

Analysis of Holistic Interventions to
Address the Mental Health of Syrian Children from a Refugee Background:
The case of Community Social Pediatric Centers in Montreal.

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ABSTRACT

This study, completed as part of a research project in the obtainment of a Master of Social Work, examines the holistic intervention approach used by Social pediatric centers to address the mental health problems of Syrian refugee children. The objectives of this study were twofold: 1) to explore the holistic intervention approach used in Social pediatric centers in Quebec; 2) to determine the advantages of the holistic approach in addressing the mental health risks of Syrian refugee children. The results indicated that the experiences of post-trauma endured by the Syrian refugee children and their families during the migratory trajectory, makes them more at risk to develop mental health problems. The holistic approach used in Social pediatric centers is for the most part advantageous as it allows the professionals working in proximity to this population, to provide specific and long-term services, while also addressing the mental health needs of the parents.

Keywords: holistic interventions, Social pediatric center, refugee, mental health.

Cette étude est complétée dans le cadre d'un mémoire pour l'obtention d'une Maîtrise en Travail Social. Elle examine l'approche d'intervention holistique, utilisée par les centres de pédiatrie sociale afin d'adresser les problèmes de santé mentale chez les enfants Syriens réfugiés au Québec. Les objectifs de cette étude sont doubles : 1) explorer l'approche holistique utilisée dans les centres de pédiatrie sociale au Québec; 2) déterminer les avantages de l'approche holistique pour adresser les risques de développer un problème de santé mentale chez les enfants réfugiés Syriens. Les résultats indiquent que les expériences de post-trauma qu'on vécue les enfants Syriens réfugiés et leurs familles lors du parcours migratoire, les mets plus à risque de développer des problèmes de santé mentale. L'approche holistique utilisée dans les centres de pédiatrie sociale est perçue comme avantageuse puisqu'elle permet aux professionnels qui travaillent à proximité de cette population, d'offrir des services spécifiques et à long-terme, elle permet également d'adresser les besoins de santé mental de toute la famille.

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INTRODUCTION

Since 2011, the Syrian conflict has caused what some would describe as the worst humanitarian crisis the modern world has witnessed thus far (Petrou, 2015). As of February 2018, 5.5 million Syrians were forced to leave their homes behind to find safety within foreign countries (United Nations, 2018). Since the Liberal government of Canada came into power in 2015, more than 50,000 Syrian refugees have been welcomed into the country (Keung, 2018). Amidst the global conflict occurring on Syrian grounds, children are suffering and their mental health is worth paying attention to (Petrou, 2015) .

According to literature, during latency age children with a refugee background are especially vulnerable to the numerous stressors encountered during the forced migration process (Bettman et al., 2017). These stressors may strongly affect their mental well-being and induce a serious effect on their socio-affective development (Bettman et al., 2017). Each phase of the migratory trajectory is source of an increased toxic stress for the child. During the pre-migration phase, the child may experience loss, violence, famine and discrimination (Delgado, Jones, & Mojdeh, 2005). During the migration phase, the difficult conditions in the refugee camps combined with dangerous travel experiences is likely to induce anxiety within the child (Delgado et al., 2005). Adjustment and acculturation are two processes which the child must undergo during the post-migration phase while coping with other stressors (Delgado, et al. 2005).

The current master paper is particularly concerned with Syrian children from a refugee background living in Quebec.

Syrian refugee children are subject to systemic discrimination when they arrive to Canada. According to the Ontario Human Rights Commissioner (2018), systemic discrimination can be explained by patterns of behaviour, policies, or practices that are part of the structures of institutional organizations which maintain racialized persons in a circle of perpetual disadvantages and a vulnerable state (Ontario Human Rights Commission , 2018). Whereas discrimination is defined by any action or decision that treats a person or a group badly for reasons such as their race, age or disability (Canadian human rights commission, 2019). A study conducted by Rousseau et al., (2010), demonstrates that the discrimination endured by minority groups in Montreal is an important determinant of their mental health (Rousseau, Hassan, Moreau, Jamil, & Lashley, 2010 p.89,90). Syrian refugee families and their children are considerably vulnerable to systemic discrimination when they arrive in the new country, especially when taking into account the traumatic events they may have gone through before arriving to Canada, and the difficulties accessing mental health services upon arrival (Zilio, 2017; Bettman, Taylor, Gamarra, Wright, & Mai, 2017). These families may require guidance and support in navigating institutional structures and assisting their children in the adaptation to the new culture. Furthermore, knowing that 60 per cent of Syrians arriving to Canada are children under eighteen, there seems to be a deficiency in interventions and services that address their mental health needs (Zilio et al., 2017: Bettman et al., 2017).

In Quebec, Community Social Pediatric Centers are available for those who are marginalized and who have difficulties accessing institutional services. These centers develop and adopt a holistic approach which considers the child as the centre of the intervention and takes into account the complete cultural, spiritual, medical, social and

mental well-being of the child and of his immediate environment (Sirin & Aber, 2017). The adversities Syrian refugee children are confronted with during migration affects their holistic development (Sirin & Aber, 2017). These developmental systems include cognition, language, physical/health, and social/emotional development and are open to influence during one's childhood (Sirin & Aber, 2017).

In the province of Quebec, Social Pediatric Centers have been recognized as an important organization in helping children from vulnerable environments to develop to their full potential. Community Social Pediatrics Centers use holistic interventions to assess the areas of concern in every case, and acquires the necessary knowledge of each child's experience to offer services and offer care practices that correspond to the child's needs and specific problems (Kelly & Horder, 2001). These centers also adopt a social medicine approach to enable a more complete diagnosis of the physical, psychological, cognitive and social health. Community Social Pediatric Centers rely on the child's strengths and use a multidisciplinary approach to reduce and eliminate stressors that hinder the well-being of the child. These centers operate in vulnerable neighborhoods to ensure that the families, children and individuals of the immediate environment, who are affected by multiple sources of toxic stress would be provided with an easy access to the center and its services.

After providing a general description of the situation of Syrian refugee children's challenges and needs, the present research seeks to answer the following question: how do the interventions used in Social Pediatric Centers address the mental health of Syrian refugee children? The first objective of this master's project is to shed light on the developmental issues and the consequences on Syrian refugee children of the trauma they've been submitted to. Our interest goes to the perspectives of professionals working

in Social pediatric centers who have intervened with these children. Our second objective is to further our understanding on the holistic interventions used in the Social pediatrics centers and the ways in which these interventions contribute to the improvement of the developmental outcome of children from a Syrian refugee background as well as the limits of such interventions. A structural understanding to these issues will also allow for a more global perspective on the ways a holistic intervention can reduce the negative effects of social injustices and systemic discrimination implicitly induced by the societal structures (Lapierre & Levesque, 2013).

Social pediatric centers are mainly operating in Quebec. For the purpose of this research three Social pediatric centers have been targeted in the region of Montreal due to the high number of Syrian refugees settled in the city (approximately 35% of Syrian refugees arriving to Canada have settled in Montreal) (Houle, 2019). These centers are: *The Community Social Pediatric Center of Côte-des-Neiges*, *Community Social Pediatric Center Au Coeur de l'enfance*, and *Community Social Pediatric Center of North Montreal*. Community social pediatrics centers are of special interest for this research due to their renown and exclusive expertise regarding interventions and their proximity to the immigrant and refugee population.

Our interest lies in the perspectives of intervenors operating in Social pediatric centers with Syrian refugee children. To instruct this work, we will conduct semi-structured interviews with health and social service professionals who are employed at these aforementioned centers and who have experienced intervening with Syrian children from a refugee background.

This master's paper will be divided into six chapters. The first chapter will explore, the migratory trajectory of Syrian refugee children as it is documented in literature. This chapter will depict the consequences and the difficulties many Syrian refugee children encounter before arriving in the host country, and the lack of adequate resources destined to these children upon arrival. The second chapter is dedicated to the literature review. The third chapter will provide the conceptual framework and will also address the theoretical framework. The fourth chapter explains the methodology of the research. We will describe the process used to collect the data, and then analyze it. In the fifth chapter, we will describe and analyze the results, and in the sixth chapter we will provide a discussion of the results. Finally, the conclusion will suggest different ways holistic approaches can be applied in interventions for Syrian refugee children, the limitations of this research, and other research avenues that could be explored.

CHAPTER 1

MIGRATORY TRAJECTORY OF SYRIAN REFUGEE CHILDREN

In this chapter, we will provide a detailed context on Syrian refugee children and the hardships they would have likely encountered during their migratory trajectory. We will also focus on the consequences these obstacles may entail on their developmental outcome and mental health.

Considering that around 60 per cent of Syrian refugees who come to Canada are children under eighteen, understanding how the migratory trajectory affects their mental health is essential to health and social service professionals working in proximity to Syrian refugee children.

In this chapter we will also decipher how the systemic discrimination encountered in the host country may contribute to the difficulties that Syrian refugee children face upon arrival in their host country. Lastly, we will examine the ways in which addressing mental health issues of Syrian refugee children has an important impact on the child's cognitive, behavioral, and emotional development.

1.1 Who are Syrian refugee children?

According to the United Nations High Commissioner for Refugees (2016), a refugee is someone who is living outside his country of citizenship because of persecution, war or violence, or the credible threat of these (United Nations High Commissioner for Refugees, 2018).

There are two types of refugees recognized by Canada. Convention refugees and refugee claimants (Immigrant Services Society , 2017). The latter, being persons who make their own way out of the country or situation from which they are fleeing (Immigrant Services Society , 2017). They apply for asylum through the in-land refugee determination system and have to wait for a period that could go up to two years before their case is processed (Immigrant Services Society , 2017). The conventional refugees have been sponsored even before their arrival to Canada by the government, or by a private group (Immigrant Services Society , 2017). They are likely to have been waiting in one of the world's many refugee camps before being chosen to resettle in Canada. Syrians fleeing their nation's crisis fall in this category. According to the United Nations, 13.1 million people inside Syria still need help, including 6.1 million internally displaced, meaning that they were removed from their homes but are still within the country's borders (Zavallis, 2016). Over 250,000 people have died in the conflict and hundreds of thousands are wounded (United Nations , 2018). Over 5.5 million Syrians have sought refuge in neighboring countries and hundreds of thousands have gone to Europe or America in hopes of a better life (United Nations , 2018). An article from the Globe and Mail on the Syrian exodus to Canada, explains the types of refugees in each province (Friesen, 2017). The first wave of refugees was mainly privately sponsored, by members of their family who are already in Canada and by religious groups (Friesen, 2017). Half of the Syrian-Canadian population reside in Quebec and 80 per cent of arrivals were privately sponsored (Friesen, 2017). In total, Ontario (about 13,000) and Quebec (about 6, 000) are the two provinces who have accepted the most Syrian refugees (Friesen, 2017). Toronto and Montreal are the most popular urban destinations for Syrian's (Friesen, 2017).

Due to a well-organized Armenian-Syrian community, Quebec was able to adequately sponsor and settle an important number of refugees, which demonstrates the importance of social networks and community involvement (Friesen, 2017). Friesen and Chidiac (2017), mention the advantage of being privately sponsored in terms of strong family networks, high levels of education attainment, and better economic success (Friesen, 2017; El-Chidiac, 2018). Whereas, government sponsored refugees tend to take longer to establish themselves due to social and educational challenges (Friesen, 2017; El-Chidiac, 2018). Despite the optimistic welcoming by the prime minister himself, the transition to Canadian life for Syrian refugees accepted in Canada was met with many hardships. Studies report a lack of adequate housing, as many large families had to remain in hotels for a long period of times and limited linguistic competencies as most of them did not speak either French or English (Friesen, 2017). In addition to this, social service and health professionals are often not prepared to meet the mental health needs of Syrian refugee children due to a lack of understanding their realities (Hadfield, Ostrowski, & Unga, 2017).

The information provided in this chapter will explain the difficult trajectory Syrian refugee families and their children must endure before arriving to Canada and the burden these experiences represent for integration and for their wellbeing. Syrian children with a refugee background have to learn to integrate the past trauma with their new identity, which may affect the child's mental health, and increase the difficulty of adapting to the new society (Bettman et al., 2017). Refugee children also endure the negative consequences of systemic discrimination and racism (Fantino & Colak, 2001). Stereotypes and prejudices of refugees are also an integral part of the child's integration in the host country.

On this specific topic, Steele (1997) sees that: “stereotypes of immigrants and refugees shape the intellectual identity and increase the number of societal obstacles they face” (Steele, 1997). All these elements, increase the difficulties endured by the Syrian refugee children in their integration process and strengthens the need in adapting services which respond to the Syrian refugee child’s needs and realities.

According to research, 45% of refugee children experience post-traumatic stress disorder symptoms, 20% have clinically diagnosable levels of depression, and half of the refugee children have possible anxiety disorders (Halevi, Djalovski, Vengrober, & Feldman, 2016; Arfken Haddad, Javanbakht, & Rosenberg, 2017). These statistics strengthen the necessity of ensuring that mental health, social and health professionals working in proximity to Syrian refugees are aware of the experiences and the possible impacts migratory trajectory can generate on the overall well-being of the Syrian refugee families and their children.

The importance of family has been highlighted by a study conducted by Fazel & Stein (2002), risk factors for mental health problems in refugee children were identified. These factors were divided into three categories: parental factors, child factors, and environmental factors (Fazel & Stein, 2002).

In the first category of parental factors the following elements are included: post-traumatic stress disorder in either parent, maternal depression, torture (especially in the mother), death of or separation from parents, direct observation of the helplessness of parents, underestimation of the stress levels in children by parents, and unemployment of parents (Fazel & Stein, 2002). In the second category are the child factors, these includes: the number of traumatic events (experienced or witnessed), expressive language difficulties,

post-traumatic stress disorder leading to long term vulnerability in stressful situations, physical health problems from trauma or malnutrition, and older age (Fazel & Stein, 2002). Finally, in the last category of environmental risk factors includes: the number of transitions, poverty, time taken for immigration status to be determined, cultural isolation, period of time the refugee camps, and the time spent in the host country where risk possibly increases with time (Fazel & Stein, 2002). These risk factors are directly linked to each phase of the migratory trajectory and they are made worse by the systemic discrimination endured when refugee families arrive to the host country. Moreover, research has shown that when the number of risk factors accumulate in the life of a refugee child, the likelihood that they will develop mental health problems increases noticeably (Masten, Best, & Garnezy, 1990; Fazel & Stein, 2002; Gagnon & Rousseau, 2017).

In order to clearly understand the realities of Syrian refugee children, it is important to understand what each phase of the migratory trajectory entails and its ramifications and this is what will be discussed in the next section.

1.2 Migratory trajectory

Children of a refugee background experience a great amount of toxic stress during each phase of the migration trajectory. According to the Center on the Developing Child at Harvard University (2019) toxic stress is defined as:

Childhood experiences of strong, frequent, and/or prolonged adversity-such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship-without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other

organ systems, and increase the risk for stress-related disease and cognitive impairment, well into adult years. (Harvard University, 2019 p. 6).

Research has documented that 45% of refugee children experience post-traumatic stress disorder symptoms, and 20% had clinically diagnosable levels of depression (Hadfield, Ungar, Ostrowski et al., 2017). These effects of the migratory trajectory hinder the proper adjustment and a positive development. The adaptation to their new societal reality for children from a refugee background is accomplished and varies depending on their experiences that may ignite a toxic stress response during their pre-migration, their migration trajectory, and the living conditions when they arrive to the host country (Gosselin-Gagné, 2014).

Given the impact on the adaptation to the host society upon arrival, it is essential that social workers and those working in proximity to children from a refugee background understand the experiences encountered during their migration trajectory.

In the coming section we will detail our understating of different steps and factors contributing to this overall situation. We will examine what occurs during to the premigration period and then during the definitive migration. In this context we'll examine interacting factors like the parents' influence, systemic discrimination and then we will address the mental health issues that may tend to arise within this context.

