INTERGENERATIONAL TRANSMISSION OF TRAUMA DUE TO WAR AND DISPLACEMENT

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1. Introduction

„Every day, all over the world, people make one of the most difficult decisions of their lives: to leave their country in search of a better, safer life“ (Amnesty International, 2018).

According to the International Organisation for Migration (IOM) and the United Nations High Commissioner for Refugees (UNHCR), 255 million people are living today outside the country they were born in. All around the world catastrophes such as climate change, natural and man-made disasters occur: in 2017 6.5 million people have been forcibly displaced due to persecution, conflict and natural disaster – an average of 28 300 people a day. This is the highest level of displacement in record of the UNHCR (2017). Seventeen percent of the 22.5 million registered refugees worldwide are fleeing to Europe. By the end of 2016, Germany alone hosted 1.27 million refugees and asylum seekers (UNHCR, 2018).

As the majority of refugees flee due to on-going war and conflicts in their home countries, the number of traumatisation amongst them is extremely high: Seventy to eighty percent of refugees coming to Germany suffer from traumatisation (Leuzinger-Bohleber & Andresen, 2017, p.8). Studies on holocaust survivors and their descendants have shown that trauma can be transmitted from one generation to the next, even if the second generation did not witness the traumatic events first hand. Furthermore, many different studies, e.g. the PISA study in Germany, have shown that children with migration background have “a bad level of education” (Klingholz, 2010, p.1299). “Every fourth child with a migration background leaves school without a certificate. Many of them become unemployed as are their parents and lead a life on the fringe of society” (Leuzinger-Bohleber, 2014, p.21). Marianne Leuzinger-Bohleber claims that the result can be an increase of violence, criminality and mental disorders, which is why early “prevention of so-called children at risk has become a paramount responsibility of society” (2014, p.22). As prevention programmes have proven to be promising and long lasting, it is crucial for social work to take action today and to focus on converting clinical knowledge and interventions in a non-clinical setting. Social workers need to be better informed, not only of the direct trauma of the population that fled the war, but also that the children that are now growing up in a safe environment, may suffer from the

trauma of their parents and that this can have negative long-term effects to their lives. In order to prevent a large number of this new generation to suffer under the unresolved trauma of their parents, action needs to be taken straight after a refugee's arrival in their host country. Therefore, findings of a past event, such as World War II, are still relevant today, looking at the concerning high number of refugees worldwide. A refugee client stated after attending a prevention programme: "With how much less effort and pain could I have been helped in kindergarten […]." (Leuzinger-Bohleber, 2014, p.28), which shows the necessity of such prevention programmes.

For this reason, my bachelor thesis tackles the issue of preventing intergenerational transmission of trauma (ITT). As part of my studies I completed my internship in a refugee accommodation in Athens, Greece in 2017 that hosted around 300 refugees with different nationalities, amongst whom many suffered from traumatisation. Not only the psychologist but the whole staff observed unusual behaviour amongst mothers towards their children, which caught my attention and interest in this topic. I chose the question of how social work can help the prevention of ITT in a non-clinical setting, as the majority of prevailing literature dealing with transmission of trauma refers to clinical treatments. However, working in a non-clinical accommodation made me realise how important it is to be aware of the intergenerational impact of trauma for anyone working with displaced persons, not only psychologists. Most refugees and asylum seekers, if not all of them, come across social workers at some point in their journey, mostly in a non-clinical setting. As social workers are "ideally placed to be the first line of help and assistance in facilitating growth and development following traumatic events" (Joseph & Murphy, 2014, S. 1095), it is necessary to educate professionals appropriately in this field and raise awareness on this issue. The focus of this thesis is the prevention of transmitted trauma rather than its treatment. Why wait until the second generation goes through the same burden as their parents, if we can take action now? The forecast of continuing catastrophes worldwide and the large number of children whose parents were or will be exposed to traumatic events is my motivation to deal with this topic in my bachelor thesis. In the whole world children are now born to parents that suffer from trauma due to war, terror and displacement. It is therefore crucial to gather more information on the effects of war and displacement, on ITT and ways to prevent it.

The literature review reflects a research based on the following key words: trauma, intergenerational transmission of trauma, war and trauma, mental health of refugees,

migration and trauma, social work and migration, and lastly prevention programmes, early childhood development, early prevention and cultural competences in social work. During my research process I made use of the online resources of the library of the University of Applied Science of Darmstadt and the Technical University of Darmstadt as well as online search engines, such as “Wiley Online Library”, “Research Gate”, the Google-scholar search and “pub-med”, in order to find a wide variety of articles and psychological journals. My main research method was the snowball sampling technique, using the reference list of publications to find further article relevant for my topic.

The current state of research is that trauma can be transmitted from one generation to successive generations. It needs to be said that the exact mechanisms of transmission have not been fully explored. Researching literature on this topic is overwhelming, as there are so many studies regarding ITT with regards to mainly Holocaust survivor, Vietnam veterans or in Israel and Palestine (Dekel & Goldblatt, 2008; Kahane-Nissenbaum, 2011). Furthermore, the literature agrees that children with an immigrant background lag behind in educational development (OECD, 2015, p.5). However, having discovered a correlation between the trauma of parents and the lack of their children’s educational development, there is still a gap in the literature on prevention, in particular in a non-clinical environment. This is why this thesis tackles the question: **How can Social Work help prevent intergenerational transmission of trauma in a non-clinical setting?**

This thesis will firstly address war and displacement as a cause of trauma, in order to understand what people go through when fleeing from war. This will also serve to comprehend why trauma can be a consequence of the different experiences prior, during and after migration. Secondly, this thesis will cover the theoretical background of intergenerational transmission of trauma by referring to respective studies, presenting the current state of research and therefore illustrating that trauma can be transmitted from one generation to another. As there are many suggestions on how trauma can be transmitted, this paper only focuses on the parent-infant interaction and caregiving behaviours. Both these chapters serve as an introduction and description of the different theoretical approaches that will be useful for answering the question on how transmitted trauma can be prevented. The main emphasis of this thesis is on the development of different prevention programmes including early childhood development interventions in order to understand the key principles for social work in a non-clinical setting. I will come to the

conclusion that focusing to create a safe space and promoting the mother-infant relation are the most effective means of preventing ITT.

2. Methodology

Within this paper I will refer to my practical experience in Athens, Greece, working in a refugee accommodation. In order to differentiate literature review from my personal experiences, latter will be highlighted it in *oblique lettering*. These references only serve as an illustrative character and do not have a proven empirical meaning.

In fall 2017 I completed my practical semester as an intern in the refugee accommodation "WELCOMMON" in Athens. "Model Hostel WELCOMMON" is an innovative community centre, hosting refugee families and individuals mainly from the MENA (Middle East and North Africa) region: primarily from Syria, Iraq and Somalia. It serves as an accommodation, offering bed, food and a safe space, especially for vulnerable groups of refugees (victims of torture, pregnant women, families with new-borns, people with disabilities, with serious medical conditions as well as mental health disorders). Additionally, WELCOMMON promotes social justice and helps the residents in their integration process (WELCOMMON, 2017).

The reason for these illustrations throughout this thesis is not only for the readers to have a better understanding of the importance of the topic and to understand the current relevance with the help of a present example, but it also serves as a personal reflection of my practical experience. As a social worker to-be it is highly necessary to combine theory and practices and beyond that to be able to reflect one's own experiences. Realizing how not only the psychological department but the whole staff lacked trauma knowledge and education, even though working with a large number of traumatised, partly highly traumatised families, it awakened me to deepen my knowledge on trauma. Answering the question of what social work can do in the process of prevention ITT in a non-clinical setting shall be referred to the practical example of WELCOMMON at the end, showing what could have been done differently and what needs to be done in other facilities working with refugees.

In this paper it will be referred to the term "refugee". As defined by UNHCR (2018) a refugee is a person that had been forced to flee from his/her country of origin, crossing international boarders due to conflict, war, persecution, violence and fear for reasons of race, religion, nationality, political opinion or membership in a particular social group. Furthermore, according to article 1 A. (2) of the Geneva Convention 1951, a refugee is unable or "unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it" (UNHCR, 2010, p.14). The term refugee in this context also contains asylum-seekers. Asylum-seekers are individuals who have sought international protection and whose claims for refugee status have not yet been determined, irrespective of when they may have been lodged (UNHCR, 2017).

The method I chose, for answering my research question, is to start with theories generally on the process of migration and displacement, before dealing with the theoretical background of intergenerational transmission, in order to better understand the broad context for prevention programmes at the last chapter. Particularly the ADAPT model of Silove (see chapter 3.2.) was helpful to start with an understanding of what refugees might experience, and therefore how the best support can be established.

3. War and displacement as a cause of trauma

As mentioned in the introduction, around 70-80% of the refugees suffer from traumatisation. In order to be able to work with refugees and offer them appropriate support, professionals need to have a better understanding of the "complexities involved" (Papadopoulos, 2007, p. 310). This chapter will examine why war and displacement can be a cause for trauma, trying to cover the complexities that interfere with refugees' mental health. The process of migration is a series of events that can be divided into three stages: pre-migration, migration and post-migration. Looking at the migration journey it becomes clear why it can be a long and difficult journey, and why it can have such severe and long-lasting impacts on mental health (Measham, Guzder, Rousseau, Pacione, Blais-McPherson, & Nadeau, 2014; George, 2012; Steel, Silove, Brooks, Momartin, Alzuhairi, & Susljik, 2006; Khawaja, White, Schweitzer, & Greenslade, 2008). "The Adaptation and

Development after Persecution and Trauma" model by Silove will support the understanding of the burdens refugees carry. Each step has its own consequences that need to be considered, in order to understand how they can cause psychological distress, such as trauma. Lastly, this chapter addresses specifically the issue of trauma.

Ongoing war and conflicts force mass of people to flee their home countries, seeking safety elsewhere. While displacement is present all over the world, 55% of refugees worldwide come from Sudan (1,4 million), Afghanistan (2,5 million) and Syria (5,5 million refugees) (UNHCR, 2017). Fleeing due to fear of persecution on account of religion, race, ethnicity, nationality or membership in a social or political group, refugees seek international protection in a new country (George, 2012; Measham et al., 2014; Onyango, 1998). The majority of refugees are hosted by developing countries, for example Pakistan hosts 1.4 million, Lebanon, Jordan and Iran host approximately 1 million refugees (UNHCR, 2018).

3.1. Refugee migration journey

The three stages of a refugee's migration journey are prior the flight ("pre-migration period"), during transit-phase (referred to as "migration period") and after the resettlement ("post-migration period").

