



Cultural Contexts of Health and Well-being

Stakeholder narratives
No. 1

Principal author
Jessica Frances Marais

Co-authors
Olga Kazakova,
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Orest Suvalo, Felicity Thomas

Understanding and building resilience to early life trauma in Belarus and Ukraine



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**World Health
Organization**

REGIONAL OFFICE FOR **Europe**

ABSTRACT

In 2018 and early 2019, the WHO Regional Office for Europe's cultural contexts of health and well-being project worked alongside the University of Exeter's WHO Collaborating Centre on Culture and Health, the Minsk Regional Centre for Psychiatry and Addiction, and the Institute of Mental Health of the Ukrainian Catholic University to engage researchers, practitioners, health-care workers and other relevant stakeholders in a series of workshops on the cultural contexts of early life trauma in Belarus and Ukraine. The initiative built on previous collaborative work to support the development of culturally informed mental health care in central and eastern Europe. This report reflects the content of the workshops through a collection of participant essays highlighting key cultural contexts and opportunities for fostering more protective and health-enhancing environments for young people in Belarus and Ukraine. It highlights the important role of subjective forms of evidence within culturally nuanced approaches to health and well-being enhancement, and aims to open up further interest in and opportunities for collaboration to address this under-researched area of mental health in the WHO European Region.

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BACKGROUND

This essay collection was developed through the WHO Regional Office for Europe. The evidence for health and well-being in context team of the Division of Information, Evidence, Research and Innovation, including Nils Fietje (Research Officer) and Andrea Scheel (Consultant), was responsible for and coordinated its development.

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Executive summary

Within Belarus and Ukraine, high levels of early life trauma have been widely linked to the significant social, political, economic and environmental upheavals experienced in the central and eastern European region over the past three decades. Early life trauma is known to be a key determinant of health and well-being throughout the life course, and both countries suffer from some of the highest levels of suicide and substance abuse among young people and adults in the world. Yet little detailed analysis of the sociocultural contexts in which this trauma is experienced, understood and responded to currently exists.

In 2018 and early 2019, the WHO Regional Office for Europe's cultural contexts of health and well-being project worked alongside the University of Exeter's WHO Collaborating Centre on Culture and Health, the Minsk Regional Centre for Psychiatry and Addiction, and the Institute of Mental Health of the Ukrainian Catholic University to engage researchers, practitioners, health workers and other relevant stakeholders in a series of three workshops on the cultural contexts of early life trauma and mental health care in Belarus and Ukraine. Building on previous collaborative work to support the development of culturally informed mental health care in central and eastern Europe, the workshops aimed to:

- support key stakeholders and service providers to better understand the causes of early life trauma and how multiple traumas interact to increase risk for mental ill health, substance abuse and suicide;
- identify the factors and mechanisms that promote resilience among those affected by early life trauma; and
- develop a network of practitioners and stakeholders dedicated to finding common goals, pooling cross-disciplinary data, and sharing experiences and good practices across countries.

This report reflects the content of the workshops by compiling essays written by a number of participants. They speak to the overall situation of early life trauma in their areas of activity and to the cultural contexts – the traditions, beliefs, cultural norms, attitudes, values, working practices and legislative frameworks – that strengthen

or weaken resilience. The essays confirm that variable attitudes, differing expectations and mixed experiences of trauma, mental illness and mental health care hinder the achievement of a consistent level of effective and empowering care in Belarus and Ukraine. They also identify opportunities for fostering more protective and health-enhancing contexts for young people in different sectors of society. Overall, they reveal three key enablers for positive change:

- **evidence-based education and training** on preventing, detecting and responding to early life trauma;
- **clear roles, protocols and communication pathways across sectors** to activate and guide the response process; and
- **intersectoral partnerships and networks** to leverage resources, mitigate burnout among practitioners, and build a continuum of support and care within communities.

Through the essays, this report highlights the important role of subjective forms of evidence within culturally nuanced approaches to health and well-being enhancement. While the subjective accounts expressed in these contributions do not necessarily reflect the views of WHO, they do enrich evidence base and help to better identify and address the needs of diverse groups. The report concludes with a list of considerations aimed at policy-makers, organizations and communities for leveraging cultural drivers to positively influence societal values and facilitate reform. Overall, it aims to open up further interest in and opportunities for collaboration to address this under-researched area of mental health in the WHO European Region, including more platforms for sharing experience.

1. Introduction: early life trauma in central and eastern Europe

The burden of mental, neurological and substance use disorders in countries of central and eastern Europe is one of the highest in the world according to data provided by the Global Burden of Disease Study (1). An analysis of the indicators, especially for years of life lost, suggests that mortality among people with mental and neurological disorders in this region is among the highest globally (2). Several recent calls for action have highlighted the urgent need to improve quality of care and scale up interventions for the mental health and well-being of people in central and eastern Europe (3,4).

Early life trauma from maltreatment, parental maladjustment, loss, illness or poverty – particularly in the first five years, a critical period of development – is known to be a key determinant of mental health and well-being throughout the life course. Literature demonstrates its impact on brain development and its associations with mood, behavioural and anxiety disorders as well as substance abuse and suicide (5–10). Results of the World Mental Health Survey Initiative suggest that 30% of all mental disorders among adults are related to adverse experiences in childhood (7).

Interventions aimed at the prevention and treatment of mental health disorders should therefore include actions to reduce traumatizing events in early life, promote post-trauma support for children and adolescents, and enhance the overall resilience of these vulnerable groups (11,12). The positive influence of such interventions on the health and well-being of communities can also yield cost savings for society as a whole (13,14).

Countries of central and eastern Europe are currently engaged in reforming their systems of mental health care and fulfilling commitments to uphold the United Nations Convention on the Rights of the Child (15). Yet variable attitudes, differing expectations, and mixed experiences of trauma, mental illness and mental health care hinder the achievement of a consistent level of effective and empowering care for all. Even when quality care is available, young people and adults impacted by early life trauma may choose not to take advantage of it due to deeply rooted stigma (16).

To give reform processes the best chance of success, a nuanced understanding of the cultural contexts that shape perceptions, norms and behaviours is needed, one that spans diverse sectors and engages the whole of society in building resilience to early life trauma.

1.1 Workshop series on early life trauma in Belarus and Ukraine

Within Belarus and Ukraine, high levels of early life trauma, substance abuse and suicide have been widely linked to the significant social, political, economic and environmental upheavals experienced in the central and eastern European region over the past three decades. Yet little detailed analysis of the sociocultural contexts in which this trauma is experienced, understood and responded to currently exists.

In response, the WHO Regional Office for Europe's cultural contexts of health and well-being project worked alongside the University of Exeter's WHO Collaborating Centre on Culture and Health, the Minsk Regional Centre for Psychiatry and Addiction, and the Institute of Mental Health of the Ukrainian Catholic University to engage researchers, practitioners, health workers and other relevant stakeholders such as patients and carers in a series of workshops on the cultural contexts of early life trauma and mental health care in Belarus and Ukraine (see Annex 1 for the list of participants). The workshop series built on collaborative work undertaken by WHO and partner organizations to support the development of culturally informed mental health care, most notably a two-day cross-disciplinary workshop on culture and mental health-care reform in central and eastern Europe in October 2017 in Klecany, Czechia (16). The series aimed to:

- support key stakeholders and service providers to better understand the causes of early life trauma and how multiple traumas interact to increase risk for mental ill health, substance abuse and suicide;
- identify the factors and mechanisms that promote resilience among those affected by early life trauma; and

- develop a network of practitioners and stakeholders dedicated to finding common goals, pooling cross-disciplinary data, and sharing experiences and good practices across countries.

This project included the creation of a website to connect people involved in work with early life trauma and promote relevant events within and beyond the eastern European region. It contains all materials from the three workshops.¹

The first workshop took place in June 2018 in Minsk, Belarus. It sought to consolidate understandings of the causes of early life trauma and the experiences that diverse groups (policy-makers, academics, members of civil society, service users and service providers) have in responding to it from biomedical, social and cultural perspectives. Participants explored how early life trauma is conceptualized and measured across sectors in Belarus and Ukraine; how cultural attitudes inform related government policies; how stigma operates as a barrier to care; and what specific cultural drivers could be leveraged to facilitate reform, enhance communication and positively influence societal attitudes.

The second workshop, held in October 2018 in Lviv, Ukraine, increased understanding of the intersections of mental and physical health by examining the connections between early life trauma, substance abuse and suicide. Participants reviewed definitions and perceptions of substance abuse and suicide in Belarus and Ukraine, including their representation in popular culture and the media, and discussed key areas for research and interventions.

The third and final workshop, held in January 2019 in Minsk, compiled learning from the previous sessions to identify good practices and opportunities for increasing resilience to early life trauma across central and eastern Europe.

Each workshop included case presentations in which professionals shared information about their work and discussed potential for closer collaboration. This report reflects the content of these presentations by compiling essays written by a number of participants. Each describes the overall situation of early life trauma in their sector of activity, as well as the cultural contexts – the traditions, beliefs, cultural norms, attitudes, values, working practices and legislative frameworks – that strengthen or weaken resilience.

¹ The website can be viewed at:
<http://earlylifetrauma.info>.

The essays confirm that many intersecting social and cultural factors complicate or undermine efforts to prevent, detect and respond to early life trauma in Belarus and Ukraine. They also reveal encouraging developments and key opportunities for influencing cultural contexts through education, communication and networking. The final section of this report draws a number of considerations from workshop discussions and the content of the essays for policy-makers, organizations and communities working to positively influence societal values and facilitate reform.

2. Background of early life trauma in Belarus and Ukraine

2.1 Belarus

Almost all families in Belarus faced serious traumatic events in the 20th century. The Second World War, for instance, led to the death of a quarter of the country's population (17), and the collapse of the Soviet Union in the 1990s triggered a dramatic economic crisis. This loss and hardship impacted generations of Belarusian children, and continues to negatively affect the health and well-being of the population.

As noted in the previous section, traumatic events in childhood can contribute to later-life problems with substance abuse, antisocial and suicidal behaviour, and other mental and somatic disorders (5–10,18–22). By 2003, the suicide rate in Belarus had risen to 35.1 per 100 000 population (23) – significantly higher than the 2003 global average of 12.9 per 100 000 per 100 000 population (24). According to the *WHO Global status report on alcohol and health 2018*, 40% of the adult male population in Belarus engages in heavy episodic drinking, more than one third has an alcohol use disorder, and one fifth experiences alcohol dependence; this is approximately 4–5 times the European average (25).

An unpublished government report states that by the end of 2018, the number of children in Belarus under observation by a psychiatrist for alcohol or drug abuse was 15 187. In 2017, the number of crimes committed by children was 1716, or 3.6 per 100 000 children (26). The number of crimes committed *against* children increased from 338 in 2011 to 549 in 2016 (27). Persistent underreporting of violence against children means that actual numbers may be higher. According to research conducted by the United Nations Children's Fund (UNICEF) in 2015, half of Belarusian children experienced physical or psychological abuse in schools, and 18.4% of children in grades 5–7 and 26.2% of those in grades 8–11 experienced domestic violence (27). Children and adolescents with disabilities in Belarus are particularly vulnerable to poverty, social exclusion and abuse (28).

The country's laws against domestic violence are currently under discussion, although Belarusian society has not yet achieved consensus in this area. This is reflected in the fact that almost a third of specialists working with psychologically traumatized children have shown a high tolerance for and willingness to justify violent forms of discipline (27). In 2015, two thirds of specialists working with families and children had no training in working with children who had experienced violence (27). Modern legislation regarding the removal of a violent spouse from the home is not yet in place (29).

