her sister through the closed door. After a short time her sister's husband decided to get rid of his young wife and set her on fire. She was severely wounded and Sana who was outside the door managed to take her to hospital in another city all by herself. There the girl died because Sana had no money to pay the doctors. Afterwards Sana spent hours in the streets begging passers by for money for a funeral. Being hunted like an animal she did not succeed, and finally the doctor at the hospital helped her so she could bury her sister. Two weeks later she defied her aunt's demand to marry the same man who killed her sister, and she was forced to leave her aunt's house as a consequence of this denial. Sana asked the police for help, but she was chased and hit. So she lived on the street until her late sister's stepson helped her to get away. She arrived to Norway 2 ½ year before our interview, believing she was in Sweden. At the time of the interview she was living in an asylum centre. She had a serious face with no smile; she was tiny and thin, looking more like a 12-13 years old child. She told about sleeping problems, headaches, and that she felt lonely and sad. The last two months she had joined the children in the mentioned action group. She had not yet got any reply at her request to get a residence permit in Norway, but she had now got a "support family" whom she could visit when she wanted. When the centre was about to close up Sana felt desperate by getting moved once more, and

together with the members of the action group she engaged in trying to stop the transfer.

Sally, 18 years from Central Africa.

Sally came alone to Norway when she was 15. She grew up in Central Africa, but her country was struck by a civil war when she was a kid, and thousands of people were massacred. She lost her parents, but she did not tell me what caused their death. However she was brought up by an "uncle" together with her 2-3 years older sister, and the girls had to quit school to do housework in the uncle's house. When her sister was 14 years old she suddenly disappeared. Her uncle seemed to know where she was but would never tell her. She never saw her again.

When Sally was 14, her uncle took her to Denmark to a friend of his who was supposed to take care of her. However in Denmark she was held prisoner in the man's house for 6 months, and was severely violated and sexually abused. One day when she was sent to a shop to buy food, she managed to escape, and a woman who occasionally was passing by took her with her to Norway. She stayed in an asylum centre, but was desperate that the Danish man would find her and kill her. She suffered from panic and psychosomatic problems; she could hardly sleep, and had problems with her concentration and short time memory. At a time she was also suicidal, and got psychosocial help almost immediately after arriving to the centre. After 6 months she was transferred to another town, and stayed in a child care collective. A psychologist was prepared to see her in the new place, as all journal documents had been sent to him before she arrived. The girl was now living with other unaccompanied refugee children in an apartment. She was doing well in

school, and apparently also in her everyday life. Now and then she was still having appointments with the psychologist whom she trusted. By the time of the interview she had just become 18 years. She was often smiling and laughing. She had got a residence permit three years ago.

In the section below the children have willingly shared their stories hoping to visualize what is important for helpers to know about refugee children's needs to as a contribution to try to make the situation for other refugee children better then their own experiences.

6.0 RESULTS; DESCRIPTIONS OF STATEMENTS
6.1 Introduction

As mentioned above there is emerging evidence that children do not share the same understanding of risk and adversity as adults. Boyden and Mann (2005) also maintain that adult expertise must be tempered with humility, and for adults to better understand children's perspective, children must be allowed to explain and interpret their childhood This implies the need for research methods and methodology that are participatory and child centred and gives a proper scope for the children's testimony (Boyden and Mann, 2005; Ungar, 2005; Ungar and Teram, 2005). To assure that the children's expressions are rendered correctly and to visualize their emotional status there has been extensive use of direct quotations.

The intention was to find what made the children feel well. However the problems and hindrances and their experiences of lack of subjective wellbeing dominated their stories. This section is describing their articulations of their experiences to

visualize eventually contradictions between their experiences and important adults'
understanding of their level of resilience. It is also describing the children's
expressions of obstacles to achieve subjective wellbeing, and these descriptions are
followed by their experiences of what is promoting subjective wellbeing in their
lives, and what actions they made to reach this feeling. They all had certain ideas
about how to achieve subjective wellbeing and in the end of this section they
contribute with their advices for how helpers might better support refugee children
to gain better mental health, subjective wellbeing and resilience.

6.2 Obstacles to achieve subjective wellbeing and mental health

6.2.2 Lack of perceived locus of control and sense of coherence

The children all described the importance of perceived locus of control and sense of
coherence for their level of wellbeing. They expressed great difficulties in their
efforts to understand the world in which they lived during the first years of their
stay in Norway. The feeling of being totally out of control was explained to be
devastating by all of them. Sally said with a sigh:

> *Can you imagine; when you are 15 years old you come to a strange country
> …you have no one in the country, just like you are born at that moment.
> You don't know where you are, and you don't know where to search.
> Everything you look at is strange and you are unsecured. It is really
> horrible, and life is tough and you feel tough*

Sana also explained her fright about not knowing her surroundings:

> *I was afraid because I did not know anyone here. Everything is new, and I
> am black. The language is so difficult! I cannot say what I mean or
> something. I was very frightened.*

She continued by illustrating how this lack of perceived control was influencing her
strength:

> *Before I came I was very strong. After I came I have started to be somewhat afraid...I don't know if I will have a permission to stay – I only know that after one year and eight months you can get a residence permit in Norway, or you may be sent back to your country(...) Remember, I am an asylum seeker, right? May be tomorrow I must go back.*
> *(*The words were followed by silence).

Mohammed also told that

> *I can't make anything – because I don't know the future. If I knew that, I could …"* (He stopped and whispered with tears in his eyes):
> *I need to stay*

Aida explained her feelings when she had to move to an orphans' home with her siblings:

> *..mummy was at the hospital, and daddy was here just occasionally, but he did not dare to live here as he was afraid that the police would come to arrest him. I went to an ordinary Norwegian school, but I did not know if I would be there or in my home country tomorrow (…) so - right then it didn't really matter whether I lived or not, because I could not see anything positive, really*

Hassan explained that when he did not feel secure, he had problems with his concentration. He continued by saying:

> *..in school it was very difficult for me to understand things. I got poorer in Norwegian; to understand the teachers and things and to make contact with persons was difficult*

Aida told that in addition to concentration problems she also had somatic problems:

> *…I was nose-bleeding every morning when I got out of bed to go to school. And headaches- that was common. Besides I was not able to sleep in the night. But since I got permission to stay, I manage in fact to concentrate! Like when I've got tests in school- I am pretty satisfied with my grades – fives and fours!*

She continued to tell about her fear that the police would come and arrest them, and about her effort to take care of her mother so *"she should not kill herself and things like that"* as she said. She told that she had difficulties to get up in the mornings to

go to school because of her sleeping problems. Sana and Mohammed also described sleeping problems connected to lack of control and sense of coherence.

Access to social justice

Closely connected to their feeling of lack of control, is their description of being controlled by a powerful external force. Aida, Hassan, Mohammed and Sana connected their feelings to the power of the migration authorities, and they repeated this several times during the interviews. They communicated with the authorities by mail, phone calls and in direct meetings. The children told about their expectations of humanity in the new country, and their disappointments when experiencing otherwise. Aida explained it like this:

> *I feel in a way that UDI – they have never treated us like human beings. You are first foreigners, you have to remember that"*, she imitated.
> *Then you are human beings, and finally – you are children!*

Sana also described how she felt about her life being totally in other people's hands, and about being transferred to another centre without being listened to:

> *They don't listen. We are not allowed to stay here!* **They** *don't see how I am doing – how I am sleeping - eating. They don't know anything! They just say "move from here!" Why should I move from here? I know nobody there. Why do I have to move when this is my home? I have the group, and everything, and I cry – but they say that I have to move.*

Sana also explained how she had talked to her teacher about her expectations of access to human rights for children, and that she felt that Norway was different from what she had expected. Hassan also questioned the human rights perspective when telling about the way he and his family had been treated from he was no more than 10 years old. He told that he did not understand much in the first time after arrival, but after some time he acknowledged that:

> *We were waiting for some kind of thing which was to come from the big ones, in a way. We waited for one year – two years- then we got a refusal. Then we made a complaint, right? And we got another refusal. Then everything started to become more and more difficult. I think we got three or four refusals*

Meanwhile his mother got seriously ill, and Hassan got psychosocial problems.

Hassan also questioned the way UDI treated the unaccompanied refugee children after the decision to close up the asylum centre; he explained how the action group had supported the children and followed them to meetings with representatives from UDI, and how he felt that the authorities had threatened the children if they did not accept their decision. He told that:

> *Everyone could hear that they threatened them: "If you don't stop, and if you complain you won't get any more money", they said. We made a report, and then UDI got furious. "This is nothing but nonsense – we have never said that…!" "But", we answered, "here is the report"…..and then we sent it to the newspaper. Afterwards the boss answered, that "this is nothing but rubbish - we have never threatened the children! We will never hear that again!" he said*

Hassan also expressed that this surprised him and frightened him a bit, and he got the impression that the boss was trying to stop their work.