Within the **pre-migration period**, refugees are still living in their home country. Every individual has his/her own unique reasons to leave their home country, however there always seem to be life-threatening experiences and traumatic events due to civil war, conflict, terrorist attack, oppression, economic, social or political chaos, and other human right abuses (George, 2012, p. 429; Silove, Steel, McGorry, & Mohan, 1998). A study on Sudanese refugees in Australia (Khawaja et al., 2008) demonstrates that people were forced to flee their home because of the lack of basic needs, such as food, water, shelter; inability to fulfil daily life activities, like education and employment, caused by the destruction of schools and workplaces; limited accessibilities and funds as well as physical and psychological trauma (p. 497). Additionally, experiences such as loss or separation of a family member or friend; escaping one's own death and torture, can cause serious stress and have longlasting consequences physically and mentally, accompanied by a feeling of insecurity and constantly thought about death (George, 2012, p. 451;

Khawaja et al., 2008, p. 496-497; Measham et al., 2014; Onyango, 1998; Steel et al., 2006, p. 59).

During the **migration period** refugees move from one country to another, crossing international boarders, where they are confronted with diverse risks and life threatening experiences. Refugees encounter exploitation and smugglers on their journey. Being separated from their family and living under temporary protection may cause severe stress, anxiety and depression (Stee et al. , 2006, p. 63). Refugees in their transitional phase are often just seen as numbers, controlled by governments, United Nation (UN) agencies or non-governmental organisations (NGO). In a study about the different experiences of a migration journey, Sudanese refugees reported to be living in a constant state of anxiety of being sent back home (Khawaja et. al, p. 501). Additional to the mental state of uncertainty about the future, the lives are often accompanied by the lack of employment, education and livelihood living within limited mobility. During the legal battle of the asylum process displaced people often face re-traumatisation (Quiroga & Berthold, 2004, p. 6). This can be caused by negative immigration detention experiences and questionings by immigration authorities. In her study on refugees George (2012) shows, that these occurrences increase even more due to the intolerance by the police officers and board members. They seem to counter refugees socially and culturally inappropriately, unwilling to consider their background or lacking knowledge about refugee rights. Furthermore, George (2012, p. 430) examines the ignorance towards traumatisation by the board members. Moreover, most refugees live in refugee camps during their transit period. These camps are often overcrowded, lack clean water and adequate food, are provided with poor sanitation and diseases are widespread (Onyango, 1998, p. 222-225). Violence, rape and rebel attacks make it a dangerous environment for everyone living there (Khawaja et al., 2008, p. 500-501).

While pre-migration experiences have a major impact on psychological distress and constitute the main focus of the literature, there are many stressors during the **post-migration period** contributing to the stress symptoms of refugees as well. It is the final phase in which refugees are relocated to a host country, where they could potentially seek asylum. Even if people have managed to overcome the lack of security, hold a legal status and have the basic necessities such as housing and food, they are confronted with culture shock, culture conflict and loss (Bhugra, 2004, p. 244-245). Language problems, acculturation stress and the difficulty of familiarisation with different values and practices

arise in the context of cultural differences. Cultural conflicts appear in the maltreatment of refugees by the host community. Prejudices, discrimination and indifference towards those living in exile create barriers for the integration process and contribute to a negative mental health (Montgomery, 2008, p. 1600). Furthermore, culture differences and therefore differences in perspectives and understandings can create tension. As their oppressors and tormentors are not available the refugee community shifts "their demand to the host government […] complain[ing] of not receiving enough" (George, 2012, p. 432). The citizens of the hosting country might misinterpret this behaviour. Moreover, they often do not consider the difficulties that come with resettling into a new world. Therefore, facing racism, sexism as well as isolation and exclusion accompanies many refugees daily. For this reason, a study on Middle East refugees in Denmark by Montgomery (2008, p. 1600) found out that even though traumatic experiences prior the escape affect the emotional wellbeing, social factors of the life in exile seem to have a greater impact for long-term mental health issues. Additionally, a study on Bosnian refugees resettling into the United States found that refugees also fight a personal conflict. While losing the sense of belonging to their original country, they seem to be "searching for a sense of belonging in their new homes and adapting, wherein the refugees chose to change their environment and themselves in their new environment" (Keyes & Kane, 2004, p. 828-829). Lastly, the effect of loss has a strong influence on one's mental health: Refugees are confronted with the loss of their place, people they loved and also parts of their identity. This could be the loss of culture, social role and habits (George, 2012, p. 431). Additionally, many reported to lack social and cultural support whilst facing financial problems and unemployment (George, 2012, p. 430; Khawaja et al., 2008). Encountering difficulties with resettlement can create a feeling of frustration, nostalgia and is often accompanied by the feeling of guilt. Furthermore, a study on Tamil refugees in Australia reported that boredom and loneliness caused "serious and very serious stress" amongst asylum-seeker (Silove et al.,1998, p. 178). These studies prove that post conflict environment impacts the dimension of the trauma, or whether a trauma develops into post-traumatic distress or not (Silove, 2013; Measham et al., 2014). Considering the three migration periods as a social worker is necessary in the process of understanding the well-being and challenges of the refugee population, in order to build appropriate support (Ostrander, Melville, & Berthold, 2017, p. 72-73). This information will be extremely useful for the development of prevention programmes in chapter five.

3.2. Disruption of the five fundamental pillars (ADAPT Model by Silove)

In order to understand how the experience of conflict, terror and persecution can result in negative psychological response such as trauma, it is crucial to examine the consequences of such events. Silove (2013) developed the "ADAPT" model ("Adaptation and Development After Persecution and Trauma") that focuses on five fundamental pillars that are negatively affected: Safety and security, bonds and networks, justice, roles and identities, and lastly, existential and meaning. The concept of the five pillars is particularly necessary for understanding the recovery process of trauma, and will therefore be used in chapter five for the development of prevention and intervention programs, which intend to rebuild these pillars.

Conditions of terror and threat have proven to increase the risk to develop post-traumatic stress reactions (Silove, 2013): As mentioned in chapter 3.1 and 3.2, refugees are exposed to constant threat, living in an ongoing state of insecurity. The loss of security can cause stress and lead to hypersensitivity to threats that can result in post-traumatic stress and other anxiety symptoms. Safety is crucial for a stable mental health. Moreover, bonds and networks are essential for human functioning and their loss can result in prolonged grief, depression and excessive preoccupation with the past (Silove, 2013, p. 239). Communities that had been forcibly displaced suffer extreme personal and material losses, which is why the study on grief is essential in this matter (p. 241). Furthermore, the sense of injustice is a normal response to human rights violation, which each refugee faces at one point within his/her migration journey. While anger is a normal response to injustice, it can develop into explosive anger. Moreover, maladaptive response to injustice can be mistrust, resentment, paranoia and unresolved sense of grievance (p. 239). In addition, Silove claims that roles and identities are challenged by conflict. Displacement affects the roles of families and society, for example change in gender roles and statues as well as change in parental expectation (Silove, 2013, p. 243). In the study by Khawaja et al. (2008), Sudanese refugees reported that there had been changes in the role of men and women in a marriage that caused issues amongst the whole family (p. 503-504). Identity confusion and the loss of the feeling of having a meaningful role affect the mental health. It can lead individuals to withdrawal, anomie and depression (p. 239 & 243). Lastly the pillar "existential and meaning" stands for the fact that beliefs and worldviews can be fundamentally challenged by war and displacement and can therefore cause alienation and depression and leave refugees feeling isolated and powerless. In

conclusion it can be said that this model of the five pillars shows how complex the causes for a trauma can be as well as how multifaceted the recovery journey might be. Social work needs to be aware of this complexity.

3.3. Mental health of refugees (trauma)

The following paragraph will summarise and further deepen on the topic of mental health of refugees. The literature review regarding this topic is overwhelming and there are many different factors and outcomes which need to be considered in order to understand the complexity. The existing literature and studies on mental health of refugees indicate a high prevalence of trauma amongst refugees. After having discussed all dimensions involved in such migration experiences, this paragraph focuses on traumatisation. The term "trauma" will be clarified and a brief overview of the state of current research on this issue will be outlined.

"(…) metaphorically [the term trauma] in psychology and psychiatry refers to a psychological injury, a deficit, a pathological state" (Papadopoulos, 2007, p. 304). According to Freud, trauma is an experience that overwhelms a person's ability to cope (Dalenberg, Straus, & Carlson, 2017, p. 15). It is a normal human response to an abnormal event that either occurred over and over again; occurred at the same time as other stressful events; is extremely terrible or happened at a very young age. Trauma itself is an extreme incriminating event that affects an individual as a stressor from outside (Leuzinger-Bohleber & Andresen, 2017, p. 7). The reaction to a sudden life threat is often defined as trauma, where people have the feeling to lose control and are overwhelmed, other than a stress reaction, where one maintains control and is able to disconnect from the thoughts. Due to threat and danger the survival part of the brain takes over and the interpretive functions collapse (Fonagy, Campbell, & Luyten, 2017, p. 379). Within a trauma one can therefore become hyper-vigilant to any threat, which can leave someone in a constant state of arousal. This can impact a person and the result can be a constant feeling on edge; sensing danger even in non-threatening situations and difficulties in emotion regulation. Symptoms such as flashbacks, stress, the feeling of guilt, isolation, avoidance, and other unexpected behaviour patterns are very common as well (Leuzinger-Bohleber & Andresen, 2017, p. 7-8). Emotional numbing as a symptom can be of particular interest related to transmission of trauma from one generation to another (Fond, 2017, p. 283; Schechter & Rusconi Serpa, 2014). According to DSM-V

(diagnostic and statistical manual of mental disorders fifth edition) emotional numbing can be described as the inability to feel or express positive emotions, as well as feeling detached from relationships (American Psychiatric Association (APA), 2013). In order to understand how trauma can be transmitted in chapter four it is necessary to consider these symptoms. Moreover, psychological trauma is often linked to the development of comorbidities and other disorders, such as eating disorder, depression and anxiety, substance abuse, disturbed relationships, somatic disorders, psychosis, and post-traumatic stress disorder (Luyten, Van Assche, Kadriu, Krans, Claes, & Fonagy, 2017, p. 244).

Under particular circumstances, a traumatic experience can develop into severe and chronic psychological problems that lead to the diagnosis of post-traumatic stress disorder (PTSD) (APA, 2013, p. 271). PTSD symptoms are severe and can have a negative effect on the whole life, such as relationships, work-life, behaviour and continuing of the symptoms. It can be said, that men-made trauma, especially caused by mass-conflict and events that occur concurrently, have severe and continuing impacts on psychological distress (Silove, 2013). Traumata, related to mass conflicts, are multiple, which is one of the reasons why PTSD is frequent amongst refugees (Silove, 2013, p. 237).