In the last decade, the socioeconomic situation in Belarus has been relatively stable, and both governmental and nongovernmental organizations (NGOs) have increased their efforts to address this legacy of trauma among the population. Different institutions have studied and addressed early life trauma mainly by examining its causes, such as domestic violence or children's separation from their families. Several governmental and nongovernmental organizations provide consultations and temporary accommodation to victims of domestic violence, but the number of these organizations is low overall and particularly low in regional cities.

As part of its mental health-care reform process, Belarus has begun the transition from institutional orphanages and shelters to a system based on foster families or family-style orphanages. The number of institutions for those aged 3–18 years fell from 32 to 17 between 2010 and 2017, and over the same period the number of children and adolescents living in family-style orphanages increased from 956 to 1885 (30). This can be considered a positive step in governmental support of children impacted by early life trauma.

Another positive step has been the recent launch of several initiatives related to early life trauma in the public sector, including new educational programmes on early life trauma for paediatricians and psychologists, some of which are supported by UNICEF. Yet the support available in this area is still scarce and the number of NGOs providing additional assistance remains inadequate. To accelerate positive change in Belarus, ongoing efforts to build societal awareness of the causes and serious impacts of early life trauma – and to destigmatize mental illness and mental health care – are critical.

2.2 Ukraine

During the twentieth century, Ukraine was the site of several social cataclysms. The First World War was followed by the Ukrainian War of Independence (1917–1921), and the de facto communist rule of the 1930s was accompanied by arrests, deportations and executions of Ukrainian intellectuals. Deaths during Holodomor, the human-made famine of 1932–1933, have been estimated at 4.5 million (3.9 million excess deaths and 0.6 million lost births) (31). The Second World War brought the horror of Nazi power to Jewish Ukrainians during the Holocaust. The deportations of Ukrainians from western Ukraine and of Crimean Tatars after the return of Soviet power to the Crimean Peninsula further traumatized society.

This legacy of intergenerational trauma has resulted in changes on both individual and societal levels. Terror, humiliation, hostility, cruelty, betrayal, dishonesty, deception, double standards and persecution for ideological dissension all formed psychological and behavioural patterns in Ukrainian communities that span generations. Collective civil passivity, obedience, depression, a sense of inferiority, distrust, fear and the distortion of values have become common psychological characteristics of post-totalitarian societies, including Ukraine (32).

Historically, Ukrainians were unable to sufficiently deal with their trauma due to lack of access to the truth, prohibition of talking about repression, and a dearth of objective analyses of past events and their impacts on people. Each generation has carried a wide array of uncontested and unprocessed psychological wounds that have not allowed for the development of a free and confident personality and a productive society (33). The use of psychiatry as a tool to punish people who were not in harmony with the policy of the Soviet Union in the 1960s and 1980s affected citizens' attitudes to the sphere of mental health care, causing distrust and fear to ask for help (32,34).

Since independence in 1991, civil society and democratic processes have begun to develop. The Revolution of Dignity that began in November 2013, also known as Maidan, demonstrated the presence of an active civil society. The subsequent conflict in eastern Ukraine increased attention to issues of mental health and psychological trauma, and catalysed the formation of a community of mental health professionals working on trauma-related mental health problems.

The violence in eastern regions of Ukraine has led to significant human losses, massive suffering, large-scale civilian displacement, and the destruction of private property and public infrastructure in the oblasts of Luhansk and Donetsk. According to official data from the Ukrainian Ministry of Social Policy, there are now more than 1.5 million internally displaced people in Ukraine (35). Children and adolescents in the eastern part of the country, especially those of internally displaced families, suffer the double trauma of remaining in a hostile region and of adapting to a new environment, including interrupted schooling. During conflicts in non-government controlled areas, 119 schools were damaged. About 54 900 children and adolescents were subsequently enrolled in schools located in safer areas, but they still face constant uncertainty and a lack of prospects. Only 16% of young people report being optimistic about their future (36).

Children and adolescents in eastern Ukraine are at risk of developing negative stress management strategies, such as alcohol and drug abuse (37). A study by the Kyiv International Institute of Sociology showed that smoking was regarded as a “cool” behaviour model by 44% of young respondents; the use of light drugs by 33%; alcohol consumption by 31%; and aggressive behaviour by 54% (36). The most recent Health Behaviour in School-aged Children study shows that 10% of 15-year-old girls and 18% of 15-year-old boys in Ukraine consume alcohol at least once a week (38). The most common behaviour problems among those aged 13–18 are attention deficit hyperactivity disorder, fear and aggression (36).

Recent data on Ukraine provided by UNICEF show that violence against children remains largely underreported in the country. As in Belarus, some forms of domestic violence against children are accepted as a social norm. According to a 2018 report, 42% of parents believe that emotional violence against a child is acceptable for educational purposes, that is, to “teach them a lesson”, and 14% permit the use of physical force against a child as a disciplinary measure (39).

At present, Ukraine is undergoing numerous reforms in various sectors, many of which are aimed at preventing and overcoming early life trauma and its consequences. These include the deinstitutionalization of orphanages and the development of family forms of care; a system of probation in the law-enforcement sector for adolescents who have committed offences; educational

reform; and health-care reform, including improvements to the system of mental health care. Civil society and numerous NGOs across the country are active in preventing early life trauma and providing assistance to those impacted by it, demonstrating their desire and the potential for further development.

Evidence suggests that traditional religious values have a strong influence on the mindsets of Belarusians, strengthening the institutions of the traditional family, parental authority and the dominant role of men. Yet modern Belarusian society also includes strong feminist movements that actively oppose domestic violence and gender discrimination.

² These include *Ponimanie* (Understanding), Belarus SOS Children's Villages, Child Fund International in Belarus, the Belarusian Association of Large Families, the Belarusian Association of Assistance to Children and Young People with Disabilities, Children in Need, Children Against Violence, Children of Chernobyl, Childhood to Children, *SemYa*, *Roditelski Dom* (Family Home), Mothers Against Drugs, the Belarusian Foundation for Charity and Health, the Association of Families with Disabled Children with Cerebral Palsy and Spinal Pathologies, and the children's charitable foundations *Prikosnoveniye K Zhizni* (Touching Life), *Belyi Aist* (White Stork) and *Shans* (Chance).

3. Perspectives from Belarus

3.1 Sustaining the critical service provision of NGOs

By **Iryna Shmak**, Head of the Happy Baby Social Centre of SOS Children's Village in Minsk, Belarus

With the collapse of the communist system and the Soviet Union, Belarusian society experienced in-depth cultural trauma, and the consequences of this are still evident today. Since the communist system gave absolute priority to institutions, its collapse completely disoriented a society that was unaccustomed to autonomy and full responsibility for its own social destiny. Independent statehood was a new experience for Belarus, and thus national transformation processes face many challenges here.

Over the past two decades, religious affiliation has begun to play a significant role in the social and political life of Belarusian society. According to a study by the Pew Research Center, 73% of Belarusians identify as Orthodox Christian, 12% as Catholic, about 11% as belonging to other faiths (unspecified), about 3% as atheist, agnostic or unaffiliated, and about 1% as Muslim (40). Evidence suggests that traditional religious values have a strong influence on the mindsets of Belarusians, strengthening the institutions of the traditional family, parental authority and the dominant role of men. Yet modern Belarusian society also includes strong feminist movements that actively oppose domestic violence and gender discrimination. Additionally, the generations born after the collapse of the Soviet Union in the 1990s have a different perception of their place in history, largely due to their participation in the global information space.

In the 1990s, the first charitable NGOs aimed at providing support to children emerged in Belarus.²

These NGOs were the first to draw the attention of the Belarusian public to the issue of early life trauma and to the needs of children exposed to psychological trauma and physical abuse or living in institutions. Since then, their awareness-raising and advocacy efforts have shaped a sustainable state system of child protection, increased the demand for private services (psychologists, lawyers,

self-help groups, etc.), and led to the creation of new community organizations and initiatives, such as mindful parenting.

NGOs in Belarus now provide diverse forms of assistance ranging from counselling, legal advice and health workshops to free food, clothing and shelter for people in crisis. Guided by best-practice methods and the recommendations of specialists in state institutions, they have enabled a growing number of children to access services and help. Yet many of these NGOs cannot perform to their full potential due to lack of funding. Only 5–10 active stakeholders among NGOs work with early life trauma, and this number is constantly decreasing. This is especially true for NGOs providing direct services to those at risk of early life trauma.

Case study 1

Nastya was referred to the Happy Baby Social Centre by the Partizanski district police department of Minsk. She was pregnant, without documents, homeless and on probation. Nastya had to stay at her registered place of residence as part of her probation conditions, but she had no home to go to. Her temporary placement in the night shelter did not solve the problem as she had to be outside during the day – this was unsafe for her and her baby during winter. Nastya's primary need was a place to live.*

Nastya has benefitted from temporary residence at the SOS Children's Village apartment for women with children since January 2017. She has accessed a comprehensive package of services including financial support, food, health products, household supplies, clothing and community assistance. She regularly participates in educational workshops on financial literacy and household issues, as well as psychological and art workshops. In turn, Nastya fulfils the role of an experienced parent in the apartment, helping young mothers to cope with domestic issues and teaching them about baby care. Even in crises, she remains calm and even-tempered. While staying in the apartment, she has followed all instructions and rules for residents.

With the help of the Social Centre's specialists and volunteers and a representative of the Ministry of Internal Affairs, Nastya also regained her passport and her son's birth certificate, received temporary registration for herself and her son, and applied for state welfare support. In addition to being a responsible parent, she has significantly increased her social viability and activity. Through this support and her own dedication, Nastya has been able to overcome her difficult life situation, which was a consequence of her own early life trauma – her mother left to look for a job when Nastya was 13 years old, leaving her in a shelter. Nastya has managed to change this pattern of behaviour, reducing the likelihood of trauma being transferred to her child.

* Name has been changed.

Much-needed efforts to develop new approaches to parenting based on values of nonviolence will also improve the mental health and well-being of our entire society over time.

Raising public awareness about early life trauma is key, as is reducing high levels of stigma, including towards children. This must be coupled with enhanced state social and psychological support to those affected by early life trauma and capacity-building for professionals working in the field. To further implement the child's right to a family environment and to help avoid the effects of early life trauma, all types of assistance to biological and foster/adoptive families must be strengthened, including financial and psychological assistance, and orphan prevention programmes must be enhanced. Much-needed efforts to develop new approaches to parenting based on values of nonviolence will also improve the mental health and well-being of our entire society over time.

3.2 Orthodox psychology: building networks to support survivors of early life trauma

By **Alexander Boyko**, Priest of the Church of the Holy Righteous Sophia of Slutskaya in Minsk, Belarus

While the Orthodox Church is separate from the state, it has established active partnerships with governmental agencies and has a significant influence on the population of Belarus. A large part of the population shares Christian values and is guided by them in everyday life.

Clergy often encounter those who have experienced early life trauma during visits to orphanages and the homes of families with complex needs, and within the Church where people seek help from God or sympathy from the community. As the Church is a spiritual asylum with rich experience and established traditions of helping those with psychological problems, priests can sometimes provide the necessary support by advocating forgiveness, self-acceptance and trust that God loves every person and is especially gracious to those who are hurt and oppressed.