Aida explained how the family during the first years tried to follow the rules, and adapt to the system. She described the development of depression and despair when their complaints were futile, and how she felt that this contributed to her parent's divorce and her mother's mental disease. Aida described her feelings of helplessness when they were refused residence in Norway:

> We *complained, but even though we had stayed here for more than four years, they thought that "no, they have got a refusal, and they have to go back home." They would not even read our papers, even if many things had happened, and a lot of new information was in the complaint. There was a report from the psychologist, (…) and mummy was in hospital, but that did not matter at all in a way*

Aida also expressed her confusion about not understanding the authorities' way of thinking:

> *I thought that – of course when you come to a country, you will get a permission to stay there. When knowing how it was like in my home country I thought that nobody would possibly send anyone back there! I did not know what asylum was like - and mummy was getting sicker. I really do not understand how they think – if she was not able to take care of us here in Norway – how could she help us if we were sent back home…?*

The power of articulated words

Some of the children also described how words articulated by important adults were affecting them; Aida told about her reactions to a statement made by a government minister:

> *After we had been talking to the media, she said that "I can understand that people get charmed by you, but you cannot charm me!" (...) What I had experienced and had difficulties to talk about…* (She burst into tears)… *Is **that** to charm somebody?*

She also described her reactions to the minister's accusations of the parents of the children, and to illustrate how it really affected her she expressed her feelings when seeing the minister live in The Norwegian Parliament once:

> *..it was the first time I saw her in person – and when I saw her I just started to cry! You have no idea how bad I have felt after her statement about our parents, and that they are abusing their children! I don't understand that she can say things like that! My mother was in hospital because she had tried to kill herself, and then she tells me when I try to help my family that it is my mummy who is abusing me! No matter what we say, they are using it against us, and I feel that they have done this to me personally!*
> (Tears were running down her cheek. She had problems to speak and needed a break)

Sally's perception of the migration authorities was more positive; she had stayed in Norway for 3 years, and for two of these years she had a residence permit. However she also had experiences about how words articulated by important adults affected

her. She described her surprise and disappointment when listening to a teacher's statement:

> *"Young people have to accept the fact",* she imitated the teacher. *"As long as you're foreigners you will never make it. I'm just giving you advice to make you understand how things are. Despite the fact that you have good grades and you read hard; when you come out to the real world, everything will be different because they consider the colour of your skin, and they consider the name too. And when you're writing your application they look at your name, and when they know you are a foreigner, they kind of push you away. (…) And if you want to become a doctor, you want to be a nurse, a lawyer, name it, you will never make it."*

Sally explained how these words in a way got printed in her mind, and how other refugee children in her class reacted with disappointment and anger, and lost their motivation to go to school. However Sally told that:

> *I remember that I answered her that…" I don't care! As long as I have my motivation I don't care!" That's the only thing I answered her.*

Aida also described how the minister's words affected her anger, and her obstinacy:

> *Such things* (she was wiping off her tears) - *I just think that I have become much stronger from it! No matter what!* (*She* took a deep breath).

Sana expressed that she did not trust the migration authorities:

> *They can say one thing to me, but suddenly I'll have to go back. I do not trust their words. And I am also scared for UDI ! I am **scared to death** for UDI! I had problems in my country, and now I have more problems in Norway, and more if I want to study and even more when UDI comes!*

To be listened to and believed in

Mohammed tried to explain in his poor English how he felt when experiencing that the unaccompanied refugee children was to be transferred to another asylum centre:

> *It's not so good you know!* (The voice was high, strong and tense) *"They just told us they will close this camp! They didn't ask us "how do you feel" or "do you want to move" or "don't you want to move". They just said you should move! And* (he took a deep breath while tears filled his eyes) - *I can't express it…*

Sana also explained her feelings when she understood that the migration authorities did not believe in her reasons for coming to Norway:

> ….I had no papers. My mother is dead, and my sister is dead as I told you. And my aunt was treating me badly. UDI does not think about "why did she come?" They believe that I may easily go from one country to another, but it is in deed very difficult! I've had many problems before I came to Norway, but they don't understand

She was also upset about that her age was questioned and she tried to explain the result of an age test which was taken of her hands:

> I have the result of my hand; in my country we have to work hard with our hands from we are 6 -7 years. It is very difficult! It is different from Norwegian children, and children in other countries. May be the test shows that I am an older girl? (…) Everybody had to get hold of their papers from their home country, and when I got my papers they did not believe in them. No, they say that I am 28 years old!
> (She expressed the frustration of not being believed in)
> Why don't they believe in me? They say that when you are under 18 you will get help. I am under 18 – I do not get help!

Lack of supervision and guidance

All the children emphasized the need for someone to help them to orientate in what they experienced as a conglomerate of rules, customs, and culture. Sana said:

> For example, if you go to Somalia – you can find a book and read about Somalia, right? Like how the culture and something like that is - but when we come here, we have not read about it; we don't know anything about this country. We are told to eat, sleep, go to school – and after school there are no one to talk to – nobody who is helping you

How to manage daily living was emphasized as a problem for the unaccompanied refugee children who were still living in the asylum centre in particular; they were supposed to make their own food except for special occasions, and also to keep their rooms clean and tidy. Sana explained that

> …many do not know how to clean and cook. They do not know because they have not learned it. We need to learn!

Mohammed also told that some of the children in the centre never had a hot meal because they did not know how to cook, and did not get any guidance.

Sana also illustrated her feelings when experiencing that the personnel in the centre did not explain rules to her and how to behave in this new culture. She described the staff in the centre as "angry", and she felt confused, frustrated and sad. She explained:

> *…in my country we eat with our fingers* (She demonstrated with her hand). *All foreigners in this centre eat with their fingers, or with a spoon. It is difficult to eat with fork and knife!* (Illustrates) *Then a woman shouted at me* (Clapped her hands and pointed at me*): "Hey! This is not your country! This is not Somalia! Do you think you are in Somalia? Then you are really mistaking!"*(She dramatized a dominating person and continued) *I did not understand the language, but I looked at her face – and it was not kind.…*

Because of the difficulties in expressing herself in a foreign language, she made extensive use of demonstrations and gesticulations and she described with tears in her eyes how she was demanded to throw away the food as she had touched it with her hand. She continued by suggesting ways to be able to learn better:

> *I am not the same as her. If she came to my country, I would not say to her "this is not your country", and "why do you eat with your hand". Then I would say "can you eat like this, with a fork?"*
> (She demonstrated with her hands and a soft voice as to somebody whom she was guiding.)

The children from Africa also suggested that it would help if Norwegian people had to learn about refugees, and that this would make their lives easier. Sally explained that

> *I just feel that they don't believe that there are people outside there who are really struggling day by day, time by time, hour by hour, just to get up - to come to school - to go outside, and just want to be accepted in the environment.….*

Sally repeated several times her problems and feelings when she found that she was not understood and believed in.

Sana told that some information would have been very important for her when she arrived to Norway. She had therefore decided to give information to newly arrived refugee children about her own experiences in order to help them to avoid getting the same problems as she did. She pointed to the necessity to guide the children immediately after arrival, and she wanted to encourage them not to give in. She also pointed to the same as Sally:

> *…not only asylum seekers should learn, but Norwegian children should also have to learn about asylum seekers. They have to learn how we are – that we are human beings like them. We have got problems, but some children do not know what the problems in Africa are; they just think that Africa is where tigers and things like that come from*

Aida and Hassan claimed that they wanted to continue with the action group in order to guide others to help them to avoid getting as badly wounded as themselves.

6.2.3 Health service and psychosocial care

All children described that they had access to health care concerning vaccinations and immunological service. However they all described the need for mental health care and somebody to talk to, and for some this had been difficult to achieve. Although Mohammed had told his medical doctor that he needed such help, he had not got it:

> *I said I needed a psychologist, and I waited for more than a month and did not get any answer (…)I need to talk to somebody about my situation.*

To the question about if it was possible to talk to the public health nurse about his problems, he answered*:*

> *I have been there for vaccine three- four times. They sent me a letter when I should come, and when I was finished they just gave me a vaccine book.*

He continued by telling that he had asked the nurse for psychological help once, but:

> *She couldn't help.*

Aida was describing stressful experiences by the primary health care, where she felt that nurses and doctors demonstrated lack of understanding of her situation. She expressed her impression about the public health care system:

> *When you want to see your medical doctor, you have to ask for an appointment, and then you may get one in a month or so. But by that time I might probably not feel so sad. Once I went to see the school health nurse as I was not able to sleep for several nights. I told her about my problems and things like that – and I asked her to write a prescription for me to get some sleeping pills because I had too much absence in school as I did not manage to get up in the mornings.*

She described the situation when the nurse followed her to ask for an appointment with her doctor, and that she was refused by his nurse. Aida was referred to the emergency ward in stead of getting an appointment by her doctor who knew her from before. She therefore resigned and decided to wait until her psychologist could see her, as she felt that it was too difficult to start all over again explaining her situation to a new person. However Aida and Hassan both told that the last couple of years they had got access to psychological health care in a talking group led by a trusted and involving psychologist. Hassan had been seeing another psychologist earlier. However he told that he had got the feeling that she was dishonest, and was also arguing with him and accusing him for doing things he had never done. He did not trust her, so he just decided to stop seeing her.

Sana was suffering from severe psychological problems and she described that she did not get any help for it at all. However she told that "a woman" had noticed her:

> *She helped me to see a doctor. After that I felt a little more pleased, and then she helped me to see a psychologist.*

She did not mention this psychologist later in the interview. In stead she said that

> *When I am sad and sorry I take sleeping medicine - Because I have nobody who can help me and talk with me*

Sally had been struggling with huge psychological problems following the trauma she had been through since the arrival to Norway. She told about sleeping problems, anxiety, depression, concentration problems, and at times she was suicidal:

> *...there comes the point where you feel that you're just drowning. You just feel like you want to get a knife and- you know- stab it through your heart and take away your life! But then, there is always a voice within you, saying that "I know you can do it, because..." It's just the voice there- I don't know where the voice is coming from- it's just there.*
> (She held her hand to her heart).

6.2.4. Alliances, attachment and appreciation

The four in the action group told that they could not identify more than one or two Norwegian persons who influenced positively their level of wellbeing. Mostly they felt that they were not wanted, listened to, believed in or understood. The children who had families had expected their parents to support them, but in stead they found that they became sick, and some got divorced. Aida explained that:

> *We felt that, okay, our parents cannot help us, and they don't listen to them (...) but what about us? Nobody had ever asked us about our opinion- we had never been to an interview! I'd been living in Norway for more than four years, and didn't feel like just going back home (...) Even though they did not consider this information important - I thought it was **very** important.* (She had an angry voice and tears in her eyes).