1.2.1 Pre-migration

During pre-migration children from a refugee background experience traumatic events due to the nature of the Syrian war (Hadfield et al., 2017). As mentioned earlier, these children face many important losses. The loss of family members, the loss of their friends, their home and their entire familiar environment (Delgado et al., 2005; Hadfield et al., 2017). Much evidence from previous studies suggests that pre-migration traumatic experiences are strongly correlated to factors associated with poor mental health in both currently resettled and long-term settled refugees (Chen, Hall, Ling, & Renzaho, 2017). A qualitative study was conducted in Toronto on the pre-migration determinants of mental health for newly arrived refugees (Murtaza, Shakya, & Wilson, 2018). The participants were asked to share personal stories of having experienced war, torture, violence, persecution, forced labor, forced migration and family separation (Murtaza et al., 2018). One Afghan refugee who participated in the aforementioned study shared the immense impact of thirty years of war in Afghanistan in the following terms:

Of course, there was war in Afghanistan for almost thirty-two years and people lost family, people lost their homes and they experienced a lot of difficulties. That is one of the most challenge in their life. People sometimes help you out. But the point is, you have to carry too heavy things that you shouldn't carry (Murtaza et al., 2018 p. 46-47).

“No one puts their children in a boat unless the water is safer than the land” (Shire, 2015). This moving sentence is taken from a poem written by Wasan Shire, a Somali-British poet intitled “Home”. The poem depicts the difficult migration experiences refugees must endure to attain safety. The expressions of trauma are here materialized through very clear

metaphors that make it easier to understand what research in this field has been documenting for decades.

1.2.2 Migration

The migration experience is tumultuous and uncertain for the children. Travelling conditions are often hazardous, and some unfortunately do not make it to where they are supposed to go. During this period, refugees are often obligated to move between different countries and different refugee camps without any notice (George, 2012).

There are approximately 2.8 million Syrian refugees living in camps across the Syrian border (Muslim Aid, 2015). Moving from refugee camp to refugee camp will often generate separation between families and friends, and create a great amount of anxiety and sense of loss (George, 2012). At this phase of the migration trajectory, children's education is often interrupted as education is not available in the refugee camp. 50 per cent of children from a refugee background receive primary education, whereas 91 per cent of children across the world receive an education (Karumba & Grandi, 2017). This equates to four million boys and girls not receiving the basic human right of an education (Karumba & Grandi, 2017). The time children remain in exile can last for years, and for some children life as a refugee is the only life, they would have known (Karumba & Grandi, 2017). These children can go on for years without education as their lives are constantly disrupted by a state of uncertainty and life-threatening circumstances (Karumba & Grandi, 2017).

Children living in refugee camps are also exposed to various diseases such as polio (Muslim Aid, 2015). Unfortunately, the camps will lack the adequate health care supplies

and vaccines to ensure that the health of those living in the camps is properly tended to (Muslim Aid, 2015).

Housing is yet another issue for Syrian families living in refugee camps face (Muslim Aid, 2015). They are usually confined into small tents with nothing to protect them from extreme weathers (Muslim Aid, 2015).

Furthermore, Syrian refugees living in camps have very few employment opportunities (Muslim Aid, 2015). Having no future prospects can greatly affect the mental health of Syrian parents, thereby also affecting the development and hindering the mental health of their children (Fazel & Stein, 2002).

If these challenges seem to be specific to the pre-migration process, some often would continue after the immigration and children refugees would also face new challenges that are specific to post-migration.

1.2.3 Post migration

During post migration, the refugee child must undergo an adjustment and acculturation in the new country (Jones et al., 2005). They are involuntarily moving to a new country with a completely different culture, a new alphabet, new food, new traditions, new religious practices, new official languages and new laws (Ungar et al., 2017). According to a study done by Porter and Haslam (2005) on the effects of pre-and post-displacement factors on adult and child refugee mental health, they indicated that post-displacement factors had moderated mental health outcomes for refugees, suggesting that there are things that can

be done during the settlement process to improve the mental health of children from a refugee background despite their exposure to traumatising events during pre-migration (Porter & Haslam, 2005).

1.2.4 Parental influence

Many Syrian parents have developed a post-traumatic stress disorder and depression due to the war conditions they have endured (Hadfield et al., 2017). This can lead to their unavailability to attend to their child's needs and to connect and perform tasks that are necessary in the proper functioning of the family (Hadfield et al., 2017).

Furthermore, refugee families face important structural barriers that impact the child-parent relationship (Hadfield et al., 2017). The parents will often have trouble finding employments and difficulties learning a new language, placing them in a state of social exclusion (Hadfield et al., 2017). This situation impacts the parenting capabilities and places the child-parent relationship in peril. In this sense, long-term parental unemployment is strongly correlated with child psychopathology (Tousignant, Habimana, Biron, Malo, Sidoli-LeBianc & Bendris, 1999; Hadfield et al., 2017).

As mentioned in the previous section, children from a refugee background may have been unable to attend school for long periods of time (Karumba & Grandi, 2017). This may cause many challenges once they would start attending school in Canada, and these challenges are amplified if they do not have the basic knowledge of French nor English (Hadfield, 2017). Studies have also proven the effects of trauma exposure on a child's development (Halevi, Djalovski, Vengrober, & Feldman, 2016). Children who are exposed to trauma are more likely to develop cognitive impairment, impaired academic

achievement, anxiety disorder, attentions-deficit/hyperactivity disorder, and conduct disorder (Halevi et al., 2016; Hadfield et al., 2017). Thus, leaving children from a refugee background with many school related challenges as a result to their post-migration and migration trauma.

In this section we examined challenges linked to internal factors and to pre-migratory traumatic experiences. However, additional factors related to the host society also have a significant influence on the wellbeing of refugee children.

1.3 Systemic discrimination

According to the Ontario Human Rights Commissioner (2018), systemic discrimination can be explained by patterns of behaviour, policies, or practices that are part of the structures of institutional organizations which maintain racialized persons in a circle of perpetual disadvantages and a vulnerable state (Ontario Human Rights Commission , 2018).The formal and informal policies, practices and formal decision-making processes create barriers for racialized individuals and minority groups, placing them in a state of social exclusion (Ontario Human Rights Commission , 2018). Our decision-making practices and policies, are not adapted for subjective considerations regarding differing cultures or individual differences or personal challenges (Ontario Human Rights Commission , 2018). Racialized minorities face systemic discrimination constantly as they try to navigate the intricate complexities of institutionalized systems and policies that are not adapted to cultural differences. These systems include social and health services, employment, welfare, housing, and child protection services.

According to the United Nations Refugee Agency, discrimination is amongst the greatest challenge refugees face when arriving to a host country (Committee on the elimination of Racial Discrimination , 2011). This discrimination can be manifested explicitly through violence or implicitly through structural access to public institutions and authorities (Achieme, 2014). Systemic discrimination also enables important challenges in securing a formal employment despite their previous training and experience (Achieme, 2014). This increases the state of vulnerability and exclusion of refugee families, placing them in the margins of society.

In a study conducted by Rousseau et al., (2010), the researchers found that the perception of discrimination doubled since the terrorist attack on September 11th 2001 both for Muslims and for minorities. This discrimination includes implicit forms of racism that is considered as politically correct, maintains ambiguity and places refugee youth and families in position of the aggressor which holds them accountable to the intangible forms of discrimination they denounce (Rousseau, Hassan, Moreau, Jamil, & Lashley, 2010). The study proves how racism and systemic discrimination endured by minority groups in Montreal is an important determinant for the mental health in newly arrived refugees (Rousseau et al., 2010).

Systemic discrimination has also been known to contribute to labour market marginalization which ultimately leads to social exclusion (Gallie, 2003). Unemployment leads to a decline of living standards and the aforementioned decline in the child-parent relationship. Today, the progressive disengagement of the government in social programs reduces the resources available to those living in vulnerable situations. When a lack of resources is combined with the stigmatic effects of unemployment, this will lead to a

growing sense of social isolation (Gallie, 2003). As previously mentioned, unemployment is likely to cause stress, trauma, and poor mental health which increases the difficulty in integrating the labour market (Wright, et al., 2016). Furthermore, parent unemployment is one of the many risk factors in developing mental health problems of refugee children.

Systemic discrimination is also present in public authority institutions such as child protection services. The language and cultural barriers that stem from systemic discrimination and push visible minorities into a state of social exclusion, also reinforces their state of vulnerability and social and financial precarity; all of which increases their chances of being victim of social injustices (Gallie & Paugman, 2002). The decisions and laws pertaining to child protection services are taken by individuals with power and in a position of authority (Commission des droits de la personne et des droits de la jeunesse Québec , 2011). Their motives rest on the security and protection according to the cultural North American norms, which can rely on factors such as one's belonging to a racialized ethnic minority (Commission des droits de la personne et des droits de la jeunesse Québec , 2011). This can entail negative consequences regarding differential discriminatory treatment of racialized children and their families in the hands of child protection services (Commission des droits de la personne et des droits de la jeunesse Québec , 2011).

Furthermore, studies have shown that individuals working in education, social or health services who report perceived abuse or negligence will be increased amongst children of racial minority (Commission des droits de la personne et des droits de la jeunesse Québec , 2011). These statistics allow us to presume a form of racial profiling, where ethnocultural prejudices and stereotypes acknowledge a false interpretation of a situation relying on the information that is available (Commission des droits de la personne et des droits de la

jeunesse Québec , 2011). These are two forms where systemic discrimination is manifested in society.

1.4 Mental health

According to the American Psychological Association (2019), mental health is the effective functioning in daily activities to enable productive activities, health relationships, and the ability to adapt to change and cope with adversity (American Psychiatric Association, 2019). Mental health issues are health conditions involving changes in emotion, thinking and behavior which is associated with distress and/or problems associated with functioning in social, work or family activities (American Psychiatric Association, 2019). The experiences the Syrian refugee children endure throughout the migration trajectory, combined with the systemic discrimination they are faced with when arriving in the host country make them more at risk of developing mental health problems. Montgomery and Foldspang have hypothesized that discrimination experienced by young refugees was associated with mental problems and the weakening of social adaptation in the host country (Montgomery & Foldspang, 2007). Syrian refugee children have endured experiences that may compromise their mental health, and develop mental health issues such as post-traumatic stress disorder, depression or anxiety.

According to a report by Save the Children (2017), the war occurring in Syria has created a mental health crisis, especially amongst children, and has created a condition known as toxic stress (Brophy, 2017; Brophy, Buswell, Khush, & McDonald, 2017). Two-thirds of the children who were interviewed in the report have lost a loved one, had their houses bombed or had been severely injured (Brophy, 2017). These children experienced severe emotional distress and lacked the psychological support because the parents themselves

were struggling to cope (Brophy, 2017). Syrian refugees seem to have experienced trauma which has a detrimental effect on their mental health and overall stability. According to many studies, PTSD is the most common mental health problem with children who were exposed to war atrocities followed by depression and anxiety (Ghumman, McCord, & Chang, 2016). A review conducted by Arfken, Haddad, Javanbakht, & Rosenberg in 2018 on Syrian refugee children who have resettled in Western countries, reported an overall PTSD prevalence of 10% to 46.8% after 1 year (Arfken, Haddad, Javanbakht, & Rosenberg, 2018). Furthermore, more than half of the Syrian refugee children who settle in the US had an anxiety disorder (Arfken et al., 2018).

Children from a refugee background also seem to have an elevated tendency to adopt externalizing problematic behaviors such as aggression (Henley & Robinson, 2011; Hadfield et al., 2017). These externalizing behaviors are often amplified by sleep disturbances due to pre-migration trauma (Henley & Robinson, 2011). If these psychological distresses are not accurately and immediately tended too, the risks of social exclusion in the host country are heightened and may cause further deterioration in the mental health of the adult and the child refugee.

There seems to be a significant correlation between the challenges Syrian refugee children face and the impact it has on their mental health (Stechyson, 2018). Canadian Paediatrics Society supports this hypothesis and presents different risk factors that Syrian refugee children may face (Canadian Paediatric Society, 2015; Stechyson, 2018). Some risk factors that were identified were: not being able to speak the same language as their new peers, exposure to violence in the country of origin, and being separated from family members (Canadian Paediatric Society, 2015; Stechyson, 2018). When these challenges are

addressed shortly after the child arrives to Canada, health and social professionals can promote resilience and a holistic sense of well-being (Stechyson, 2018). By immediately addressing the mental health needs, it has been shown that children will do better in school and adapt better to their new environment (Stechyson, 2018).

About 4,300 to 5,100 of the refugees who arrive to Canada, require formal mental health clinical intervention to help them rise through the trauma (Dharssi, 2018). There is also an increase in refugees seeking counselling, but unfortunately the health and social service professionals already have major caseloads, which makes it impossible to ensure accurate mental health interventions (Dharssi, 2018). Delayed funding from the Canadian government has also forced settlement agencies to make cuts to remove necessary resources such as mental health counselling (Miller, 2017). Another structural barrier to mental health services refugees must face upon arrival is the lack of cross-cultural and trauma-informed capacity of the provincial health care systems (Dharssi, 2018). As a result, these cultural differences may prevent children from a refugee background and their families from accessing mental health services (Hadfield et al., 2017).

Despite having counseling and mental health services available for refugees, most of these services do not consider the experiences and realities of the children. If the mental health needs of children from a refugee background are not accurately addressed, this may entail repercussions in the academic, family, health and social sphere of the child's life.

Ben Kuo (2016), a psychology professor from the University of Windsor states that the biggest concern about refugee integration is Canada's capacity to provide adequate mental health support as they attempt to adjust to their new life while dealing with old traumas of

war. He further mentions that as everything could seem well for the first couple of years, mental trauma could resurface all of a sudden (Kuo, 2017). According to an article published by Abedi (2018), immigrant and refugee youth in Canada are more likely to visit the emergency room for mental health reasons than Canadians. Moreover, the study published in the Canadian Medical Association Journal has stated that for children from a refugee background aged ten to fourteen the emergency room is the first point of contact (Abedi, 2018). If the mental health of these children is not accounted for shortly after arrival, the symptoms may appear later on in life and they may develop externalizing problem behaviors that are misunderstood, especially in the academic setting. Children from a refugee background with mental health issues will be socially excluded from Canadian society, amplifying the negative consequences of their mental health, and those around them.

The following chapter will provide a literature review to support our analysis of the effects of mental health issues on the developmental outcomes of the Syrian refugee children. We will also provide a deeper understanding on the holistic approach used in the Social pediatric centers and the effects this approach has in addressing mental health and developmental issues.

CHAPITRE 2

LITERATURE REVIEW

This chapter aims to provide a comprehension of the effects of mental health issues on the global development of children through existing literature. In order to understand which intervention approaches are documented as being efficient to address the mental health of Syrian refugee children, we must understand the possible risks of developing mental health issues on the development of the child.

The theory that we will explore here, will provide a more profound understanding on how society contributes to the development of mental health issues in refugees and which existing approaches are the most effective in building resilience in children refugees (2.1). We will then examine the services and coverage that are offered to Syrian refugee children (2.2).

Holistic interventions are another concept that we will address as it allows social service and mental health professionals a complete understanding of the child's medical, social, ethnic and cultural background and how the experiences in the past affect the child's state of mind in the present (2.3).

The structural approach allows a deeper comprehension into the issue of settlement programs for children from a refugee background, and a deeper insight into the exclusion mechanisms which unconsciously reduce or restrict an individual's rights and true identity (Legault & Rachédi, 2008). Many studies have demonstrated the relation between social capital, socioeconomic status and mental health (2.4).

And finally, we will examine the resilience in Syrian refugee children due to its' importance in mitigating the risk of developing mental health issues (2.5).