Yet the tools traditionally used by the Church to help people with early life trauma are often insufficient. Priests may lack the education, training, knowledge and skills to identify early life trauma and provide proper assistance. For the most part, clergy understand that when they are unable to cope on their own, the best thing they can do is to refer a person to relevant specialists. However, these specialists do not always enjoy the trust and confidence

Some people suffering from mental ill health avoid professional medical assistance in the belief that only direct divine intervention – a miracle – will solve their problem. However, the tradition of the Church argues that medical care and professional knowledge are key to the provision of support.

of the people – including some priests – due to certain misconceptions and stereotypes still prevailing in our country.

In addition, mental disorders are often confused with spiritual ailments in spite of the fact that Christian psychology makes a distinction between the two. Consequently, Christian people suffering from early life trauma might try curing their pain with the means used for the treatment of spiritual diseases, such as enhanced prayer and strict fasting. In some cases, the psychological intensity of ascetic exercises may actually worsen the situation.

This problem is aggravated when people suffering from certain psychological problems display a neurotic type of religiosity, which focuses not on talking to God but rather on reading prayers over and over without realizing their spiritual values and meaning. They may rely on church folklore in spite of the fact that the traditional teachings of the Church are fundamentally different.

Some people suffering from mental ill health avoid professional medical assistance in the belief that only direct divine intervention – a miracle – will solve their problem. However, the tradition of the Church argues that medical care and professional knowledge are key to the provision of support. Vivid examples of this union are found in people who practiced the art of medicine

Case study 2

At the age of seven, Sofia, a member of our parish, was abused by a man and lost her ability to walk. The trauma was aggravated by the fact that her family had been dysfunctional for many years and, therefore, she did not receive adequate support and care from her parents. Now, Sofia is an adolescent. She finds support in the Church and among Church members who are sensitive to her misfortune. She also receives moral support in the form of confession, communion, confidential conversation and consolation from the priests serving the parish. Parish members also help her with mobility issues and financial problems.*

However, this is not enough to solve the problem of early life trauma. Sofia is reluctant to seek assistance from a mental health professional and, as such, systemic support has been impossible. In my opinion, if the parish had a relationship with a mental health professional who was willing to cooperate with the Church, Sofia could be supported in a much more effective way.

* Name has been changed.

and at the same time achieved the ideal of holiness and sainthood (for example, the Holy Apostle Luke, the Great Martyr Pantaleon and St Luka Voyno-Yasenetsky). Priests can best help people impacted by early life trauma by showing them Christian love, attention and sympathy, and by working together with an Orthodox psychologist or a psychotherapist who combines psychology with the Church's perspective on a problem.

Orthodox psychology is becoming popular and much in demand. It combines the achievements of modern medicine and the experience of the Church, which for a long time was the only place a person struggling with mental illness could come. Unfortunately, the current level of cooperation between the Church and organizations/professionals dealing with early life trauma is far from comprehensive. Some estrangement persists between mental health professionals and Orthodox clergy.

It would be useful to intensify efforts to integrate these social institutions through joint lectures, seminars and the exchange of experience. For example, I organized a meeting of our parishioners with a psychotherapist who works with early life trauma, among other things. This workshop revealed tremendous potential for the development of cooperation between the Church and representatives of conventional medicine. Our parishioners with experience of early life trauma demonstrated clear interest in working with a professional who is a committed Christian, and who they can therefore trust with their most intimate problems.

3.3 Understanding the role of paediatricians in detecting and responding to early life trauma

By **Maryna Tsikhanavets**, Paediatrician and Vice Director of the Minsk Regional Children's Clinic, Belarus

Medical professionals involved in children's health care play an important role in the lives of families by helping young parents to take proper care of their new babies, and by helping babies to develop to their full potential. The Belarusian system focuses on outpatient care and organizes paediatric work on a district principle. Thus, the main figure providing medical care to children in a local clinic is a district paediatrician. The paediatrician

It is critical that paediatricians and other health workers are able to recognize the signs of child abuse in the early stages, assess the risk of harm and identify consequences.

remains close to the family for a long time, sometimes observing the children of several generations, and takes care of both the physical and psychological aspects of their health. His or her advice, recommendations and answers can help parents to feel reassured and confident and to raise healthy and well-adjusted children.

Paediatricians also help families to cope during difficult moments and crises. They play a key role in identifying and preventing early life trauma during home visits and medical examinations. Their identification of risk factors, including poverty, illness, disability, poor housing, unemployment, alcohol or drug use and violence, begins before a child's birth and continues throughout childhood. Often, when parental neglect or violence poses a real threat to a child, paediatricians are the first to notice.

It is critical that paediatricians and other health workers are able to recognize the signs of child abuse in the early stages, assess the risk of harm and identify consequences. The Department of Outpatient Paediatrics of the Medical Academy for Postgraduate Education

Case study 3

Health workers of one of the district health organizations monitored the K. family, which included nine children under the age of 18. They carried out medical supervision of the children according to Decree No. 96 of the Ministry of Health, "On approval of the instructions on the procedure for clinical examination", and kept all required medical documentation. The parents followed all recommendations for the care of their children, and promptly sought medical help in the event of any acute illness.

Full clinical supervision gave no reason to doubt the family's well-being. However, during a visit with one of the older children, a paediatrician noticed atypical behaviour: low spirits, low emotional activity and apathy. This prompted a more thorough medical examination and careful study of the child's medical history. The paediatrician found traces of physical abuse on the child's body and detected signs of long-time family dysfunction. It became clear that the parents, being dedicated followers of a religious sect, practiced a very strict system of child rearing, severely disciplining their children with corporal punishment and psychological pressure for the slightest deviation from the family rules. This was carefully hidden from society by family members, and as a result their reputation had never been in doubt.

The paediatrician's report successfully broke the vicious circle of violence in this family. Complex preventive work was carried out both with the children and the parents, which made it possible to improve the situation and keep the family together.

conducts a series of trainings supported by UNICEF on home visits for paediatricians and paediatric nurses where, among other things, they learn to detect signs of early life trauma.

Family dysfunction is often carefully hidden by both aggressors and victims due to fear of punishment, lack of awareness of how serious the situation is, distrust of service providers, etc. In such cases, physical, emotional and behavioural signs help to identify abuse or neglect. These signs are not always obvious, and their discovery requires careful communication with both children and parents.

With children's best interests at heart, paediatricians find ways to establish contact with families, listen to them, build trust, provide medical care and refer them to appropriate services when necessary. They can quickly inform relevant stakeholders about children in vulnerable situations through interdepartmental and interagency cooperation, including with professionals who specialize in the prevention of child neglect and juvenile delinquency, teachers, psychologists, social workers, and guardianship and custody specialists.

Laws regulate paediatricians' actions upon detecting psychological or physical violence against a child. As part of their official duties, paediatricians must strictly follow protocol and interact in each specific case with management teams and colleagues and with other entities working in this field. This enables them to provide timely assistance to children.

3.4 Linking educational and psychological resources for children and adolescents

By **Natalia Masyukevich**, *Psychologist at the City Centre for Psychological and Pedagogical Assistance of the Minsk State Palace of Children and Youth, Belarus*

The City Centre for Psychological and Pedagogical Assistance has existed since 1999, and now has a staff of six psychologists and a supervisor. At the beginning of the year, educational psychologists identify individuals among the approximately 8000 students attending the Minsk State Palace of Children and Youth who may benefit from increased support, for example, those from

The current situation shows that educational psychologists working within educational institutions often lack a basic level of knowledge about psychological trauma, signs indicating traumatization, the consequences of trauma for mental health, and strategies for organizing care. In universities, medical psychology students master the basics of providing psychological assistance in crisis situations, but they must seek out advanced training on early childhood trauma at their own expense.

single-parent families or with psychophysical development challenges. With consent, psychologists work with these children and adolescents by organizing training sessions, conducting individual consultations, sharing conversations, creating interactive platforms, and facilitating conflict resolution with teachers or parents.

The Centre also provides psychological assistance to young people in Minsk who find themselves in difficult life situations. In accordance with the Law on Psychological Aid, any parent can ask for help by giving a description of their child's problem. At that point or during an initial meeting, the parent's request is clarified and the Centre offers appropriate assistance. If the Centre cannot provide assistance, staff direct the parent to another educational or health-care institution.

In addition, the Centre also implements educational projects for children/adolescents and their parents with the aim of increasing psychological competence, solving developmental problems, and preserving and strengthening psychophysical health.

Since its founding, the Centre has observed a constant increase in the number of requests for individual psychological assistance. The share of these requests related to early life trauma is also growing: according to the analytical report for 2017–2018, it is 23%. Educational psychologists have analysed the nature of these complaints and rank them by frequency of occurrence:

1. the divorce of parents
2. domestic violence
3. bullying in the classroom
4. the sudden death of a family member
5. separation from a significant adult
6. a road crash
7. the loss of the home (fire, relocation due to hostilities, etc.)
8. a disability or a serious illness in the family.

The current situation shows that educational psychologists working within educational institutions often lack a basic level of knowledge about psychological trauma, signs indicating traumatization, the consequences of trauma for mental health, and strategies for organizing care. In universities, medical psychology students master the basics of providing psychological assistance in crisis situations, but they must seek out advanced training on early childhood trauma at their own expense. It is especially important to know how to work with early life trauma when dealing with children who have asocial behaviour or those who are at risk. These children have often survived a traumatic event at an early age, which distorts their psychosocial development and influences the entire life course.

Case study 4

A mother called to schedule a therapy consultation for her 9-year-old daughter Daria, who was displaying an emerging obsessive fear of getting sick. Daria is the only child in the family and has steady, positive attachment to her parents. The family has an active lifestyle, is united, spends time together and shares positive emotions. Yet Daria had recently become anxious and complaining, and had begun taking her temperature many times a day, compulsively washing her hands and face, and having sleeping problems. The parents pointed out her newly childish behaviour and speech, characterized by grimacing and a change in intonation, rhythm and pitch.*

During the consultation, I discovered that Daria's grandfather had a heart attack while visiting the family three months prior. I hypothesized that the sight of the grandfather's health crisis was a traumatic event, and that the fear of death has been actualized. Later, this was confirmed. The child had four individual therapy sessions, and the parents had two sessions. After the fourth individual session, the girl joined a remedial group run by the Centre. The goal of the group is to enhance children's perception of the world of emotions, teach them how to respond to negative feelings in a socially acceptable way, and help them develop self-regulation skills. Daria attended seven group sessions.

In this case, several factors were key to success. First, the parents asked for help in due time (three weeks after the onset of symptoms), were motivated, followed the recommendations of the educational psychologist, collaborated, and shared responsibility for initiating change. Second, they made an appointment with an experienced, specialized psychologist upon recommendation. Third, my training in early life trauma allowed me to identify Daria's symptoms as derivatives of an adverse experience, which helped to reveal the traumatic event and recommend a course of action. Fourth, the services were free. This is key for families in crisis.

* Name has been changed.

It should be noted that rendering assistance to traumatized children requires not only professional skills, but also a certain level of psycho-emotional self-regulation. The intensity of certain activities combined with a lack of care and support for the specialists themselves can lead to emotional burnout and the rapid turnover of personnel.

The Centre's specialists conduct seminars for the educational team as well as courses on psychological trauma. They analyse problem cases to strengthen teachers' psychological awareness and their ability to recognize markers of distress. This builds teachers' capacity to help traumatized children, to initiate actions that have a positive impact on their well-being, and to avoid or prevent actions that can worsen the situation. The Centre also cooperates with health-care institutions and non-profit organizations, updates specialists in the field of crisis psychology and, if necessary, provides information to clients.