After living in an asylum centre for more then four years, Aida and Hassan felt that they had a comprehension of what was happening. Aida told that

I began to understand- not only I, but all who were living here- we started to understand that the only thing they wanted was to get us out of this country; nothing else mattered to them! And, it was really awful!

The organisation of the activity group was a result of this comprehension.

Mohammed had the same feeling, and he said silently, with a deep sigh:

They want to throw us away to other camps- and (...) they don't want me.

Sana described her need for a caring and supporting environment; in an almost whispering voice and with tears in her eyes she said:

Living in a reception centre is very difficult; it's very difficult to get help from those who work there - I never get that! I'm just gaining strength by myself. So, all the time I just sit there crying. May be I'll die, but they won't see me. They never open my door. They just come to see if I have cleaned my room. I just cry, and nobody see it - not only me but everyone who does not have a family. They do not talk to us.

She started to cry.

After some minutes she calmed down, and continued by telling that she did not need much practical help, like somebody to do her laundry or to buy food – She emphasized that the only thing she needed was that somebody asked her:

Are you all right? How was your exam? Why do you cry? Have you eaten?

She expressed her feeling of loneliness:

I don't feel like asking for help all the time – so I prepare my food alone, I eat alone, go to my room and sit alone writing, and I am sad. In school I am also alone and sad – I eat my packet of sandwiches - all the time I am alone. Those who work here don't help me at all….

The need for a caring person was also described by Sally:

When I'm crying, the best thing is … I need someone to come into my room and give me a hug.

However she had persons in her environment who supported her, and she described the importance of these persons. In addition all the unaccompanied refugee children expressed their desire to belong to a family. Sana expressed the difference between the children in the action group who lived with their families, and herself:

> *The children in the group have problems, but they have other problems then me; some have a family and they can be happy together with them even though they have had war. This is very different from me; I have lost everything – I have lost my family, so they cannot help me!*

She continued by telling how important the members of the action group was for her wellbeing, though she had just known them for two months.

The need for a competent guardian was expressed. Sana emphasized the need for a trustworthy guardian, and she explained how her guardian helped her when she stayed in another reception centre:

> S*he bought for me all things I needed. She showed me what was important.*

However, after having been transferred to a new centre, she had the opinion that she did not get much help from the new guardian.

Like Sana, Mohammed also had the experience that he did not get much support from his guardian:

> *She's too busy, and – she hasn't time for me (...).You know, they should first meet us, but they don't. If they have to come here by car, they say that the government should pay for it, and it's expensive! And then they don't have time…. Okay, when you don't have time, why are you going to be a guardian?*

Sally expressed her close relationship with friends and her longing for home:

> *Friends can't replace your family, and can't replace your relatives (…) though they are there! (...) Coping with your life is never easy. In spite of the fact that you've come to this country , you get your stay here, and then you might get married here, have kids, there's something that's always going to hold you back; you know, they say "east, west- home is best".*

On the other hand she continued by describing the difficulties when feeling that she no longer belonged to her home country:

> *You know no one there anymore - it's like, by the time you grow up, you become a stranger in your own home country. So this is the situation when you're forced to leave your country when you're young. And now, when you go back when you have grown up – no one recognizes you- and you don't recognize them either*

6.2.5. The level of happiness

All the children expressed the feeling of sadness and depression during the time in the asylum centre. They described loneliness, sleeping problems, crying, confusion and need for psychological support. When being asked to focus on what made them happy, Aida said:

> *It is a great difference between now and then. Now it may be just small things - ordinary things like getting a pair of new jeans, or being together with that nice boy or something. But earlier – I really can't imagine that my life actually has been the way it was! The only thing we thought about was residence permit- residence permit- residence permit- residence permit. (…)And each time I wished something for my birthday, my only wish was to get a residence permit.*

Sally and Hassan were the only participants who were laughing now and then during the interview. Hassan explained that what was making him happy were things that differed from his experiences of being a refugee:

> *Things that - that are easy to understand! Things with no conflicts and quarrelling in; relaxing, not stressing or something like that. Something that is nice to hear, or do, I get happy of that!*

Like the others Mohammed also expressed that the only thing that would make him happy was to get a residence permit, and Sana had problems finding anything that could make her happy at all. When rethinking several times she finally found that when the teacher listened to her, she felt pleased even though the teacher did not

interfere directly to make her situation better or help her gaining residence permit; Just the fact that she listened was good, she said. However, when she was asked later in the interview about her wishes for her future, she answered quietly after thinking carefully:

> *I want to be happy – to be happy for half an hour perhaps – or twenty minutes. Then I will be very pleased.*

When seeing the surprised look in my face she explained while shrugging her shoulders:

> For *twenty minutes. It – I cannot think any longer than that. But one day, may be I can.*

She confirmed that she had never been happy for that long before.

6.3 Motivating force to make the healthy choice the easy choice

All the children talked about how they tried to achieve subjective wellbeing, and many aspects were mentioned.

6.3.1. A friendly, supporting environment and alliances

The children connected most of their positive behaviour to the support from important adults and alliances. Even though they described just a few such persons, they were very important to them. Sally had more supporters than the others, and she said:

> *I feel that I have a line of people who are helping me, who wish me the best and are supporting me (…) I know they trust me and believe in me, and that's very important for me. Whenever I kind of get down and I feel like I'm almost giving up, I always think and know I have people who are backing me up (…), and won't let me down. And that's very important.*

Most of all she enhanced the importance of the support from what she called the "psychiatric persons" and she emphasized this several times during the interview:

…in times when I really feel down, and I feel like I am giving up and I can't go any further, then when I'm talking to them they give you a chance! (...)They don't promise me anything, and they tell me it's hard, and that it's even going to be more hard, but they give me advice, and they tell me at least how I can deal with the situation (...)The only person you can tell is the psychiatric person, (…) they are just like a waist bin where you pour in all your problems, and then they are there to listen to you (...) and that's very, very important!(…) I think that what has helped me to really build up is others!

Aida also enhanced the importance of her psychologist, and of talking and being listened to. She emphasized that it was

*..the talking groups which actually made us believe that we are valuable- that we in fact are **someone**, and that we have human rights. The psychologist was in fact the only one who listened to us, and thought that it was wrong that we should live the way we did. To those who were processing our cases, it was of no importance!*

Sally also described the importance of cooperation between mental health workers in the process when she was transferred from one asylum centre to another. Because of such cooperation she felt there was continuity in her therapy, and that she was cared for. She also enhanced that it felt good when professionals called her to make sure she was all right in the process of moving from one centre to another:

And that's really important to someone, because if someone calls you and ask you how your day is, that means that the person is really caring. And she, or he, really confirm you, and that will give you the feed back that you're ok; at least I have people who trust in me, and who tell me that "I know you can make it (...) I know you've got the strength!" Then definitely you just rise up.

Mohammed and Sana did not feel that they had much support, but they emphasized their need for it. However Sana told that she had lately got a certain feeling of attachment to her newly appointed support family, although she did not see them very often. Both Sana and Mohammed articulated the value of being attached to

somebody who really cared for them, and that they needed somebody to talk to, and who could listen to them.

Aida enhanced the importance of a social worker and the psychologist in a talking group for her wellbeing, saying:

> *We got support from some single persons, and that was actually very important to us. When we finally called the press, we surprisingly experienced that we got positive feed back, and that people became more interested in our cases. And then we said, okay- people want to listen to us, so why not just keep on working! Why are we just going to hang around until we kill ourselves?*

The importance of the genuine interest from the psychologist in the talking group was also associated to Sally's descriptions above about the importance of the psychosocial help from somebody who cared.

Supervision and guidance

All the children enhanced the importance of access to guidance and supervision. When the situation for Aida and Hassan became too difficult and they felt that nothing was done for them, they decided to try to help themselves. Hassan explained that

> *If you sit all the time waiting for somebody to do something for you, then it might never happen. But if you get up and work with it yourself, then you are sure that somebody is working on it; you do it yourself!*

Hassan also told that the changes in his wellbeing occurred after he had started his work in the action group, but he also thought that the fact that he was growing older was important for his participation. He claimed however that the support and guiding from important adults was crucial to encourage him to participate in his own life:

> *...we were strolling around talking about it (…) Then we asked for a meeting with the social worker (…) He advised us about what to do in order to succeed; (…) we didn't know about rules and such things, and he explained to us where **they** are, and where **we** are, and how we could reach up to where they are. And then there was the psychologist. He was here many, many times. He helped us to write a letter to a person. Everybody was allowed to write their opinions, and he put it all together in one paper, and we sent it. (…)I don't think we could have managed it without their support.*

Mohammed also enhanced the importance of the support of adults when describing what was helping him to raise up:

> *If I need help? (…)You know – I can just say what I think to two persons - (...) they just showed me the way, and how to find which way is the best; (…) they told me that if you do this you will have this kind of problem, and if you do that you will have that kind of problem. And I thought which one was the best – and I chose that.*

The access to friends

Sally, Hassan and Aida all enhanced the importance of good friends to gain strength. Aida even said that

> *..as far as I am concerned my friends were the reason for my participation in the group.*

Hassan and Aida's friends were all in the same group; they had lived together in asylum centres since they were ten-eleven years old, they shared each others' problems and they felt attached to each other. Aida continued:

> *We went to the same school, we grew up together, we were the only ones who had known each others since we came to Norway, and we had the same problems. We talked to each others about things we could not talk to Norwegian friends about.*

Hassan was certain that it was his friends and the process in the action group that contributed to his feeling of a higher level of self-esteem:

> *Before that I had no idea about how to trust in myself in a way. Like for instance, to keep going, and not give in and things like that….*

The support in the talking group was also emphasized to reinforce the ties between the children. Aida said:

> *The talking group - that was the thing that made us feel more connected to each other and much stronger, so we felt that – okay, we'll try!*

Sally, who had no connections to the action group, also emphasized friends as important for her wellbeing:

> *They haven't been where the worst things that happened to me, but they have been through other difficult situations, and then I feel that they are easy to talk to ;(..) They understand you, and they are always there for you. When you're sick or when you're unhappy, they will help me to kind of move on (…) I am really happy that I have friends- they accept me who I am, and I accept them who they are, and when we have fun, we have fun to the fullest.* (Laughing)

Sana and Mohammed did not talk about friends, except from their connection to children in the action group the last two months.