2.1 Toxic stressors and mental health in children

The effect of stress on the early human development induces biological effects which has been scientifically proven recently (Shonkoff & Garner, 2012). Studies have shown that early experiences and environmental influences can have an important impact on the stress reactivity of a child (Shonkoff & Garner, 2012).

Everyone will experience stress at some moment in time in their life. When stress occurs, there is a hormonal response which affects the way the brain will react to the stressor (Bélanger, Julien, & Marin, 2017). When there is a stressful situation, the brain receives a signal to reduce or stop the functioning of certain organs, in order to increase cortisol (Bélanger et al., 2017). When there is too much cortisol for a long period of time, the brain may be in a state which seems like depression (Bélanger et al., 2017). When there is not enough cortisol for a long period of time, the individual may be in a state of post-traumatic stress disorder (Bélanger et al., 2017). When the individual is under constant stress, physical manifestations may occur. The immune system may be more vulnerable to diseases when the person is exposed to prolonged stress. Stress may also contribute to increasing complications and risk factors associated with health such as increase in heartbeat or an increased blood sugar, increased weight, and truncal obesity (Bélanger et al., 2017). Prolonged stress on the child can also be manifested through the child's behaviour (Shonkoff & Garner, 2012). The child may be more agitated or on the contrary can become completely passive (Bélanger et al., 2017).

The child can also experience psychological manifestations of chronic stress (Bélanger et al., 2017). The child will likely experience intense emotions such as sadness, joy, and fear (Bélanger et al., 2017). The child may also experience intense anger outbursts and tantrums (Bélanger et al., 2017).

Chronic stress will also affect memory and the child's ability to pay attention, thereby instigating academic difficulties (Bélanger et al., 2017). Studies have shown that there is an important impact of maternal stress on the child's development (Kaplan, Stolk, Valbhoy, Tucker, & Baker, 2015). The child may have more difficulty in regulating his/her emotions, may be disorganized, and develop difficulties in language (Kaplan et al., 2015). Considering the experiences Syrian refugee children have gone through during the migratory trajectory and the factors of toxic stress they have faced; these children may be more inclined to develop the aforementioned developmental difficulties. Furthermore, there is an undeniable link between the socio-economic status and stress (Bélanger et al., 2017). Socio-economic status correlated with neighborhood quality, has a predictable effect in life stress but also to physical health, mental health and cognitive ability (Bélanger et al., 2017). When there is an increased economic disparity and the child is in a low socio-economic environment, there is a rise in health issues such as diseases, infections and asthma (Bélanger et al., 2017). Therefore, the structural social system implicitly places refugees in a state of economic vulnerability through systemic discrimination, increasing their stress levels and making them more prone to physiological and psychological issues in long term.

Toxic stress is defined as severe, prolonged, or repetitive adversity with a lack of the necessary nurturance or support of a caregiver to prevent an abnormal stress response

(Harvard University, 2019). Studies have shown that children who experience toxic stress early in life are at risk of long-term adverse effects such as a lack of adaptive coping skills, poor stress management, unhealthy lifestyles, mental illness and physical disease (Harvard University, 2019). Examples of toxic stress include abuse, neglect, poverty, violence, food scarcity and instability. The toxic stress response is believed to play a role in psychological issues such as depressive disorders, behavioral dysregulation, PTSD, and psychosis (Harvard University, 2019). As mentioned in the previous chapter, Syrian refugee children have endured violence, extreme poverty, food scarcity, often times abuse, and neglect before coming into the host country and during the migration trajectory. In his article on toxic stress in refugee children, Murray (2017) mentions that: “the prolonged brutal and traumatizing war in Syria has a profound impact on the physical and mental health of child refugees at a distressing rate”. He continues by mentioning the importance of toxic stress prevention, which should be the goal of all pediatric health care professionals (Murray, 2017).

Kaplan and colleagues (2015), have also found that the quality of family functioning affects mental health and cognitive development (Kaplan et al., 2015). Studies show that family stressors can lead to anxiety, depression, and time away from school. Some refugee children will receive very minimal emotional support from their parents who are themselves struggling with past traumatic experiences or settlement stressors such as unemployment, insecure housing, and systemic discrimination. Studies have shown that children of refugee background may be at increased risk of a disrupted attachment due to the parents who themselves are traumatized and thereby become unresponsive to their

children's trauma (Kaplan et al., 2016). Disrupted attachment may also lead to increased anxiety, depression and disorganization.

A study conducted by Kaplan et al., (2015) found that the experience of traumatic events of a refugee child can cause cognitive, emotional, and behavioural changes that undeniably affect academic performance (Kaplan et al., 2015).

Evidence have shown that PTSD occurs frequently amongst refugee children (Kaplan et al., 2015). According to a review on refugee children resettled in western countries by Bronstein and Montgomery (2011), they found that prevalence rates of anxiety ranged from 33 to 50%, depression ranged from 3 to 30%, and PTSD from 19 to 54%, whereas the prevalence rate for non-refugee children ranges from 2 to 9 % (Bronstein & Montgomery, 2011). These mental health issues enable symptoms which directly or indirectly affect the learning capacity of refugee children (Kaplan et al., 2015). One symptom that PTSD, depression, and anxiety have in common is poor concentration. Poor concentration may result in difficulty in the acquisition of new information, the development of cognitive skills, and academic performance in general (Kaplan et al., 2015). The memories of traumatic events may cause the child to be distracted from certain academic tasks and develop mechanisms to forget memories, but which may also inhibit spontaneous thoughts (Bélanger et al., 2017).

2.2 Mental health and health services and coverage available for Syrian refugee families

Research has shown that there is a lack of attention given to the mental health needs of Syrian children from a refugee background when they enter Canada (Bettmann et al., 2017). Syrian children from a refugee background have endured experiences which heighten their vulnerability to develop mental health issues (Bettmann et al., 2017). Mental health problems have been known to interfere with the social adaptation process in the host country (Montgomery & Foldspang, 2007). Conversely, research demonstrates that children of a refugee background will often have unattended needs in the social, emotional, and cultural spheres as the resettlement programs focus mainly on attaining the basic survival needs and assimilation (Bettman et al., 2017). According to Chris Friesen, the director of settlement services at Immigrant Services Society of British Columbia (2018): “The biggest gap in Canada’s resettlement program is on the mental health piece, and this has direct impact to learn English or French, their ability to retain employment, and their ability to parent their children”. Furthermore, about 4,300 to 5,100 refugees who arrive to Canada require formal mental health clinical intervention to help them rise through the trauma (Dharssi, 2018). There is also an increase in refugees seeking counselling, but unfortunately the health and social service professionals already have major caseloads, which makes it impossible to ensure and accurate mental health interventions (Dharssi, 2018). Delayed funding from the Canadian government have also forced settlement agencies to remove necessary resources such as mental health counselling (Miller, 2017).

Another structural barrier to mental health services refugees inevitably face upon arrival is the lack of cross-cultural capacity and trauma-informed capacity of the provincial health

care systems (Dharssi, 2018). As a result, cultural differences may prevent children from a refugee background and their families from accessing mental health services (Hadfield et al., 2017). Often, refugees will report feeling misunderstood by service workers and have difficulty in trusting them (Hadfield et al., 2017). In a study, Hassan and colleagues (2016) mention that: “refugees, in common with many in the general population, may avoid visiting mental health care practitioners because of shame, embarrassment or fear of rejection by family or friends and being labelled ‘mad’ or ‘crazy’” (Hassan, Ventevogel, Jefee-Bahoul, Barkil-Oteo, & Kirmayer, 2016, p.134).

In 2012, the conservative government has made major cuts to the Interim Federal Health Program (IFHP). In 2016, the government reversed the cuts to offer basic temporary coverage of health-care benefits to refugees. The basic coverage includes: in-patient/out-patient hospital services, services from medical doctors, registered nurses and other health-care professionals including pre-and post-natal care (Government of Canada , 2018). Laboratory diagnostic and ambulance services are also included in the IFHP basic coverage (Government of Canada , 2018). Unfortunately, still one year after the changes many refugees continued to be without adequate health care (Chen & Yun Lieuw, 2017). This is due to the confusion where health and social service professionals still deny services based on the false assumption that refugees are no longer covered (Chen & Yun Lieuw, 2017). Some are aware of the changes, but still deny services because of its’ perceived complexity (Chen & Yun Lieuw, 2017).

2.2.1 Limits to the services available

Despite having counseling and mental health services available to refugees, these services do not consider the experiences and realities of these children. If the mental health needs of children from a refugee background are not accurately addressed, this may entail repercussions in the academic, family and social sphere of the child's life. Ben Kuo (2016), a psychology professor from the University of Windsor states that the biggest concern about refugee integration is Canada's capacity to provide adequate mental health support as they attempt to adjust to their new life while dealing with old traumas of war. He further mentions that if everything could seem well for the first couple of years, mental trauma could resurface all suddenly (Kuo, 2017). According to Abedi (2018), immigrant and refugee youth in Canada are more likely to visit emergency rooms for mental health reasons than Canadians. Moreover, this study stated that for children from a refugee background aged ten to fourteen the emergency room is the first point of contact with mental health services (Abedi, 2018).

Mental health professionals and organizations are not prepared to meet the complex challenges in addressing the health care needs of refugees. These challenges are often unfamiliar and therefore practice standards are not adjusted to address them (Wylie, Van Meyel, Javeed, Luc, Hooman, Wardrap, 2018).

Refugees arriving to Canada need social and psychological supports which are understanding to the challenges they've faced in order to overcome trauma. Unfortunately, the health care system is not organized to favor such an approach. Young refugees who have multiple complex health challenges often have to retell their trauma story to many

different health care providers, which may discourage them to continue seeking help (Wylie et al., 2018). The widespread problem of overcrowding and long waiting lists is also a documented challenge with accessing the health-care system (Wylie et al., 2018). Accessibility also materializes the fact that mental health professionals have a very big work load, which does not leave them with enough time to build a trusting and long-lasting therapeutic relationship which is essential for those experiencing trauma (Wylie et al., 2018).

2.3 A holistic intervention approach to address mental health and developmental needs

Mental health care in Canadian structures today, use mainly a biomedicine approach. Biomedicine focuses on the human body and physiological needs, and tends to neglect the individual's psychosocial, existential and spiritual needs (Koslander, Barbosa, & Roxberg, 2009). A holistic approach to mental health care will take into consideration the individual's knowledge, environment, resources, and its background (Koslander et al., 2009). Research has shown that mental health care patients who are suffering from depressions or anxiety will have symptoms of fear, despair, hopelessness, and isolation (Koslander et al., 2009). Using a holistic approach will yield positive effects and help diminish these symptoms of fear and isolation (Koslander et al., 2009). In this sense, Charles Watters stated that:

Without an opportunity to articulate their own experiences in their own terms and to identify their own priorities in terms of service provision, refugees may be the subject of institutional responses that

are influenced by stereotypes and the homogenising of refugees into a single pathologized identity (Watters, 2001 p. 1710).

This statement emphasises the need for holistic mental health care especially for refugees and denounces the predefined and compartmentalised institutional structures which tends to ignore the resilience need in many refugees (Watters, 2001). Adopting a holistic approach instead of other approaches such as: the cognitive behavioural approach, the biomedicine approach, the solution focused approach or the attachment approach will lower the boundaries between health and social care. Making mental health more focused on the patient's needs and realities will help the refugee navigate the host country while considering mental health needs of the entire family. In many cultures, there is a clear correlation between physiological problems and emotional and/or social problems. Literature has also documented the impact of mental health on the individual social and intellectual capacities. With that in mind, moving health care interventions towards a more holistic approach, will allow the integration of both mind and body as influences of psychological and physiological changes (Watters, 2001). Much recent research has put forward the importance of psychological factors on the cardiovascular system, thereby accentuating the importance of adopting an analysis of the mind and body interrelation. Researchers such as Goldberg and Huxley have accentuated the importance of examining the interdependence of the mind and body in order to analyze the affected mental disorder (Goldberg & Huxley, 1992). They stated that:

It now seems clear that stressful life events are not merely important in determining onsets of anxiety and depression, but also realize episodes of physical illness (Goldberg & Huxley, 1992, p.133).

Adopting a holistic approach will allow professionals to take into consideration the refugees' point of view on their condition. It will obliterate the dual definition of the patient having either a physiological problem or a psychological one (Watters, 2001). Mental health and health professionals will need to embrace an openness to receive the refugees' explanations on the causes of their own discomfort or distress (Watters, 2001).

Enabling a holistic approach to health and mental health care should be done at a macro and micro level. It should allow creativity and cultural sensitivity in regards to mental health at the institutional level, service level and treatment level. This will allow enhanced services which pay attention to cultural differences, to the migratory trajectory of refugees and their desired treatment (Hassan, Ventevogel, Jefee-Bahloul, & Barkil-Oteo, 2016).

Considering the detrimental affects the migratory trajectory can have on children from a refugee background, the need for interventions that cultivate the psychosocial development and the resilience of these children is vital. As mentioned earlier, research demonstrates that children of a refugee background will often have unattended needs in the social, emotional, and cultural spheres as the resettlement programs focus mainly on attaining the basic survival needs and assimilation (Bettman et al., 2017). The community social pediatrics center use holistic interventions to assess the areas of concern, and acquires the necessary knowledge of each child's experience in offering services and care practices that correspond to the child's needs and problems (Kelly & Horder, 2001). In the province of Quebec, social pediatrics centers have been recognized as an important establishment in helping children from vulnerable environments in developing their full potential. These centers adopt an approach of social medicine to enable a more complete diagnosis of the physical, psychological, cognitive and social health. The social pediatrics centers rely on

the child's strengths and use an interdisciplinary approach to reduce and eliminate stressors that hinder the well-being of the child. They use empowerment, cultural competence, interdisciplinary approach, and the integration of all necessary family members. Social pediatric community centers are based on holistic intervention ideals that could adequately address mental health needs of children from a refugee background to ensure their optimal development and integration in the host country.

To define the Social pediatric approach Dr. Gilles Julien, the founder and main figure of these centers in Quebec states the following:

We get to know each other by talking and sharing – first toys, then deeper thoughts and feelings. We establish a connection and then we start working together to find solutions. This is what community social pediatrics is all about. It's an approach based on science, but it's also an art – the art of engaging, listening, comforting, supporting (Julien, 2018, p.1).

Other community organisations and institutional services opt for holistic interventions as well, although Social pediatric centers are known in Quebec for their biopsychosocial and spiritual approach destined for children in situations of precarity. These centers open in difficult and vulnerable neighborhoods to ensure that the families and children affected by multiple sources of toxic stress have easy access to the center. For the purpose of this research three social pediatrics centers will be targeted in the region of Montreal due to the high number of Syrian refugees settled in the city (approximately 35% of Syrian refugees arriving to Canada have settled in Montreal) (Houle, 2019). The holistic approach to refugee children needs and challenges seems to be the adequate approach to their healing

and resilience. However, other approaches have demonstrated their efficiency, like the structural approach which seems to complete holistic approaches.

2.4 The structural approach in understanding the mental health concerns of Syrian refugee children

Mental health concerns of Syrian refugee children who arrive to Canada, raises societal and institutional questions which need to be addressed in order to adequately provide mental health and social services which respond to their needs and realities. The structural approach is concerned with power and the different interrelations between people and specific social, political and economic situations (Moreau, 1979). The main concern of the structural approach according to Moreau (1979) are the injustices of the economic inequalities (Moreau, 1979). The structural approach emphasizes the society's demands of attaining material success, which is inevitably accompanied by unequal opportunity structures (Moreau, 1979). It allows a deeper comprehension into the issue of settlement programs for children from a refugee background, and a deeper insight into the exclusion mechanisms which unconsciously reduce or restrict an individual's rights or true identity (Legault & Rachédi, 2008).