Key challenges include the engagement of multiple participants (teachers, parents, siblings of different ages) in various activities, and educational psychologists' lack of specialization in early life trauma. Currently, only two of the six specialists at the Centre have expertise in this area, and training opportunities for all staff are needed. It is important that educational psychologists recognize the value of collaboration and place a special emphasis on multiple preventive measures. While working directly with the deep feelings associated with early life trauma is a long process, the resolution of related issues (legal, medical, etc.) through the involvement of various specialists, can be helpful. To improve outreach efforts, we must also ensure that information about the services available at the Centre is publicly available.

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3.5 Expanding training and collaboration to improve diagnostics and continuity of care

By **Anna Savitckaya**, Psychotherapist at the Outpatient Psychiatric Department in the Minsk Regional Clinical Centre "Psychiatry–Narcology", Belarus

As a psychotherapist in the outpatient psychiatric department the Minsk Regional Clinical Centre "Psychiatry–Narcology", I work with children, adolescents and adults referred by a psychiatrist

or independently seeking care. Most of my work is long-term existential psychotherapy, and I offer consultations related to diagnostics and the prescription of drug treatment. The Clinical Centre also employs addiction psychiatrists who deal with diagnostics and medication support for patients; psychologists who deal with psycho-diagnostics and psychological intervention; and social workers who supervise patients unable to come to the Clinical Centre for health reasons. The Clinical Centre also runs a helpline around the clock to respond to crises and a peer support group for patients with mental disorders and their families.

It is safe to say that all children and adults who come for psychotherapy have an experience of early life trauma related to neglect or abuse by parents or other caregivers. A great number of adolescents referred to psychotherapy after a suicide attempt report that their parents neglected them and ignored their emotional lives. The loss of a significant adult in early childhood through divorce or death is another frequent cause of psychological difficulties. I also see cases of physical violence against children in the form of disciplinary punishment, and sexual abuse, including incest.

Adolescents who come for therapy are mostly from dysfunctional families. Most are girls, although lately the number of boys coming for therapy has increased. The largest demographic seeking psychotherapy is 20–35-year-olds, and the majority are women. While these individuals may have once been more likely to ask for medical treatment for their conditions, they are increasingly eager to begin psychotherapy.

In relation to the cultural context of early life trauma in Belarus, it is worth reiterating that our country has an incredibly complex and dramatic history. The deaths, deportations, poverty, hunger and dispossession of the 20th century left countless broken families and established an intergenerational legacy of trauma. It is almost impossible to find a family that has lived during the past century in Belarus and has not suffered terrible losses.

We can confidently say that all of the signs indicating early life trauma within an individual are manifest in our country at the national level, including prevalence of alcohol abuse and high rates of suicides. This contributes to a less attentive attitude to particular cases of traumatic experience; I see this as one of the main difficulties

Case study 5

Marina was referred to me by a child psychiatrist for therapy when she was 13 years old. Her story was shocking. Marina's mother, who abused alcohol, was deprived of parental rights on the initiative of the girls' father when Marina was five years old and her sister was three. Both daughters stayed with their father and no longer saw their mother. At the age of 11, Marina was raped by her father for the first time.*

When we met, Marina was living with her mother, who had regained her parental rights, and her mother's second husband, as well as Marina's sister and two younger children from the second marriage. Due to constant quarrels with her mother, Marina had begun to run away from home, and as a result she was obliged to visit a psychotherapist. We worked together for about four months and managed to establish good contact. Marina began to access difficult, deeply hidden experiences and talk about her relationship with her mother and stepfather. She willingly attended sessions. Her mother refused to join her, explaining that she was too busy.

After one of the quarrels with her mother, Marina had an epileptic seizure. Examinations did not reveal any organic pathology, but Marina's mother decided that it was too dangerous for her daughter to travel to psychotherapy alone. Attempts to bring Marina back into therapy were unsuccessful. Marina's mother stopped answering phone calls from the Clinical Centre. We attempted to contact Marina's school, but received no response.

This case presents an example of the "prism of injury" through which Marina's mother, who had endured her own severe traumatic experiences, looks at the world. This prevented her from noticing the serious consequences of Marina's traumatic experience and taking action to help her. I believe this blindness and inaction comes from the emotional paralysis of being confronted with something so terrible.

Even as a psychotherapist, I was troubled by seeing a child with such grave experience for the first time. It was the first case of incest in my practice, and I did not have the skills required to work with such children. I had to obtain them on my own from available sources. Lack of awareness, education and skill in the field of trauma blocked Marina from receiving help at earlier stages.

This case also highlights the imperfection of the legal system, which re-traumatized Marina through unskilled interrogations. Marina's father, her rapist, was present in the courtroom while she was testifying against him, and she did not have the support of a psychologist while listening to his testimony. He even managed to utter threats to Marina while passing by. I should point out that Belarus now has several interview rooms where a child is interviewed in the presence of a psychologist, but these are still rare. Court officials still lack training in the particularities of questioning children, which also creates a risk of re-traumatization.

Finally, Marina's case illustrates the lack of interdepartmental cooperation that made it impossible to begin therapy earlier or to resume therapy after it was interrupted. Marina was not referred to therapy during or after the trial due to a lack of communication between judicial and psychotherapeutic services. The school system did not follow up on our inquiries, and the confidentiality clause of the Law on Mental Health restricted us from seeking other ways to communicate with the girl's family.

* Name has been changed.

Specialized education for paediatric psychotherapists is not available in Belarus, and training is limited to a two-week paediatric psychotherapy course in the general training programme for psychotherapists. Specialists must obtain necessary information on early life trauma independently, or through courses that are usually expensive for those working in a public institution.

of working with early life trauma in our country. Another layer of complexity is the fairly widespread loyalty to the physical punishment of children, based on the perceived necessity of strict and rigid parenting.

The Clinical Centre's work with children and young people contributes to preventing or reducing the severity of the effects of early life trauma by mitigating suicidal behaviour and self-harm; rehabilitating people who are dependant on psychoactive substances; and providing accessible psychotherapeutic help, including on an anonymous basis. The Clinical Centre also maintains social media accounts and posts educational articles on psychology to reduce stigma, raise public awareness of mental health issues and encourage people who need help to access our services. Our social media pages are mostly followed by young people.

There are, of course, also weaknesses in the assistance system for early life trauma, both in the Clinical Centre and in similar institutions. The most significant is the lack of qualified specialists able to diagnose and assist patients who have experienced early life trauma. Specialized education for paediatric psychotherapists is not available in Belarus, and training is limited to a two-week paediatric psychotherapy course in the general training programme for psychotherapists. Specialists must obtain necessary information on early life trauma independently, or through courses that are usually expensive for those working in a public institution.

Low wages and heavy workloads (both physical and psychological) due to the lack of specialists in this area reduce motivation to work with early life trauma. For professionals who do work with early life trauma, a lack of professional support groups contributes to burnout and a sense of isolation. As a result, many experts change the scope of their activities after several years of work. Inadequate interdepartmental interaction, illustrated in the case below, also impedes work with early life trauma.

To address these issues, Belarus must improve training for specialists in diagnostics and early life trauma, and increase the availability of material and technical support, such as clinical space, remuneration, professional support groups, supervision systems, interventions, etc. These changes could lead to an increase in the number of qualified specialists, which would improve the availability of assistance and the possibility of long-term work with those who have undergone early life trauma.

From a cultural perspective, because our country long regarded early life trauma and related issues such as domestic violence and bullying as forbidden topics, a great deal of silence and misunderstanding remain.

4. Perspectives from Ukraine

4.1 Addressing legal barriers to increase access to care

By **Angela Kihichak-Borshchevska**, Child Psychiatrist, Psychotherapist and Associate Professor in the Department of Psychiatry and Psychotherapy at Danylo Halytsky Lviv National Medical University; National Trainer for Childhood Without Violence, Ukraine

The team at the Department of Psychiatry and Psychotherapy consists of psychiatrists, child psychiatrists, psychotherapists and narcologists, all with academic degrees. As we are situated within the Department of Postgraduate Education, physicians from across Ukraine come here to complete postgraduate studies and professional development courses. Our specialists train psychiatry interns and run courses on medical psychology and countering domestic violence for interns of all specialties. The Department has developed courses for broadening the competencies of paediatricians, family physicians and neurologists, which include components on preventive measures, detection and therapeutic strategies for early life trauma.

As an associate professor, I observe that the theme of early life trauma raises fears and anxiety among physicians of different specialties. This is due in part to the extensive health system reforms currently taking place in Ukraine. Working conditions for many physicians have become much more complicated, and levels of burnout have increased. To address early life trauma, physicians must shoulder additional responsibility regarding little-known aspects and without enough legal expertise or protection. From a cultural perspective, because our country long regarded early life trauma and related issues such as domestic violence and bullying as forbidden topics, a great deal of silence and misunderstanding remain.

Now, the country is seeing many progressive changes. For example, the international women's rights centre La Strada established a hotline in 2010, and many local crisis hotlines are now in operation. Special police units dealing with domestic violence have been functioning for several years, and a relevant educational programme for medical professionals has been launched. It will take time before these developments and resources promote trust in society. It will also take time to broaden outlooks and improve the skills of professionals from

different fields, particularly health professionals. Increasing health professionals' legal expertise and forming multidisciplinary teams would accelerate this transition.

Case study 6

I have been Kateryna's group psychotherapist for two years. Kateryna is 49 years old, and has been suffering from psychological and mental problems for nearly 21 years. Her mother also suffered from a mental disorder, and so her childhood was full of complicated, traumatic communication in an unhealthy family environment. At first, outpatient psychiatric treatment helped to stabilize her condition (in those years, there was no psychotherapy as such in Ukraine). Fourteen years ago, Kateryna was hospitalized for the first time. Since then, the Lviv Regional Psychiatric Hospital has become a home away from home where Kateryna has hidden for months at a time from the stormy world around her.*

Though she was in a difficult, acute phase of her psychosis when she joined the group, Kateryna struck me immediately as someone with great intellectual promise and spiritual wealth. She continually expressed gratitude to all the people who supported her in her fight against her illness, and generously shared her experience of even minor successes with other group members. She would rush to support them even when she herself was lacking energy and a sense of potential.

A vivid story of Kateryna's stoic father stays with me. Kateryna explained that he taught her at an early age that "there is no place for weakness and tears in our life". When, as a small boy, he fell from a tree, he forbade himself to cry and tried to cope with his pain alone. What a revelation it was when Kateryna heard the recommendation to listen to her feelings and learn how to express them in a healthy way. How diligently she worked to do so.

Kateryna also explored the significant influence of her relationship with her mother in the group sessions. In less than a year and a half, she made the revolutionary transition from a sense of guilt before the mother she worshipped, grief at losing her, and feelings of loneliness and disability in her own life to increased self-confidence and positive social development. This manifested in an improved relationship with her children, her ability to start earning money, and, finally, her ability to move from her parents' apartment to a shared space with her children. Kateryna's story speaks to enormous human capabilities and the desire to take advantage of them.

At all stages of her journey, Kateryna required assistance, in particular in her search for accessible legal resources to implement changes in her life. However, she faced Ukraine's serious shortage of legal and social support for disabled people, especially those with mental illness. At present, public resources are insufficient and very chaotic.

* Name has been changed.

Department staff have huge potential for developing a culture of engagement related to risk factors for early life trauma, and for building awareness of the significance of early life trauma for the mental and physical health of children and adults. This engagement will contribute to the development of the country's system of preventive measures and treatment.

Department staff have huge potential for developing a culture of engagement related to risk factors for early life trauma, and for building awareness of the significance of early life trauma for the mental and physical health of children and adults. This engagement will contribute to the development of the country's system of preventive measures and treatment.

