Trauma in refugees

Author: Stéphanie De Maesschalck

Case study

X. is an eight-year-old girl from Georgia. She is signed up because she faints or has a panic attack every time she sees a police officer or hears a siren. To protect her, parents decide to keep her inside as much as possible. She is also allowed to sleep with mum and dad again. In her home country, X. witnessed a raid on her home by soldiers. She saw her father being taken away violently. Despite her fears, X. goes to school and quickly picks up the language. But going to school becomes difficult because of anxiety attacks on the way to school.

General

- In a traumatic experience, the life or physical integrity is threatened: of the child himself or of someone important to that child, especially a care figure.
- The interpretation and reaction of parents and other adults are important for the child to assess the severity of an event.
- Traumatic experiences involve
    - thoughts about oneself, others and the world: I am helpless, I cannot trust anyone, it is my fault, ...
    - an overwhelming feeling of powerlessness, helplessness and fear
    - intense physical reactions: palpitations, accelerated breathing

Types of trauma

- **Acute**: a one-off event that lasts for a short time, e.g. a bus accident, a physical or sexual assault, seeing a loved one die.
- **Chronic**: multiple, traumatic events over an extended period of time. Chronic trauma makes the child more prone to a traumatic reaction to a new frightening event.
- **Complex**: a chronic trauma to which the child has been exposed before the age of 5 years. The trauma was caused by adults assumed to be care figures.

Trauma can have profound effects on the child's physical and psychological development, more specifically on

- reactions to stress
- adaptability to new situations
- a child's ability to trust others
- sense of personal security
- ability to manage emotions

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Effects of trauma

There are four types of traumatic stress reactions (DSM V):

1. **Relive**
    - penetrating thoughts
    - images, feelings and memories
    - nightmares
    - flashbacks
    - repetitive game

2. **Avoid**
    - Internal: painful memories, thoughts, feelings.
    - external: places, people, objects that evoke thoughts, feelings, memories of the trauma or things related to it.

3. **Negative thoughts and mood**
    - cannot remember important things about the trauma.
    - persistent negative beliefs or expectations about oneself, others, the world. Feeling alienated from others
    - persistent negative emotional state (fear, shame, guilt, ...)

4. **Hyperarousa**l
    - tantrums
    - irritability
    - reckless, self-destructive behaviour
    - concentration problems

Do the above reactions persist for more than a month and do they get in the way of a normal life (e.g. the child drops out of school and free time)? Then we speak of PTSD, **Post Traumatic Stress Syndrome.**

What do you see in the child?

- difficulty concentrating, learning or absorbing new information
- difficulty sleeping in and out, nightmares
- emotional instability
- nervous, skittish, anxious
- isolation in activities, from friends
- regression: functioning emotionally at a younger age
- traumatic play: repetitively repeating the trauma, taking the perspective of perpetrator, stuck in a particular moment, at a particular event (solidified in time), offering solutions.

➔ need for professional assistance!

Risk factors for developing PTSD

- age and stage of development
- temperament: anxious or sensitive disposition
- low intelligence
- previous stressful factors, e.g. unfavourable childhood, more trauma in the past
- previous psychiatric or developmental disorders
- lower social class
- non-availability or insufficient availability of adults
- insufficient or no normalisation of life after trauma
- bodily injuries
- permanent injuries
- offender and victim know each other
- be an offender yourself

Protective factors

- be religiously oriented
- a healthy self-awareness
- being in the labour market
- strong family and social support
- express feelings spontaneously

Role of resilience

- Resilience is the ability to continue living and developing despite adverse life circumstances (Rutter, 1985).
- Resilience is a potentiality, depending on
    - individual physiological and psychological characteristics
    - family and social context
- Resilience must be addressed!