The relationship between the structural approach and mental health has been highlighted in many studies. In a study done by Hassanzadeh and colleagues (2016), the findings indicate a clear association between social capital, socioeconomic status and mental health. One explanation pertaining to the association between social capital and mental health is that lower social capital can directly lead to deterioration of one's mental health by

increasing feelings of loneliness, and reducing expectations about future accomplishments (Hassanzadeh, Asadi-Larie, Baghbanian, Aziz, & Abbas, 2016).

Therefore, individuals who are at a social disadvantage in means of multiple deprivations such as lack of social capital and a low socio-economic status enter a state of social exclusion. Social exclusion is a paradigm that extends to the non-participation which arises through discrimination, chronic illness or cultural identification (Thapa & Kumar, 2015). Social exclusion has been defined in many different ways depending on the theoretical and ideological background of the author defining it (Thapa & Kumar, 2015). Thorat and Miller (2009) defined social exclusion by placing emphasis on the denial of fair and equal opportunities to certain social groups in multiple social spheres and their consequent inability to participate in the political, economic and social functioning of society. The loss of one's role, meaningful relationships and discrimination is often implied in the concept of social exclusion, but also precedes and accompanies mental illness leading to further stigmatisation (Thapa & Kumar, 2015). While the objective of the current master's project is to increase our understanding of the holistic approach used in social pediatric centers to address the mental health of Syrian refugee children, it is important to understand how societal and institutional structures may implicitly contribute in increasing the development of mental health issues in this population.

2.5 Resilience in Syrian refugee children

Children from a refugee background endure tumultuous experiences throughout their migration process which include traumatic events and many factors contributing to toxic stress (Kaplan et al., 2015). Despite this, many children from a refugee background show

positive outcomes in the host country (Marley & Mauki, 2018). Resilience is considered as an important success factor in children from a refugee background to withstand adversity (Marley & Mauki, 2018). Resilience can be defined as the capacity of an individual to maintain a balanced psychological functioning throughout moments of adversity, thereby experiencing a “stable trajectory of healthy functioning across time” (Marley & Mauki, 2018). A study was conducted by Marley and Mauki (2018) to extract relevant predictors of positive outcomes in the face of adversity for children from a refugee background. They found three different levels of protective factors that allow children to harbor resilience (Marley & Mauki, 2018). The first type of protective factors is at an individual level. These include personal characteristics such as age, gender, attitudes, beliefs, and behaviours (Marley & Mauki, 2018). Studies suggest that younger refugee children display more positive outcomes than older refugee children (Marley & Mauki, 2018). The authors also found that those who demonstrated high self-esteem, prosocial behavior, and intelligence were associated with adaptive abilities in the face of adversity (Marley & Mauki, 2018). Lastly, findings show that children who experience high levels of self-efficacy, commitment and involvement in their schools experienced lower levels of psychological and emotional difficulties (Marley & Mauki, 2018).

The second type of protective factors is at a relationship level, which encompasses the immediate social circle, family cohesiveness, professional relationships, and their role within different societal spheres (Marley & Mauki, 2018). Studies suggest that peer support, family unity, endorsing a positive relationship with their mothers, and fathers with a high educational level contributed to positive outcomes after experiencing traumatic events (Marley & Mauki, 2018).

The third type of protective factor occurs at a community level which refers to settings such as schools, workplace, neighborhoods, where social relationships occur (Marley & Mauki, 2018). A sense of safety and belonging to the school, reduces the sense of social isolation, and strategies for improving housing and financial prospects are part of community level protective factors (Marley & Mauki, 2018).

Societal level protective factors include societal factors that help create an environment where positive outcomes for refugees arriving to the host country can be attained. Such factors relate to social and cultural norms as well as governmental policies (Marley & Mauki, 2018). These factors promote a sense of belonging and inclusion to societal contexts (Marley & Mauki, 2018).

Understanding the factors which predict these outcomes is necessary to ensure the well-being and positive settlement experience of children from a refugee background. As previously mentioned, a child's resilience consists of many protective factors stemming from multiple domains. These protective factors must be understood and applied to settlement services who are compelled to assist the child from a refugee background through the integration process of the host society by ensuring a psychological well-being. The holistic intervention approach used in the Social pediatric centers have been known to use these protective factors in increasing the child's resilience and promote his/her empowerment.

This chapter was intended to provide a brief overlook at what was already researched on the mental health and developmental outcomes of Syrian refugee children. It also provided

an insight on the holistic intervention approach used in the Social pediatric centers and how this approach can address the mental health of Syrian refugee children.

The objective of this master's project is to understand how the holistic approach used in the Social pediatric centers addresses the mental health concerns of Syrian refugee children. In the next chapter, we will detail the methodology adopted in this research project.

CHAPTER 3

A QUALITATIVE METHODOLOGY TO EXPLORE AND UNDERSTAND THE HOLISTIC APPROACH TO ADDRESS MENTAL HEALTH IN SYRIAN REFUGEE CHILDREN

In this chapter, we will address our methodological approach that was adopted to explore the impact of holistic approach to mental health in Syrian refugee children. We recruited mental health and social service professionals from pediatric centers in Montreal and we've been able to approach three different participants in three different centers. Once the participants were recruited, we conducted semi-structured interviews. After the data collection, we did a content analysis to describe and to theorize our findings. The chapter is divided into seven sections which further details our methodology process. We will describe the methodological steps of the data collection, from the inclusion criteria, to the effective recruitment. We will also discuss the ethical considerations that were important in the context of this study. Finally, we will present the strategies we adopted for data analysis

3.1 General methodological approach

When conducting a study, an important element that should initially be considered is the methodological approach. There are many methodological approaches depending on the objectives of the research.

For the purpose of this research, we will be adopting a qualitative methodological approach. A qualitative research design allows the researcher to offer a description and an

understanding of the signification of certain concepts or phenomenon (Fortin, 2010). Qualitative research enables a profound and global understanding on a concept or phenomenon that is less known, by discovering how individuals perceive their own experience within a given social context (Noiseaux, 2006). To understand the ways in which holistic intervention methods are beneficial in addressing the mental health of Syrian refugee children, we needed to adopt a qualitative approach which seeks to understand the individual experiences of those working in proximity to refugee children. Qualitative methods in themselves are founded on holistic beliefs of human beings, in which the entire research process is oriented in such a way (Stainback & Stainback, 1988 p. 3-13). The qualitative methodological approach includes ethnography, grounded theory, case study and phenomenology (Noiseaux, 2006). For the purpose of this research, we decided to use grounded theory as our methodological approach.

The grounded theory approach is used within qualitative research to eventually construct an empirical theory from collected data sets (Pierre, 1994). The researcher using this method inductively attempts to identify meanings, categories and correlations that can prosper into a new understanding of a social phenomenon (Pierre, 1994). This understanding must be strongly grounded within the empirical data that was collected, in order to reach the level of theorisation that is aimed for (Pierre, 1994).

Grounded theory allows for the exploration of a certain social experience or phenomena without having a specific question in mind to ensure the openness and inductive nature of the approach (Guillemette, 2006).

For the purpose of this research, a broad research question was predetermined to help the researcher guide her interviews, research objectives, and data analysis, but also due to time constraints. At the start of the research, the data is collected, compared, coded and analytical categories are identified to develop more data collection (Charmaz & Belgrave, Grounded Theory , 2015). Therefore, the data collection and analysis are done simultaneously (Charmaz & Belgrave, Grounded Theory , 2015). Grounded theory method suspends the use of an existing theoretical frame as a systemic refusal of inducing an explanatory framework to the collected data (Guillemette, 2006).

Our decision to use grounded theory as or methodology, would allow us to highlight the values of the individual experiences of different health and social service professionals when working with Syrian refugee children within their professional and societal structures. Using the grounded theory will allow the identification of concepts and the construction of theories from the data that was collected and analyzed. The experiences of the health and social service professionals using holistic interventions when addressing the mental health of Syrian refugee children will be gathered to allow the possible construction of a theory.

However, the current research employs a more constructivist ideal of grounded theory (Richardson & Kramer, 2006). We used mechanisms known as abductive inferences to allow a more heuristic and pragmatic approach while maintaining the openness and flexibility of grounded theory (Richardson & Kramer, 2006). These abductive inferences generate a process by which we study facts and then develop a theory to explain these facts, this is known as abduction (Cunningham, 1998). It consists of finding hypothetical explanations to factual observations (Richardson & Kramer, 2006). Therefore, abduction

is used in grounded theory to collect and connect facts using theories, to generate ideas and then develop hypotheses (Coffey & Atkinson, 1996). Abduction in grounded theory is meaningful in this research, as it allows for new empirical data and explanations to arise through the elaboration and combination of pre-existing concepts (Richardson & Kramer, 2006). This methodology allows for flexibility and openness, but also allows the integration of theoretical knowledge and pre-existing concepts and to construct new ideas to help us attain our research objectives.

The abductive grounded theory methodology consists of acquiring a deeper understanding regarding the holistic interventions used in Social Pediatric Centers in Montreal. The methodology allows open questions regarding the advantages and disadvantages of using holistic interventions when addressing the mental health of Syrian Refugee children.

The reports on the arrival of Syrian refugees to Canada, have elicited academic questions pertaining to the integration, the mental and physical health of Syrian refugees; the cultural barriers in structural and systemic government services; and culturally sensitive social and health service that are offered to respond to the refugee population.

Given the lack of information pertaining to the mental health services readily available for children from a refugee background, grounded theory method would allow the development of one's comprehension of a phenomena that has not yet been fully studied (Charmaz, 2008). In using an abductive approach to grounded theory, we are able to go back and forth between the information available in the literature and the data collected portraying the mental health of Syrian refugee children.

Lastly, the grounded theory method allows for the research to facilitate the sharing of information between the researcher and the participants (Charmaz, 2008). In this meaning, Coffey and Atkinson (1996:155) stated that:

Our important ideas are not in the data, and however hard we work, we will not find those ideas simply by scrutinizing our data ever more obsessively. We need to work at analysis and theorizing, and we need to do the intellectual, imaginative work of ideas in parallel to the other tasks of data collection and analysis.

This methodology is often used in health care to capture the experiences of patients and health care professionals (Glaser & Strauss, 2017). The research that will be conducted is interested in mental health issues in refugee children and the experiences of the social and health professionals in regards to intervening with children of a refugee background. Using the grounded theory method will allow the researcher to construct theories from the data that was collected and analyzed.

The technique that was used to collect the data was semi-structured interviews. According to Dunn (2005), semi-structured interviews use some form of a predetermined order of questions while ensuring flexibility in the way discussion topics are addressed by the interviewer. Furthermore, semi-structured interviews are done in a conversation and informal way (Clifford, Cope, Gillepsie, & Shaun, 2016). Semi-structured interviews allow the researcher and the participant with an openness, by allowing the participant to answer using their own words and experiences rather than a yes or no (Clifford et al., 2016).

When conducting a qualitative research, one must carefully follow and respect certain rules (Gaudet, 2009). Ethical considerations in research asks that we consider and carefully weigh the advantages and the inconvenient of the research (Gaudet, 2009). The moral

objective is to protect the negative consequences of the participants which is linked to their collaboration, by ensuring the proper boundaries to avoid eventual dilemmas and offer the participants protection through confidentiality and anonymity (Gaudet, 2009). Ethical considerations must be taken in every main part of the research: the recruitment, asking for consent, data collection, data analysis and publication of results (Gaudet, 2009).

The relationship between the participant and the researcher must remain on an equal basis, and value respect, dignity, confidentiality, anonymity, and participants' rights.

This qualitative method will allow the researcher to obtain a complete understanding concerning the use of holistic interventions used by health and social service professionals working in Community Social Pediatric centers to address mental health issues of Syrian refugee children.

3.2 Research design

In this section we will present the targeted profile and inclusion criteria as well as the recruitment process.

3.2.1 Participants

We aimed to approach participants who would be professionals who are employed at Social Pediatric Centers in Montreal.

3.2.2 Sample study

We are specifically interested in professionals employed in Social pediatric centers who have experience working alongside Syrian refugee children. Our objective consisted of 3

professionals with whom we aimed to conduct 3 interviews (one interview per professional). We privileged different professional profiles (social workers, health professionals et practitioners, etc.) but we finally came to approach only participants who accepted the interview.

3.2.3 Inclusion and exclusion criteria

The following inclusion and exclusion criteria are significant for the purpose of our study to ensure that the information gathered through the interviews responds to our research question. It ensures that the possible participants have sufficient knowledge pertaining to the Social pediatric center where they work, and that they have had experience intervening with the population in question in the present research. The principal inclusion criteria of our sample study are the following:

1. Needs to be employed at one of the selected social pediatric centers (*The community social pediatric center of Côte-des-Neiges, Community social pediatric center Au Coeur de l'enfance, and Community social pediatric center of North Montreal*) at the time of the interview.
2. Be a mental health, social service or health professional who has experience intervening with Syrian refugee children.

3.2.4 Recruitment process

Our recruitment process consisted of two scenarios. First, we sent a letter to the general directors of the Social pediatric centers as a formality to present our research project and to advise them that we would be conducting a research with their employees. We also asked

for permission to display the recruitment posters in the employee lunch room. The recruitment posters describe the research project, the sampling criteria, and the complete contact information to allow potential participants to contact us by email or phone number. We obtained one participant using this method (annex 2).

Prior research on Social pediatric centers revealed that the contact information of certain employees was made available through the website of the selected three centers. Therefore, once we obtained the approval from the directors, we sent our recruitment letter along with the recruitment poster directly to the employees. This recruitment strategy was efficient in recruiting one of the two participants.

3.3 Data Collection

To collect the data, we conducted semi-structured interviews with the participants who expressed a desire to partake in the study. The length of the interviews was between 45 to 60 minutes. The time, date and place of the interviews were selected by the participants.

Two participants expressed interest within a month and a half. Both participants decided to conduct the interview by Skype in order to save time and transportation fees. We conducted the online interviews in a private room, with a closed door and wearing headphones. The first interview was held in the evening from 7 pm to 8:30 pm. Whereas the second interview was held during lunch time on a weekday, and lasted 45 minutes.

The consent form was sent beforehand and also read out loud before the beginning of the interview. Both interviews were recorded with the agreement of participants, and notes were being taken simultaneously, to help in the recollection of thoughts and ideas.

3.3.1 The interviews

The interviews took place in the beginning of June 2019. Due to time constraints, we were able to recruit only two participants. Also, that period of recruitment coincided with the busy time of year in the Social pediatric centers, it was not possible for us to meet our initial objective of three participants. This will be further mentioned in the limitations of the research.

The date, time and location of the interview were decided by our participants, and both interviews were conducted using Skype. The participants decided to use Skype for multiple reasons. First, due to their busy schedule and their family responsibilities. They both felt it was easier to co-ordinate the interviews via Skype. Both participants lived outside Montreal, Skype seemed to simplify the issue of transportation. It also allowed more flexibility as to the date and time of the interview. The interviews via Skype were done in a secure and closed office and we used headphones to ensure intimacy, confidentiality, and anonymity.

We conducted two interviews of 45 to 90 minutes with our participants. We began the interview by restating the research subject and the desired objectives. Followed by, certain ethical aspects such as anonymity, the use and the access of the collected data. We then read out loud the content of the consent form and obtained a verbal consent agreement by the participant. Before beginning the interview, we informed the participants that at any moment they were free to stop the interview, and/or not respond to certain questions. The interviews thereby began and proceeded with the questions from our interview guide. The interview guide was sent three days before the interview to allow the participants to

properly prepare their questions, and to save time during the interview. Both participants had elaborated answers to the questions and answered thoroughly. They seemed to be genuinely interested in the questions and the subject being studied. The interviews allowed for a rich data collection and elicited unexpected subjects. Both participants mentioned their concern regarding asylum-seeking families who seem to be in a greater state of precarity and vulnerability.