However, looking at the negative outcomes from traumatic events, it needs to be considered that all the events and experiences mentioned above do not only cause negative mental health, but can also result in a neutral response: resilience; as well as positive consequences: such as strength, growth and positive adaptation (Silove, 2013, p. 237-238; Papadopoulos, 2007, p. 304-308). It is crucial to emphasise, that even though most literature focuses on PTSD in the context of refugee mental health, not all people living in exile develop PTSD, despite their negative experiences (Papadopoulos, 2007, p. 305-306). Though as the topic of this thesis is on trauma due to war and displacement, the focus of this chapter lies on trauma as a negative outcome. For the development of prevention programme positive and neutral reactions, such as resilience and post-traumatic growth need to be considered, as the goal should be to promote health instead of focusing on disorders (Emde, 2014, p. 8, Silove, 2013).

A better knowledge on trauma is essential for social workers to understand how it develops and what symptoms can arise, in order to better recognise trauma and encounter the people more appropriately. Joseph and Murphy (2014) state that “whilst there is

clearly a shortage of social workers knowledgeable and skilled in working with trauma, many traumatised people are nonetheless in contact with and seeking help from social work" (p. 1106).

In my work with refugees in the accommodation WELCOMMON in Greece I made the same observation. We hosted refugees with diverse mental and physical problems, amongst whom many of them have shown traumatised behaviour. However, there was never a briefing about trauma. Not on how to recognise it, how to treat traumatised people, or how trauma can affect individuals. The majority of the staff had never worked in the field of migration and refuge before, and many did not even work in the humanitarian sector. For example, employees working at the reception and therefore being a contact person for any issue during the whole day and night had worked the field of purchase and sales prior to their work at WELCOMMON. The result for not being informed and trained were a series of fights between staff and inhabitants that caused mistrust, indisposition and a tense atmosphere. The inhabitants had the feeling that no one cared about them and that even in a place that was supposed to give them security and comfort they did not feel safe. Though the staff felt disappointed, that even though they offered their time and attention towards the refugees they never seemed to be pleased.

In conclusion it can be said that a refugee undergoes a series of events and different experiences that can have severe impact on their mental health. Each step of the migration journey has its own challenges and whether a refugee left voluntarily or was forced makes a different in the impact as well (Kunz, 1981). Trauma is a common result amongst those that were forcibly displaced due to man-made disaster, such as armed conflict and now live in exile.

4. Intergenerational transmission of trauma

The following chapter will briefly define the intergenerational transmission of trauma in order to then present different mechanisms and theories on how and why trauma can be transmitted from parents onto their children. Lastly, the appearances of transmitted trauma will be presented, while referring to prior studies on this topic.

The intergenerational transmission of trauma (ITT) refers to the exposure to a traumatic event of an earlier generation that continues to affect the successive generations. The American Psychological Association (APA) defines ITT as an unresolved trauma in a parent, that seems to be transmitted on younger family members, regardless whether they had experienced the traumatic event first hand or not (Fonagy, Campbell, & Luyten, 2017, p. 276-277; Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009, p. 160; Lev-Wiesel, 2007, p. 76; Schechter & Rusconi Serpa, 2014, p. 92). There are many studies on this issue with the result that ITT is "real" and therefore a "global statement" (Kaitz et al., 2009, p. 163). The following chapter will mainly refer to maternal trauma, though it needs to be stressed that fathers may transmit their trauma onto their children as well (Dekel & Goldblatt, 2008). The reason for this is that prevention programmes illustrated in chapter five will focus on the interaction between caregiver and child, aged zero to three. The following chapter will mainly refer to maternal trauma, though fathers surely being a relevant bonding person transmit certain symptoms as well. Nevertheless, research focuses mainly on mothers, in the context of trauma transmission. In this particular period mothers are generally closer to their children, which can be related to John Bowlby's attachment theory and the represented argument that children bond to their mothers (Bowlby, 1988; Posada, 2008). As Posada (2008) stated "most children are still being raised predominantly by their mother" (p. 96), which is why the thesis highlights the mother-infant relation as well.

Many research studies have confirmed that not only the second but also the third generation can be affected (Kaitz et al., 2009). This has been examined especially amongst Holocaust survivors. Furthermore, children living with two parents who suffer from trauma reactions are particularly affected (Kaitz et al., 2009, p. 170). Moreover, it needs to be clarified that not only parents with PTSD transmit their trauma to the following generation, but also those that are not diagnosed with a specific pathology and rather suffer from trauma symptoms that may not be as clear as PTSD (Scharf, 2007). As mentioned in chapter three there are many different negative responses to traumatic events that occur during war and the displacement journey and they can all have an impact on the next generation.

4.1. Mechanisms of transmission

In order to understand how trauma can be transmitted onto the successive generation, even if they did not witness the traumatic event first hand, it is necessary to look at different mechanisms and theories of transmission. It needs to be stressed that the exact mechanisms have not been fully explored, which is why only potential explanation can be discussed.

Many different factors influence the process of transmission. According to Kahane-Nissenbaum (2011) there are four main theoretical perspectives of transmission: biological, sociocultural, psychodynamic, and the family system (p. 5). Trauma can be passed onto the following generation through biochemical mechanisms and genetic factors as well as stress-related impairments during pregnancy (Kahane-Nissenbaum, 2011; Kaitz et al., 2009). Additionally, transmission may occur through cultural aspects and social norms. However, for reasons of narrowing, this thesis will focus on the "psychodynamic" factors, such as unconscious transmission through projective identification, as well as the "family system", that is related to caregiving behaviour patterns and the parent-infant interaction. Furthermore, transmission can on the one hand be indirect and general, through dysfunctional relationships; on the other hand direct and specific, with the result of maladaptive thinking and behaviour, for example the parent is teaching its child that the world is a dangerous place and the infant therefore develops anxiety (Babcock Fenerci & Deprince, 2017; p. 8).

Children arrange their reality from what they learn from their parents: through verbal and non-verbal communication; through observation and projection; and lastly, through identification (Dekel & Goldblatt, 2008; Kaitz et al., 2009; Lev-Wiesel, 2007, p. 285; Scharf, 2007; Schechter & Rusconi Serpa, 2014). Children still have limited capacities to regulate their own emotions, which is why they need to learn self-regulation through a connection with their caregivers (Schechter & Rusconi Serpa, 2014, p. 92). This can happen during social interplay or moments of mutuality on the micro level, as caregivers provide some hidden regulatory functions (Schechter & Rusconi Serpa, 2014; Kaitz et al., 2009, p. 164-165). On the macro level children learn how to gain trust and security with their parents as a base, strengthening the skill of a child to trust itself and others within positive interaction, as well as building a safe and secure attachment to their parents (Kaitz et al., 2009). It is also crucial for a child's development that its parents can

regulate the relationships between closeness and distance towards their children appropriately, such as letting their child explore and at the same time being present (Posada, 2008).

As this paper refers to the **attachment theory**, developed by John Bowlby and Mary Ainsworth, it will be briefly explained in this paragraph. The attachment theory deals with the development of human relationships and with the role these relationships play on each individual's development (Posada, 2008, p. 96). Children are using their mother as a secure base in order to explore their environment and to develop a sense of trust. The four attachment types are: secure attachment, anxious-ambivalent/-resistant attachment, anxious-avoidant attachment and lastly, disorganised/disoriented attachment (Bowlby, 1988, p. 124-125). Securely attached children perceive their parents as emotional available, responsive, helpful and sensitive to their signals (Bowlby, 1988, p. 124), which promotes the feeling of comfort and security (Kaitz et al., 2009, p. 167). Secondly, anxious-resistant patterns stand for the uncertainty, whether a parent is available and responsive when needed or not. Within an anxious-avoidant attachment, the child perceives his parent as pre-occupied and not emotional available (Bowlby, 1998, p. 124). Lastly, disoriented and disorganised children often were not able to „acquire a stable inner working model", which can be due to the mother being so physically and mentally occupied by their personal trauma that they were not able to create a consistent attachment to their child (Leuzinger-Bohleber, 2014, p. 32). "Secure attachment […] can act as a protective factor for the child's development" (Neubert, Läzer, Hartmann, Fischmann, & Leuzinger-Bohleber, 2014, p. 250), which is why the knowledge on attachment is necessary for social work in this context.

Through trauma cognitive functions collapse and this can affect the capacity for parents to interpret their children's feelings and thoughts. As mentioned in Chapter three, traumatised people face fears, insecurities and express depression, anger, as well as physical and emotional pain. Hence parents that experienced a traumatic event may not be able to fully function as a caregiver, which is why their relationship is often challenged by the lack of the parent to provide security, guidance and regulations (Kaitz et al., 2009, p. 162; Schechter & Rusconi Serpa, 2014). In the following paragraph it will be further explained, how dysfunctional relationships, insecure and disturbed attachment and problems with emotion regulation can transmit trauma on a conscious as well as

unconscious level (Kahane-Nissenbaum, 2011; Lev-Wiesel, 2007; Babcock Fenerci & Deprince, 2017).