6.3.2 Health actions

All children described how they negotiated and navigated to achieve subjective wellbeing. Aida expressed how writing a diary made her feel more organized; she always put her thoughts in writing before going to an important meeting. Sana also found comfort in writing. She described that

> *I like to listen to music, and write poems and so – not in Norwegian, but in Arabic. When there is much to think about and when I am sad, then I just write and write. It helps a bit, because then I stop crying*

Sana told that putting pen to paper was a substitute for having nobody to talk to. However she told that her teacher in addition to the members of the action group guided her about Norway and human rights.

Hassan highlighted how participating in his music group and playing soccer maintained subjective wellbeing in his life:

> *It's cool to get out every now and then. It is fun- sports, music, something that force you to think of something else;(…) you have to concentrate about the ball, and then you have to run for the ball and actively join the match! If I think of something else, then I lose my concentration. And – of course I have to fight to win!*

The importance to focus on something else in order to forget about the feeling of misery was also described by Sally:

> *Me and my friends, we go shopping. If we have money we go to restaurants, have dinner, or have lunch. We may also go to a café or to the cinema (…) and it's very important with humour, because …if all the time you're sad, it has something to do with your psychological state. When you deal with the situation and the problems that you're going through, it's very important that you have friends with humour; (…) they help you to forget whatever pressure you're being through*

Sally needed support to change her psychosocial status and to learn about her new environment. She had found that support and felt that she was safe in Norway. She told how she was thinking, trying and rethinking, and tried to do her best in school. She was actively participating in her therapy to be able to cope with her severe trauma experiences, and she engaged in supporting her friends in "keeping up their motivation", as she said.

Hassan and Aida both felt that what was really encouraging them to continue was the feeling that somebody was listening to them. They did not know if their actions would give positive results, but as Aida said:

> *We talked to newspaper, bishops, and we met regularly in the talking group. We also talked to politicians, and then we felt that this couldn't get worse than it already was, sitting in our rooms crying. We had tried that for many years and it was of no use! It was painful anyway so why shouldn't we tell the world about our pain when it was already there? It wouldn't be any better if we shut up and did as they wanted. So – we decided that we could not lose anything by telling what we felt like, (...) even though __I__ - did*

> *not really believe that things would sort themselves out in the end. But I thought that, okay; then we have at least tried!*

She added that:

> *I thought that it was because of fate that these things happened to us, but in fact it isn't! You can change it if you know or have understood!*

Hassan told how he used to do nothing but hang around in the streets, and how participation in the action group totally changed that. He told about the work in the group:

> *We were drawing on the board, we were writing, and we learned about children's human rights*

He explained how they succeeded to change an important national rule, and how children who had stayed in Norway for more than three years without having their case closed, got permission to stay in Norway because of that rule. Like Aida he told how their meetings with politicians, bishops and journalists in newspapers and TV made them succeed, and his face burst in a big smile:

> *That's it! If you are standing with a lot of problems ahead of you, then you've got to accept it, get up on your feet and try to fight back. If you don't fight back, then you'll be one of those who are just standing there saying "oh- why me? Why couldn't it be someone else?*
> (He gesticulated and tried to imitate some helpless person) *If you try to fight back, you will rise up tomorrow saying "Oh- it was not me!" He-he-he- So we have to prepare for tomorrow today!*

He finished by slapping his hands on the table in front of him, laughing.

However Aida was quite certain that it was not just the participation and the support that contributed to her wellbeing:

> *If we had been working in the action group without getting this response, then things would not have been any better, right? So this has a lot to do with the case; the problems don't get solved just because somebody is comforting you. It actually has to bring results!*

Mohammed also emphasized that he would feel stronger only if he might manage to stop the closing up of the centre he lived in, but he added after rethinking:

> *If I lose, I will say I just tried. If I could do something, I did it. And I believe it is helping*

He also thought that the process when participating in the action group was important for him:

> *You know, I feel like I'm going up. (…)I feel that now I'm stronger than a year ago – two years ago, and I hope in two years from now I will be even stronger. You know, the process is very good, because I couldn't do that before I got to know these people*

Mohammed was determined to keep on fighting, and Sana also highlighted the feeling of attachment to the group members although she did not mention that the process in the group made her feel stronger.

Aida also discussed the importance of transforming the pain she felt into words during the participation process:

> *I think I dare a lot more now than earlier - then I was just afraid! But I don't know what kept us going on all that time and fight for it till the end; I think that it might be because we had not spoken about it to anyone for so many years, and things got just worse and worse and worse, and when we finally started to get it out it became much easier; we had so much inside us which we had never been aware of before*

Hassan and Aida explained that their reasons for continuing their work even after having achieved good results for themselves were that they wished to help other children to avoid being wounded as badly as them. To help others was also described to be important to both Sana and Sally. Hassan enhanced the need for refugee children to learn:

> *Learning is never ending! You can always learn just as much as an adult, and you can use this knowledge in your life. So, if you win a fight today,*

you'll get proud of yourself, and you try to intensify for the next fight. Then you have learnt something from that fight that you can use for the next! (…)The more you learn, the stronger you get, and show a respectable attitude to make people accept what you say

Attributions to get a sense of coherence

The children described how they searched to understand their situation and what had happened to them. Aida said that when she understood what happened to her and what happened in her surroundings, she felt like gaining some kind of control.

Sally tried to look for explanations for her traumatic experiences, and to understand her abuser:

> *I think that the people who do all these bad things to us - may be they too have been through a difficult situation; they've had a difficult upbringing, but they won't show it to other people. (…)May be they didn't have a chance to express it or they didn't have someone to talk to - someone to show them that they are worth living (…). So then they transform it to other people, (…) they'll make other people suffer, and that makes them feel good. But then, why? (…) This person could have done it (…) to the people who brought him up, but why us?*

With tears in her eyes she added silently: "*I don't think I will find answers to that!*"

Like the others Sana and Mohammed tried to find reasons for their situation. Sana said that she did not find answers to all her miseries in her home country, but in Norway she was blaming the external forces represented by the migration authorities and some of the employees at the asylum centre. Mohammed also connected his problems to the migration authorities, and did not mention his home country at all. He told that what had influenced him to try to act by himself was:

> The *situation! And also that I see these people who are watching you, and even though they see that you have a problem, they don't do anything about it!*

Hassan and Aida were mainly connecting their subjective wellbeing to the fact that they got permission to stay in Norway. Hassan said that

> *Now as we have got an answer and a letter that tells us that we have permission to stay here, (…) it is easier to understand, and easier to be more open. Now I can understand what the teachers say, and I've got many Norwegian friends*

Mohammed and Sana who had not yet got residence permit struggled hard, and they described how their actions were mainly aimed to get such permit.

Internal power

As the children expressed their effort to understand the world in which they lived, they also described their actions to gain control over their lives in order to achieve a stronger internal power. Sana and Sally described their experiences of having this internal power long before they came to Norway. Sally explained carefully her impression about the origin of her motivating force:

> *I think we are all born with it! (…) I don't think anyone is born mean! I don't think anyone is born with a bad heart (…) or a hatred heart. I think we are all born alike; we have the same heart, and we are born with a good spirit (…) I don't know if the strength that is within you - to always get up whatever is wrong - has something to do with your upbringing, or it has something to do with your environment, with the parents, with the people around you (…) The one thing I do believe in is to be open with a good heart!*

Hope for the future

All the children had hopes for their future. Aida hoped that her father would come back to her, Sana and Mohammed were hoping to have a residence permit, and Sana hoped that one day she would be happy for twenty minutes. Mohammed told that:

> *You know- I want to be an engineer – at a power station – I will study!*

In addition Sana, Sally, Hassan and Aida explained their wishes to help others in the future; Hassan wanted to keep on working in the action group, and later to educate

to work with children. Aida wanted to become a lawyer to help other refugee children. Sana completed:

> *I want to be a politician – I want to study world-politics! But if I am not clever enough, I want to become a journalist (...) because then you have to write about everything that is wrong to make somebody happy. I cannot talk very well, but my pencil will make me strong!*

For the first time during the interview her voice sounded enthusiastic:

> *The smallest kids can't say anything, they get afraid (…) like me for instance; they cannot talk, they cannot do anything, but I can help them! I can write (…), and they can read about it or listen to it on the radio or TV*

She continued by telling me how she planned to study in the future and that she thought that this would strengthen her.