3.3.2. The interview guide¹

We created an interview guide that corresponded to the objectives of the research. The interview guide covers important themes which are intended to explore the holistic intervention approach used in Social pediatric centers, and why they are efficient in addressing the mental health of Syrian refugee children. Briefly, the themes of the interview guide consisted of understanding the structure of the Social pediatric centers; the interventions that are used within the centers; the mental health issue and how it impacts the interventions used in social pediatric centers; and a demand of a critical reflection to understand the participants' point of view on the issue discussed and to understand other issues or concerns that haven't been approached by the interview guide. We used the same guide for both participants, although the order of the questions varied due to the open nature of semi-structured interviews. All the questions in the interview guide are open in order to collect the specific perspective and point of view of the two participants. The questions allow participants to reflect on their experience and accumulated knowledge, and go into more detail about how their experiences has shaped their interventions and beliefs.

¹ The interview guide is available in the annex of the paper (see annex 2)

The first part of the interview guide is meant to understand the role of the Social pediatric centers in the community and what holistic interventions are. We also question the role of the participant and the structure of the organization. The next set of question addresses the intervention approaches and methods themselves. The third set of questions seeks to obtain a deeper comprehension on the mental health issues of Syrian refugee children and why it is such a problem today, as well as the favorable ways that the mental health should be addressed. Lastly, we ask the participant to critically reflect on the holistic interventions; the advantages and disadvantages; as well as ways we could improve Syrian refugee's integration in society. These sections make up a total of twenty questions.

3.4 Ethical considerations and research limits

In this section, we will discuss the ethical considerations, the difficulties and the limits that were encountered during the study. The first difficulty is linked to time constraint. Furthermore, we encountered difficulties in the recruitment process. Due to the limited time frame and the busy work load of the employees working at the center, the recruitment process also took a significant amount of time. Unfortunately, these constraints also resulted in attaining less participants than we had hoped.

Having previously completed an internship in a Social pediatric center in Magog, it was important that we remain open-minded to the questions that we wanted answered. Because of that previous experience in a Social pediatric center, we also needed to ensure that we were free of pre-conceptions when conducting the interviews to not have biased results. To do so, we ensured that the questions were free of any judgement or underlying prepossession and remained opened to the participants suggestions.

Both participants had different roles within the community and came from two different centers. Even if we had a limited number of participants their affiliation increased the variability and the richness of the data gathered. The first participant is a pediatric doctor and intervenes with children on a punctual basis. Whereas the second participant is a social worker and is constantly in intervention situations with the children. Both participants have experience intervening with Syrian refugee children. These differing roles allowed for different views on the Syrian refugee children's mental health and alternative ways and methods used to intervene with them. The profile of the participants is thoroughly discussed and detailed in the description of results.

3.4.1 Confidentiality and anonymity

Considering that there is a limited number of Social pediatric centers in the province of Quebec and especially Montreal, the confidentiality of the participants may have been disclosed if the names of centers where the participants work were shared in this work.

For a research to be considered ethical it must ensure the confidentiality and anonymity of its' participants. Different steps were taken to ensure the confidentiality, anonymity and to ensure that the research is completely voluntary and has no attachment to the Social Pediatric Center. First, we informed the Social pediatric center of the research project by sending a presentation letter. The letter was intended to inform them of the research objectives, that we will be recruiting participants who are employed at their center, and to obtain the authorisation to hang a recruitment poster where it can be easily seen by the employees. Second, we did preliminary research which helped us identify that the contact information of potential participants was available online on the websites of all three social

pediatric centers selected. The recruitment letter was then sent by email to all potential participants to inform them about the details of the research and the inclusion criteria. The final step that was taken to ensure the participant's confidentiality and anonymity was giving them the choice of where, when and how the interview would take place.

The measure we have taken once the interviews were completed was to omit the names of the approached centers along with any information that could potentially identify the participant. Therefore, information regarding the Social pediatric center where the participant is employed, and their name and ethnic origin.

3.4.2 Research limits

All scientific research must be able to recognize the limits of the study. This current study is not generalizable to the entire population of health, mental health and social service professionals as the study sample was fairly small.

The experiences regarding the holistic interventions in Social pediatric centers also vary depending on the participants' title, the number of years the participant has been working in the center, and the number of interventions that were done with Syrian refugee children. Despite being employed at various Social pediatric centers, and using the same intervention approach, the individual experiences and one's reactions are different and therefore cannot be generalized.

Another limit of the research is that the Syrian refugee children were not included as potential participants for the study. Considering the objectives of the research and the research question, obtaining the opinion of the health, social services and mental health

professional as well as the Syrian refugee families themselves, would have been beneficial and complimentary for the research. Once again, due to time, length and ethical constraints, obtaining Syrian refugee children participants was not possible in the context of a master thesis proposal.

3.5 Data analysis modalities

Considering that the data was collected through individual interviews, we conducted a content analysis. Multiple steps were taken for the data analysis.

The data was analyzed using an open coding technique which favors a more open approach and mindset to what emerges from the data (Khandkar Huq, 2009). Open coding requires line-by-line coding and uses in vivo and constructed codes (Khandkar Huq, 2009). In vivo codes are words that are used exactly as they are used by the participants (Khandkar Huq, 2009). Whereas constructed codes are coded data from in vivo codes, but are created by the researcher to be transferred into academic terms (Khandkar Huq, 2009). When conducting open coding the researcher places his knowledge pertaining to the research subject into parentheses to ensure maximal openness of the information that will be obtained from the collected data (Khandkar Huq, 2009).

Afterwards, when the data is coded, it is then interpreted in light of concepts and literature (Khandkar Huq, 2009). Concepts are labeled sections of the data that are abstract representations of relevant events, objects, actions or interactions which are deemed relevant for the objectives of the research (Khandkar Huq, 2009).

We gathered data on the structural aspect of the Social pediatric centers to understand the functioning and how these centers differ from institutional centers such as the Integrated health and social service centres or the Integrated university health and social service centres. In the second part of the questionnaire we wanted to collect data regarding the intervention approaches that are used, and more specifically the holistic approach. Considering that our research question revolves around Syrian children with mental health problems, we collected data revolving on the professional point of view regarding mental health in general and mental health of Syrian refugee children. Lastly, we questioned the advantages and disadvantages of using the holistic intervention approach on Syrian refugee children and their families. Certain themes were brought up such as: systemic discrimination, trauma and resilience. There were also unexpected themes such as: empowerment, security, and therapeutic alliance. The fourth chapter will give a detailed account on the results gathered.

CHAPTER 4

PRESENTATION OF THE RESULTS: HOW IS THE HOLISTIC APPROACH BENEFICIAL TO SYRIAN REFUGEE CHILDREN

In the previous chapter, we discussed the methodology that was used to collect and analyze the data. In this chapter, we will describe the data that was collected.

We will first describe the profile of the participants in further detail to establish a clear portrait of their role and how these roles within the Social pediatric center influence their responses and ideas throughout the interview. We will then describe and analyze the functioning of the social pediatric center by breaking the processes into various steps. To pursue the data analysis, we have broken up the qualitative results into eight different themes. For the purpose of the current chapter we have broken up the eight themes into six different sections: The description and portrayal of the participants, the mission and values of the Social pediatric centers, the structural functioning of these centers, families who receive services at the Social pediatric center; intervention approaches and methods used within the Social pediatric centers; and the mental health issue of Syrian refugee children.

4.1. Descriptions of the participants

As previously mentioned, we recruited a total of two participants. Both participants have an important role within the organization and are constantly in contact with children from all backgrounds. We will use pseudonyms for each participant. Both interviews were conducted in French. For the purpose of this paper, the extracts used were translated.

Sandra is the participant from the first interview. The role of Sandra is that of a pediatrics doctor who works at the Social pediatric center. Sandra is a woman with many years of experience as a pediatrics doctor and has been involved in the center since 2011.

The second participant is Abby. Abby is a social worker within the social pediatric center where she's been employed there for four years. As of this chapter, we will refer to the participants accordingly.

4.1.2 Profile of Participants

In order to adequately situate the data, we will portray the individuals who have accepted to take part in this current research. Considering that one of our objectives for the research was to understand the intervention approaches used in Social pediatric centers and how they are beneficial or not to address the mental health of Syrian refugee children, we recruited professionals from three different centers in Montreal. Although the centers will remain anonymous for confidentiality reasons, the centers were selected based on their proximity to neighborhoods predominately populated by newly arrived families. Furthermore, considering that Montreal is the second most important urban destination for Syrian refugees in Canada not far behind Toronto, identifying three centers which work in proximity to newly arrived families was essential in obtaining relevant data (Freisen, 2016).

As mentioned in the preceding chapter, Sandra is represented by the first participant to conduct the interview. Sandra's role is that of a pediatric doctor. Sandra's tasks are mainly to meet with the families in the clinical settings, accompanied by the social worker and any other external participants. During these encounters which occur two to three times a year

per family, the pediatric doctor looks at the child's physical health, psychological health, the child's development and does any prevention intervention deemed necessary.

Abby is represented by the second participant to conduct the interview. Abby's role within the Social Pediatric center is that of a social worker. The social worker's task is plentiful within the center. They are constantly in correspondence with the family, the external partners and the other social service or mental health professionals working at the center. They also participate in the clinical meetings with the family and the doctor; they ensure a consistent follow-up; and can also partake in individual psychosocial meetings with the child or the parents. Lastly, the social worker must ensure the transcription of evolutive notes after each encounter and follow-up.

Table 1: Portrait of Participants

Participants	Role	Specific tasks	Common tasks
Sandra	Pediatric doctor	Limited role, intervenes punctually (sees the families 1 to 3 times per year), ensures the child and family is in good physical and mental health.	Participates in clinical meetings with the family, orients the necessary services, writes follow-up reports, works with an interdisciplinary team.
Abby	Social Worker	Ensures the follow-ups with the families, accompanies certain families to external services, writes follow-up reports, conducts follow-up phone calls.	

Table 2: Profile of participants

	Sandra	Abby
Occupation	Pediatrics doctor	Social worker
Number of years of experience	20 years	6 years

The interview is composed of 4 main thematic sections that correspond to the structure of the interview guide. The first section seeks to understand the functioning and interventions used in the Social pediatric centers in Québec (4.1). The second section pertains to the knowledge and comprehension of holistic interventions and their advantage when intervening with Syrian children from a refugee background (4.2). The third section addresses questions related to mental health in Syrian refugee children enrolled in Social pediatric centers in Québec (4.3), and lastly the fourth section seeks to obtain a critical reflection of how mental health and social services could be improved to address the incoming of Syrian refugee children (4.4).

This chapter is divided accordingly, to provide a clear understanding of the information that was gathered throughout the interview.

4.2 The mission and goal of Community Social Pediatric centers

In this section we will discuss the main topics that emerged from the interviews regarding the mission, goals and the work performed by the Social pediatric centers. In a first section we will mainly address the ethics of practice and work in these centers (4.2.1. and 4.2.3) and in a second part we will address the functioning of these centers (4.2.4.)

4.2.1. Ethics of practice and work in Social pediatric centers:

The mission of the Social Pediatric centers was explained by both participants as being a place where children and families in a state of vulnerability are welcomed and accompanied in a way that is adapted to their needs. Their mission also involves a global approach in an interdisciplinary team to facilitate a partnership with the families. This partnership will

allow the improvement of the well-being of the child as well as their health, learning and development for a positive future. One of the participants situates his/her own ethics of interventions in terms “care” and “responsibility” and states the following when asked about the center’s mission:

Well, the center’s mission is to care and take in our responsibility the well-being of children in situations of extreme vulnerability...it is an approach of partnership with the patients, in a co-construction of an action plan, to have children improve to a maximum their well-being (Sandra/pediatrics doctor, June 6th 2019).

Similarly, Abby mentioned:

It is welcoming the families of our community in our living environment, and offer them support which is adapted and responds well to their needs (Abby/social worker, June 14th 2019).

The values of the Social Pediatric Centers are plentiful. The most important value and fundamental to the practice seems to be the welcoming of the families, which in French is known as the “accueil”. In the Social pediatric centers, it is important to offer a non-judgemental and warm welcome to the families who arrive to make them feel at home. Besides the professional ethics behind this “welcoming” mission (that is common in many Canadian profession and social and health services), there is also the value of benevolence, team work, active listening, respect, non-judgement, partnership, co-construction, open-mindedness, and giving the family the best support and accompaniment, which best responds to their needs. In substance, beside its practicality, these kinds of interventions represent an ideal model of anti-oppressive interventions.

A second major value that is situated by our respondents is “sharing”. The sharing of knowledge, the sharing of opportunities, and the sharing of services, empathy and support.

Sandra mentions:

Well, there are plenty of values! There are the welcoming, ethical values, interdisciplinary approach, teamwork, active listening, non-judgement, respect, partnership, co-construction, openness, support, attention and sharing (Sandra/Pediatric doctor, June 6th 2019).

Abby also mentions sharing when she states:

Um well the vales are benevolence, sharing and welcoming. Sharing is an important one (Abby/ Social worker, June 14th 2019).

Knowing the values of an organisation is essential in understanding their role within the community and their structural functioning. It also allows us to understand more clearly the intervention approach and methods that are used and why.

4.2.2 Understanding the role of Social pediatric centers within the community

The participants were asked to describe the structural aspects of the Social pediatric centers. To fully comprehend the functioning of Social pediatric centers, we must understand who the families receiving services are, and how they come to receive the services from the Social pediatric centers. The following is an excerpt to the explanation of Abby:

Well here at our center, the families who can benefit from our services need to have a reference from an external partner. Therefore, there must be a reference from either the school, the CPE (*centre de la petite enfance*), from a CLSC, from a hospital, or a community organisation. We then evaluate the reference and determine whether or not the family can receive services (Abby/ Social worker, June 14th 2019).

It is important to keep in mind that although the Social pediatric centers adopt the same mission, values and basic functioning, the processes to which one center accepts the families and their children may differ from one to another. What also differs, is the number of families that are obtaining services at their center. From the participants who were interviewed, this amount ranges from 200 to 600 families.

4.2.3 Structure of the Social pediatric centers

Social Pediatric centers are a non-profit organisation which benefit from the Dr. Gilles Julien Foundation established between 1991-1996 (Julien, 2018). Now there are about twenty-six Social pediatric centers that have opened their doors across Quebec (Julien, 2018). Although the foundation of the Social pediatric centers has started in Quebec, the movement has gained popularity across Canada and the United States (Julien, 2018).

Once the center receives the reference, it is directed to an agent where it is analyzed and processed. Then, the family proceeds to a pre-evaluation. The pre-evaluation is a small interview of about fifteen minutes, where one of the parent answers factual questions and also summarily explains their situation. The center then contacts any external relevant partners for additional information and to make sure that there is no duplication of the services being offered.

Following the reference analysis, the next step is to schedule the clinical appointment with the family. The center also invites any other external partners if necessary.

Following the clinical appointment, the social worker must continuously ensure an adequate follow-up and that the child and the family is receiving the intended services.

A family may stop receiving services at the Social pediatric center whenever they think it is necessary to them. The family will stop receiving services at the Social pediatric center once the child has turned 18 years old and if the family moves out of the circumscribed area.

Table 3: The functioning of a Social Pediatric Center

Step 1	Receiving a reference from an external partner. Example: CPE, CLSC, schools, CPEJ, hospitals.	<i>People involved:</i> the family, external partners, referral agent from the social pediatric center.
Step 2	Evaluate if the family in question corresponds to the criteria of the social pediatric centers.	<i>People involved:</i> referral agent from the social pediatric center and the external partners.
Step 3	Schedule the clinical appointment with the family.	<i>People involved:</i> family, pediatric doctor, social worker, and any other external sources if needed.
Step 4	Continuously ensure an adequate follow-up with the family and external partners.	<i>People involved:</i> Social worker and the interdisciplinary team.

According to the information gathered by both participants, it is an organisational structure which fosters the child’s and the family’s well-being. It is a structure which relies heavily on the friendly and non-judgemental welcoming to rapidly make the child and the parents feel safe and at home.