The caregiver and child are alert to one another through a common focus of attention and the acknowledgment of a shared focus (Schechter & Rusconi Serpa, 2014, p. 98). The attention of both individuals can either be directed to external objects or to internal states (Schechter et al., 2010). In order to assist the infant with emotion regulation the mother needs internal state awareness. On the one hand, she needs to be able to recognize her own mental state, while distinguishing it from the mental state of her child; whilst on the other hand, try to read the intentions and emotions of her child (Schechter & Rusconi Serpa, 2014; Schechter et al., 2010). When parents themselves suffer from psychopathology, this mutual regulation can be disrupted. The fear, helplessness or frustration of a child can trigger these behavioural patterns within the mother and reminds of her own traumatic experience. This may lead to the mother being preoccupied with her own emotions and not being able to focus on her child, which again may increase dysfunctional emotion regulation within the child, which can create an „intergenerational communication of trauma“ (Schechter & Rusconi Serpa, 2014, p. 92).
Schechter and Rusconi Serpa (2014) came to the conclusion that maternal PTSD can be related to the disturbance of child-parent attachment (p. 99). **Atypical caregiving patterns** such as overprotectiveness; avoidant behaviour, withdrawal and disengagement; aggressive and violent behaviour; role and boundary confusion; falling silent as well as replacing their hopes into their children, have been found in many different studies (Dekel & Goldblatt, 2008; Kahane-Nissenbaum, 2011; Kaitz et al., 2009; Lev-Wiesel, 2007; Schechter & Rusconi Serpa, 2014). Overprotectiveness and intrusiveness is often the result of living in a constant state of fear. As their sense of safety changed due to some severe traumatic events, mothers reported that they felt the need of controlling their surrounding and therefore reacted with overprotection. In Levy's study in Israel a mother stated: "I was filled with fears. I was afraid of everything. I raised my son in an atmosphere of fear, my fears, protection, and over-protection. I limited him. Till this day he suffers from my fears“ (Kaitz et al., 2009). In order to prevent any further painful and negative experience parents limit and restrict their children. Secondly, avoidant and withdrawal behaviour had been observed amongst mothers, also as a strategy to protect themselves from further emotional pain (Schechter & Rusconi Serpa, 2014). Next, parents were more likely to develop aggressive and violent behaviour. A study conducted

amongst fathers that suffer from PTSD showed that the loss of self-control and a low-frustration limit of the caregiver led to inappropriate problem solving and therefore to more violence (Dekel & Goldblatt, 2008). Silent falling had been witnessed within parents that suffered from trauma as well (p. 177). Lastly, studies identified that mothers gained new hope and love of live, giving birth to a new human. They even expressed the feeling of having replaced a lost one. In this case parents placed all their hopes and positive emotions into their children, which were therefore not only suffering from the lack of freedom but additionally did not learn to express negative emotions in front of their parents in order to protect them (Kaitz et al., 2009, p. 164). Schechter & Rusconi Serpa (2014) found in a study that mothers, who suffered from PTSD, often labelled their children as one of the main stressors in their lives, rather than a source of joy. Measured by the "parenting-stress-index" they felt more parenting stress and described their children as more negatively (p. 97).

4.2. Appearance of transmitted trauma

The following abstract will examine what can be transmitted and how it appears in the successive generation. The information is gathered from a collection of different studies, conducted on Holocaust survivors, Vietnam veterans, those that witnessed 9/11 as well as on people that live in Israel and the occupied territories of Palestine. Dekel and Goldblatt (2008) compared 15 different studies and the collected information, which was of great help for this chapter. Even though the focus lies on the negative outcomes in the following, it needs to be stressed that many studies identified positive outcomes as well, for example pride, strength and resilience (Kahane-Nissenbaum, 2011; Lev-Wiesel, 2007, p. 83; Yehuda et al., 1998, p. 640).

The findings of consequences and appearance of transmitted trauma can be divided into three categories: unhealthy relationships, maladaptive behaviour and mental disorders, though they are all are linked to each other.

As a result of the mechanisms mentioned above, the successive generation seemed to suffer from those unhealthy family functioning's and they themselves build **unhealthy relationships** with others, within and outside the family. They seemed to mistrust others more or fall into social isolation (Lev-Wiesel, 2007). "Insecure relationship (…) increase children's risk for a wide range of developmental problems" (Kaitz et al., 2009, p. 167).

Maladaptive behaviour can be: developmental problems, academic and behavioural issues and the children seemed to be affected in their perceptions and expectations (Dekel & Goldblatt, 2008, p. 283; Scharf, 2007, p. 619).

Concerning the negative appearances in **mental distress** that had been investigated were firstly increase of psychological problems (Pine, Costello, & Masten, 2005). For example in a study conducted in Australia, Davidson and Mellor (2001) compared children descended from Vietnam veterans with PTSD, veterans without PTSD and civilians, who did not fight in the Vietnam War. The results show that psychological distress and common disorders such as eating disorder, depression, personal disorders and anxiety were higher amongst descendants of parents diagnosed with PTSD and they were described as more fragile and vulnerable (Ahmadzadeh & Malekian, 2004, p. 232-233; Davidson & Mellor, 2001; Davidson, Smith, & Kudle, 1989, p. 342-343; Yehuda et al., 1998, p. 639). Furthermore children of parents with an unresolved trauma may "develop contrasting, skewed, and incoherent representations of self and others that can lead to maladaptive coping strategies, chronic or recurrent stress" (Kaitz et al., 2009, p. 168). One of the most common observations were difficulties of children to cope with their feelings, poor problem solving and the inability to regulate emotion and respond appropriate to stressful situations (Davidson & Mellor, 2001, p. 345; Kaitz et al., 2009, p. 162). "Children learned helplessness, lack of control, chronic stress, deficits in self-regulation, and felt-insecurity" (p. 164). Lastly, due to the identification with their parents' experiences, offspring often adopted basic emotions of their parents and perceived them as their own (Dekel & Goldblatt, 2008, p. 284; Lev-Wiesel, 2007). Feelings of guilt, shame but also anger and stress seem to be higher compared to children of parents with no traumatic background (Kaitz et al., 2009). Furthermore, they show greater vulnerability to stress (Yehuda et al., 1998).

In a study conducted in Israel amongst three different families with three different kind of traumatic experiences Lev-Wiesel (2007) found out that the impact and severity of transmission differ according to the traumatic event. The traumata differ from each other due to different events the first generation of each family experienced. The first generation of one family survived the Holocaust and the trauma could be found within all three generations. The second generation had been diagnosed with PTSD and they reported nightmares of being chased by Nazis. All three generations perceived life as fragile and temporary and they all share the mission to never forget what had happened

during the Holocaust (p. 83). The second families' first generation had been forcibly displaced from their – at, that time Palestinian – village, that now lies in Israel. All three generations share the sense of belonging to a home, to which they are denied the right to return. They share the mission and wish to return and therefore are all actively participating in demonstrations and protest. The strong feeling of coherence can be observed amongst the whole community, as all experience feelings of longing. Lastly, the first generation of the third family resettled as Jews from Morocco in Israel after World War II. They had to stay in transit camps, where they faced discrimination and injustice in comparison to the western Jewish refugees (p. 88). According to Plutchik's (1989) theory of emotions (Lev-Wiesel, 2007, p. 91) each emotion has another effect. The first family undergoes the emotion of sadness, causing people to close themselves up from the rest of the world; anger, as experienced by the second family, leads to taking action; the third family faces shame, which either motivates to act towards change or can lead to dissociating from the shameful experience of the older generations. In conclusion the emotions of sadness, mistrust, fear, anger and shame can be found within the results of this study as well as other researches (Kahane-Nissenbaum, 2011; Lev-Wiesel, 2007). The degree to which trauma is passed on, depends on the level of trauma experienced by the following generation and it also depends on the vulnerability and resilience of each individual and his/her social and personal adaptation resources (Lev-Wiesel, 2007, p. 91). This study depicts how different traumatic events can have different impacts and highlights the importance to understand the dimension of a trauma as a social worker.

Conclusively it can be said that the trauma experienced by an older generation can have a great impact on the mental health of the growing generation, which is why social work needs to be aware of this issue (Lev-Wiesel, 2007, p. 92).

While working in the refugee accommodation in Greece we often observed similar dysfunctional family systems and mother-child interactions as mentioned above, especially avoidant and withdrawal behaviour of mothers towards their children. As we spent a lot of time with the children we observed aggressive and violent behaviour amongst them. Though in this case the majority of the children had experienced all three periods of migration themselves and may therefore be affected first hand by the traumatic events. This is generally a big issue that all children resettling into Germany experienced the traumatic events first hand, which is however another issue. Nevertheless, we did (volunteers, psychologists and social worker) observe unhealthy interaction between

mother and infant as well as role and boundary confusion. Whether this may be due to the unresolved trauma within the mothers or whether these patterns already consisted before the migration period due to cultural differences cannot be determined in this context. However, gaining new knowledge about trauma due to war and displacement as well as on ITT I developed a new perspective and attitude and I realised that some conflicts that occurred in our work could be judged differently if we all had this knowledge. Just as Lev-Wiesel concluded in her study I agree, that social work needs to be more aware of the consequences trauma can have not only on those that had been directly exposed to the traumatic events but also on the following generations.

5. Prevention

In chapter three we learned that refugees and migrant families undergo many traumatising experiences, which can negatively impact mental health and the well-being of the people, while chapter four examines the effect on successive generations. Moreover, many studies come to the result that in comparison to other children, those with an immigration or migration background lag behind in their educational achievements (OECD (The Organisation for Economic Co-operation and Development), 2015, p. 5) and that they often suffer more from psychological and behavioural problems. The unresolved trauma of mothers can be one of the reasons for this unsatisfactory result. To prevent the transmission of trauma including the associated adverse effects, it is crucial to draw attention to the manifold opportunities that social work can offer. Social workers are active in various areas and settings, where they meet the refugee population in different contexts and therefore play an important supportive role (Ostrander, Melville, & Berthold, 2017). As the literature in question mainly suggests psychological interventions in the case of trauma, the focus of the following chapter lies on possible intervention and prevention programmes in a non-clinical setting, with the focus on what specifically the social work profession can contribute to such prevention programmes. Firstly, it will be illustrated why prevention in the context of early childhood development is highly necessary for diverse reasons. The second paragraph tackles the issue of social work in the context of working with traumatised refugees, which then leads to the presentation of existing prevention programmes as leading examples for the prevention of intergenerational trauma transmission: The model pilot programme “Step-

by-Step" conceptualised amongst others by Prof. Dr. Marianne Leuzinger-Bohleber for the refugee first reception centre "Michaelisdorf" in Darmstadt (Leuzinger-Bohleber & Andresen, 2017; Leuzinger-Bohleber, Rickmeyer, Tahiri, Hettich, & Fischmann, 2016); the "First Steps" prevention programme in Belgium (Meurs, 2014) and a similar project in Frankfurt, also called "Erste Schritte" (Early Steps). The concept of Silove (chapter 3.2) helps to evaluate whether the prevention programmes serve the rebuilding of the five pillars. Lastly, the chapter tackles common challenges arising for social work in this context.

5.1. Importance of prevention programmes and early childhood development

Early childhood prevention and investment programmes are of utmost importance for two reasons. (1) The appearance of ITT can have negative impacts within the first years of the life of a new-born of the successive generation, on the development of behaviour patterns and mental health problems. (2) Early childhood development affects educational and psychological development later in youth and adulthood. "What happens during the early years is of crucial importance for every child's development. It is a period of great opportunity, but also of vulnerability to negative influence" (UNICEF, 2013). This can be of great motivation for governments and institutions to invest in early prevention programmes.