My colleague and I have been running a psychotherapeutic group in the women's inpatient department of the Lviv Regional Psychiatric Hospital, where the Department of Psychiatry and Psychotherapy is situated. Most of our patients suffer from severe, chronic psychiatric disorders, and most receive social aid (disability insurance); this aid is structured in a way that leads to feelings of helplessness and diminished worth, even during periods of remission. It is vital to develop legal services to protect such patients, both within their families and within society.

4.2 Destigmatizing mental health care in communities

By **Yuliana Maslak**, Child Psychiatrist and Psychotherapist at the Circle of Family Centre in Lviv, Ukraine

Working in the field of mental health, I pay particular attention to the consequences of trauma in early childhood. Short-term consequences most commonly include the development of behavioural difficulties, but some individuals suffer from severe behavioural problems with psychopathological development. The number of complaints of depression is growing, as are suicide attempts, self-inflicted injuries, psychoactive substance abuse, bullying in educational institutions, and emotional, physical and sexual abuse within families. It is my understanding that the key problems lie in the inadequate gratification of basic psychological needs by the family, as well as in negative peer influences. However, even if a family takes good care of their children, it is very easy to experience trauma in everyday life.

I observe how children experience conflict situations that match the profile of bullying starting from their time in preschool. Unfortunately, due to inadequate levels of social and emotional competence in our society, many still view these conflicts and dysfunctional behaviour strategies as normal and acceptable – even,

While more and more evidence concerning the negative impact of bullying is now available, schools lack comprehensive anti-bullying programmes and many people remain unaware of its very serious impact on the development of the future society of our country.

Psychoactive substance abuse with subsequent addiction at a young age is one of the biggest problems today. The accessibility of alcohol and a lack of unawareness of its consequences only contribute to the problem.

at times, beneficial. As children grow up, this leads to increasingly serious intimidation, persecution and bullying in secondary schools. While more and more evidence concerning the negative impact of bullying is now available, schools lack comprehensive anti-bullying programmes and many people remain unaware of its very serious impact on the development of the future society of our country (41).

A large percentage of adolescents who consult a specialist have difficulties with emotional regulation and impulsivity. To cope with these issues and in an attempt to satisfy boredom, they resort to various pathologic or risky behaviours and coping strategies such as self-harm and drug and alcohol abuse. Psychoactive substance abuse with subsequent addiction at a young age is one of the biggest problems today. The accessibility of alcohol and a lack of unawareness of its consequences only contribute to the problem. The proliferation of non-contact sales of psychoactive substances through social networking websites and messaging applications is also a serious issue in Ukraine. Police, mental health professionals, physicians, parents, NGOs and activists are working to engage citizens in positive solutions.

In a cultural context, seeking support from a specialist in the early stages of problematic behaviour development arouses shame among certain segments of the population. Many find it difficult to understand that psychological support can have a preventive effect, and instead perceive it as a stigma. Bringing up a stigmatized issue with a client can be quite painful, because they may suspect questions to be aimed at the detection of mental pathologies rather than at prevention and care.

Anonymous counselling centres and collaborative prevention efforts can help in the struggle against drug and alcohol addiction. People healing from addiction who have the courage to share their stories can also serve as mentors for others and inspire faith and motivation. Those who have recovered should be involved in awareness-raising work in schools and organizations for adolescents.

Scientifically grounded, high-quality psychological services are available to individuals who are willing to change. Unfortunately, however, most assistance services cost money and are thus not always affordable for vulnerable social groups. The support of charitable

The cooperation of educational psychologists with qualified mental health specialists to provide high-quality services (often at school) lowers the risk of young people developing severe pathology related to trauma. Programmes to support the development of parenting skills among vulnerable social groups can also increase their ability to build healthy relationships and potentially lower the risk of disorder development.

organizations and the development of new governmental assistance programmes will be needed to address these financial barriers.

Multidisciplinary teams comprised of psychiatrists, psychologists, social workers and other physicians are also key to helping people who have experienced early life trauma. The provision of medical assistance, psychological interventions and social support is often a result of good teamwork. The cooperation of educational psychologists with qualified mental health specialists to provide high-quality services (often at school) lowers the risk of young people developing severe pathology related to trauma. Programmes to support the development of parenting skills among vulnerable social groups can also increase their ability to build healthy relationships and potentially lower the risk of disorder development.

I consider good communication between qualified psychologists and at-risk adolescents to be an effective tool for addressing early life trauma. Ideally, this leads to synchronized efforts and therapeutic interventions throughout the life spheres of children and adolescents (school, home, places of leisure, etc.). Yet such coordinated work is inhibited by the fact that society as a whole lacks modern scientific knowledge of the impact of early life trauma and mental illness. This is true even among specialists who deal with children and adolescents, such as educational psychologists. This acts as a barrier to proper diagnostics, psychoeducation and interventions.

4.3 Building capacity within schools to detect and respond to early life trauma

By **Lidiia Bozhenko**, Methodologist at the Lviv Teaching Resource Centre for Education; Supervisor of Psychological Services for the Lviv Educational System, Ukraine

Ukrainian legislation defines many categories of children in difficult life circumstances, including children who have lost one or both parents due to war or other circumstances, children affected by disaster or violence, children with a disability, children living in poverty, children of forced internal migrants, and others. Yet several barriers impede the delivery of assistance to these vulnerable groups.

In some Lviv schools, school psychologists hold courses to teach parents about early childhood development and the influence of parenting strategies and social factors on children's states of mind.

First, there is a shortage of school psychologists and pedagogues in schools. Second, according to Ukrainian legislation, assistance can be provided only with permission from the child's parents or guardian, and thus it is not always possible to detect a child's trauma if parents are unwilling to report it. Third, school psychologists lack clear criteria for defining trauma and for providing further assistance both within and outside of the educational institution. Finally, as children in difficult life circumstances are often from low-income families, it is harder for them to access professional psychotherapeutic assistance.

On the positive side, close cooperation occurs between the social service offices for children and families, and with the department of child services that provides eligible families with appropriate assistance. Various NGOs also offer professional education and training to school psychologists and pedagogues. In some Lviv schools, school psychologists hold courses to teach parents about early childhood development and the influence of parenting strategies and social factors on children's states of mind. Lviv also has distinct cultural traditions that contribute significantly to early childhood development, including religious preferences, traditions, celebrations, etc. The church community eagerly helps children who find themselves in difficult circumstances.

Nevertheless, for psychological, economic and legal reasons, it is often impossible for children in an unhealthy or unsafe situation to leave their social environment. When it is possible, it is only temporary. For example, if a child experiencing domestic violence tells a psychologist of the problem, the psychologist can inform the appropriate services to relocate him or her for a certain period of time. However, without serious grounds to remove the child from the family, he or she will return within the month and may face worsened consequences at home. Ukraine does not have a state programme for working collaboratively to support addicted or abusive parents, and it can be extremely difficult to engage the whole family in finding solutions.

On the state level, work to open family-style children's homes is in progress, but the number of families willing to participate is inadequate due to low levels of motivation and lack of understanding of their role in the process. At present, Lviv has one such children's home and potential to open a second, but each

To detect trauma, cooperation with teachers and educational assistants works well; they are often the ones to alert a school psychologist when they notice alarming changes in a child's behaviour. Close cooperation with public social services can also help to ensure that families receive assistance. Detection and response are even more effective when educational psychologists have psychotherapeutic education as well as relevant professional skills.

can accept a maximum of only 15 children – this is insufficient to meet demand.

Detecting early life trauma can be difficult. Families often carefully conceal problems such as abuse, addiction, poverty, neglect and even serious illness. Children may suffer for long periods and receive emotional support only after a crisis. To detect trauma, cooperation with teachers and educational assistants works well; they are often the ones to alert a school psychologist when they notice alarming changes in a child's behaviour. Close cooperation with public social services can also help to ensure that families receive assistance. Detection and response are even more effective when educational psychologists have psychotherapeutic education as well as relevant professional skills.

To build resilience to early life trauma in Ukraine, the country must provide basic psychological education to everyone involved in educating and raising children, including information on the importance of early intervention and the types of assistance available. Schools could seek assistance from medical centres for cases of early sexual activity, drug abuse, etc., and actively involve local communities, such as members of apartment cooperatives where vulnerable children reside, in watching out for their interests. Schools could also increase vulnerable children's access to various extracurricular activities after school, on weekends and during holidays, when they would normally be alone with their troubles.

Free psychological assistance to families unable to pay, perhaps at outpatient departments, churches, social service offices, etc., would increase the accessibility of care. Finally, better legislation regarding working with families would make it easier to assist children in unsafe family circumstances.

4.4 Strengthening ethical frameworks for journalists reporting on trauma

By **Marharyta Tulup**, Journalist in Kyiv, Ukraine

Journalists must comply with standards and ethical regulations for media content in order to protect children, and yet Ukrainian mass media sources still regularly violate the rights of children.

Yet journalists who lack psychological training and a sense of responsibility are unable to assess the risks of poor communication with vulnerable children or the use of unethical images of children. Their careless treatment of victims of early life trauma is not necessarily deliberate, but is often due to ignorance and the rush to meet tight deadlines.

They traumatize children either directly during content creation (during interviews, for example, or when they use images of children for greater impact and to increase the number of views), or indirectly through children's consumption of disturbing content.

Unfortunately, because our society lacks a culture of seeking professional psychological and psychotherapeutic assistance, journalists do not always consult with these experts when working on stories related to early life trauma. Yet journalists who lack psychological training and a sense of responsibility are unable to assess the risks of poor communication with vulnerable children or the use of unethical images of children. Their careless treatment of victims of early life trauma is not necessarily deliberate, but is often due to ignorance and the rush to meet tight deadlines.

According to legislation, journalists are allowed to show the faces of children and adolescents under the age of 18 only with the consent of their parents or guardians. However, without an efficient sanction system on the part of regulatory institutions and in the absence of consequences, journalists do not always adhere to such frameworks. Even when journalists do conceal the face of a child, they may still provide enough details to enable viewers to identify him or her. Additionally, when seeking consent to show a child's face, journalists may fail to consider the emotional stability and circumstances of the adults who grant permission. Parents or guardians may be traumatized and unable to properly assess the possible negative consequences of publicity, or may be seeking personal benefit from the content disclosure.

To improve the situation, the country should introduce sanctions for the unethical coverage of topics involving children, and additional legislation to safeguard children. Journalists and mass media outlets should participate in the development of such sanctions. It would also be worthwhile to develop a unified national system of smart symbols indicating age-specific content and to expand its application to television to warn of inappropriate or traumatic content.

Journalists' cooperation with experts and NGOs in the prepublication phase can also mitigate these issues. NGOs could also build stronger, longer-term relationships with the media by familiarizing journalists with their activities, disseminating newsletters and providing the contact information of subject-matter experts. These experts can

Case study 7

In February 2017, Ukrainian mass media first started covering a wave of adolescent suicides that appeared to be connected to online suicide games. Immediately, the Ukrainian police began posting about these so-called death groups on their social networking pages, and by mid-month they had released a list of online communities dangerous to children. In two days, journalists covered a story about two teenagers, referred to as “game victims”, who committed suicide in the west of the country. At the same time, the President of Ukraine issued the decree “On the threats to the cybersecurity of the country”. At the end of February, the police reported saving two girls from suicide, and then announced new victims in Kryvyi Rih, Ternopil and Kherson Region. Following these events, the President issued the decree “On cybersecurity policy”.