When describing the families that are referred to the center, Abby states the following:

So, most families will be those whom we believe have many difficulties. Especially at our center, where most our families are newly arrived families. These newly arrived families will go through adaptation difficulties,

difficulties at school, there could also be concerns regarding the child's developmental level. Furthermore, these families will likely not have a family doctor right away, which could be an important reason these families receive social pediatric services (Abby/ Social worker, June 14th 2019).

When considering Abby's description of the families who are referred to the center, refugee families fit the description as most are likely to be going through adaptation difficulties and difficulties in their surrounding environment.

4.2.4 Social pediatric families

As we discuss Social pediatric centers, it is important to fully understand who these families are, and why they are admissible in obtaining the services offered at the center. The data analysis allowed us to determine that it is mainly families who undergo many difficulties and are in a situation of continuous precarity. They are also the families who are referred from external resources because they are at an impasse to the services they can receive, or they are mistrustful of institutional services such as the CLSC. The families receiving services at the social pediatric centers are also those who are very isolated. They usually have limited support from a social circle. This is often the case with newly arrived families such as refugee and asylum-seeking families. Social pediatric centers will also accept families who are continuously in vulnerable situations.

Other common points between the participants that were mentioned during the interview which are to be considered when accepting a new family, is the difficulty newly arrived families have in adapting to the new country. Often schools and daycare centers will also refer children who they suspect have various developmental needs or difficulties and need any health prevention.

During the first interview, Sandra mentioned: “we take the families no one wants (Sandra/pediatric doctor, June 6th 2019)”. This means that Social pediatric centers accept families who fall within the cracks of society. Thereby, Syrian refugee families who have difficulty adapting, a small support system and who do not completely understand the functioning of institutionalized structures fit well within the description of the families who are accepted within the Social pediatric centers.

4.3 Intervention approaches and methods used within the Social pediatric centers

The Social pediatric centers mainly follow the biopsychosocial approach to illness. It requires the professionals working at the centers to regard the social environment and the child’s past as well as the family’s past before turning to merely medical explanations of an illness or issue. It seeks to fully understand the child’s emotional, cultural, social and medical background before administering a diagnosis. It also seeks to eliminate as many toxic stressors within the child’s environment to understand the child’s challenges and difficulties.

Another important approach that is used commonly in Social pediatric centers is empowerment. In order to make the child and the family feel at home and in a trusting environment, the professionals working with the families look at their strengths, their capacities and their social support. To empower the child and the family and help them build and realize their strengths, the professionals working with the family encourage them to pursue activities which will help the child gain confidence and realize that he or she has the tools necessary to overcome the current difficulties.

Other intervention approaches that were specifically mentioned are spiritual, intercultural, systemic and humanist. Considering that these are Social pediatric centers which assist many newly arrived families, spiritual and intercultural approaches are essential to adopt. It will allow the social workers, doctors and other professionals to understand their cultural, religious and spiritual background to better tend to their needs and offer adequate services which appeal to them. These approaches are all compatible with what makes up the holistic intervention approaches. The holistic approach as mentioned beforehand is characterized by addressing the whole person and considering the mental, social, spiritual, and cultural factors rather than just the symptoms of the illness (Boll, 2014). They seek to understand the complete individual background of every child in its own uniqueness, challenges and strengths. This allows a complete action plan and provides services which decipher a deep portrait of the child's past, present and cultural baggage to administer what the child actually needs and what he or she believes they need.

Aligned with these intervention approaches are the intervention methods the professionals apply when they interact with the Syrian refugee child and their family. An important intervention method that is widely used amongst all professionals working at the center is active listening. According to the participants interviewed, active listening is essential when working with Syrian refugees. It is essential that we listen to the child as much as we would listen to the entire family. The professionals working with Syrian refugees must listen to their migratory stories, listen to their traumatic experiences, listen to their needs and then try to respond to these needs the best way possible. Active listening also implies that as professionals, there are still certain limits to what can be accomplished.

Furthermore, Sandra repeatedly mentioned the lack of adapted resources and services that were available for refugee families. When they arrive, refugees are quickly required to integrate into the new society, and the post-trauma is hardly accounted for. No one is there to listen to their needs, their hardships nor their stressors. This accentuates the need for a resource which takes into consideration all these factors through active listening. With the act of active listening also comes the act of responding to the concrete needs of the family (material, housing, or psychological needs) and advocating for their rights which are often unknown to them.

Within the clinical meeting accompanied by the family, the doctor and the social worker, the professionals employ the following intervention methods as often as possible: openness, respect, drawing and the use of games. Using these methods, especially the use of games allows the child to put down his guard and becomes rapidly comfortable with the environment. It also allows to quickly create an alliance of trust with the family, which is essential to understand where they come from, what they have gone through and the stressors they are currently dealing with.

4.3.1 “Holistic” and other types of interventions used in the Social Pediatric Centers

The following section addresses the intervention approaches that are adopted at the Social pediatric center’s and the methods used.

One of the intervention approaches that is favored in Social pediatric centers is an approach known as the biopsychosocial and spiritual approach. This approach is strongly in line with the holistic approach. The biopsychosocial and spiritual approach was first proposed by the

medical doctor, Engel (Berquin, 2010). This approach believes that all illnesses can have biological, psychological, social, and spiritual factors of explanation to the cause of the illness (Berquin, 2010). Sandra mentions:

It consists of detecting the unique difficulties of each family. Sometimes, we have Syrian refugee parents wondering why their child is afraid to go to the park or sliding on the toboggans. They then remember that they would never go to parks by fear of being bombed. All of this, helps us understand their realities and help us navigate their needs and the services that best responds to these needs. It consists of better understanding and trying to show them that we are there for them and bringing them to what we know here and what we can do to help (Sandra/ pediatric doctor, June 6th 2019).

Abby also mentions certain intervention approaches which are all interconnected to the holistic approach:

As I explained earlier, here at the center we mainly welcome newly arrived families, so immigrant families. Therefore, the major part of our approach is intercultural. We also have humanist and systemic approaches which are related to the holistic intervention approach (Abby/social worker, June 14th 2019).

Considering the important amount of newly arrived families in Montreal, it is important for Social Pediatric centers to also adopt an intercultural approach. This will allow the immigrant, refugee or asylum-seeking families to be better understood, and supported. The other important approaches that were mentioned were systemic and humanist. All these mentioned approaches are harmonious with the holistic approach.

4.3.2. Methods of interventions: different methods to respond to different situations

Social pediatric centers mobilize the interventions of different practitioners having an expertise with children: social workers, psychologists, pediatricians, etc. It seems obvious that their intervention methods and techniques would vary according to their specific professional expertise. However, that variation in intervention techniques could also stem from the diversity of the examined situations.

When asked about the methods of intervention, Sandra mentioned that decisive element when selecting an intervention method is the situation itself.

It is actually very variable and depends on the situation...the idea is to first, welcome the family in our center. Then we must build a relationship of trust with the child... we then try to find out about the child and family's strength's by having them participate in various activities (Sandra/pediatric doctor, June 6th 2019).

Even though interventions could considerably vary, it seems that there are some specific techniques to determine which intervention is the most appropriated. An important intervention method which is used to respond to refugee children from Syria, and that was mentioned during the interview was "active listening". This implies that one fully listens to the child and the family as they recount their migratory trajectory, the traumatic events that occurred, listening to the needs of the family to be able to adequately provide services which address these needs. It also requires that those working with the family respond to the needs whether these needs are material needs, housing needs, fighting for their rights, or mental health needs. Abby mentions the following:

In general, the intervention techniques that we use is active listening. We also intervene with families, therefore listening to the family, we can also say that it consists of listening to their migratory trajectory and their traumatic episodes. But I would say listening. It also implies listening to the child's needs, and to respond to those needs. And sometimes, we will not always have the resources to answer these needs. That being, we must listen and understand that we do not have all the answers all the time (Abby/ social worker, June 14th 2019).

These intervention methods and approaches are valuable when intervening with Syrian refugee children because they allow those working alongside the family to actually take the time to listen to their stories and the obstacles they encountered. It also allows for the families to have a voice, and say what their needs are and what they perceive as being challenging to them. Lastly, it helps the child and the family integrate easier by feeling accepted in a safe and understanding environment. Sandra mentioned:

The idea is to give them confidence and show them that they have their place here, and to help them adapt to the new environment. Also, we must never have a pre-conceived idea or a plan. That does not work and that can not work (Sandra/pediatric doctor, June 6th 2019).

This flexibility in interventions is very meaningful when working with fragile children and their families. In this line of thoughts, Abby also mentioned: "These interventions help build resilience, helps the child adapt to the new country and it also helps the child feel at home. Syrian refugee children have a lot of resilient which help them overcome the trauma they endured (Abby/social worker, June 14th 2019)."

Table 4: Data comparison between both participants

Themes	Participant A	Participant B	Common Concepts
Social pediatric families	<ul style="list-style-type: none"> - Families who know us through the community - Families who need health prevention. 	<ul style="list-style-type: none"> - Newly arrived families - Families who have difficulty adapting - Children we suspect have developmental difficulties 	<ul style="list-style-type: none"> - Families with many difficulties and in a situation of precarity - Families who are referred - Families who are isolated and in vulnerable situations.
Intervention approaches	Biopsychosocial et spiritual	Intercultural, systemic and humanist	Empowerment
Intervention methods	<ul style="list-style-type: none"> - Openness - Respect - Welcoming - Drawing - Games. 	<ul style="list-style-type: none"> - Responding to the concrete needs of the family: material needs, housing needs, psychological needs. - Advocating for their rights. 	<ul style="list-style-type: none"> - Active listening
Mental Health	<ul style="list-style-type: none"> - Anxiety 	<ul style="list-style-type: none"> - Parental stress 	<ul style="list-style-type: none"> - Resilience - Post-trauma - Witness most distress amongst asylum seeking families.
Advantages of holistic interventions for addressing mental health	<ul style="list-style-type: none"> - Allows the child to excel at something. - Allows the child to think about something other than his anxiety by paying attention to something else. 	<ul style="list-style-type: none"> - Gives access to services - Allows for specific resources. - More sporadic interventions 	<ul style="list-style-type: none"> - Allows interventions that take the parents' mental health into consideration. - Take the time to listen to the migratory trajectory of the family.

Disadvantages of holistic interventions for addressing mental health	<ul style="list-style-type: none"> - Not many use these interventions. - There are certain psychological situations which exceed our capacities. 	<ul style="list-style-type: none"> - Did not see any disadvantages. 	
Difficulties intervening with Syrian refugee children	<ul style="list-style-type: none"> - Not immediate openness or willingness to share. 	<ul style="list-style-type: none"> - Language barrier 	<ul style="list-style-type: none"> - Lack of resources - Experienced most difficulties intervening with asylum seeking families.
How we could improve as professionals and a society	<ul style="list-style-type: none"> - Improve the wait list at the CLSC. - Listen to the concerns of the families as soon as they are welcomed. - More long-term interventions. 	<ul style="list-style-type: none"> - Increase access to psychological screening. - Advocating for the rights of newly arrived families. 	<ul style="list-style-type: none"> - Eliminate systemic discrimination. - Increase accessible psychological services. - Increase parent’s participation in psychological interventions with the child.

This previous table depicts the major points that were discussed amongst participants. It allows to quickly revise and analyze the common and differing information that were mentioned between Sandra and Abby.

4.4 Understanding the mental health concerns of Syrian refugee children

Although the expertise and intervention techniques used in Social pediatric centers seem to be very diverse and evolving, there’s a need that channels most of the effort and interventions.

Mental health is a main challenge faced by Syrian refugee children. Both participants clearly identified mental health as a major issue with refugee children and discussed its prevalence, contributing factors to developing it and protective factors that help to decrease the risks in developing mental health issues

The prevalence of mental health problems in this population seems to be quite high, nevertheless both participants of the study highlighted the resilience capacities they saw in children with whom they intervened in their respective practices. Resilience was discussed many times during the interviews by both participants as an important element in Syrian refugee children. Abby mentioned the following:

Concerning the mental health issues, what I greatly observed in Syrian refugee children is a lot of resilience. There is a lot of resilience in these children and what I have noticed, is that considering they have access to institutions and that they know they have their permanent residency this tends to help them adapt quickly and to become resilient (Abby/social worker, June 14th 2019).

Sandra also mentions resilience she witnessed in her practice:

Of course, it depends what they have lived and gone through and in what state of mind they arrive here. But these children also have resilience which will help them overcome their past experiences (Sandra/social pediatric doctor, June 6th 2019).

Both participants see resilience in Syrian refugee children as an effective way of overcoming adversity and trauma.

4.4.1. Anxiety in Syrian refugee children in Québec

Despite having great resilience, Syrian refugee children also face important challenges. Sandra talks about how different the lived experiences of each child was before migration

and she points to the variety of life conditions upon arrival are. She found that many Syrian refugee children face anxiety. This anxiety can be embodied differently and in ways which are not always obvious. She mentions how hard it was to get a sense of what was happening in these children's minds:

You know there are some children who do not say anything and seem like there is nothing wrong, and then you have children who hit others and have a totally different behaviour...these may all be underlying problems of anxiety which are expressed differently...but I have the impression that when the child arrives and starts to gain confidence, the mental health problems reduce considerably (Sandra/pediatric doctor, June 6th 2019).

Abby mentions another aspect that characterizes anxiety in children from a Syrian refugee background. She mentions how anxiety seems to spread inside Syrian families:

It seems that if the parent is going through anxiety, the child also has more chances of becoming anxious and that is true for all children, but especially Syrian refugees (Abby/social worker, June 14th 2019).

At multiple times during the interview, both participants compared the situation of Syrian refugee children and their families with children and families who are asylum-seekers. Asylum-seeking families in Canada lack the security and stability that most Syrian refugees have upon their arrival. The status that families receive upon arrival has an important impact in their sense of security in the new country. Asylum-seeking families do not immediately obtain permanent residency and may remain in constant fear of deportation. Furthermore, they don't have access to many institutional services such as subsidized daycare, free medical care and public transportation as their status is not accepted yet. In this sense Abby mentions the following:

Unfortunately, I am making a lot of comparisons between the two, but I see at what point the Syrian refugees as I said have a lot of luck to be able to

access services and when they arrive they already have a permanent residency and I think that this helps a lot with resilience, adaptation, and to feel at home. Which the children who are asylum seekers do not have. They have a larger gate to cross and much more obstacles to face (Abby/social worker, June 14th 2019).

This extract brings to light important information. It demonstrates the impact of security and stability on the amount of resilience. In doing so, it assumes that Syrian refugee children have more security due to their permanent residency which may help them be more resilient when they are faced with challenges. Whereas, asylum-seeking children have no security when they arrive and may face deportation at any moment. This may make it more difficult for the latter to remain resilient when as they face challenges within the host country.

This topic will be further discussed in the analysis section of this project due to its relevance and esteemed importance within the Social pediatric centers.

4.4.2. Contributing factors to developing anxieties

Another important aspect in regards to anxiety that emerged from the interviews, is the fact that schools seek to integrate the Syrian refugee child quickly, ignoring the importance of their migratory trajectory. This may ultimately have beneficial effects, but it is also important to consider and ensure that the child's post-trauma experience is addressed by acknowledging the complicated and traumatic experiences most of these children had on their migration routes to Canada. Abby mentions the importance of understanding these complex migration strategies:

When the child arrived here, there was a lot of stress from the parents, a language barrier, a miscomprehension of the functioning of the different

systems, and a misunderstanding of their rights (Abby/social worker, June 14th 2019).

When asked whether Syrian children from a refugee background were more at risk in developing certain mental health or physical health problems post-arrival, Sandra pointed to the fragility these children have towards common and simple problems and highlighted the importance of providing a secure life environment to avoid the exacerbation of past traumas lived by Syrian refugee children:

For sure when they arrive here, after they must be in a secure space...they must be very secure. So, for sure any small extra traumatic experience that happens, even breaking a leg, can be more difficult and intense (Sandra/pediatric doctor, June 6th 2019).