Studies have shown that children with an immigrant background have more likely psychological problems and lag behind in educational achievements. This had been measured in the intelligence quotient (IQ) and can be found in the PISA results ("Program for International Student Assessment") (Lebiger-Vogel, Rickmeyer, Busse, Fritzmeyer, Rüger, & Leuzinger-Bohleber, 2015, p. 2-3; Lebiger-Vogel, Busse, Fritzmeyer, Paul, & Leuzinger-Bohleber, 2014, p. 265-267; Meurs, Jullian, & Vliegen, 2006, p. 259). The OECD ("The Organisation for Economic Co-operation and Development") complains that immigrant children in Germany have a poor level of education, not only compared to other children in Germany but also in comparison with other countries in Europe (Klingholz, 2010; Migrationsrecht.net). "Every fourth child with a background of migration leaves school without a certificate. Many of them become unemployed as are their parents and lead a life on the fringe of society" (Leuzinger-Bohleber, 2014, p. 21). Additionally to the educational outcomes, children with an immigrant background show an increase in emotional difficulties and behaviour

problems (Meurs, 2014, p. 167). “It needs to be kept in mind that it is not the immigration background per se that puts children at risk of becoming disadvantaged. It is rather the factors that are associated with their parents’ migration, psychological factors due to the different phases of migration […] that create difficult developmental environments for children” (Lebiger-Vogel et al., 2014, p. 266). Which brings us to the findings from chapter four, that the cause for psychological problems and development difficulties of children can be the early exposure to the trauma of their parents (Leuzinger-Bohleber, Läzer, Pfenning-Meerkötter, Neubert, Rüger, & Firschmann, 2016, p. 112-114), particularly in regard to the mother-child interaction and early attachment experiences (chapter four). If prevention programmes focus on supporting and promoting a secure attachment, “higher levels of social competence, more advanced emotional understanding, higher cognitive and language skills, and less dependence on adults” can be achieved (Neubert, Läzer, Hartmann, Fischmann, & Leuzinger-Bohleber, 2014, p. 250). Children that grow up in a positive and emotional secure environment seem to be more creative, less aggressive, have a better cognitive, affective and socio-emotional development, as well as learn languages more easily (Lebiger-Vogel et al., 2015, p. 2-3).

According to the current state of research, another point for the necessity of investing in early childhood development and therefore in early prevention programmes is the correlation of early childhood development to the general development of a country (UNICEF, 2014). According to UNICEF (2013) more than 200 million children do not reach their full human potential, which leads to an approximate value of twenty percent loss in adult productivity. ITT is a result of not receiving appropriate care, the exposure to violence and neglect as well as growing up in a stressful family environment (UNICEF, 2013). It is not just their right to develop properly, moreover “(…) consistent loving care and encouragement to learn in the early years of life help[s] children to do better at school, be healthier, have higher earnings and participate more in society” (UNICEF, 2013). If a child receives appropriate stimulation and care, safety and protection, health and nutrition, and early childhood education their brain can develop fully and they can therefore form the basis of intelligence, personality, learning capacities and social behaviour during their first years. Early childhood investment has proven to be successful and effective. The result is an increase in social and cognitive development, better health, more success at school, lower crime rate during adulthood and higher employment rate later on in life (UNICEF, 2013). Furthermore, early childhood development is highly

correlating with the human development index (HDI) of a country. The higher the "chances for a young child to be on track in his/her development" the higher is the HDI for a country (UNICEF, 2014). This indicates that early childhood development is the "foundation of human development" (UNICEF, 2014). While the early childhood development index (ECDI) is measured through the learning, literacy-numeracy, physical and social-emotional dimension the HDI is measured through three dimensions: life expectancy, years of schooling and a decent standard of living, with the help of the GNI (Gross National Income). Therefore, "efforts to improve early child development are an investment, not a cost" (UNICEF, 2013).

Early prevention programmes have been proven to be effective, "promising and long-lasting" (Leuzinger-Bohleber, Läzer et al., 2016, p. 112). Participants of early prevention programmes showed improvement in their individual and educational development and scored overall a higher employment rate later in life. The motivation for organisations and governments to support and invest in such programmes should therefore be that due to an increase of chances later in life for the children and overall a better development, expenses will be saved in the long run. By doing this it is possible to save up to seven times of the amount of money that otherwise would be needed later on to support struggling adults (Meurs, 2016, p. 7-11). The investigations by Meurs and Jullian (Meurs, 2016, p. 10) over a period of 15 years of families that attended prevention programmes came to the result that the attendance in early prevention programmes has an effect on different areas of individuals: an increase in secure attachment between mother and child, less violence within families, a decrease of learning difficulties in the successive generation, an increase of seeking adequate help if needed, as the participants gained more trust in their environment, and overall a better mental health. Moreover, due to less unemployment and better educational degree they seemed to need less help in adulthood (Meurs, 2016, p. 10). The "Early Head Start Project" in the United States of America compared families that attended prevention programmes with families that did not, over a period of 35 years and came to a similar conclusion (Meurs, 2016, p. 10). Particular the prevention programme in Frankfurt, which will be further inspected in the subsequent paragraph, resulted in a decrease in aggression, anxiety and hyperactivity (Neubert et al., 2014, p. 249). Marianne Leuzinger-Bohleber also came to similar results: violence, criminality and mental disorders decrease. "[E]arly support […] [is therefore] promising and sustainable" (2014, p. 21-22). The example of a woman from Morocco, who attended

the prevention programme “First Steps” in Belgium, shows that the programme is also able to change her view on the society in Belgium. Before attending the programme she felt like a stranger left alone with her newborn, however due to attending the programme regularly and receiving support, she was able to participate more with the development of her child and gained a different view on society as a whole, realising that she is not left alone and that people care about her (Meurs, 2016, p. 8-10). These experiences led institutions, governments and experts to the agreement that migrant families need to be supported as early as possible (Sigmund Freund Institute, 2008).

5.2. Prevention programmes for trauma-transmission

This paragraph will illustrate, why primary prevention is effective in the case of preventing transmissions of trauma and why there should be a broader focus on non-clinical interventions. Thereafter, existing prevention programmes will be explained. These findings will help to develop principles that are necessary when working with traumatised refugees (chapter 5.3).

There are three different categories of prevention programmes: primary, secondary and tertiary prevention. While primary prevention focuses for example on preventing the onset of a disorder, secondary prevention is “designed to deal with early identification and [early] treatment of a disorder”. Tertiary prevention approaches to minimise the disorder, once it is identified (Emde, 2014, p. 3-4). This paper will focus mainly on primary prevention, where programmes are designed to work with mothers and children aged zero to three. As mentioned above, within the first three years of life children develop emotion regulation, language and communication skills and an attachment to their caregivers (Lebiger-Vogel et al., 2014, p. 269; Meurs, Jullian, & Vliegen, 2006, p. 225), which is why the transmission of trauma subconsciously takes place in the first years of a child’s life. In order to prevent such transmission and therefore moderate the need for support later in life, primary prevention should be in the main focus to minimize further costs. However, secondary and tertiary prevention is of high importance when the transmission of trauma already took place. Hence professionals need to be trained to identify the first appearances of transmitted trauma when working with children of the age of kindergarten and primary school children.

The principles for prevention programmes developed by Emde (2014) can serve as an orientation: Prevention should focus on promoting health instead of focusing on disorders or illness. Next, all preventive programmes "deal with context", which is why cultures, circumstances and relationships must be "understood and taken into account" (p. 8). Moreover, prevention deals with development, which is why the goal "is to promote healthy development and prevent disruptions in development within individuals over time" (p. 8). Lastly, Emde suggests appreciating the "complexity of disorders". Unique genetic factors and environmental conditions need to be taken into account, as well as every individual's own pathway (p. 9).

The main literature seems to overlook the broader environment of the person concerned and instead suggests to treat ITT with psychoanalytical trained staff only. One-to-one assessment and videotaping had been used as a technique to identify the attachment type of the clients (Lebiger-Vogel et al., 2014, p. 280). Dealing with this issue in a non-clinical setting, however offers several benefits and can cure several shortcomings.

From my personal experiences working in Greece in the refugee accommodation "Model Hostel WELCOMMON", it is just not possible to cover most of the cases with such an in-depth care. Firstly, there is not sufficient funding for such profound psychological support, and secondly, there are not enough trained professionals in that field in order to cover these cases. It is crucial to cooperate and work together with psychologists, however, the number of refugees that are in need of support is extremely high, which is why ways to support them in a non-clinical setting with sufficient resources need to be established. Furthermore, people that come from a collectivist society may not feel as comfortable in a one-on-one individual consultation. My experiences have shown that they commonly preferred to gather in groups, exchange their concerns amongst each other and did not mind to express their feelings in front of a whole group. Therefore, when developing prevention programmes it needs to be taken into account what is suitable for the community. Cultural sensitivity is one of the main concerns when working with a refugee population in a non-clinical setting.

The current literature focuses on psychoanalytical or even clinical intervention, working with trauma therapy and psychological consultation. Only very few suggestions on non-clinical intervention can be found, which is why this thesis is focusing on that gap and suggests to further research in that matter. Refugees quite often have limited knowledge

about certain offers or access for support (Leuzinger-Bohleber, Läzer et al., 2016, p. 115). Therefore, recruiting these "hard-to-reach" groups should be one of the main priorities (Cooney, Small, O'Connor, 2007; Doherty, Stott, Kinder, 2004; Lebiger-Vogel et al., 2014). The knowledge gained from psychoanalytical based prevention programmes such as "First Steps" can be used for the development of further prevention programmes. The concept of "child friendly spaces" by UNICEF can be of great help in this matter as well and will be illustrated at the end of the following paragraph.