Sally wanted to become a nurse, and thought she might be doing a good job because of her trauma experiences:

> *I hope that I get a brighter future (…) Because (…) I have the motivation and I believe in myself. So, I believe that I'll make it, and (…) I want to become a nurse. If you are a nurse you have a wide opportunity. You can always travel and work, you know, in different organisations, and help the kids there, and then I can travel to my home country and help the people there- with the aids (…) I know that as I've been through all these tough situations since when I was a kid (…) I can deal with the situation wherever I go*

Hassan concluded his thoughts for the future this way:

> *Well- the only thing that makes me go on is the fact that I look at the world in the way I do now; to strive to manage on my own and try to win, to go forwards, on the right way,- on the positive side!*

He continued by using metaphors from his music group:

> *Of course, (…) life is not going to be quite accurate all the time – suddenly you drop out of the rhythm, and then you've got to stop to get into it again. And that happens to absolutely everyone! Should anyone have a perfect life since he was born, really??*

6.4 The children's advices to helpers

In addition to the children's experiences about what had made their life difficult and what had strengthened them, they wanted very much to participate in giving direct advices to people who were dealing with refugee children, and how they might contribute to the development of subjective wellbeing and resilience. Aida said that:

> *You have to listen to what the children are saying, and to show that you respect them and that you agree with them, no matter if it is right or wrong. (…) In this way you can make them feel that they are considered seriously! I don't expect that when I talk to a Norwegian girl she will understand everything, but it is important for me that she at least tries to understand! Even though they cannot give me a residence permit they can at least tell me that they want me to stay here.*

She continued stating the affect of good and bad attitudes:

> *When people do something positive to you- it is of a very big importance, but when people do something negative to you, then it affects you even more; when you're already sad and having a difficult time it is much easier to be even sadder in a way.*

Mohammed also emphasized the importance of being listened to:

> *You know, they should first listen to us, but no one did, because we are just children. (…) we shouldn't stay for a long time waiting for everything. They should do it in a short time! And then they should help us to go to school every day! For example, when somebody has problems to make food, they should help him (...). And they* (teachers) *know how everything is here, so they should teach us about Norway, and about the situation and how we could do well in school (…)*

About the need to have psychotherapy he said:

> *You know, they should get it as soon as possible, but they didn't say anything – they just said I shouldn't. (…)*

He finished while twisting his hands, fighting with his tears.

Like the African children Hassan also pointed to the need to inform Norwegians to make them try to understand how it is like to live in an asylum centre. He also

wanted to encourage refugees themselves to try to do something about their situation if *"nobody else does anything about it,"* as he said while shrugging his shoulders. He added that if people who were hired to do a job for refugee children really did what they were supposed to, many problems would have been solved.

Sana also emphasized the importance of a friendly attitude and to support the children to learn:

> *They have to remember that we are children – the same children that they have at home. They also have to teach me about Norwegian culture and such things, to make me feel strong. And not just to make me strong, but they also should say some nice words to me to make me feel happy (...) they don't need to do other things, like preparing food for us, or guarding us while we are sleeping. (...) This is very important, and I hope they will do it!*

The children also explained which characteristics they considered important for a person working with unaccompanied refugee children. Sally said:

> *The person has to be loving, kind, a good listener, and then understand my situation - that's the most important thing! (…) And then the person has to be caring; (…) when I look at you and I tell you the situation I've been through, and when I see your face and can read your face (…)I can know whether you really believe in me or you don't. And then, the response you give me has something to do with your attitude to me!*

She concluded with the advice:

> *The only thing is to create peace! We all need peace. Create peace- you have to write that! And you have to have love in your heart. I mean, consider that it's your own kid! (..) Treat the kid the way you treat your kid, and the way you want to be treated! That's it!*

7.0 DISCUSSION

The point of departure for this study was certain ideas about empowerment and participation as crucial issues for the development of resilience, and Ungar's

constructionist's approach to children as negotiators and navigators trying to achieve subjective wellbeing and resilience fitted well with my ideas.

There were reasons to believe that the participants of this study had achieved a high level of wellbeing subsequent to their participation in trying to change their own lives. However it seemed to be much more complicated than this. This section will discuss the children's expressions above, and compare them to theories and related studies mentioned in this paper to try to find answers to the question: what is promoting subjective wellbeing, resilience and mental health in refugee children, and how important is participation and empowerment in this process. There is a need to localize this power to find how to use it for navigating towards a resilience that is experienced by the children as well as the community.

7.1 Good versus bad

All the interviews were dominated by the children's bad feelings and despair connected to their situation as refugees in Norway. The children's descriptions consisted of very harsh experiences, and those experiences as well as the few positive were basically connected to important adults. One question which repeatedly suggested itself was: What could be the reasons why their stories so strongly were dominated by negative events? One possible reason is described in the theories mentioned above about positive psychology and the effect of "good" and "bad" experiences of human's experience of wellbeing (Reis and Gable, 2003); it is emphasized that the emotional impact on social rejection is greater than the emotional impact of social acceptance in children as well as in adults. This might indicate that for the children in this study to feel good, they probably needed far more intensive positive stimuli to account for the bad in order to give them a general impression of good experiences. It might therefore seem logical that when

feeling alone and vulnerable children are in highly need for helpers who have a genuine unconditional positive regard and attitude to them. For helpers to be able to feel this unconditional positive regard, they need to understand the situation of the children, and also involve in their lives. This is also expressed by the children who emphasize the special importance of such care when feeling particularly down. When experiencing that they had no more than one or two trustworthy people in their environment, the imbalance between negative and positive events probably increased in favour of the negative. Connected to the theory above it is likely that the quality of the intervention of these few "trustworthy people" must have been very high as they reached through the dominating negative experiences in the way they did. It also seemed like they managed to make the important alliances with the children, but it would have been very interesting to study such positive relations and their impact on mental health promotion more thoroughly in a later occasion.

7.2 Group processes

Another interesting perspective was the possible effects of group processes and – dynamics and how such processes might affect the participants in the action group and the talking group when searching for alternate reasons for their level of wellbeing. There is evidence in psychology as well as communication theories that if a group is considered very important for a group member to be able to achieve the feeling of safety, belonging, self esteem and wellbeing, the group achieves a strong cohesion. It has also a higher level of pressure of conformity (Kvalbein 2000). It could be a possibility that this had influenced the children's level of wellbeing; four of the children in this study stated that they needed each other's friendship to a high extent and that this friendship was important to be able to participate in their lives. Thus the group was probably considered important for the feeling of belonging.

This might also contribute to the increased feeling of strength, and encourage them to act to reach the common goal to get residence permit in Norway. However, because of the pressure of conformity there is also a possibility that it could be difficult for a group member to have another opinion than the majority of the group, and this pressure might also tighten the strong negative feelings towards the migration authorities. Nevertheless the experiences described by the children were shared by all group members, and these experiences alone might be sufficient to explain the children's feelings with or without the group.

7.3 Articulated words and vulnerability

The children described how words and actions from adults in the centre, school, health service, politicians and other authorities had a harmful impact as far as promoting mental health was concerned. Paolo Freire is claiming that "the articulated word" is very important when an individual is developing his/her picture of the "world". The words people use to describe the world, and individuals in the world, is influencing other human beings' attributions of the surroundings and individuals (Freire, 2002), and positive words are important to make others feel well. This is also an important result of this study. The words chosen by persons who are interpreted as authorities by the public to describe refugees in general, may influence public's comprehension of refugees. Freire (2002) claims that this comprehension may in its turn also influence publics' *behaviour* towards the actual minority group, and it may even influence the members of the described group's own perceptions of themselves and their environment as well as their feeling of wellbeing. It is also likely that this may in its turn influence the individual's self esteem and ability to participate in a positive way to achieve the experience of empowerment.

When a person is living under extreme conditions and is feeling vulnerable and hurt, he is particular sensitive to words and actions in the environment. These experiences might fester as "everlasting lessons" as described by Lindy and Wilson (1994) and may cause damage through the rest of their lives if not dealt with in a proper way. This is also emphasized in theories about crisis (Falk, 1999; Culberg, 1981), and from the descriptions of the children and theories above, their childhood seem to have been influenced by a life in a long-lasting crisis; when experiencing a crisis with low level of perceived locus of control and sense of coherence, several reactions may occur, and in this situation children are particularly vulnerable and need to be treated in ways that "raise them above zero".

Whatever way one might choose to attribute causes for the children's conditions and their experiences of life, the consequences of their bad feelings may be huge and have to be taken seriously; individually because it effects their level of subjective wellbeing and health, but also socially as they may navigate into groups of delinquent youth searching for the feeling of friendship and belonging which they do not find elsewhere. Therefore it is of utmost importance to listen to their stories and advises for what is essential in their lives.

7.4 The concepts of "negotiation and navigation"

Ungar is using the concepts of "negotiation" and "navigation" to describe children's pathways to resilience, and as these words are central in this study there is a need for an explanation. There seem to be no common and shared definition of "negotiation" and the definition chosen here is described in the Negotiation Theory within Social Sciences;

> *a process of combining conflicting positions into a common position under a decision rule of unanimity, a phenomenon in which the outcome is determined by the process* (Wikipedia.org).

In this way decisions of individuals or groups are determined by considering the probability and utility of different outcomes. "Navigation" as Ungar uses it is the decision that follows the negotiation. Originally the term navigation applies to the process of directing a ship to a destination. Navigation Research deals with fundamental aspects of navigation in general. It can be defined as

> *the process of determining and maintaining a course or trajectory to a goal location* (Franz Mallot, 2000).