We must therefore remember their background and where they come from when supporting Syrian refugee children through different obstacles of the host country. Situations or events which can seem completely harmless to those born and raised in Quebec, can be seen as a major challenge for Syrian refugee children.

The interview allowed us to understand the mental health concerns professionals working at the Social pediatric centers are faced with when working with Syrian refugee children. Due to the traumatic experiences during the migratory trajectory, Syrian refugee children are likely to develop anxiety that expresses in different and not always responded too by resilience. The following section will help us understand which interventions are used to respond the mental health needs of Syrian refugee children.

4.5 Intervention with Syrian refugee children with mental health difficulties

When questioned about the intervention methods used in a mental health context for Syrian refugee children, both participants mentioned important factors in relation to the broad life environment of these children. The first factor to be considered is the parents' trajectories and lived experiences in the host country.

The importance of the structuring role of parents is mentioned by Abby,

We must always pay close attention to the experiences lived by the parents...for me, I am unable to dissociate the migratory trajectory, the reason surrounding why the parents fled, and the well-being of the child (Abby/social worker, June 14th 2019).

Considering the importance of the parents' experiences means that adopting an open and global comprehension of the child's and family experiences to understand the mental health of the children is very important. It also implies steering away from the uniformization of services and to apply more individual action plans which respond to the child's and families' needs. As Sandra stated, Social pediatric centers support families in vulnerable situations by giving them services that correspond to their specific needs.

According to Sandra, considering that most children suffer from anxiety the interventions used, allow the child to reduce the all-encompassing anxiety that is present in the child's mind. Sandra also mentions:

I think it is advantageous because we will little by little diminish the anxiety or other issues which take up almost all the room in the brain. And we also practice giving our complete attention to and with the child, which is one way that the child can gain power over their anxiety (Sandra/pediatric doctor, June 6th 2019).

There are many advantages in using the aforementioned intervention methods when addressing the mental health of Syrian refugee children. These intervention methods allow increased access to multiple services; it allows more access to specific services for the whole family and they are not interventions which are homogenous to all children.

Abby explains the potential of holistic interventions, by stating the following:

There is interest in yes having homogenous interventions and services, but I also think that it is in our best interest to offer services that are specific to these children even if it is something that is more sporadic and even if we can put into place projects that address specifically the families and children of refugee background (Abby/social worker, June 14th 2019).

This part of the interview proved that the mental health of Syrian refugee children as an integral part of their life. Many will develop anxiety mainly due to the migratory trajectory that is unaccounted for in integration services provided by the host country. This may develop into further complications regarding the well-being of the child and affect his or her development, academic success and adaptation to the new country.

4.5.1 Critical reflection on the interventions used and what should be done

The critical reflection in the interview was meant to have the participants think on what they believe the advantages and disadvantages are of using the holistic intervention approach. It also questioned their thoughts on what could be done as a mental health and health professional, but also as a society to improve the integration services of Syrian refugees arriving to Canada to reduce the risk of developing mental health issues.

4.5.2 Advantages and disadvantages associated with using holistic interventions

The section begins by questioning the advantages and disadvantages of the interventions used in the context of a Social pediatric center

An important disadvantage that was stated is the lack of professionals using the interventions method consistently within their services. Sandra mentions: “the disadvantages are that we are not many to be able to apply these interventions all the time (Sandra/ Pediatric doctor, June 6th 2019)” the participant continues by saying: “often, the families must wait, and the services around them are not always efficient, but on another hand this allows them to gain autonomy (Sandra/Pediatric doctor, June 6th 2019).” As stated in Sandra’s statement, the main limitation of the intervention of Social pediatric centers is the incapacity of having a constant offer, which translates in waiting times and delays in getting service.

Whereas Abby could did not identify any disadvantages. This could be explained by the different roles each participant has in the context of the Social pediatric center. Abby, being a full-time employee may be less aware of what occurs in another institutional organisation. Whereas Sandra, who is also employed at the Integrated university health and social service centre may have more insight on what goes on.

There are also disadvantages according to both participants in regard to the accessibility of different external services. As Sandra mentioned:

There are situations which exceed our capacities. When we are presented with severe mental health situations, we need to refer to other services. Other services

which are more psychological you know, which will dig deeper into the question of trauma, I and we are unable to...well, we know our limits as well. What I mean is that we are aware of what we can do, and we see when there are moments where we are unable to do anything. What we do sometimes is not sufficient enough (Sandra/pediatric doctor, June 6th 2019).

In relation to the specific situation and needs of Syrian refugee children, and when asked about the challenges of intervening with the Syrian refugee children population, both participants reiterated the lack of available resources to Syrian refugees. Often times, this lack results, as Sandra mentions, in the children or families not opening up right away and being on their guard. If the families are on their guard, it may slow down the adaptation process, and result in additional difficulties encountered by the child. The situation may then become more complex and take longer to attain the desired objectives.

In line to what the specific literature documented we asked our participants complementary questions that pointed out to additional (and external to Social pediatric centers) difficulties. In this sense, when we asked about the difficulties pertaining to the language barrier, both participants mentioned that they did not see it as a challenge. Sandra mentioned language couldn't represent a barrier:

So, no I did not find that the language barrier...I think of one family where they did not speak so much French yet, but there was still, I don't know, there was this positive attitude will which made it seem like we were able to get somewhere. And especially when they really believe that we are there for them, I think that that really helps to let go of many things (Sandra/pediatric doctor, June 6th 2019).

Perhaps, the family's eagerness to adapt to the host country combined with the mental health and social service professionals' openness to understand their realities and needs is an important combination in removing language as an obstacle to provide adequate support.

4.5.3 Improving the practice with refugee children facing mental health issues

Both participants were asked to reflect on how as mental health and social service professionals they could improve interventions methods to address the mental health of Syrian refugee children and to ensure their positive development. The responses elicited many interesting and differing views.

Sandra pointed out the accessibility of services and to issues regarding the waiting list for services at the CLSC:

Of course, it is all the wait around services for the CLSC, they say: “well you will be able to receive help in 6 months, in one year”, all this wait is very hard and heavy on individuals who are more fragile. Because in reality the wait worsens everything (Sandra/pediatric doctor, June 6th 2019).

Furthermore, both participants discussed the difficulties encountered when trying to obtain services at the CLSC. Abby mentions:

I also think that the screening is done too late. To benefit from first line services the child has to be between 0 and 5 years old. And well the children who are above that age well oops they never got the chance because they arrived too late. And I believe that for these children it is an important loss, only because they arrived to Canada too late. I had a case where the child was a Syrian refugee who was 5 years old. He did not have the chance to receive any evaluation for speech therapy at the CLSC. At school, the waiting list is too high and he is not priority. The wait list is 3 years. And for me that is problematic (Abby/social worker, June 14th).

This situation is troublesome because as Abby mentioned, the child may eventually be more at risk of developing mental health problems. He will also compare himself to others and he will realize that he is unable to learn and to get where he is supposed to be. Often, the child will not have support, and will then become disorganized, he will also develop difficulties in adapting to different school environments. Sandra, points out to the

interactions with the patient and/or their family as a site of improvements. She suggests that when the professionals first meet the family during the welcoming process of first-line services, it is important not to make false promises or beliefs to the patients and/or their families. The professional otherwise suggests to advance progressively in the therapeutic relationship and also to continuously listen to patients' stories, their migratory trajectories, their needs, and their perspectives; the active listening processes and adaptability to the patient's pace and needs are elements that often came up during the interviews. One very important factor (mentioned above) and reiterated by participants is that we must show the refugee families that we are there in the long term.

In this sense, Abby mentioned the importance of using intervention methods and services that include the family in the entire process. Abby mentions:

Sometimes, when we work, we do not notice the difficulty these parents have in understanding the systems and this results in the reality that they often feel not included. Or, they do not feel legitimate to be included in any process. Even with us. We often see it that the parents are unwilling, they are unwilling to ask questions, do not think that they have rights, they say that they do not understand the system, but well we still try to go on knowing that (Abby/social worker, June 14th 2019).

One suggestion that was advanced is that, in order for social services, mental health and health professionals to apply interventions that are beneficial for Syrian refugee families, they must start by asking the questions themselves to the families to ensure that they understand the system, and the services they offered, their rights and invite them to ask the questions they may have wherever they may be. It is also ensuring, as professionals that families understand their right to a translator in any context.

Lastly, Abby highlights once again the importance of addressing the parents' mental health simultaneously with the child.

We must always be aware of the migratory trajectory of the parents. And for myself, I cannot dissociate the migratory trajectory of the parents, the reason the parents arrived in a new country, and finally the well-being of the children (Abby, social worker, June 14th 2019).

There seems to be a strong link between the incidence of anxiety and mental health problems in children with that found in their parents. Addressing the mental health needs of the whole family guarantees that the children will evolve in a sane environment.

4.6 Helping refugee children, a collective responsibility

The last question of the interview guide questions the participant's point of view on how as a society, we could improve the integration services for Syrian refugee children in order to help them cope with stress and post-trauma and ensure a positive development. Both participants mentioned the importance of eliminating all forms of systemic discrimination. Sandra points to the law project 21 (now voted and enacted) where the Prime Minister of Quebec decided to prohibit the wearing of the veil in public services. Even if this policy does not have a direct impact on his/her practice, Sandra identifies the ways in which it could possibly interfere with the situation of his/her patients:

Already, we should not prohibit moms from working even if they are wearing a veil. This for me is very important. I feel like we are creating something that is difficult to live with because for me, well all the women that I am talking about, who open up and look for a job, well they are wearing the veil. And who cares ?!But I believe that if we feel the discrimination, it is worse. I think it is worse for those children and parents who can sense the discrimination (Sandra/pediatric doctor, June 6th 2019).

Having the ability to extend services for newly arrived children and Syrian refugee children is another factor that was mentioned. Abby, sees that ideally, it would be useful to increase the available resources in psychology for Syrian refugee children arriving to Canada in order to address post-trauma related issues immediately upon arrival. Abby mentioned:

It would be to extend the access to services for all children, but more specifically for newly arrived and Syrian refugee families who have difficulties. And sometimes, well oops it is too late, and they have past the age, and there are not sufficient resources in schools. The wait lists are up to three years at time (Abby/social worker, June 6th 2019).

Another interesting point that was mentioned by the participants is to have services and resources which correspond to the identity of the neighborhood available to clients. Abby mentions the importance of adopting resources to the issues of each neighborhood in order to adequately respond to the needs of those living in it.

Conclusion

The interviews that were conducted were very valuable in obtaining a professional's perspective on the intervention approaches and methods used to address the mental health of Syrian refugee children in the context of Social pediatric centers. It elicited new ways of thinking and a different perspective. The following section analyzes the results to obtain a deeper understanding of the topics that were mentioned in the interview and also bring to light the common and diverging themes and concepts which were brought up by the participants.

Both our participants, Sandra and Abby had different roles within different Social pediatric centers. This allowed the interview to have varying information, but also allowed us to

witness commonalities within many of the questions. The common mission of Social pediatric centers is to support families who are in vulnerable situations and help them eliminate factors of toxic stress to allow the children to develop positively. Both centers are located in communities that are predominated by newly arrived families. Therefore, the majority of children who receive services are newly arrived children. According to the interviews, these children seem to develop anxiety, considering the migratory experiences the family has endured. That being said, both participants agreed that these were children with immense resilience. The intervention methods used for the specific population were also discussed as well as the advantages and disadvantages. Lastly, we discussed ways that as a society and professionals, could improve the integration services for Syrian refugee children.

The upcoming chapter will analyze the data that was gathered to further theorize and understand the important concepts.

CHAPTER 5

DATA ANALYSIS

In the previous chapter, we described and analyzed the results that were gathered in this research. The current chapter will go deeper into discussing these results, and theorize the data. First, we will begin by a global analysis of the mental health issues that were addressed during the interview. Following this analysis, we will situate the advantages and disadvantages of the holistic interventions used to address the mental health of Syrian refugee children. Then we'll explore the difficulties intervening with this population. The last important question that will be analyzed concerns the integration services on how they could be improved to better meet the needs of Syrian refugee children.

5.1 Mental Health Issue in Syrian Refugee Children

Resilience and its positive effects in Syrian refugee children is the major question that was identified in both interviews. The other major element mentioned by both participants was the post-trauma resulting from traumatic experiences endured before coming to Canada and that Syrian refugees express through a delayed process. Post-trauma seems to be often neglected in some social settings such as schools, hospitals and daycares. The desire to quickly integrate the Syrian refugee family, disregards the importance of addressing the psychological needs of these families and their children.

Sandra mentioned the possibility that eventually the child may develop anxiety related problems. This is likely due to the past traumatic experiences and also the stressors experienced upon arrival. Parental stress is also a key component in the Syrian refugee child's mental health and was constantly acknowledged by Abby throughout the interview.

Abby stresses the importance of the interrelation between the migratory trajectory, the parent's mental health and the child's well-being. The mental health of the child's environment will ultimately have an impact on the child's development, integration and mental health. As professionals working in proximity to Syrian refugee families, it is not possible to address the child's post-trauma without addressing the family trauma simultaneously.

Throughout the interview, both participants continuously compared the situation of Syrian refugee children and asylum-seeking children. They found an important gap between the security of refugee children when they arrive to Canada, compared to asylum-seekers. Syrian refugee children are granted permanent residency upon their arrival which allows them access different services such as: health care, housing and grants them with the security knowing that they will remain safe in Canada. Whereas asylum-seeking families have no permanent residency and live in the constant fear of being sent back to the place they were fleeing in the first place. Without the permanent residency, asylum-seeking children have no access to daycare, health care, the parents are unable to find a job, and live in a constant state of insecurity. Therefore, we can suggest that the asylum-seeking children and their parents face much more toxic stressors which undoubtedly affects the child and the parents mental-health (Batista, Burhorst, & Wiese, 2007).

Children who face toxic stress often develop mental, physical and developmental difficulties in time. Considering the traumatic experiences endured by Syrian refugee children during the migratory trajectory, it is no doubt that these families have faced toxic stress. Regardless of the resilience these children have, the participants mention that they still seem to harbor anxiety which may not always be visible at first. As Bettman (2017)

mentioned, children of a refugee background will often have unattended needs in the social, emotional, and cultural spheres as the resettlement programs focus mainly on assimilation (Bettman et al., 2017). All these needs are part of the protective factors which help build resilience in the child. These protective factors are personal characteristics, relationships, sense of community, and societal factors. By ensuring the child has the protective factors, we can ensure that he or she develops resilience to overcome other difficulties.

5.2 Advantages and disadvantages of the holistic interventions to address mental health

The advantages in using holistic interventions to address the mental health of Syria refugee children are numerous. Both participants agreed that these interventions allowed to take into consideration the parent's mental health. As we mentioned earlier, taking the parents mental health into consideration is essential to ensure the child's well-being in the long-term. Both participants also agreed that active listening and an approach which takes into consideration the child's cultural and spiritual background allows to take the time to listen to the migratory story of the family, and adapt the services to their needs.

Other advantages include the fact that the interventions give access to a larger realm of services such as: art therapy, zotherapy, psychoeducation, occupational therapy, psychosocial follow-ups and more depending on the center in question. It also allows Syrian refugee children to benefit from specific resources and sporadic interventions such as projects or events, which correspond to the child's experiences, cultural background and needs. The empowerment, humanist and systemic approach allows the child and family to partake in different activities and find something the child excels at. These intervention

approaches will also allow the Syrian refugee children to think about something other than their pain or their anxiety. Sandra compares anxiety to pain. She mentions that like pain, anxiety will take the entire space in your head. When you are anxious, all you think about is that one thing and nothing else. The only thing we are concentrated about is anxiety. Sandra states:

I think that these interventions are advantageous because it will diminish that all-encompassing ball of anxiety that consumes our entire thoughts...by giving our complete attention to the child and letting him express his needs, allows the child to gain control over their situation (Sandra/pediatric doctor, June 6th 2019).