5.2.1. Existing prevention programmes as an example:

"Erste Schritte" (early steps) is a prevention programme of the Sigmund Freud Institute (SFI) in cooperation with the Anna Freud Institute in Frankfurt. It is based on the ideas of the "First Steps" programme in Belgium, a psychoanalytical prevention programme for immigrant families that particularly addresses mothers and children aged zero to three. It aims to offer support in childhood development, in the integration of children and mothers while promoting successful parent-child interaction, as well as offering the children alternative and supportive object-relationships (Lebiger-Vogel et al., 2015, p. 3; Leuzinger-Bohleber, Läzer et al., 2016, p. 125). The "Erste Schritte" programme consists of weekly meetings, in which professionals meet each family individually, and group meetings, where mothers have the opportunity to meet other mothers and their children, accompanied by trained staff. The offer is built around the needs of young parents and the main focus lies on supporting parents to provide their children a good development. The key element is the support of women during their pregnancy, shortly after giving birth and in early relationship experiences by trained professional. The programme promotes attachment security, positive child development, parent's reflective functions, healthy emotion regulation and parenting behaviour and competencies (Lebiger-Vogel et al., 2015; Lebiger-Vogel et al., 2014, p. 267). Topics of the weekly group meetings are the exchange about parenting, motherhood and the development of their children. Furthermore, these meetings give the opportunity to the women to build friendships and to learn that they are not alone with their concerns. This idea contributes to the aim of preventing isolation and withdrawal of the women from society. "Erste Schritte" combines the weekly meetings with regular phone calls and home-visits. These phone calls have proven to be particular effective as a reminder a day before a session, as well as in the case when a mother was not able to attend a meeting, checking on her and letting her know that someone cares (Cooney, Small, & O'Connor, 2007). Home visits have

established to be helpful for mothers from a culture, where it is not common for women to leave the house for a couple of weeks after giving birth. Moreover, staying in close contact allows the staff to be more aware of each individual situation and provides the opportunity to improve the relationship to the mother (Lebiger-Vogel et al., 2014). Part of the "Erste Schritte" concept is also the presence of a psychotherapist at the centre once a week in order to offer counselling to the parents and teachers if needed. Another key element of the "Erste Schritte" programme is the fact that the staff is psychoanalytically trained, which enables them to pass their theoretical knowledge onto the mothers in order to improve success and motivation. If the mothers understand the importance of attending the programme, they are more likely to participate regularly (Cooney, Small, & O'Connor, 2007; Lebiger-Vogel et al., 2014, p. 275). Additionally, the personnel participate in practice reflection and regular supervision in order to better understand "the unconscious conflicts and motives of the children and to help them handle difficult conflicts and situations" (Neubert et al., 2014, p. 251-252). The personnel has a holding and containing function and serves as a "secure base". In a study that compared "Erste Schritte" with another similar prevention programme, which is carried out and planned by paraprofessionals that do not receive the same support and supervision as the team of "Erste Schritte", has shown the importance and benefits of trained staff (Lebiger-Vogel et al., 2015; Lebiger-Vogel et al., 2014). The approach of this elaborated and individualized program is to understand the individual child and their family, and to consider them as unique. The program has proven successful in considering each child's specific skills and resources. „Hence, child behaviour is not seen as dysfunctional but rather as the expression of a hidden (unconscious), reasonable, mental event" (Leuzinger-Bohleber et al., 2016).

"First Steps", the precursor of "Erste Schritte", is a psychoanalytical based early prevention programme in Belgium, with a similar focus and concept. The programme focuses in the three domains of education and development, language acquisition, and nutrition (Meurs, Jullian, & Vliegen, 2006). With the concept of regular group meetings amongst infants and their parents, and home-visits if needed (Meurs, 2014, p. 169), the programme aims to offer "unique […] learning environment for immigrant children who mostly remain at home until age three", particularly as immigrant families don't place their children in early education programmes as much, which can be due to lack of access, lack of financial reasons or due to differences in cultural and community habits.

Again, “First Steps” sets high value on staff supervision and training in giving clear instructions on how to interact appropriately with the participants (Meurs, 2016; Meurs, 2014).

The **“Step-by-Step”** programme had been developed for the reception centre “Michaelisdorf” for refugees in Darmstadt, Germany. The ministry of social affairs of the state of Hessen in Germany asked the SFI to conceptualise a programme as a reaction to the “refugee-crisis” in 2016, the high number of traumatised refugees coming to Germany (Leuzinger-Bohleber & Andresen, 2017) and the gained knowledge about early development and trauma transmission (Leuzinger-Bohleber, Rickmeyer et al., 2016). From what had been examined in chapter three it is well known that migration and flight is often linked to severe traumatisation, despite the “hope for a better [and] safer life” (Leuzinger-Bohleber, Rickmeyer et al., 2016, p. 1079). Research on trauma has shown that the first experiences, following such life threatening and traumatising events, are essential for the proximate recovery and integration, which served as a motivation for the development of this programme. The aim of this program is to generate a feeling of security with other human beings and their environment. Even though many refugee families do not stay very long in first reception centres it is crucial to create a daily routine and to motivate and activate the people to commit to some activities. They need to be informed that the programme is important for their well-being and integration process (Leuzinger-Bohleber et al., 2016, p. 1080). Furthermore, the goal is to promote children’s early development and well-being, as well as alleviate withdrawal, similar to the programmes “First Steps” and “Erste Schritte”. Moreover, the centre of achievement is to work on acute traumatisation, support “at-risk” families, promote communication and cooperation structures and stimulate safety and care through the creation of a safe space (Leuzinger-Bohleber et al., 2016, p. 1081). Both leisure activities and educational programmes are implemented in the “Step-by-Step” programme, in combination with giving mothers and children the opportunity to add their own ideas to the programme. Another similar element in this programme is again the staff supervision, as it can be extremely challenging to work with traumatised people, with cultural differences and in a constantly changing context. “Weekly […] supervision for the whole team has proven extremely helpful” (p. 1082). The staff needs to have an understanding of traumatisation and how to cope with the individual experiences of their clients. Supervision will give them the opportunity to maintain professional boarders and to counter overload. The

social work team is in addition asked to refer individual cases to psychoanalytical consultation hours and crisis interventions in case of observing emergency situations. The concept of arranging weekly meetings for mothers to exchange about parenting, motherhood, migration circumstances and mother-child interactions has proven to be successful here as well. The "Step-by-Step" programme also includes psychosocial support for children, not only for parents. This can be achieved by activities such as painting to give them the "opportunity to express their burdening experiences […] [and] are not left alone with their experiences, but rather have the opportunity to talk about them in a protected space within a psychoanalytic setting" (p. 1085). In order to meet the needs of traumatised people, which face fears, nightmares, sleeping disorders and more (chapter three), "Michaelisdorf" provides special care through psychosocial, medical and psychotherapeutic support and crisis intervention (Leuzinger-Bohleber & Andresen, 2017, p. 12-15). The five basic principles of the „step-by-step" programmes are: (1) safe, reliable structures; (2) creating interpersonal relationships and empathising with the refugee and their brutal experiences. ; (3) offering alternative relationships that strengthen resilience; (4) offering meaningful activities; (5) and lastly, regaining human dignity. These will be further examined with reference to the concept of Silove in chapter 5.2.2.

Lastly, the concept and guidelines of creating a "safe space" for children, developed by UNICEF, can serve as a leading example with regards to preventing trauma transmission in a non-clinical setting. **Child friendly spaces** (CFS) were established in order to support the well-being of children" in the midst of emergencies" (Davis & Iltus, 2009, p. 9). As mentioned before the main focus and narrowing of this paper will be primary prevention, which is why the focus lies on children aged zero to three. However, some of the principles for a safe space can rather be applied for children above the age of three, which is why they serve more for secondary or tertiary prevention programmes. The following paragraph will briefly illustrate some of the principles for such child friendly spaces, that are of interest for a prevention programme for trauma transmission: creating a secure and safe space, establishing a stimulating, supportive and participatory environment, building on existing structures, capacities and mobilising the community, and lastly, staff and programme need to be inclusive and non-discriminatory.

Child friendly spaces need to be a secure, safe and protective environment. They need to provide a "quick and efficient support system", as the target group is in immediate need of a supportive, healing and safe setting (Davis & Iltus, 2009, p. 10). The space has to be

free of violence, exploitation and abuse and the staff is not allowed to use physical punishments, but rather "positive discipline" techniques (Davis & Iltus, 2009, p. 9; UNICEF, 2011, p. 7). Furthermore, informing the parents and children on the issue of child protection and children's rights through awareness-raising sessions is part of the agenda (UNICEF, 2011, p. 5-7). The staff is trained in identifying abuse, violence and neglect as well as traumatisation and mental disorders within the parents. Stimulating, participatory and supportive environments can be established by appropriate psychosocial support. Activities and play include dancing, drawing, drama, singing, sports and anything that promotes useful skills and that is culture, age and gender appropriate. The concept is to create a stimulating and engaging environment for the children by balancing planned activities and free play and offering interactive group activities and individual use of available materials. (Davis & Iltus, 2009; UNICEF, 2011). The space also needs to be appropriate for the special needs of babies. Another crucial point of CFS in regard to refugee children is the implementation of a clear, predictable and well-structured programme in order to rebuild a "structure in their lives" (Davis & Iltus, 2009, p. 10). This will serve to "support children's resilience and return to normalcy, bringing a sense of order and routine back into the[ir] lives" (Davis & Iltus, 2009, p. 11). To accomplish participation, parents need to be involved in the planning and implementation of activities, which can be challenging. Their involvement does not only empower them and bring back a feeling of control over their lives, moreover they know best what is good for their children and what activities suit their culture and community best. This practice helps to prevent misunderstanding between refugees and the programme providers. Furthermore, the participatory approach is designed to encourage children to "share what they had learned with those who had not participated in the activities" (UNICEF, 2011, p. 6). Within awareness-raising sessions parents get the chance to exchange information and learn to take responsibility as early as possible. It is a great format for women with similar culture and/or the same language to connect and support each other. Especially for young single-mothers this mutual support can be of great relief. (Leuzinger-Bohleber, Rickmeyer, Tahiri, Hettich, & Fischmann, 2016, p. 1085). Involving and mobilising the community will also strengthen and promote recovery and the ability to support one another in the community (Davis & Iltus, 2009; UNICEF, 2011). This can be particularly helpful when working with communities that are suffering from disrupted routines due to an emergency situation. Involving the parents in the creation of a safe space for their children will give the staff the opportunity to learn about the community and their culture

and therefore the ability to optimise the use of the available resources (UNICEF, 2011, p. 5-7). All in all, the principle of building on existing structures and capacities of a community can be extremely useful, as the parents know best what support and what kind of activities they need. To understand survival mechanisms that communities develop during crisis situations is particularly important in the process of understanding how they "perceive and pursue their livelihoods under crisis situations" (Davis & Iltus, 2009, p. 11). Lastly, making the CFS inclusive and non-discriminatory means that the space should be open for all children "regardless of their class, gender, abilities, language, ethnicity […], religion and nationality" (Davis & Iltus, 2009, p. 13) without stigmatisation (UNICEF, 2011, p. 6).

A problem that UNICEF faces in their commitment of reaching out to children in need seems to be the effective recruitment of this target group. The difficulty is caused by the fact that these programmes are voluntary rather than mandatory and the lack of knowledge on the parent's behalf about the necessity and values of these programmes. Parents are either not aware of their existence or they fear the programme conflict with cultural beliefs. However, making sure that the programme is non-discriminatory and allows contribution to the design can help to overcome these challenges (Davis & Iltus, 2009, p. 13). Moreover, CFS are even more successful if they follow a multi-sectorial approach (UNICEF, 2011, p. 4). Coordinating with other organisations concerned with the issue of child protection, as well as linking and collaborating the programme to the educational sector can be effective. Overall, CFS promote creativity, skills for problem solving, critical thinking, communication and assures that children are treated with respect and kindness (UNICEF, 2011, p. 8).