Overall, the media’s discussion of the suicides centred on building an image of the internet as an enemy. Such intonations triggered moral panic among the population and also enhanced interest among teenagers – those who did not know about the games got to know them, and those who were already familiar with them sensed that the stakes had gone up. Some were intrigued by the prospect of playing with something that was instilling fear in society.

One of the most popular television shows in the country dedicated a 90-minute programme to the topic of death groups, asking, “Who is behind the screen commanding children to kill themselves?” The episode received half a million views, and many more people likely watched the show online. In their coverage of the deaths, the media described details of how and when the suicides had occurred, posted suicide notes and photos of the bodies with their faces blocked out, called the suicides “romantic” and noted that the young people sought out “a special way” to kill themselves.

In this situation, journalists made several mistakes. Critically, they failed to confirm the relationship between the deaths or to question whether this online activity was in fact the trigger or motivation for suicide. This resulted in misleading and factually incorrect reporting: in the end, none of the suicides were found to be a result of the group activities. They also used emotionally charged vocabulary in their coverage of the deaths, and failed to seek commentary from experts.

Finally, journalists did not provide information on how young people could overcome psychological pressure or seek professional psychological assistance, or how parents could help their children if they suspected they were at risk. Rather than prompting parents to talk to their children from a perspective of interest and care, the media urged them to strengthen their control of children by inspecting their arms for signs of self-harm, restricting their time on the internet, secretly monitoring the content of their online communications, etc. Such recommendations imply that children are objects rather than subjects, and send the message that difficult topics such as depression and death are taboo. Yet if these are taboo subjects at home and in society, talking of them will be outsourced to other communities.

Enhanced training could enable journalists to participate in awareness-raising initiatives and create educational content related to early life trauma. This would help to build a positive culture among journalists in which colleagues uphold ethical frameworks and point out violations to one another. It could also support journalists to cope with personal burnout caused by constantly witnessing and reporting on traumatic situations.

report journalists' errors or inappropriate activities to regulatory institutions or point them out to content authors to prevent operational mistakes. Experts could also encourage journalists to show positive norms of behaviour and to cover stories of people healing from common forms of early life trauma. This could counter the trend of disproportionately covering cases of extreme trauma, which can distort society's perception of their frequency and normalcy.

At present, journalism curriculum in Ukraine does not include psychological or legal training or address issues related to early life trauma. To fill these gaps, experts could offer to teach workshops in faculties of journalism to help future journalists understand how trauma influences brain functioning, identify signs of early life trauma in children and adults during communication, and learn techniques to avoid re-traumatizing these individuals during interviews.

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4.5 Challenging norms of alcohol abuse to build resilience in communities

By **Ihor Kozankevych**, Priest of the Ukrainian Greek Catholic Church; Head of For the Sobriety of Life; Director of Caritas (Sambir–Drohobych Eparhy); Head of the Nazareth Rehabilitation Centre, Ukraine

Several important factors influence the prevalence of early life trauma in Ukraine, including the protracted economic crisis; a post-Soviet mentality characterized by feelings of inferiority and discouragement; the ongoing violence in eastern regions of Ukraine that continues to cause great tension and stress; forced internal migration; and the mass migration of Ukrainians to other countries to study and work. As a result, Ukraine experiences high mortality rates and low levels of medical and social care, lacks highly qualified experts and high-quality programmes with adequate funding, and has low levels of awareness of early life trauma and other dangers.

All of this leads to self-destructive behaviours, including alcohol and drug abuse and gambling addiction. As of 2018, annual alcohol consumption in Ukraine was equal to 8.6 litres of pure alcohol per capita (42). A 2019 UNICEF study found that, by the age of 10, 14% of Ukrainian children have already consumed alcohol at least once; among 17-year-olds this figure rises to over 60% (43,44). Twenty-five percent of adolescents have been intoxicated at least once in their lives, with figures of 6.4% for 10-year-olds and 48.0% for 17-year-olds (43,44).

According to Iryna Ivanchuk, Head of the Section on Substitution Maintenance Therapy of the Centre of Public Health of the Ministry of Health of Ukraine, an estimated 346 000 people use injecting drugs in Ukraine. Considering the spread of new forms of addictive substances, the number of drug-addicted people is likely much higher (45). Every tenth child is born with various health issues as a consequence of alcohol or drug use by parents before or during pregnancy (46,47).

Many cultural norms in Ukraine exacerbate the situation of early life trauma. In terms of traditions, holidays both large and small involve drinking alcohol. Even in schools, some young people gather to “celebrate” the completion of exams with alcohol. All toasts and wishes are pronounced holding a glass, and drinking the entire glass is viewed as a sign of respect. Songs and jokes referencing drunkenness are common. During town and city celebrations, bars are set up in the squares on a massive scale, and widespread binge drinking takes place while children are present.

In everyday life, it is customary to invite others for a drink of strong spirits such as vodka. If someone declines the drink, it is often viewed negatively. In many families, parents allow children as young as 14 to drink a small amount of alcohol at home. People also consume alcoholic beverages in the workplace, and many do not consider it a problem to drink a small amount of alcohol and get behind the wheel of a car.

Alcohol is comparatively cheap and accessible, and can be purchased in many shops at any time. Punishment for producing and distributing illegal alcohol is inadequate, as is punishment for corruption in this sector. It is clear that legislative frameworks must be improved.

Overall, our society resorts to stereotypes of alcohol as a curative or tonic that reduces fatigue and gives courage. Thus it is very important to create greater social awareness of the risks of alcohol consumption, to change perceptions of alcohol and drunkenness, and to create new traditions.

Overall, our society resorts to stereotypes of alcohol as a curative or tonic that reduces fatigue and gives courage. Thus it is very important to create greater social awareness of the risks of alcohol consumption, to change perceptions of alcohol and drunkenness, and to create new traditions.

Although churches have adopted resolutions regarding the reduction of alcohol consumption, believers remain quite tolerant of alcohol and holy days are often accompanied by banquets with excessive drinking. Yet positive cultural influences are also at play in the context of the Church. Believers may inflict less harm on others and overcome trauma more quickly with the support of their faith. The Church also has a tradition of abstinence from alcohol, for example, during the period of Lent.

The Nazareth Rehabilitation Centre for those who suffer from alcohol, drug or gambling addiction has been operating for 15 years at Caritas Ukraine. Larger Caritas centres throughout Ukraine feature a network of 17 child and family counselling centres that deal with early life trauma. The Ukrainian Greek Catholic Church subcommittee For the Sobriety of Life also lobbies for changes on the legislative level, organizes awareness-raising campaigns in schools and through social media networks, provides consultations through a hotline, informs and trains clergy on the prevention of early life trauma, and engages the academic community at Drohobych State Pedagogical University in the development of preventive measures and assistance to children impacted by early life trauma.

A situation analysis of early life trauma and a national plan would be helpful in driving this work forward. We must also continue to develop solutions in collaboration with international experts and NGOs, and to train experts in counteracting early life trauma.

The main factor that influences early life trauma management in the legal sphere is the legislative framework. A large number of legal provisions in Ukraine date back to the Soviet era, and new legal provisions are in one way or another influenced by the principles of Soviet law. This negative trend is on the decline, but has not yet disappeared completely.

4.6 Protecting the rights of children in the legal system

By **Stanislav Borisov**, Lawyer in Kharkiv, Ukraine; and **Benedetta Ubertazzi**, Attorney in Milan, Italy; Aggregate Professor in the School of Law, University of Milano-Bicocca, Italy; Facilitator and Evaluator for Intangible Cultural Heritage, United Nations Educational, Scientific and Cultural Organization

People encounter early life trauma in the legal sphere mainly during trials or pre-trial investigations by law enforcement authorities. A significant number of cases considered in the courts of Ukraine (civil and criminal) in one sense or another concern a child or somehow negatively affect a child's life. Children may have been victims or witnesses of a crime, or be negatively impacted by the lawsuit itself, such as in alimony civil cases or cases to determine their place of residence or parental visitation rights.

Current legislation in Ukraine provides specific conditions and procedures to protect children during pre-trial investigations and during trials. In general, most officials of public and law enforcement authorities have sufficient knowledge and skills to work effectively with children. However, some issues have no legislative regulation, and when officials lack clear protocols for difficult situations, they may fail to take initiative to look for a solution on their own.

The main factor that influences early life trauma management in the legal sphere is the legislative framework. A large number of legal provisions in Ukraine date back to the Soviet era, and new legal provisions are in one way or another influenced by the principles of Soviet law. This negative trend is on the decline, but has not yet disappeared completely. At the same time, Ukraine's more recent legislation has been developed under the influence of applicable international laws and regulations. This can lead to legal conflicts when the provisions of international and national legislation do not concur.

Public and law enforcement officials have a strong tradition of working with children in a particular way. Most commonly, this involves giving priority to the opinions of parents or other authorized adults rather than to those of children. Article 160 of the Family Code of Ukraine, for example, dictates that the place of residence of children aged 10 years or older is determined by the consent of the parents

To better protect children in Ukraine, national legislation must be brought in line with the provisions of international and European legislation, and standard procedures must be developed for specific situations. It is also necessary to train lawyers, judges and civil servants in basic methods for working with children in line with international and European standards, and in the peculiarities of procedures and processes.

and of the child – this means that officials may not even consider the opinion of a child under the age of 10. Yet with the assistance of qualified professionals such as child psychologists, it is entirely possible to learn the preferences of a younger child and to take these into account while deciding a case to their benefit. In the legal sphere, this type of collaboration functions very well.

To better protect children in Ukraine, national legislation must be brought in line with the provisions of international and European legislation, and standard procedures must be developed for specific situations. It is also necessary to train lawyers, judges and civil servants in basic methods for working with children in line with international and European standards, and in the peculiarities of procedures and processes. Finally, we must ensure that information on how to involve relevant experts such as psychologists is readily available, including their contact details.

Case study 8

In a civil case, I was representing the interests of a psychiatrist who provided consultative assistance to a child at the mother's request. Following a divorce, the child resided with the mother, though the parents were engaged in a legal case regarding parental and visitation rights. One day, the father used physical force to take the child from the mother; this terrified the child, and as a result the child began suffering from panic attacks, incontinence, sleep disturbances and so forth.

Based on the consultation with the child, the psychiatrist provided recommendations that the father was not satisfied with. The father filed a legal claim deeming the psychiatrist's actions and conclusions illegal. The Ukrainian courts settled the father's claim and deemed the psychiatrist's actions and conclusions illegal because the consultation with the child had been conducted without the father's consent. Although international regulatory documents allow for the delivery of children's health services at the request of one parent, national legislation requires the consent of both.

Such a court judgement sets a dangerous precedent that can paralyse the delivery of psychiatric help to children if only one parent is seeking assistance. Discrepancies between national and international legislation provisions can also lead to the abuse of parents' rights and to numerous lawsuits.

Case study 9

As described above, some situations involving children are not regulated by law, leaving civil servants and law enforcement officers without clear instructions or protocols. An example of such a situation is the adoption of a 16-year-old boy living in one of the orphanages of Ukraine by a family of foreigners. Through our participation in this case, we came to understand that the adoption process in Ukraine is very complex and contains many unnecessary bureaucratic elements. In addition, the country's adoption procedures are inconsistent with international legal documents, namely those that safeguard the fundamental right of a child to be heard.