Trauma in refugee children

Risk factors that increase the likelihood of PTSD in refugee (children):

1. **The nature of trauma**
    - chronic: war, persecution, ethnic conflict
    - frequent interpersonal violence
    - frequently witness the life or death of a care figure
    - being perpetrators themselves, e.g. child soldier

2. **Parental support is limitedly emotionally available** (or seemingly absent)
    - as a result of the war: family separation
    - specific vulnerability of unaccompanied minors
    - due to the parents' own trauma or fragilisation in their parenting by

- migration: parenting is preparing your child for a place in context, but parents do not always read this context properly.
- institutionalisation in collective reception structures.
- tension among parents due to lack of control.

3. **The migration process**
   - a massive loss experience
     - of your socio-cultural frame of reference
     - your trusted network
     - your identity (you remain who you used to be and you have to become who you are)
     - your role in society
   - different integration rates of different family members (circumstances sometimes change family roles)
   - the image of parents as protectors is often shattered (e.g. they have no say vis-à-vis human traffickers)
   - guilt towards the family left behind
   - an extra developmental task due to the changing environment: children have to create their own synthesis between the culture they bring from home and the culture of the new environment.

4. **An uncertain future/asylum procedure**

5. **Cultures adopting fatalistic and self-blaming coping mechanisms**

➔ All these factors make
- normalisation of life after trauma is not evident.
- recognised refugees often have a lower socio-economic status.
- care figures are often unavailable or inadequate.
- refugees have an increased prevalence of PTSD, depression and anxiety symptoms.

Treatment of PTSD in refugees

- Post Traumatic Stress Syndrome is a Vietnam War-era diagnosis for the classification and treatment of veterans' symptoms.
- This is a universal neurobiological response, with ethnocultural variation in its forms of expression. We mainly see avoidance symptoms, "numbing" and frequent somatic complaints
- Actually, this is a Western view, which reduces trauma to an individual pathology:
  - the vulnerability of the individual and what is "traumatic"
  - protective factors: importance of faith, philosophy and social interactions
- Trauma in refugee children is a social pathology with frequent loss. It is a normal response to abnormal events.

- Treating trauma in refugee children should be done in **two domains**. Why? Because the stressors resulting from the migration and acculturation process interact with the pre-migration trauma. They can exacerbate or perpetuate each other.

Domain 1: treatment by a professional trauma therapist

- Working in the mother tongue
- Importance of non-verbal language: trauma-sensitive yoga, drawing, playing
- Importance of psychoeducation:
    - not they are crazy (what they often think) but they show normal reactions (flashbacks , somatic reactions) to abnormal, maddening events.
    - no debriefing: given the nature of the trauma (man-made, often repetitive, time passed), one should avoid touching the trauma and not force the refugee. It is the traumatised refugee who should be ready to talk about it, preferably in a professional setting of a qualified trauma therapist.

Domain 2: supporting the people surrounding the child by the trauma therapist (see also fact sheet PACCT). Why?

- Addressing the child's resilience
    - Look for talents to be encouraged and valued.
    - Encourage activities and school work to become more structured in life:
        - feeling in control of life
        - re-energise solidified time due to trauma by attending school and participating in activities
    - Create positive experiences with adults who do no harm, look for a positive role model.
    - Insert activities in which the child takes on a role for another person.
    - Mobilising parents to take up their protective parent role.
    - Making connections with the neighbourhood, the community, the leisure club, ...
- Culture-sensitive working
    - Help be the bridge to the new environment in which the child has to function. To do this, however, you must first understand the parent/child's frame of reference.
    - Making connections with the past, especially the positive memories/experiences.
- Early detection and referral when resilience is insufficient and the child's development is at risk.

In conclusion

Of course, not all refugees have a PTSD in need of professional trauma help. Certainly children have great resilience. It is important that this is mobilised. The majority of children recover without professional trauma help.

Solentra examined 93 applications between July 2011 and June 2015. Of the 31 applications with "trauma", only 14 cases were actually diagnosed as trauma.

All refugee (children) do go through a grieving process. But a normal grieving process does not require therapy, on the contrary: the outcome is often worse then. Only a stalled grief process (e.g. the child fails in two of the three life domains) requires therapy.

Want to know more?

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