5.2.2. Principles for working with traumatised refugees

Above all, no matter how well a prevention programme is designed, it is not effective if the target group does not participate (Cooney, Small, & O'Connor, 2007, p. 1). For this reason the paper includes a paragraph on how to recruit "hard-to-reach" groups, which can be very challenging working with refugees and migrant families of concern.

Recruitment of "hard-to-reach" groups

According to Doherty, Stott & Kinder (2004), "hard-to-reach" groups are defined by one or more of the following criteria: the client's behaviour, their needs, psychical and social

isolation and prior negative experiences with similar services. Migrant and refugee families can often be considered as "hard-to-reach" because they often belong to an ethnic minority or are a marginalised group that is unable to articulate their needs due to language or cultural differences. They are often "invisible" and overlooked in society and have resistance towards the provided service as a result of ignorance or distrust (Doherty, Stott, & Kinder, 2004, p. 3-4). As examined in chapter three, having gone through many traumatising experiences aroused by other people refugees appear to be a particular target group for mistrusting "white" staff (Cooney, Small, & O'Connor, 2007, p. 1). Refugees fear the abolishment of their resident status, the detection of undocumented immigration and being send back home, which add to obstructions to participation. In order to address the issue, Doherty, Stott & Kinder (2004) suggest to identify the factors that make the services inaccessible or unworthy in the eyes of the refugee population. Educational and language difficulties and lack of mobility need to be tackled, too (p. 5). Furthermore, the cultural background needs to be taken into account to consider differing opinions on parenting and services. It is therefore crucial to be aware of the different dimensions of each culture. Geert Hofstede developed a model that allows a comparison of countries on six specific dimensions. Comparing Germany and Syria for example shows that Germany is rather an individualistic society with the strong idea of self-actualisation, while Syria is considered a collectivistic society where loyalty "overrides most other societal rules and regulations" (Hofstede Insight, 2018). While the focus within a German family usually lies in the direct parent-child relation, the collectivist society, such as Syria, has a long-term commitment to the extended family. Families are a "product of their society" and also the first group where one starts to learn about culture (Hofstede, 2001, p. 225). "Most people grow up in collectivist societies, among a number of people living closely together, not just their parents and siblings, but also members of the extended family" (Hofstede, 2001, p. 225). This proves that differences in parenting and parenthood are not wrong per se but need to be considered within a cultural context.

Another way of reaching more people of the target group is by networking with other organisations that offer similar or other services to refugee and migrant families (Doherty et al., 2004, p. 8). One of the key aspects in improving the number of participation is involvement of the target group in assessing and planning the programme (Cooney et al., 2007, p. 2). In showing commitment of the staff towards the community the programme provider will gain and maintain trust among refugees. Involving well-trusted and respected members of the community of the target group increases the motivation of

others to participate. Lastly, choosing a location that is familiar and accessible and where the participants feel safe and comfortable is indispensable. In this matter, cooperating with existing programmes such as integration courses in order to share the same location can help for the issue of transportation (Cooney et al., 2007; Doherty et al., 2004).

Rebuilding the five pillars (ADAPTS model Silove)

Silove (2013) developed the "ADAPT" model (chapter 3.2.) to better understand the consequences of the experiences of traumatised refugees. In order to be able to develop appropriate prevention programmes that address the needs of traumatised refugees and that help prevent intergenerational transmission of trauma, the five pillars of the "ADAPT" model need to be rebuild. The following paragraph will combine the concept by Silove with the principles by Leuzinger-Bohleber and Andresen (2007) for the "Step-by-Step" programme and the ideas by Cooney, Small and O'Connor (2007), on how to recruit "hard-to-reach" groups.

(1) The pillar of **safety and security** needs to be addressed. As mentioned before, the post-traumatic environment and the first experiences after traumatising events are extremely important for the process of recovery. It is therefore necessary to create a safe environment with the prevention programme. The idea of a safe space developed by UNICEF serves as a model (see 5.2.1). The arrangements have to be predictable for the participant and promote the urgent need for safety, stability and protection (Leuzinger-Bohleber & Andresen, 2017; Leuzinger-Bohleber, Rickmeyer, et-al. 2016; Silove, 2013). Especially due to experiencing uncertainty about the future during the different phases of the migration journey, it is crucial that programmes address the lack of control and social support (Silove, 2013, p. 241). Involving the participants in the creation of programmes and structures will on the one hand ensure that they feel comfortable with the agenda, and on the other hand address the feeling of powerlessness and helplessness. Furthermore, structures need to be reliable, culturally appropriate and clear in the given instructions (Leuzinger-Bohleber & Andresen, 2017). Continuity can be created by offering daily routines and specific rituals, for example using the same opening at every beginning of each group session or by making sure to maintain the same staff, so that the participants can build trust and do not face too many changes (Cooney et al., 2007; Lebiger-Vogel et al., 2014; Lebiger-Vogel et al., 2015; Leuzinger-Bohleber & Andresen, 2017; Leuzinger-Bohleber, Rickmeyer et al., 2016; Meurs, Jullian, & Vliegen, 2006). The location choice

can also contribute to feelings of safety (Cooney et al., 2007; Silove, 2013). When working with refugees, it is necessary to be flexible, especially regarding scheduling and working hours. It is advised to build the programme „outside of traditional working hours“ (Cooney et al., 2007, p. 3). The “importance of establishing conditions of safety, stability and predictability [helps] to achieve mental health recovery for those exposed to conflict and displacement”, which is why educating the community about possible responses to trauma and providing them with cultural appropriate stress management techniques encourages them to address their unresolved trauma (Silove, 2013, p. 241).

(2) **Bonds and networks** need to be re-established (Silove, 2013). Due to the process of displacement refugees face personal and material loss, which is why the programme needs to provide a response to the grief of the target group. For this process it can be very helpful to rebuild networks and to respond with “interpersonal bonds and social support” (Silove, 2013, p. 241). In this matter, it should be re-emphasised that it is significant to train the staff in cultural sensitivity in the importance of remaining non-judgmental and of building interpersonal relationships to the clients (Cooney, Small, & O'Connor, 2007; Leuzinger-Bohleber & Andresen, 2017). Furthermore, empathising with the unimaginable that humans can do to other humans is necessary in the process of regaining faith to humanity, especially after what many have experienced on their journey or in their home country (Leuzinger-Bohleber & Andresen, 2017). Even though it can be extremely challenging, social workers in this context need to “open up and listen to the witnesses of the ‘incomprehensible’, namely, of what human beings are capable of doing to others in man-made disasters” (Leuzinger-Bohleber, Rickmeyer et al., 2016, p. 1079). Regaining feeling that someone cares about them can be achieved through frequent phone-calls or checking on the client when they missed a session (Cooney et al., 2007; Lebiger-Vogel et al., 2014; Lebiger-Vogel et al., 2015). This will reassure them that they are valued and that someone cares about them. Furthermore, involving trusted members of the community will add local knowledge to the prevention programme and will strengthen the network (Cooney et al., 2007).

(3) In order to regain a feeling of **justice**, group meetings need to address experiences of injustice and anger that have developed over the migration period and reflect on human right lessons learned from the past (Silove, 2013). As mentioned in the paragraph above, listening to their inhumane stories and trying to rebuild trust and faith in humanity is of extreme importance in this context. Additionally, keeping promises and appointments is

highly necessary as well. The staff needs to make sure that no promises are made which can not be kept, in order to stabilise the trust-building process (Cooney et al., 2007).

This had been a crucial point that often resulted in conflicts between the staff working at WELCOMMON and the inhabitants. As the staff members were neither trained in cultural sensitivity nor in trauma knowledge, they were not aware of the sensitivity to the issue of justice. It had been extremely frustrating fighting about house rules and the distribution of food or clothing. With the gained knowledge of the literature, it is now easier to reflect on what had gone wrong. The staff who worked at the reception often told the inhabitants, that they were able to receive something the following day, even though that might not probably happen. Looking deeper into the experiences and psychological consequences the migration journey can bring about, it becomes clear that it is extremely important to try to rebuild trust in humanity, rather than fighting about the distribution of materials and expecting gratitude.

(4) With the focus on rebuilding **roles and identities**, programmes need to promote the feeling of community, a sense of identity and welcome, as well as giving the participant meaningful roles (Silove, 2013). The concept of "giving something" and "receiving something" can be helpful in this process (Leuzinger-Bohleber, Rickmeyer et al., 2016, p. 1080). "Giving something" can be in the form of "personally carrying out an activity" (p. 1080). For example mothers can offer their help by translating an activity for children (p. 1086). "Receiving something" could be to receive an offer each day of support. In this way the participants gain a specific role and it can support the process of rebuilding the feeling of belonging (Silove, 2013). Furthermore, immigrant parents seem to be "extremely sensitive to […] cultural identity". This is why the programme needs to give space to express and to meet amongst likeminded people from the same immigrant background or a similar culture (Meurs, Jullian, & Vliegen, 2006). Involving the parents in the process of planning and conducting activities and making sure that the programme seems worthwhile to the participants is highly advisable in developing new roles and identities (Cooney et al., 2007; Silove, 2013).

(5) **Existential meaning** needs to be re-established (Silove, 2013). Due to displacement the sense of life and purpose can be lost and the continuity of life is disrupted (p. 244). This does not only affect mental health, but can lead into isolation and the feeling of powerlessness. This proves again the importance of assuring participation, which helps to

counteract isolation. However, keeping cultural sensitivity and adopting policies and principles of multiculturalism is very crucial in this context. Moreover, meaningful activities promote self-agency, which is why the search for meaning should be addressed within the group meetings (Silove, 2013, p. 244), additionally to issues on parenting and the development of the child. This is a highly personal matter that might better be addressed individually.

As mentioned before, implementing group sessions that leave space for women to feel welcome, to exchange and meet amongst each other and to share the feelings of joy and sadness needs to be suitable "within a multicultural perspective" (Meurs, Jullien, & Vliegen, 2006, p. 263). An important aspect for cultural sensitive elements is the adjustment of goals, programmes and language into "culture specific categories". The prevention program uses "channels of the host culture and of the culture of origin and (…) group work has an important equivalent" (Meurs, Jullien, Vliegen, 2006, p. 265).

To sum up the principles of working with refugees, the ITT prevention programme needs to "support all three processes – acquisition of cultural competence, mourning losses as well as becoming a mother – at the same time" (Lebiger-Vogel et al., 2014, p. 268). Even though it can be helpful to work closely with clinical interventions in some cases, the focus in a non-clinical setting needs to be on improvement of the early childhood development by promoting and supporting the mother-child interaction, building a supportive system and creating a safe space.