It concerns basically all moving agents, biological or artificial, autonomous or remote controlled. Thus children's negotiation may be considered as how they observe and experience their environment, and compare reality with their experience of it in order to find which direction will lead them to the best beneficial outcomes. "Navigation" towards resilience is thus the movement towards an aim where the children believe they will find subjective wellbeing, and this may be a more or less conscious process. It may in this way also be a result of despair when all possible ways are blocked to reach the goal of wellbeing. Consequently children may try to escape the harsh reality, and navigate towards less healthy environments like youth gangs and delinquency to achieve the feeling of belonging and wellbeing. When being prevented for any navigation at all it may seem like the condition of learned helplessness may lead them towards conditions of depression, anxiety or a giving up syndrome. Negotiation and navigation are processes that are considered closely connected to participation and empowerment.

7.5 The importance of a healthy public policy for the development of resilience

According to Paolo Freire (2002) the feeling of "oppression" or "violation" is a subjective experience of being controlled by an external power, and the way he explains "violation" leaves an impression that this is actually underlining the feelings that the children tried to describe. The way they seemed more or less to demonize the migration authorities and some helpers in their descriptions was probably due to their subjective experiences of the situation as refugees, but it also seemed to be doubtlessly connected to the actual behaviour of important persons in their lives. A phenomenological study and Ungar's perspective to focus on the children's stories, demand that the children must be listened to and believed in by the researcher. The acknowledgement that children understand risk, adversity and life different from adults, demands that researchers have to temper adult expertise with humility, and allow children to explain and interpret their childhood (Boyden and Mann, 2005). This implies the need for participatory and child centred research methods and methodologies that gives a proper scope for children's testimony (Boyden and Mann 2005; Ungar and Teram, 2005; Ungar, 2005). Following these theories and the children's expressions there is no doubt that their situation as refugees has been experienced very harsh and that a friendly environment is urgently needed for the development of subjective wellbeing and mental health. A healthy public policy is important for that matter.

The UN standards set by the Convention on the rights of the child are stating that:

> *"Every child has the right to "such protection and care as is necessary for his or her well-being" (Art. 3.1,* United Nations High Commissioner for Refugees, 1994),

The Convention was from November 2003 incorporated in Norwegian Law. Most countries have ratified the Convention of the Rights of the Child but when comparing the children's statements to theory and related studies, there are reasons to join Boyden and Mann (2005) in questioning if children and their families and communities necessarily can count on the promises made by the international Treaties? Seen in the light of this research, there is also a need to ask who has the capacity to decide what "is necessary for his or her well-being" and what is causing the difficulties in their lives? Boyden and Mann argue that there is evidence that shortcomings in policy and practice are the result of

> *..erroneous conceptualization of problems and their solutions, inadequate empirical evidence to support specific interventions, and unquestioned assumptions about children's development and their relative capacities and vulnerabilities* (Boyden and Mann, 2005:4).

Through this it asserts the need for research, policy, and programmatic interventions to consider carefully the reality of children's lives in order to improve the effectiveness of interventions designed to assist them (Boyden and Mann, 2005).

The difficulties of the long asylum procedure and the feeling of futile struggle against authorities were visible in this study as well as in the mentioned related studies. It was also apparently obstacles for the children's participation and empowerment. All mentioned studies emphasize the need for psychosocial care for unaccompanied refugee children because of the difficult situation in the new host country, and because of their traumatic experiences from their refuge or home country. This is similar to what the participants in the present study described as their needs. They all called for access to health care by specially educated persons

within psycho-social work, and according to the UN standards and the Convention on the rights of the child

> *…every child who is a victim of "any form" of abuse or neglect has the right to "physical and psychological recovery and social reintegration (Art. 39)* (United Nations High Commissioner for Refugees, 1994).

When children learn that responding to an uncontrollable event is futile, they may feel that they are prevented from navigating towards health and wellbeing. When they feel that there is no possibility for navigation, they may give up and escape into a condition of anxiety and depression, or "learned helplessness" (Tones and Green, 2004). Tunstrøm's research and the following up research of his study seemed to point to the extreme consequences of such learned helplessness, and this is also visible in the stories of some of the children in this study.

When comparing these studies and literature mentioned in this paper to the stories of the children in my study there are shortcomings in practice and policy concerning refugee children in Norway, as well as other western countries. This seems to be a stumbling block for the development of their subjective wellbeing and mental health. There is indeed a need for attention to refugee children's own understandings of their experiences and needs when planning a healthy public policy that aims to attend to the human rights of these children and support them in their effort to achieve subjective wellbeing and resilience (Carolyn Williams, 1991; ECRE, 2004; CRMD, 2003).

7.6 Children's negotiations and navigations to achieve subjective wellbeing, mental health and resilience.

The children repeatedly told about situations which they felt were preventing them from subjective wellbeing. When negotiating with themselves and their

environment to search for different solutions only to find none, they tried to escape from their painful reality, or navigate away from it. They negotiated to find ways to keep a distance to people whom they felt were tearing them down and navigated away from them whether it was health care personnel, teachers, and staff at the centre or others in their search for subjective wellbeing. However, what four of them found most disparaging was the contact with the migration authorities, and they described the feeling of depression, despair, anxiety and suicidal thoughts connected to the physical and written contact with persons from the directorate. The children seemed to be convinced that the migration authorities had the key to a safe and happy life for them, but were lacking the will to open up. The children expressed their sense of helplessness when feeling that they were not wanted in Norway, and when all their applications were dismissed; this seemed to alert the feeling of learned helplessness and psychological problems (Tones and Green, 2004; Ungar, 2005; Freire, 2002).

However they negotiated with themselves and their environment to find ways to feel better, and then they navigated towards what they identified as "the best ways". The experience of alliances with trustworthy adults who apparently appreciated them seemed to enhance self esteem and courage for self actualisation, and this encouraged them to take a hold on their life and start fighting for residence permit. The children apparently considered this struggle as a fight for their lives, and this may explain the high level of investment of power in the participation; this is in accordance to Maslow's theory which claims that general physiological needs must be satisfied before higher order needs can be fully achieved (Maslow, 1970). In the same way The Ottawa Charter (1986) and WHO is also stating that the need for

peace, safety and security must be satisfied before people consider adopting behaviour that will improve their health (Tones and Green, 2004: 84; Pan American Health Organization, 2000).

Another kind of navigation was the participation in the action group. The children described how they worked and their feelings when they succeeded. In particular Hassan showed his enthusiasm and was obviously very proud when telling about it; He laughed, rose up in his chair, and seemed happy making entertaining jokes. He also explained that before the engagement in the action group he used to hang around in the street doing nothing at all. His turning point was the action group and the alliance with the social worker, and this also encouraged him to engage in music and football to try to forget about what he experienced as awful. The others also described how they navigated towards different activities, and it seemed like their contact with trusted adults and good friends helped them to navigate in a healthy direction. There are reasons to believe that without them they might have searched for their wellbeing in not so healthy environments like youth gangs who might lead them into pathways of delinquency (Ungar, 2005; 2005a). In this way it seems incredibly important to establish attachments to trustworthy adults and friends; these people could be important components of their negotiations and navigations towards a positive direction where they may be considered resilient by themselves as well as the society. It seemed like the caregivers who were defined positive by the children listened to the children and were seriously considering what they described as their needs, and in this way the alliance that is so important for a healthy development was established.

7.7 The need for psychosocial support to navigate towards resilience

All children emphasized an urgent need for access to psychological help. Three had found such support in their psychologist, while two were still searching for a professional to trust and to talk to. Miller et al enhances that in addition to the feeling of an alliance with a therapist, the clients' expectation of a professional helper is important for the outcome of therapy (Miller, Duncan and Sparks 2004).

The children seemed to have certain expectations to a psychologist and his professional role, but this alone did not answer for their belief in them as Hassan already had navigated away from another psychologist. Due to description and theory the reason seemed more to be that these professional persons engaged in their lives and their adversities and had an unconditional positive regard towards them (Roberts, 1980; Freire, 2002; Maslow, 1970; Berscheid, 2004; Miller et al, 2004; Røkenes and Hanssen, 2006). Besides they also tried to help them to change their situation. Many professionals often claim that it is important not to bring politics into therapeutic interventions. The results of this study and health promotion theories, critical theory and empowerment theories seemed to enhance the opposite; this is confirmed by Wiley, A. and Rappaport, J. (2000). Tones and Green (2004) claim that critical health promotion call for health professionals to take political action to challenge adverse environmental circumstances. Prilleltensky & Prilleltensky emphasize that:

> *Professionals cannot stand back and hope that personal resilience will emerge from their therapeutic interventions alone. Community change, not just personal change; political change, not just psychological change; and justice, not just caring, are all urgently needed* (Prilleltensky & Prilleltensky, 2005:101).

Tones and Green (2004) enhance that empowerment does not only happen; there is a reciprocal relationship between individuals and their environment and there is a need to strengthen this relationship. The therapists and the social worker mentioned in this study had apparently established good relations to the children, and assumingly the view mentioned by Prilleltensky and Prilleltensky and Tones and Green above, was their successful strategy together with the unconditional positive regard.

7.8 Participation, empowerment and resilience in a health promotion perspective

According to the Health Action Model (HAM) mentioned in theory above children bring with them their personalities, based on their belief system, motivation system and the normative system (Tones and Green, 2004:79). All the participants in this study seemed to have a high level of internal strength; the unaccompanied refugee children had survived extreme adversities before they came to Norway all by themselves, and the two others grew up in Norway under difficult circumstances. All the participants seemed to have qualifications to manage their lives in Norway in a good way; they wanted to live a peaceful life, they wanted a safe home, supporting adults and friends, they wanted to get an education, a job and a family. However, when they arrived they felt that the environment which they expected to support them and protect them surprisingly seemed to let them down. Only Sally experienced that she mainly got the help she needed; she had more people whom she trusted, and she described the following up from her psychologist as the most important for her "rising up" as she said. The unaccompanied children who did not have any family suffered in particular from the lack of support. Besides they described their future as unpredictable and they strived to get a sense of coherence

and a perceived locus of control. They clearly stated the negative affect of not understanding the world in which they lived.