In this case, such inconsistencies created particular difficulties when the boy's biological parents and relatives repeatedly asked the administration of the orphanage to share information about him and to arrange visitation sessions. These demands were contrary to the will of the boy, who expressly stated that he wished to have no contact with his biological family. Despite the clear expression of his wishes, the administration did not know how to respond. This confusion stemmed from a lack of clear guidelines for establishing boundaries between the boy and his biological family in line with international procedures for handling such difficult situations.

For instance, Article 4 of the United Nations Convention on the Rights of the Child stipulates that certain procedures for hearing the child and recognizing their wishes must be established and must prioritize the interests of the child (15). A conflict of interest between the wishes of the child and those of the parents necessitates a special representative in proceedings before a judicial authority (48). Such procedural guarantees are also established by Article 12 of the Convention, which details the proper methodology for hearing the views of children and their inclusion in all matters affecting them (15). The European Court of Human Rights (49) and the Charter of Fundamental Rights of the European Union (50) affirm these rights, stipulating:

in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration (48).

In this case, the lack of guidelines negatively affected all parties: the boy because he did not want to talk with his biological parents and relatives, the adopters because they did not want to disseminate information about themselves and the boy, and the administration because their actions (or lack thereof) could have led to the violation of the lawful rights of others involved in this case.

The 16-year-old boy, whose views were based on his own negative experiences with his biological family and the environment they provided for him, and who was fully capable of forming his own opinion, clearly met the criteria set by international legal precedent for the recognition of a child's voice and interests (15,49). To defend his right to be heard, his representatives collaborated with a lawyer who explained to the administration of the orphanage what they could and could not do according to the legislation of Ukraine. In addition, the lawyer was able to assert, with reference to the legislation of Ukraine, that the demands of the biological parents and relatives were illegal and could violate the aforementioned interests of the boy and his adopters.

As a compliment to the Ukrainian legislation, it should be noted that the interests and desires of the child are taken into account by the court. In this case, the boy participated in court sessions and had his opinion repeatedly heard by the court. The most important question to which he responded in court was that of his personal consent to his adoption by this family, which he affirmed. Without the legal help of the lawyer, however, the interests of the boy and the adopters could have been violated. Thus, it was wise of the adopters to seek the legal help of a Ukrainian lawyer.

5. Conclusions

5.1 Cultural contexts of early life trauma

While Belarus and Ukraine differ in important ways, the essays reveal a number of shared social and cultural contexts that undermine resilience to early life trauma. These include:

- widespread historical trauma, including oppressive social regimes, war and violence, family separation, and environmental crises;
- a lingering distrust of mental health professionals and subsequent reluctance to seek help, perpetuated in part by traditions of institutionalized mental health care that span social, clinical and political realms;
- the persistent stigmatization of mental ill health, including through obsolete discrimination practices that prevent individuals with mental or substance use disorders from obtaining a driving license or occupying some professions;
- a lack of modern legislation on preventing domestic violence, including to remove a violent spouse from the home;
- resistance to introducing modern sexual and reproductive health education in schools;
- insufficient understanding within governmental programmes of the relationship between early life trauma, mental ill health and noncommunicable diseases;
- the normalization of trauma and violence, including bullying in school environments and violent forms of discipline in homes, linked to inadequate understandings of trauma's individual and societal impacts;
- the normalization of unhealthy coping strategies such as alcohol abuse, combined with insufficient enforcement of age-related restrictions on the sale of alcohol and tobacco;

- siloed departments and agencies resulting in opaque decision-making processes and a lack of coherent support services across the life spheres of young people;
- a lack of accessible professional training and peer support for mental health professionals and school psychologists, leading to less effective interventions and high rates of burnout; and
- limited funding for services and support for those impacted by early life trauma.

Despite these challenges, efforts to build protective and health-enhancing cultural contexts for children and adults in Belarus and Ukraine are gaining traction. Throughout the essays, authors point to three key enablers for advancing this work:

- **evidence-based education and training** on early life trauma – what it is and how to recognize it, how it affects individuals and communities across the life course, and how to respond to it effectively;
- **clear roles, protocols and communication pathways** to activate and guide the response process; and
- **intersectoral partnerships and networks** spanning the life spheres of young people to leverage resources and build a continuum of support and care within communities.

5.2 Building resilience: considerations for policy-makers, organizations and communities

This section presents a number of ideas and opportunities identified in workshop discussions and the essays for weaving these enablers more deeply into the fabric of Belarusian and Ukrainian society. They are the result of a bottom-up, culturally centred approach that places the experiences and expertise of key stakeholders at the centre of the analytical process. As such, they do not express any opinion on the part of WHO. They may be more or less relevant in each of the countries, and will play out differently in unique national contexts.

5.2.1 Popular culture and the media

- Members of the media could partner with NGOs and public health agencies to develop a coherent message on early life trauma and mental health, and coordinate the use of social media platforms to share evidence, challenge stereotypes and generate dialogue.
- Journalism/communications programmes could invite experts to teach modules on early life trauma and mental health. Journalists could also participate in the development of more robust legislation to protect young people's rights during content creation, including through communication protocols and consultation with subject-matter experts when reporting on trauma-related events.
- Other cultural influencers such as writers, filmmakers, theatre groups, artists and radio personalities could be engaged more systematically in the creation of socially oriented content that builds public awareness of early life trauma and mental health issues. Survivors of trauma and people living with mental health conditions who have the courage to share their stories could be given more opportunities to speak and teach.

5.2.2 Homes and communities

- Communities could expand support groups and programmes for parents and carers to promote positive parenting strategies, build understanding of early childhood development and increase receptivity to the emotional life of children.
- Communities could strengthen networks of caring adults who are aware of children's rights and invested in protecting them, such as health professionals who conduct home visits and neighbourhood/apartment associations. Trainings, pocket guides and other information products could be helpful tools.
- Community workers could conduct screenings for alcohol and drug abuse, provide brief interventions and referrals to treatment for those in need, and provide further support to families in reducing substance abuse.

- Communities could seek opportunities to offer free, informal mental health services such as peer support or service-user groups in community spaces (town halls, churches, etc.) to increase accessibility and emphasize integration and recovery.

5.2.3 Schools

- Ministries of education and educational institutions could build the capacity of teachers and school psychologists to protect and support students by offering professional training in trauma detection and response, by reducing workloads through the creation of more positions, and by developing professional networks to share information, resources and emotional support.
- Schools could challenge cultural norms of intimidation and bullying through dedicated programmes that include staff training and professional support to recognize and address harmful behaviours. This awareness could be transferred to students through class presentations, creative projects, mentorship opportunities and anti-bullying student groups.
- Schools could help to protect the health and well-being of children and adolescents by introducing comprehensive, age- and development-appropriate sexuality and reproductive health education.
- Schools could expand children's access to safe spaces by providing more activities after school and on weekends, especially for those at greater risk of social exclusion (those living in poverty, with disabilities, etc.).
- Schools could establish stronger links with health centres and social service organizations to prevent children and adolescents from falling through cracks in the system.

5.2.4 Health-care systems

- More affordable, accessible, evidence-based training on early life trauma for medical students and health workers could streamline

trauma prevention and care. Specialized education is especially important for paediatric psychotherapists.

- Broader incentives to recruit and retain qualified mental health professionals could shift organizational cultures and increase the focus on prevention and integrated care.
- More multidisciplinary teams with clear referral pathways and responsibilities could improve service provision and continuity of care.
- Tutorials and pocket guides on legal issues could reduce health workers' uncertainty and stress regarding the legal implications of assisting traumatized children and adolescents.
- More collegial support groups and platforms for sharing could provide mental health professionals with opportunities to connect, discuss difficult cases and avoid burnout.
- Ending discriminatory practices – such as reporting diagnoses of mental or substance use disorders to ministries of the interior and road police – would protect patients' confidentiality and access to opportunities, and diminish fears related to seeking care.

5.2.5 Religious communities

- Religious leaders could build on the traditional role of the church as a safe space for people impacted by trauma or mental ill health by developing stronger relationships with mental health professionals. Joint activities such as presentations and support groups within churches could open pathways to comprehensive care.
- In collaboration with mental health professionals, churches could build awareness of religious folk beliefs and ascetic practices that may exacerbate mental health conditions.

5.2.6 Legal and governmental systems

- Legal systems could better protect children by further aligning with international human rights treaties, particularly legislation on the right of the child to be heard and the right of the child to be raised in a family environment. A clear distribution of responsibilities among governmental agencies for carrying through systemic change could streamline communication and improve efficiency.
- Courts could strengthen protocols for including qualified mental health professionals in cases involving children, and make every effort to consider children's experiences, needs and rights in investigations and trials. Regular training and reviews for legal professionals would build capacity in this area.
- In some cases, governments could clarify legislation related to working with families in difficult situations, including the process of removing children from unsafe family circumstances and ensuring children's access to psychological support.
- Governments could implement national actions to reduce alcohol consumption – such as stronger enforcement of age-related restrictions on retail sales, restrictions on alcohol availability, pricing policies to increase the cost of alcohol, drink-driving countermeasures, and bans or comprehensive restrictions on alcohol promotion – to shift societal attitudes towards drinking, lower the incidence of alcohol abuse and interrupt related cycles of trauma.
- Governments could implement broad poverty-prevention and social support programmes to reduce financial and psychological pressure on biological and foster/adoptive families. The inclusion of more counselling, education and employment opportunities could empower service users.

5.2.7 Nongovernmental and charitable organizations

- Collaboration with research initiatives could build the evidence base for social interventions and strengthen applications for funding to expand programming.
- Additional partnerships with governmental organizations and the private sector could leverage resources and broaden outreach, furthering efforts to raise public awareness and shift cultural norms. New communication platforms, intersectoral workshops and venues for collaboration would facilitate this.

5.3 Towards a culture of collaboration

The workshops and essays on understanding and building resilience to early life trauma in Belarus and Ukraine represent a culturally nuanced approach to the reform of mental health care that integrates lived experience into an expanded evidence base. This approach involves listening to and amplifying the voices of those most intensely involved in and personally impacted by work in the field of early life trauma. It acts on the strong recommendation that professionals, researchers and policy-makers re-evaluate assumptions of what constitutes evidence while critically examining their own shared values and priorities related to health and well-being (51).

This approach also responds to the call for building cultures of collaboration among stakeholders in mental health-care reform in central and eastern Europe (16). By gathering the perspectives and experiences of people working in different sectors, it seeks to break down silos, facilitate the identification of common goals and unique approaches, and build solidarity. Workshops participants in Belarus and Ukraine voiced their appreciation for a space in which, as professionals and as people, they were encouraged to discuss their challenges, ideas and hopes with the aim of discovering a shared vision. In presenting their contributions in their own words, this report aims to generate further interest in and opportunities for working together to address this under-researched area of mental health in the WHO European Region.

References

1. Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2016 Reference Life Table. Seattle: Institute for Health Metrics and Evaluation; 2017.
2. Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *Lancet*. 2013;382(9904):1575–86. doi: 10.1016/S0140-6736(13)61611-6.
3. Krupchanka D, Winkler P. State of mental healthcare systems in Eastern Europe: do we really understand what is going on? *Br J Psych Int*. 2016; 13: 96–9.
4. Winkler P, Krupchanka D, Roberts T et al. A blind spot on the global mental health map: a scoping review of 25 years' development of mental health care for people with severe mental illnesses in central and eastern Europe. *Lancet Psychiatry*. 2017;4(8):634–42. doi: 10.1016/S2215-0366(17)30135-9.
5. Shonkoff J, Garner S, Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption and Dependant Care, Section on Developmental and Behavioural Pediatrics et al. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1):e224–e231. doi: 10.1542/peds.2011-2662.
6. Von Korff M, Scott K, Alonso J, Angermeyer MC. Mental-physical co-morbidity and its relationship with disability: results from the World Mental Health Surveys. *Psychological Medicine*. 2009;39(1):33–43. doi: 10.1017/S0033291708003188.
7. Kessler R, McLaughlin KA, Green JG, Gruber MJ, Sampson MA, Zaslavsky AM et al. Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *BJP*. 2018;197(5):378–85. doi: 10.1192/bjp.bp.110.080499.
8. Herzog JI, Schmahl C. Adverse childhood experiences and the consequences on neurobiological, psychosocial and somatic conditions across the lifespan. *Front Psychiatry*. 2018;9:420. doi: 10.3389/fpsy.2018.00420.