5.4. Challenges of social work in the setting of working with traumatised refugees in a non clinical setting

Working with traumatised people in a non-clinical setting within a continuously changing context, social work can bear many challenges. In order to be prepared as a social worker it is therefore highly advisable to deal with these difficulties, which is why this paragraph will tackle some of the most common issues: Training and supervision of staff, cultural differences, recruitment and participation of the clients, dealing with traumatisation, as well as the feeling of overload and powerlessness.

Bearing insecurities, supporting and psychologically supporting the client, while at the same time maintaining professional boards, calls for the need of **professional training and supervision**. "Weekly […] supervision for the whole team has proven extremely

helpful" (Leuzinger-Bohleber, Rickmeyer et al., 2016, p. 1082). However, *my experiences in Greece have shown how difficult it can be to provide and sustain such support and supervision for the staff. Firstly, the staff came from a variety of different professional backgrounds before working at the accommodation, which is why many were not sensitised to traumatisation, cultural sensibility or in general what experiences the inhabitants have faced during their migration period. As there was also no supervision and very few team meetings there was no space to talk about the conflicts that often occurred between the staff and the residents. The inhabitants often mistrusted the staff and complained about the little control they had in their lives, for example about the food the accommodation offered. However, the staff judged this behaviour often as ungrateful, rather than interpreting the behaviour in the context of response to trauma, injustice and lack of control over their lives. A trained staff could have reacted more appropriately to the feelings and wishes of the inhabitants.*

One of the biggest challenges for social work is having to deal with **cultural differences**. The literature often stresses the importance of cultural competences of the professionals working in the context of displacement and migration. However, what that practically means is hardly ever clarified, as there are so many different aspects that need to be considered. *My experience in Greece demonstrated the challenge of working with different cultures and understanding of, for example committing to the programme, time scheduling, parenthood, the roles of women in society and more. This often led to lack of participation in activities, which again caused some activities to be cancelled in general, even though the inhabitants often complained about boredom and lack of support. Different interpretations of parenthood is a challenge that will most likely arise in prevention programmes on trauma transmission. It is of fundamental importance to state that differences in opinion on how to raise children does not mean that what one learns as a social worker in a society, for example in Germany, is right and anything else is wrong. Which brings us to the point that in general implementing theories gained in social work studies in countries like Germany is not always realisable or even suitable when working with communities from different cultural backgrounds. Social workers need to be open-minded and sensitive for differences.* Language barriers also add to the challenges of cultural differences. "Working with the help of translators and understanding the inner world of refugees coming from different cultures, religions,

upbringings and so on, remains a great challenge" (Leuzinger-Bohleber, Rickmeyer et al., 2016, p. 1092).

It is difficult to assess the attachment type in a non-clinical setting, and it might also not be helpful in this case. The focus should rather be on bringing the mothers together and hosting awareness sessions on parenting issues, trauma transmission and early childhood development, as well as ensuing that there is a space for them to express their feelings, emotions and concerns.

As mentioned above, **recruitment and participation** is key for successful prevention programmes, however so-called "hard-to-reach" groups are very difficult to win and motivate (see chapter 5.2.2). This goes hand in hand in regaining trust to people that have lost trust in humanity as a whole, which bears one of the biggest challenges for social workers. The same applies for addressing the issue of justice (Silove, 2013) and the process of regaining dignity (Leuzinger-Bohleber & Andresen, 2017).

The aspect of **facing traumatisation** can be very challenging and incriminating for social workers themselves. The staff needs to firstly understand traumatisation, the possible causes, results and the signs of traumatisation. Secondly, it is necessary to know how to cope with traumatisation. A common reaction to such "extreme experiences that expose the self to fear of death, helplessness, and powerlessness, […] [where] fundamental confidence in a helpful inner object and an active self collapses", is "to look away, to deny and to turn a blind eye to the unbearable" (Leuzinger-Bohleber, Rickmeyer et al., 2016, p. 1078). The challenge lies therefore in counteracting these negative impulses with empathy and supportive attention, as well as maintaining the balance of empathising with what humans can do to other humans, establishing containment and support, but at the same time keeping a professional boarder. Furthermore, the difficulties of identifying trauma need to be considered. There is direct and indirect (vicarious) trauma. Direct trauma, where individuals experienced a disaster or sudden life-threatening event first hand, is easier to identify (Berceli & Napoli, 2006, p. 154). However many refugees carry less obvious traumata in them, which often leads to misinterpreting their behaviour. Additionally, social work needs to understand and consider all three phases of migration in order to fully recognise their psychological well-being and the "interconnectedness" of the refugee's life journey (Ostrander, Melville, & Berthold, 2017, p. 72). It needs to be mentioned in this matter that professionals are "often less aware of the more subtle

effects of […] secondary trauma they have experienced from their clients" (Berceli & Napoli, 2006, p. 154). This kind of trauma had been wrongly diagnosed as burnout or countertransference. But secondary traumatisation is a serious issue, as it can negatively impact the well-being and health of the professionals. It is particularly common amongst professionals that work with marginalized populations. Berceli and Napoli (2006) propose that professionals in this context need to "learn effective self-directed techniques to maintain equanimity in the face of danger and human suffering, thereby reducing the incidence of secondary of vicarious traumatisation and secondary PTSD" (p. 154). One suggestion is their "Mindfulness-based Trauma Prevention Program" that focuses on preventing professionals from secondary trauma. Regular supervision can also be useful in this matter.

Responding to the "growing number of poor people throughout the world, [and] dealing with problems that cross boarders" generates challenges for social work in a globalised context (Dominelli, 2010, p. 603), the process of fighting for social justice and human rights across boarders can be very frustrating.

This leads to the following challenge: dealing with the **feelings of powerlessness and overload**. It is common amongst staff working in the context of migration and refugee to work 60 hours a week and to be at risk for burnout. If there is no supervision staff members could suffer from overload and may not be able to sense all emergency situations (Leuzinger-Bohleber, Rickmeyer et al., 2016, p. 1082-1083). "Professionals who work in traumatic environments often feel isolated, overworked, and powerless, thus increasing the possibility of being vicariously traumatised while offering services to communities that are victims of tragedy" (Berceli & Napoli, 2006, p. 153).

The whole staff at WELOCOMMON constantly complained about helplessness, overloads and excessive demands: on how to handle the conflicts with the inhabitants about food or material distribution, how to handle the conflicts between different ethnic groups amongst the residents, or they expressed the extreme burden of listening to the traumatising stories of the people. Still, after reading a lot on the issue of social work with traumatised refugees, it seems like a difficult challenge to counteract these confrontations. As mentioned above, working with traumatised people, especially those that tell stories about what they had gone through and experienced by other humans (man-made-disaster, torture) is extremely difficult to cope with. The dilemma of being

there for them, but at the same time keeping a professional distance, in order to protect yourself, is very challenging.

The position that can be found in literature is that social work must expand their knowledge as well as widen their ideas and views on social work and its impact to current issues, such as flight, migration and asylum (Nash, Wong, & Trlin, 2006, p. 359-360). New challenges arise on national and international levels that need to be countered with formulating new theories and practices (Dominelli, 2010; Cemlyn & Briskman, 2003, p. 173). This could be the involvement of "a wide range of methodologies, from clinical interventions with individuals, […] to community-based interventions, policy practice and social development" (Hare, 2004, p. 417), and extending the perspective at the macro, meso and miso level (Nash, Wong, & Trlin, 2006; Ostrader, Melville, & Berthold, 2017): On the macro level, this can be "learning more about human rights, social justice and advocacy work relating to migration, displacement, citizenship and (re)settlement", while the meso level must deal with "community development and good networking guided by knowledge relating to this new field", and lastly the miso level is engaged in problem-solving interventions" (Nash, Wong, & Trlin, 2006, p. 360). "While social workers are seen as the professional group to address these issues, they are also most often the professional group target when poor professional practices across sectors are identified in such areas as childcare and protection […] and the treatment of refugees, asylum seekers" (Noble & Irwin, 2009, p. 359).

6. Conclusion

In this paper, I developed a framework for programmes aiming to prevent or reduce the effects of transmitted trauma in families who have been forced to flee their home country. Having analysed already existing prevention programmes and the relevant literature, I argue that more emphasis needs to be put on the non-clinical sector and the role of social work in intervention and prevention of ITT. I elaborated with the use of the ADAPT model five principles for social work that can be implemented in a non-clinical setting:

(1) Creating safe and reliable structures, in order to re-establish safety, security and protection and at the same time stability and predictability;
(2) Creating interpersonal relationships;

(3) Rebuilding trust and faith in humanity by empathising with the refugee's traumatic experiences;
(4) Encouraging engagement and participation and giving the refugee a meaningful role within the programme;
(5) Re-establishing existential values and dignity by implementing meaningful activities.

This paper demonstrates that social work needs to firstly focus on the unresolved trauma of mothers, and secondly support the mother-infant interaction as well as promote secure attachment, in order to help prevent the intergenerational transmission of trauma. A successful prevention programme needs to work with pregnant women and mothers with children aged zero to three.

Despite my high expectations of finding the all-encompassing programme framework, I found that there is no 'one size fits all' solution. There are different approaches that have proven to be successful in certain contexts and environments, which is why I chose to introduce programmes such as "First Steps" or the concept of "Child Friendly Spaces" by UNICEF. Some tact and sensitivity towards the situation and person at hand will always form the basis in dealing with intergenerational transmission of trauma. Building safe, secure and reliable structures might seem like an obvious starting point but, if anything, this thesis has stressed their importance more than once. So what at first appeared to be a gap in literature evolved into possibly the most crucial foundation of the prevention programmes. This made me rethink and reflect on the experiences I have had at the refugee accommodation in Greece. As important as it is to create a safe environment for refugees all the more difficult it will be to put theory into practice.

For this reason cultural appropriate social work needs to be researched further, as well as the exact mechanisms of trauma transmission. As ITT is a serious public health problem, not only social workers but also political scientist and psychologists need to draw their attention on trauma, the transmission of trauma and ways to establish realistic and accessible programmes.

Lastly, it can be said that these principles of creating a safe space and supporting the mothers in their process of dealing with their trauma is a global issue and challenges and practices are not only implementable for Greece and Germany, but in every country that hosts refugees. I myself came across the concept of child friendly spaces and awareness-

raising sessions with parents in my practical experiences working with refugees in Jordan, which both proved to be successful and beneficial for the clients.

In this paper, I aimed to highlight the importance of working with mothers and their new-born children and in general of supporting refugees and immigrants in their process of integration and trauma recovery. A healthy relationship is the foundation for mothers to give their children the best development they possibly can. Children are our future and we must take care of them as much as we can!

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