Bandura (1992) argue that self efficacy, which is the judgement of how well one can execute courses of action required to deal with prospective situations, is of great importance for the feeling of self esteem. Self efficacy is influenced by mastery, and health promotion is to influence the experiences of mastery to enhance the feeling of self efficacy and self esteem. In this way it is also related to participation and empowerment. It is considered important to get a sense of personal control to all intents and purposes and to get a feeling of commitment to and involvement with community and life in general. By doing this, change of life may be viewed as a challenge, and a feeling of hardiness may be established. Hardiness is also described as virtually synonymous with the notion of "resilience" (Tones and Green, 2004). According to statements by the children their feelings of succeeding in their action group seemed to be important to enhance strength.

The importance of achieving knowledge about the world you live in is also considered important according to the HAM. The way children attribute causes for their problems, influences their level of participation. When the participants of my study were guided by somebody whom they trusted and got the knowledge about how the Norwegian democratic system was functioning they used the information to negotiate and to make decisions about how to behave. By reducing the children's entropy the important adults in their lives contributed to change the children's perception about a situation where it was futile to act, to a situation which became less chaotic and more meaningful for them. In this way they learned that their pain

was not caused by "fate" but by human beings and their own lack of understanding. This is also a very central part of Paolo Freire's critical consciousness raising theory, and he claims that when a person is acknowledging that it is no "magic power" that causes a human's feeling of oppression, it is possible to participate and fight. In this way they gained a higher feeling of self esteem and navigated to achieve a higher level of subjective wellbeing and resilience by this participation.

The need of social interactions was apparently considered by the children as most important for their subjective wellbeing. The quality of that interaction was the foundation for whether they decided to participate or not, or for what kind of actions they chose when participating. In this way participation and the feeling of empowerment seemed to be the results of positive interactions with one or more safe adults, and / or with friends; somebody had to be there for them to enhance the feeling of self esteem, and to feel wanted, appreciated and valued. The importance of having the particular right person for that purpose seemed to be crucial for their decision to participate to make a healthy choice, and in this way to be considered resilient by themselves as well as the environment. An important aspect to this matter is the acknowledgement that the choices people make by themselves are the choices that may cause the most rapid and lasting changes (Freire,2002; Tones and Green, 2004),

As mentioned above, disparaging words used by politicians or other authorities may result in the feeling of being oppressed, and may thus also influence children's behaviour. However, Freire (2002) also claims that the feeling of oppression in addition may contribute to anger and it may encourage people to participate some

times for good and some times for bad, as described by Aida and Sally. The question is then: what actions may vulnerable children choose if they feel oppressed and do not find somebody who may support them to make the healthy choice the easy choice? Will they navigate into gangs of delinquent youth, or fade away into psychiatry? Trying to stop the children's effort to participate in their lives might be unhealthy; Ungar states for instance that a remarkably diverse collection of studies have found that resistance is not all bad, and that in fact the children and families who challenge authority are often those who maintain health better than the "*passive victims of structurally exploitive educational and welfare systems*" (Ungar, 2005a). Health promotion is as much about a healthy community as a healthy individual.

7.9 Human relations as contributors for development of resilience

When listening to the children's descriptions and when reading about theories, literature and other research, it became convincing that the solution to the research problem in this thesis was far more complicated than connecting it to participation alone. Ellen Berscheid claims that all behaviour seem to be in coexistence with others and can not be considered isolated (Berscheid, 2003). The importance of alliances and relations to other people to feel well is documented in theories above, and are also described by my participants.

There are several aspects concerning the importance of relationship for subjective wellbeing; the unconditional positive regard that characterizes Carl Rogers' and Paolo Freire' attitude, seem crucial for children's wellbeing. However this might not be simple to effectuate if the staff do not have sufficient knowledge about the

efficiency of such attitude and have no education about children, cultures and trauma. If staff does not understand reasons for wounded children's behaviour and their actions, they might easily feel overwhelmed and conclude that the child or youth is nothing but troublesome or delinquent. The behaviour following this attitude may be strict limits, punishment of different sorts, and an autocratic environment. Connecting it to Reiss and Gable's theories above about "bad" being superior "good", such treatment affects the children's wellbeing to a great extent, even if it is carried out by just a few persons in the environment. It is also a great contrast to how the children in my study describe their needs. This indicates the request for education in this special work to be able to support children in their navigation towards resilience and subjective wellbeing.

An interesting perspective cropping up in this study was the question why staff and guardians, who were appointed to assure that the separated children should get adequate help, were experienced more like the children's enemies in stead of trusted caretakers. It is important to understand reasons for their described behaviour, to adjust the situation to a more positive experience for all. One way to explain it is that the behaviour might be possible symptoms of Event CTRs (Lindy and Wilson, 1994). In this way their behaviour is more comprehensible, though in deed unfortunate for the children as it seemed to affect the relationship between helpers and children in a negative way and to influence the children's lack of ability to participate in their lives and feel empowered. According to Susanne Bang (2003) supervision and training might prevent the destroying CTRs. Such training is aiming to support helpers in identifying their feelings and to establish the good

alliances which seem to be so important for the children's negotiation and navigation towards subjective wellbeing and resilience.

The children also emphasized the need for belonging to somebody. According to Berscheid there is an expressive array of evidence that humans possess a "need to belong" (Berscheid, 2003). She also claims that the presence of an attachment figure in stressful situations may reduce the intensity of the individual psychological reaction to the stressful event. This knowledge should be taken quite seriously considering the consequences for refugee children as well as for the society in which they live. Berscheid's theory was underlined by my participants. They described that when they found who appreciated them, wanted them, were kind to them and supported them, they felt safer, and they tried to follow these important adults' advices. In this way these persons became incredible important for which way the children would possibly navigate. Tones and Green claim that the environment is influencing the self, its beliefs and motivations, and a supportive environment is thus of special importance "*to make the healthy choice the easy choice*" (Tones and Green, 2004: 79).

The children also described how they had negotiated and navigated to try to raise their self esteem, and the importance of a friendly environment was emphasized. In addition to their statements and theories above Ellen Berscheid is emphasizing that it is within relationships with others that most people typically experience the positive emotions of love, joy, happiness and contentment, and that they successfully overcome the physical and psychological challenges to wellbeing and survival that all humans encounter (Berscheid, 2003).

Self esteem is a key feature of mental health, and it can be influenced in various ways; one of the most important is a belief about being in control. Tones and Green claim that

> *It is virtually axiomatic that self esteem has a significant effect on health-both directly and indirectly* (Tones and Green, 2004:92).

The participants demonstrated that self esteem was boosted by participating and by the success and mastering of their struggle. This success encouraged them to help the unaccompanied refugee children in their effort to avoid being transferred from what they were acquainted to. The wish to help others seemed to be an important motivating force for all the children. They showed this by telling how they would like to help others in their situation here and now, and also by telling about their hopes about education and future professions. The need to and the effect of doing well to others is also emphasized in positive psychology, and Piliavin (2003) is enhancing that doing good to others may be a benefit for the benefactor. This knowledge might be used by helpers to encourage the children to participate in different kinds of activities, like for instance household, to demonstrate that they are needed and valuable.

Health promotion is defined as health education multiplied with a healthy public policy, and to be healthy is parted into physical health, mental health, like for example by "being all that you can be" (Maslow, 1970), and social health. Along with the social health of the individual, the health of society is considered crucial for individuals. Tones and Green (2004) enhance independence, interpersonal relationship, and responsibility and culture norms as important health determinants.

They also describe an unhealthy society as a society characterized by malaise, anomie, alienation, and lack of commitment to human rights. Taking in consideration theories about the importance of locus of control, sense of coherence and the children's descriptions, there is in deed a need to consider these recognitions seriously when planning a public policy which is meant to be healthy for refugee children.

7.10 Children's advices and characteristics of positive caregivers

The children eagerly described their opinions of how helpers most effectually could contribute to their subjective wellbeing and development of resilience; they needed to trust them, and found it trustworthy when somebody treated them as important, and respected them. The words people use in direct and indirect interactions with them was considered very important for their feeling of wellbeing, and friendly and kind words were highlighted. They stated that they needed somebody to have faith in them, and particularly Sally and Sana enlightened that. They emphasized that words like "I know you can do it", "You are clever", "How was your exams?" and words that indicated that someone had faith in them, were encouraging them. They also described that it was of a great importance for their wellbeing that they felt that people's "caring" was based on a true loving attitude; some called it "love", and others "care". Particularly the unaccompanied refugee children explained that they needed somebody in whom they trusted and could lean upon. All the time they negotiated with themselves and their environment to find a trustworthy person.

By negotiation and navigations they also experienced that certain characteristics of a person supported them best on their pathways towards resilience: The person had

to be experienced as kind, loving, respectful, listening, understanding, and he /she had to visualize that the children were accepted as valuable human beings. In addition they had to remember that they were children, like the children they had at home. These statements are supported by theory in this paper. Berscheid claims that nearly all existing research incorporate some of the basic themes involved in positive-quality relationship. She arrays these themes to be:

> *Affection, caring, reassurance of worth, advice and guidance, proximity to caregivers, coping assistance, opportunities to nurture, reliable alliances and tangible assistance* (Berscheid, 2004:41).

All these issues are mentioned by my participants as important for their subjective wellbeing. Paolo Freire also highlights the importance of "the dialogue" for learning and to raise the self esteem, and he claims that there can not be an honest dialogue if it is not influenced by true love, true modesty and faith in human beings (Freire, 2002). This is also underlining the importance of a congruent and warm attitude by helpers to encourage the children to make the healthy choice the easy choice, and participate in their lives.