The disadvantages were hard to identify by the participants. Abby did not determine any disadvantages to using the aforementioned intervention approaches to mental health. Although, some disadvantages that could be identified, is the limited amount of resources that use these approaches. This can create a gap in the services offered especially if the family is already seeking services amongst the CSLC or other community organization. Furthermore, there are certain situations which exceed the center's capacities especially psychological needs. Very few Social pediatric centers will have psychological services for children which is often necessary for Syrian refugee children.

All in all, there are many advantages to using the holistic approach to address the mental health of Syrian children. Despite the few disadvantages, it is an approach which is worth looking in, and deserves to be applied to other integration services and institutionalized settings such as the hospital and the CSLC. The holistic interventions will allow

professionals to address the protective factors that help foster resilience and see those who are missing.

5.3 Difficulties intervening with the Syrian refugee children population

The difficulties encountered when intervening with Syrian refugee children are those we would expect and are not specific to this population only. The lack of resources is one major difficulty the professionals employed at the social pediatric center encounter. Certain children in need of specific services such as speech therapy, occupational therapy, and child psychology are not being seen due to the important wait list and the lack of available resources. There is also a gap of services for Syrian refugee children who arrive over the age of five. This is because the first line services at the CLSC are for children aged from 0 to 5, thereby leaving those over the age of five to receive services from the school, and will often not be prioritized due to the short amount of time they have been at the school compared to other students.

Once again, both participants mentioned that they experienced more difficulties intervening with asylum-seeking families due to their status of instability. They also tend to not share as much information with others due to their constant fear of being sent back to their country.

Another difficulty encountered, that is mentioned in multiple studies is the language barrier between those working at the center and the Syrian families. This difficulty can unwillingly affect the child's and family's openness and desire to share their life course.

5.4 Improving integration services for Syrian refugee children

In light of all the information gathered from the interviews, a few thoughts on how social service and mental health professionals, as well as society as a whole can improve the mental health of Syrian refugee children arriving to Canada were discussed. An important way society could improve the mental health of Syrian refugee children is by eliminating systemic discrimination. In the literature review, we discuss the presence of systemic discrimination in our society. We also mention the negative impact it has on the mental health and integration of refugee families. Considering the important impact of the parent's mental health on their children, we cannot undermine the consequences of parents who experience systemic discrimination which implicitly affect the child's overall well-being and mental health. The desire to quickly integrate and adapt the newly arrived families immediately, can be argued as a form of systemic discrimination.

In many parts of the world who are accepting Syrian refugees, systemic discrimination is implicitly present within the integration and assimilation policies (Humpage, 2001). These resettlement policies ensure universal standards to unequal situations (Humpage, 2001). As mentioned before, these forms of implicit racism are seen as politically acceptable which maintain ambiguity and place children and their families in a constant position of the invader and become responsible for the intangible forms of discrimination to which they are constantly victim too. These forms of implicit racism can be found in employment, child protection services, welfare benefits, educational requirements etc. A concrete example of systemic discrimination is the new law project 21 which prohibits women in Quebec to work with their veil. This is an act of systemic discrimination which restrains

individual in their right for independence, autonomy, fulfillment, and their right to attain basic needs because of their religious beliefs.

Furthermore, the participants also mentioned that the systemic discrimination endured by the parents can have an effect on the mental health of the children. As a society, we can also advocate for the rights of newly arrived families, especially when they remain unaware of their rights in the new country. Newly arrived families also have difficulties navigating the institutional systems and are unaware of the possibilities which are available to them. By advocating for the rights of newly arrived families, society can alleviate stressful situations encountered during the integration process of the refugees and implicitly reduce the development of mental health issues.

For social and mental health professionals, many measures can be taken to improve the integration services and improve the mental health and overall development of the Syrian refugee children arriving to Canada. One way that this could be done is by increasing the accessibility to psychological services, shortly upon arrival of the family. In doing so, it will favor the child's integration to the new society and will allow greater academic achievement. As professionals working in proximity with refugee families, the goal is to increase the parents' participation in the mental health and social interventions with the child. As mentioned earlier, addressing the mental health of parents is essential in understanding the mental health of the children. It also requires that professionals listen to the concerns and past experiences of the families as soon as they are welcomed in the host country. It may also be advantageous for the newly arrived families to receive more long-term interventions. This would allow more time to build the alliance of trust with the family, to listen to their experiences and address the post-trauma, stress and concerns of

the entire family. These are all suggestions which would contribute to the integration of the holistic approach in various services.

CONCLUSION

Literature about holistic intervention approaches to address the mental health of refugee children is limited. Although we suspected the approach to be advantageous, we were not aware of why and how it was beneficial for the specific population. We also wanted to see if there were any disadvantages to this approach. Our objectives for the research were the following:

- 1) To increase understanding of the mental health issues of the Syrian children from refugee background identified in Social pediatric centers.
- 2) To obtain knowledge on the holistic interventions that are used in the Social pediatric centers and the way these interventions contribute or not to the improvement of the mental health of Syrian refugee children.

To help us attain these objectives, we wanted to interview mental health, health and social service professionals working in the Social pediatric centers. This allowed us to obtain first-hand information on the experiences these professionals have on working with Syrian refugee children and how they use the holistic approach in their interventions.

To complete our understanding, we conducted two semi-structured interviews with two different professionals, with different expertise, working in one of the three social pediatric centers that were selected in Montreal. Using grounded theory, the participant shared valuable information which helped us attain our objectives.

First, we obtained a complete understanding of the role of each participant and what their concrete tasks within the center are. Knowing this, allowed us to acquire an understanding

on how the centers proceed when accepting a new family. These families who receive services from Social pediatric centers are families who are currently in an extreme vulnerable situation and are referred by external services.

After understanding the structure of the Social pediatric centers, the interventions were addressed. Social pediatric centers use a biopsychosocial and spiritual approach which is strongly in agreement with the holistic approach. The holistic approach encompasses multiple intervention ideals which allow the professionals to regard each sphere of the child's life. The Social pediatric centers also strongly favor the intercultural approach due to the large amount of newly arrived families who ask for services. The intervention methods vary from active listening, advocating for the rights of newly arrived family's rights and creating an alliance of trust through games with the children.

The mental health risks of Syrian refugee children were also discussed. Syrian refugees are extremely resilient despite the challenges they have faced and the challenges they endure upon arrival. Acknowledging parental stress is also an important element when evaluating the risk of mental health issues in the refugee children. Lastly, anxiety was mentioned by both participant as a probable issue that Syrian refugee children may develop. Considering the post-trauma to which they endured pre-migration, if it is not immediately accounted for upon arrival there are increased chances that the child may develop anxiety related problems. but there are various protective factors which build resilience and may help prevent the development of anxiety. The biggest advantages of using a holistic approach towards Syrian refugee children, is that it allows time to understand the experiences of the entire family and to address the mental health of the parents.

Asylum-seeking families and their children are at greater risk in developing mental health related difficulties. Professionals have recently been exposed to this population on many occasions. They have experienced greater challenges when intervening with asylum-seeking children than Syrian refugee children. Due to their uncertain status and the lack of security they endure, asylum-seeking families and their children are more vulnerable and in a state of precarity and are likely to face more factors of toxic stress.

We began by globally discussing about the situation regarding Syrian refugee children. We then addressed the migratory trajectory that these children and their families endure before arriving to Canada. The second chapter aimed to provide background knowledge on the mental health concerns of Syrian refugee children and the holistic interventions used in Social pediatric centers. Chapter three is focused on the complete methodological process that was used to gather and analyze the data. This chapter also describes the recruitment and limitations that were encountered during the study. The next chapter describes in detail the data that was gathered and propose an analysis of the main themes that emerged from the interviews. The fifth chapter discusses the results and the importance of fostering resilience in integration services by using holistic interventions. The discussion of the results is centralized around the interconnection of the mental health of the parents, the trauma they endured, and the mental health concerns of the children. This can be done using the holistic intervention approach as we learn about the child in his environment.

On a more theoretical perspective, this study sheds light on the importance of harboring resilience in Syrian refugee children who have undergone many traumatic experiences. It also allows us to further our comprehension regarding the difficulties and mental health concerns Syrian refugee children deal with when arriving. One surprising element that was

continuously discussed is the increased vulnerability found in asylum-seeking children compared to Syrian refugee children due to their status. This accentuates the need for further investigation to clearly and how we can best address it as a society and as professionals. On a more practical plan, the results demonstrated the intervention approach that could be fostered to help Syrian refugee children develop resilience and support them through mental health concerns and any other difficulties encountered in the host country.

Two major limitations of this project were identified. The first concerned the small number of participants. Our initial goal was to reach at least three participants. Unfortunately, due to the timing and the limited time frame of when the interviews needed to be done, the employees working at the center were not readily available. In Social pediatric centers, the end of Spring is a very busy time for them as they have to deal with finishing up reports and planning summer activities. This also means that the results are not generalizable to the entire population of mental health, health and social service professionals. The mental health issues that were discussed regarding Syrian refugee children are also not generalizable to the Syrian refugee population as it is only a small sample that is seen in Social pediatric centers.

Another limitation to our research is the fact that we did not question the Syrian refugee children themselves in regards to how they believe the holistic interventions are beneficial to them. This would have been an empowering approach to include the thoughts and perceptions of the Syrian refugee children and their families.

The current project allowed us to gain a deeper understanding on the interventions used in Social pediatric centers, and more specifically holistic interventions. The project also

allows other integration services and those working in proximity with Syrian refugee children to understand the mental health risks they face and the interventions that are advantageous at their regard.

For future research projects, obtaining a deeper understanding on the challenges asylum-seeking children face and how these challenges impact their mental health would be beneficial. We also recommend to pursue the investigation on holistic interventions and how this approach could be applied in other institutions. To do so, researchers could apply this approach as explained by the participants and other research to different populations. Furthermore, to further understand the interconnection of the mental health of parents and how it impacts the mental health and development of their children, we recommend pursuing the research by interviewing Syrian refugee families themselves.

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ANNEXES

Annex 1: Recruitment poster

 uOttawa

**ANALYSE DES INTERVENTIONS
HOLISTIQUES POUR ADRESSER LA
SANTÉ MENTALE DES ENFANTS
SYRIENS RÉFUGIÉS. LE CAS DES
CENTRES DE PÉDIATRIE SOCIALE EN
COMMUNAUTÉ À MONTRÉAL**

**PARTICIPANTS RECHERCHÉS
VOUS ÊTES ÉLIGIBLE À PARTICIPER
SI VOUS ÊTES:**

Un professionnel de la santé mentale et
des services sociaux.
Qui travaille dans un Centre de pédiatrie
sociale en communauté à Montréal.

ET

Vous avez déjà travaillé auprès d'enfants
réfugiés Syriens.

**VOUS ÊTES INVITÉE À PARTICIPER À UNE
ENTREVUE DE 30 À 45 MINUTES PORTANT
SUR LES INTERVENTIONS HOLISTIQUES
AUPRÈS D'ENFANTS RÉFUGIÉS SYRIENS.**

Cette recherche est complètement volontaire et confidentielle.
Si vous êtes intéressée à participer ou pour toute autre question veuillez contacter :
Chercheuse principale: Noémie Robin Superviseure : Professor
Tel: 819-232-0702 Sanabien Saltane
Email: nrob038@uottawa.ca sbensalt@uottawa.ca

Annex 2: Interview guide

Guide d'entrevue

Analyse des interventions holistiques pour adresser la santé mentale des enfants Syriens réfugiés. Le cas des Centres de pédiatrie sociale à Montréal.

La grille des questions est d'ordre indicatif, les questions peuvent être aménagées selon le profil d'expertise de la répondante et selon son besoin et sa perspective.

Comprendre l'intervention holistique

1. Quelle est la mission du Centre de pédiatrie sociale?
2. Selon vous, quels sont les valeurs du Centre de pédiatrie sociale?
3. Questionner le rôle du participant au sein de l'organisation.
4. Expliquer le processus et le fonctionnement du centre de pédiatrie Sociale en communauté pour les familles.
5. Qui peut bénéficier des services du Centre de pédiatrie sociale?
6. Combien de familles sont desservis au Centre de pédiatrie sociale?

Les interventions

7. Quelles sont les approches d'interventions utilisées au Centre de pédiatrie sociale, et spécifiquement l'approche holistique?
8. Pourquoi ses approches sont-elles appliquées dans un tel contexte?
9. Quelles sont les méthodes d'interventions utilisées auprès des enfants réfugiés? Donner des exemples.
10. Pourquoi ses interventions sont-elles favorables pour les enfants Syriens réfugiés?

La santé mentale

11. Pouvez-vous me parler de votre perspective sur les problématiques de santé mentale chez les enfants réfugiés de manière générale, et sur les enfants réfugiés Syriens en particulier ?
12. Pensez-vous que les enfants réfugiés Syriens sont plus à risque de développer des problèmes de santé mentale ou certains problèmes en particulier?
13. Comment adressez-vous les problèmes de santé mentale chez un enfant né et ayant grandi au Québec ?
14. Comment adressez-vous les problèmes de santé mentale chez un enfant Syrien réfugié?
15. Pourquoi les interventions nommées ci-haut sont-elles avantageuses ou pas pour répondre aux problèmes de santé mentale?

Réflexion critique

16. Quelles sont les **avantages** des méthodes d'interventions mentionnées?
17. Quelles sont les **désavantages** des méthodes d'interventions utilisées?
18. Quelles sont les difficultés rencontrées lorsque vous intervenez auprès de cette population?
19. Comment pourriez-vous en tant que professionnel de la santé mentale et des services sociaux, améliorer les interventions utilisées pour adresser la santé mentale

des enfants réfugiés Syriens afin de promouvoir un développement optimal chez l'enfant?

20. Comment pourrait-on en tant que société améliorer les services d'intégrations pour les enfants réfugiés Syriens afin d'améliorer leur santé mentale et de promouvoir un développement optimal chez l'enfant?

INTERVIEW GUIDE

Analysis of Holistic Interventions to Address the Mental Health of Syrian Children from a Refugee Background: The Case of Community Social Pediatric Centers in Montreal.

Understanding Holistic Interventions

1. What is the mission of the center?
2. What do you think are the values of the Community Social Pediatric Centers?
3. Question the role of the participant within the Community Social Pediatric Center.
4. Explain of the process and the functioning of the Community Social Pediatric Center for families.
5. Who can benefit from the services offered at the Social Pediatric Center?
6. How many families are currently obtaining services from the Social Pediatric Center?

The Interventions

7. What intervention methods are used in the Social Pediatric Center, and specifically for the holistic approach?
8. Why are these approaches used in the context of Social Pediatric Centers?
9. What are the interventions methods used for children of a refugee background? Give examples.
10. Why are these interventions favorable for addressing the mental health of Syrian children from a refugee background?

Mental Health

11. Could you talk about your perspective on the mental health issue for refugee children in general ? and for Syrian refugee children in particular?
12. Do you believe Syrian children from a refugee background are more at risk in developing mental health issues or other problems in particular?
13. How do you address mental health issues of a child born and raised in Quebec?
14. How do you address mental health issues of a Syrian refugee child?
15. Why are the interventions described above advantageous to address mental health problems of children?

Critical reflection

16. What are the **advantages** of the aforementioned intervention methods?
17. What are the **disadvantages** of the intervention methods?
18. What are the difficulties encountered when intervening with this population?

19. As mental health and social service professional, how could you improve the interventions used to address the mental health of Syrian children from a refugee background to attain an optimal development?
20. As a society, how do you think we could improve integration services for Syrian children from a refugee background to improve their mental health and attain a healthy development?