9. Bloomfield M. Trauma and post-traumatic stress disorder: children should be seen and heard. *Lancet Psychiatry*. 2019;6(3):193–4. doi: 10.1016/S2215-0366(19)30037-9.
10. Adverse childhood experiences and health-harming behaviours among students in Ukraine. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0004/370390/ace-ukraine-eng.pdf?ua=1, accessed 14 June 2019).
11. European mental health action plan 2013–2020. Copenhagen: WHO Regional Office for Europe; 2015 (http://www.euro.who.int/__data/assets/pdf_file/0020/280604/WHO-Europe-Mental-Health-Action-Plan-2013-2020.pdf, accessed 14 June 2019).
12. Investing in children: the European child and adolescent health strategy 2015–2020. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0010/253729/64wd12e_InvestCAHstrategy_140440.pdf?ua=1, accessed 14 June 2019).
13. Gospodarevskaya E, Segal L. Cost-utility analysis of different treatments for post-traumatic stress disorder in sexually abused children. *Child Adolesc Psychiatry Ment Health*. 2012;10(6):15. doi: 10.1186/1753-2000-6-15.
14. WHO Regional Office for Europe, United Nations Interagency Task Force on NCDs, United Nations Development Programme. Prevention and control of noncommunicable diseases in Belarus. The case for investment. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0010/367561/bizz-case-bel-eng.pdf?ua=1, accessed 5 September 2019).
15. United Nations Convention on the Rights of the Child. Geneva: Office of the United Nations High Commissioner for Human Rights; 1990 (<https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>, accessed 14 June 2019).

16. Culture and reform of mental health care in central and eastern Europe. Copenhagen: WHO Regional Office for Europe; 2018 (<https://apps.who.int/iris/bitstream/handle/10665/312314/9789289053075-eng.pdf?sequence=1&isAllowed=y>, accessed 14 June 2019).
17. Gerlach C. Kalkulierte Morde: die deutsche Wirtschafts- und Vernichtungspolitik in Weißrußland, 1941–1944 [Calculated murders: the German economic and extermination policy in Belarus, 1941–1944]. Hamburg: Hamburger Edition; 2000 (in German).
18. Hasin D, Grant B. National Epidemiologic Survey of Alcohol and Related Conditions (NESARC) waves 1 and 2: review and summary of findings. *Soc Psychiatry Psychiatr Epidemiol*. 2015;50(11):1609–40. doi: 10.1007/s00127-015-1088-0.
19. Afifi TO, McMillan KA, Asmundson GJ, Pietrzak RH, Sareen J. An examination of the relation between conduct disorder, childhood and adulthood traumatic events, and post-traumatic stress disorder in a nationally representative sample. *J Psychiatr Res*. 2011;45(12):1564–72. doi: 10.1016/j.jpsychires.2011.08.005.
20. Park S, Hong JP, Jeon HJ, Seong S, Cho MJ. Childhood exposure to psychological trauma and the risk of suicide attempts: the modulating effect of psychiatric disorders. *Psychiatry Investig*. 2015;12(2):171–6. doi: 10.4306/pi.2015.12.2.171.
21. Kessler R, McLaughlin KA, Green JG, Gruber MJ, Sampson MA, Zaslavsky AM et al. Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *Br J Psychiatry*. 2018;197(5): 378–85. doi: 10.1192/bjp.bp.110.080499.
22. Brown, DW, Anda RF, Tiemeier H, Felitti VJ, Edwards VJ, Croft JB, Giles WH. Adverse childhood experiences and the risk of premature mortality. *Am J Prev Med*. 2009;37(5):389–96. doi: 10.1016/j.amepre.2009.06.021.
23. Республика Беларусь : стат. ежегодник, 2003 [Belarus annual statistical report, 2003]. Minsk: National Statistical Committee of the Republic of Belarus; 2003 (in Russian).

24. Global health estimates [website]. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/global_burden_disease/en/, accessed 1 July 2019).
25. Global status report on alcohol and health 2018. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf?ua=1>, accessed 5 August 2019).
26. О положении молодежи в Республике Беларусь в 2017 году [National report on the state of youth in the Republic of Belarus in 2017] Minsk: Ministry of Education of the Republic of Belarus; 2018 (in Russian) (http://nihe.bsu.by/images/mol-pol/Национальный_доклад_О_положении_молодежи_в_РБ_за_2017.pdf, accessed 14 June 2019).
27. Краткий отчет по результатам исследования «Оценка ситуации с насилием в отношении детей в Республике Беларусь» [Summary report on the results of the study “Evaluation of the situation of violence against children in the Republic of Belarus”]. Minsk: UNICEF Belarus; 2018 (in Russian) (<https://www.unicef.by/uploads/models/2018/04/unicef-belarus-vac-report-2018.pdf>, accessed 14 June 2019).
28. UNICEF annual report 2017: Belarus. Minsk: UNICEF Belarus; 2017 (https://www.unicef.org/about/annualreport/files/Belarus_2017_COAR.pdf, accessed 14 June 2019).
29. Belarus country profile – European facts and the Global status report on violence prevention 2014. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0003/301584/Belarus-GSRVP-2014-en.pdf?ua=1, accessed 5 September 2019).
30. Республика Беларусь : стат. ежегодник, 2018 [Belarus annual statistical report, 2018]. Minsk: National Statistical Committee of the Republic of Belarus; 2018 (in Russian) (<http://www.belstat.gov.by/en/>, accessed 1 June 2019).
31. Wolowyna O, Plokhyy S, Levchuk N, Rudnytskyi O, Kovbasiuk A, Shevchuk P. Regional variations of 1932–34 famine losses in Ukraine. *Canadian Studies in Population*. 2016;43:175–202.

32. Klicperová-Baker M. Post-communist syndrome. Budapest: Open Society Institute; 1999.
33. Kuznetsova I, Catling J, Mikheieva O, Round J, Babenko S. Mental health in Ukraine. The results of a national survey and interviews with professionals. Birmingham: University of Birmingham; 2019.
34. Ougrin D, Gluzman S, Dratcu L. Psychiatry in post-communist Ukraine: dismantling the past, paving the way for the future. *Psychiatrist*. 2006;30:456–9.
35. Ukraine: humanitarian response plan, January–December 2018. New York: United Nations Office for the Coordination of Humanitarian Affairs; 2018 (<https://www.who.int/health-cluster/countries/ukraine/Ukraine-2019-HRP.pdf?ua=1>, accessed 4 September 2019).
36. Mental health in Donetsk and Luhansk oblasts – 2018. Kyiv: Kyiv International Institute of Sociology; 2018 (https://reliefweb.int/sites/reliefweb.int/files/resources/2018_mhpss_report_en.pdf, accessed 14 June 2018).
37. An evidence-based analysis of the psychosocial adaptability of conflict-exposed adolescents and the role of the education system as a protective environment. Kyiv: UNICEF Ukraine; 2019 (<https://www.unicef.org/ukraine/reports/evidence-based-analysis-psychosocial-adaptability-conflict-exposed-adolescents>, accessed 14 June 2019).
38. European Health Information Gateway: Ukraine [website]. Copenhagen: WHO Regional Office for Europe; 2019 (<https://gateway.euro.who.int/en/country-profiles/ukraine/#HBSC>, accessed 11 June 2019).
39. Underreported violence against children in Ukraine requires joint action. Kyiv: UNICEF Ukraine; 2019 (<https://www.unicef.org/ukraine/press-releases/underreported-violence-against-children-ukraine-requires-joint-action>, accessed 14 June 2019).

40. Religious belief and national belonging in central and eastern Europe. Washington (DC): Pew Research Center; 2017 (<http://assets.pewresearch.org/wp-content/uploads/sites/11/2017/05/15120244/CEUP-FULL-REPORT.pdf>, accessed 14 June 2019).
41. European status report on preventing child maltreatment. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/__data/assets/pdf_file/0017/381140/wh12-ecm-rep-eng.pdf?ua=1, accessed 5 September 2019).
42. Ukraine country profile. Copenhagen: WHO Regional Office for Europe; 2018 (https://www.who.int/substance_abuse/publications/global_alcohol_report/profiles/ukr.pdf?ua=1, accessed 14 June 2019).
43. UNICEF press release: Ukrainian adolescents neglect their health, eat unhealthy food and spend their lives on social networks [website]. Kyiv: UNICEF Ukraine; 2019 (<https://www.unicef.org/ukraine/press-releases/unicef-ukrainian-adolescents-neglect-their-health-eat-unhealthy-food-and-spend-their>, accessed 5 September 2019).
44. UNICEF, Oleksandr Yaremenko Ukrainian Institute for Social Research. Соціальна обумовленість та показники здоров'я підлітків та молоді [Social conditionality and indicators of adolescent and youth health in Ukraine]. Kyiv: UNICEF Ukraine; 2019 (in Ukrainian) (<https://www.unicef.org/ukraine/reports/social-conditionality-and-indicators-adolescent-and-youth-health-ukraine>, accessed 5 September 2019).
45. У МОЗ підраховали приблизну кількість ін'єкційних наркоманів [Ministry of Health estimates number of drug users] [website]. Kyiv: Ukrinform; 2019 (in Ukrainian) (<https://www.ukrinform.ua/rubric-society/2488445-u-moz-pidrahuvali-pribliznu-kilkist-inekciynih-narkomaniv.html>, accessed 14 June 2019).
46. Вживання алкоголю під час вагітності [Alcohol use during pregnancy] [website]. Kyiv: IBIS Birth Defects International Information System; 2019 (in Ukrainian) (<http://ukr.ibis-birthdefects.org/alcogol-use-during-pregnancy/>, accessed 14 June 2019).

47. All-Ukrainian population census. Kyiv: State Statistics Service of Ukraine; 2019 (<http://www.ukrcensus.gov.ua/eng/>, accessed 8 July 2019).
48. Ubertazzi B. The hearing of the child in the Brussels IIa Regulation and its recast proposal. *Journal of Private International Law*. 2017(3):568–601. doi: 10.1080/17441048.2017.1386262.
49. European Union Agency for Fundamental Rights, European Court of Human Rights, European Council. Handbook on European law relating to the rights of the child. Luxembourg: Publications Office of the European Union; 2019 (https://www.echr.coe.int/Documents/Handbook_rights_child_ENG.PDF, accessed 14 June 2019).
50. Charter of Fundamental Rights of the European Union. Luxembourg: Publications Office of the European Union; 2012 (<https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:12012P/TXT&from=EN>, accessed 14 June 2019).
51. Culture matters: using a cultural contexts of health approach to enhance policy-making. Copenhagen: WHO Regional Office for Europe; 2017 (http://www.euro.who.int/__data/assets/pdf_file/0009/334269/14780_World-Health-Organisation_Context-of-Health_TEXT-AW-WEB.pdf?ua=1, accessed 14 June 2019).

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