8.0 CONCLUSION

The purpose of this study was to learn about the connections between what is promoting subjective wellbeing and resilience in refugee children, and the contribution of participation and empowerment for that development. The intension was also to find how children described their pathways to subjective wellbeing and resilience, hoping to find better ways to support them in their negotiation and navigation.

Qualitative resilience research is about individuals and personal agency in its many forms to more effectively point out connections between the choices made by the youth and the contexts for making these choices. The point of the constructionist perspective of resilience research is to highlight these connections, and emphasize that unless they are changed, children and youth will continue to be resilient in ways that may not confirm to society's norms (Ungar and Teram, 2005). A challenge is therefore to come to terms with the contradiction between respecting youth's definition of resilience and health and our understanding of it. This perspective has been useful in this study to show how the adolescents define what they consider important, and compare it to theories and literature.

 Another purpose of the study was to advocate together with refugee children for a more caring and just society, and the children emphasized that it had been important for them to participate in this study to try to influence the condition for other children.

The study did not uncover many contradictions between related studies, theories and the children's stories. The children considered participation and empowerment important for the development of resilience, mental health and subjective wellbeing and their experiences fit with related studies and theory. There is a need for interference on several levels; a healthy public policy is crucial to that matter, and the children were determined that without the support and unique concern from trustworthy adults and friends, they might probably not be able to participate positively in their lives at all. The participants negotiated and navigated a long time before they finally found important persons who helped them making the healthy choice the easy choice. However there may be many refugee children who do not

find such support and there are reasons to worry about in which direction their lack of navigation opportunities to achieve subjective wellbeing will lead them; sometimes it may not be for the best of either the child or the society.

However it is important to emphasize that along with the results in this study, many new questions emerged. Some of these may be interesting to follow up in eventually further research; For instance, how important are words articulated by important persons for refugee children's mental health promotion? And how does love actually influence the development of resilience, mental health and subjective wellbeing in refugee children, and also in human beings in general? Another interesting question is: how strongly may Event Counter Transference Reactions in professionals influence health promotion, therapy, teaching, human rights work, supervision, child care and health service, and how may it in its turn contribute to community's attitude to refugee children? Another perspective of this aspect that cropped up during this present study was the possible occurrence of Counter Transference Reactions in researchers when interviewing traumatized people, and the danger of bias in the study as a consequence of such feelings and reactions. To find answers to these questions seem important in the light of health promotion and the development of resilience.

An important issue is that although all participants in this study came from different countries with different cultures, they all expressed certain common fundamental needs which had to be fulfilled before they managed to participate in making the healthy choice the easy choice; security, peace and the experience of alliance with important adults who showed genuine interest, respect and a loving attitude to them.

Although Ungar claims that development of resilience is influenced by different factors in different cultures and contexts, he also admits that some factors are so ubiquitous as to be universal: we agree not to do violence to one another; we share food with loved ones; we form attachments, and we seek power over our lives and a position of recognition in our communities (Ungar, 2005a). These are all essential elements of resilience that appear in global studies of health, and also in this present study.

Finally, an important force for the children in this study to participate and navigate towards resilience and subjective wellbeing was apparently their internal strength; but where did that strength come from? The children connected it to alliances with important adults and friends, communication processes, a friendly environment and peace, but The Grand Question is: What is the power behind these processes? This paper does not aim to answer this fundamental question, and it is left open for further reflections. However it seems appropriate to summarize the needs and the advice of the brave and wise children in this study in the words of late Abraham Maslow:

> *Our duty is clear here. We must understand love; we must be able to teach it, to create it, to predict it, or else the world is lost to hostility and to suspicion*
>
> (Abraham Maslow, 1970:181)

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APPENDIX

1. INTERVIEW GUIDE

Questions

1. Can you tell me about your situation since you came to Norway? Where have you lived? For how long?

2. Can you describe yourself today? Is it different from one year ago? Or when you came to Norway? What is the difference?

3. What have been the most important to make you try to change your condition? A situation? A person? Characteristics? Words? Are there any of these characteristics that strengthen your trust in yourself to act to change your situation?

4. Are there specific services, persons, or situations that facilitated change in your situation? In what way was change facilitated?

5. Can you describe to me what was important for you in this process?

6. What relation do you have to people in your environment (teachers, peers in the centre, Norwegian peers, camp personal, health personal, coaches etc). What does this relation mean to you?

7. If you could try to explain any reasons for the way your life has turned out to be, how would you do it?

8. What makes you happy? What do you do then? What makes you feel bad? What do you do then?

9. What wishes do you have for the future? Can you describe for me how you think you can fulfil your wishes?

10. Would you please give some advices to Norwegians about how to support children and youth in similar situations as yours?

The questions must be considered just advisory, and may be changed, mixed and reformulated as the conversation is going on.

2. INFORMASJON TIL DELTAKERE

1. Prosjektets tittel:

Unaccompanied minor refugees and resilience; Empowerment, participation and subjective well being

2. Prosjektets bakgrunn og formål

Bakgrunnen for studiet

er mitt arbeid som psykiatrisk sykepleier for flyktningebarn og ungdom i 12 år. Gjennom dette arbeidet ble jeg opptatt av hvordan vi best kan legge forholdene til rette for denne gruppen som dere også tilhører. Representanter for deres gruppe har vært presentert i media fordi dere har jobbet med deres egen situasjon og ønsker å bedre situasjonen også for andre i samme situasjon. Jeg ser det som viktig å kartlegge deres erfaringer med dette arbeidet, og mitt håp er at dette på sikt skal kunne bidra til utvikling av planer for en bedre ivaretakelse av deres gruppe.

Formål med studiet:

- Å finne ut mer om hvordan det er å være barn og ungdom og flyktning i Norge. Jeg ønsker også å finne ut hva som har bidratt til at dere har tatt fatt i situasjonen deres og prøver å gjøre noe med den selv, og hvordan dette oppleves for dere.

- I tillegg vil undersøkelsen kunne gi et viktig bidrag til dem som har mye kontakt med flyktningebarn og ungdom, som mottaksarbeidere, helse-og sosialarbeidere, lærere, frtitidsarbeidere, om hvordan dere selv mener at støtten kan utformes.

3. Hvilke metoder som skal benyttes for å innhente opplysninger, og hvilke opplysninger som innhentes.

Jeg ønsker å intervjue dere om hvordan dere har opplevd situasjonen som flyktning i Norge. Særlig er jeg interessert i hva som førte til at dere aktivt prøver å få økt innflytelse i forhold til deres egen situasjon og hva det har betydd for dere å jobbe med dette. Jeg vil helst intervjue dere en og en, for at hver best mulig skal få komme fram med sin historie.

Jeg vil gjerne bruke båndopptaker under intervjuet for å oppfatte og kunne gjenhente det dere sier mest mulig riktig. Jeg kommer ikke til å gi disse båndene videre til noen, men skrive disse ut etter intervjuene. Dersom dere er usikker på om jeg har forstått dere rett, kan dere lese gjennom utskriften av intervjuet etterpå og godkjenne det eller be om endringer. Før intervjuet vil jeg spørre om det er i orden at jeg bruker båndopptaker. Om du ikke ønsker at den skal benyttes er det helt i orden.

4. Hva opplysningene konkret skal brukes til.

Opplysningene skal brukes til min master oppgave ved HEMIL- senteret. Min plan er også å skrive artikler ut fra dette, der deres stemmer blir det viktigste bidraget. Artiklene skal prøves utgitt i fagtidsskrifter, men også i vanlige aviser.

5. Navn og adresse på institusjonen som prosjektleder er tilknyttet

HEMIL- senteret, psykologisk fakultet, ved Universitetet i Bergen

6. Navn og adresse på prosjektleder og veileder.

Prosjektleder: Siv Førde, Kleiva 79, 6900 Florø

Veileder: Mai Bente Snipstad, Universitetet i Bergen

7. Navn og adresse på databehandler.

HEMIL- senteret, Universitetet i Bergen

8. Finansiering av prosjektet.

Egenfinansiering ved HEMIL- senteret

9. Frivillighet

Det er frivillig å delta og du kan trekke deg på et hvilket som helst tidspunkt.

Om du velger å trekke seg får det ingen konsekvenser for deg, og du behøver ikke gi noen grunn for dette.

10. Tid for prosjektslutt og lagring av data

Prosjektet skal være ferdig våren 2006. Alle opplysninger skal anonymiseres før de lagres i låst arkivskap.

11. Foresatte/verge

Dersom dere har foreldre eller verge har disse rett til å se spørreskjema før intervjuet dersom de ønsker det.

12. Taushetsplikt

Jeg er underlagt taushetsplikt og alt dere opplyser om skal behandles konfidensielt. Opplysningene blir ikke utlevert til andre. Opplysningene som framkommer i sluttrapporten skal ikke kunne tilbakeføres til enkeltpersoner.

13. Innsynsrett

Du har innsynsrett i alle opplysninger jeg får som omhandler deg.

Prosjektet er meldt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Dersom du er villig til å delta i denne undersøkelsen, ber jeg deg om å skrive navnet ditt på vedlagte skjema "Erklæring om samtykke".

Med vennlig hilsen

Siv Førde

SAMTYKKE- ERKLÆRING

Jeg ønsker å delta i Siv Førde's prosjekt om " Empowerment, participation and subjective well-being". Jeg har lest informasjonen ovenfor og fått forklart hva denne innebærer. Jeg godtar at opplysningene jeg gir blir brukt kun i tråd med det som blir opplyst i informasjonsskrivet.

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    Navn   Verge/ foresatte