Trauma in refugees

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Case

X. is an eight-year-old girl from Georgia. She is being registered because she faints on a very regular basis or suffers a panic attack if she sees a police officer or hears a siren. In order to protect her, her parents decide to keep her inside as much as possible. She is also allowed to sleep in mum and dad's bed again. In her home country, X. was witness to a raid on her house by soldiers. She saw her father being violently taken away. Despite her anxieties, X. goes to school and picks up the language quickly. But going to school is difficult because of the anxiety attacks she suffers on the way there.

General

- A traumatic experience often features a threat to life or physical integrity: of the child or someone who is important to the child, especially a care figure.
- The interpretation and reaction of adults and other adults are important for a child to be able to assess the severity of an incident.
- Traumatic experiences go hand-in-hand with
    - thoughts about oneself, the other and the world: I'm helpless, I can't trust anybody, it's my fault, ...
    - an overwhelming feeling of helplessness, powerlessness and anxiety
    - intense physical reactions: heart palpitations, rapid breathing

Types of trauma

- Acute: a single event that lasts for a short period of time, such as a bus accident, a physical or sexual attack, seeing a loved one die.
- Chronic: several traumatic events that happen over a longer period of time. Chronic trauma makes the child more susceptible to a traumatic reaction to a new distressing event.
- Complex: chronic trauma to which the child was exposed before reaching 5 years of age. This trauma is caused by adults who are presumed to be care figures.

Trauma can have far-reaching effects on the physical and psychological development of the child, especially regarding

- reactions to stress
- the ability to adapt to new situations
- the ability of a child to trust others
- the feeling of personal safety
- the ability to manage emotions

Effects of trauma

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

1. Flashbacks

- intrusive thoughts
- images, feelings and memories
- nightmares
- flashbacks
- repetitive play

2. Avoidance

- internal: painful memories, thoughts, feelings.
- external: places, people, objects which provoke thoughts, feelings, memories of the trauma or things related to the trauma.

3. Negative thoughts and mood

- inability to remember important aspects of the trauma.
- persisting negative convictions or expectations concerning oneself, others, the world; feeling alienated from others
- persisting negative emotional state (fear, shame, guilt, ...)

4. Hyper-arousal

- fits of rage
- irritability
- reckless, self-destructive behaviour
- concentration problems

Have the above-listed reactions persisted for longer than one month and are getting in the way or normal life (e.g. the child is attracting attention at school and in his/her free time)? Then we refer to PTSD, Post Traumatic Stress Disorder.

What will you notice in a child?

- problems with concentration, learning or absorbing new information, difficulty falling asleep and sleeping uninterrupted, nightmares
- emotional instability
- nervous, jumpy, anxious
- isolation during activities, from friends
- regression: acting younger than he/she is in terms of emotions
- traumatic play: repeatedly replaying the trauma, taking on the perspective of the perpetrator, remaining stuck in a particular moment, at a particular event (stuck in time), offering solutions.

requires professional support!

Risk factors for the development of PTSD

- age and development phase
- temperament: anxious or sensitive disposition

- less intelligent
- stress factors from earlier in life, e.g. an adverse childhood, more traumas in the past
- previous psychological disorders or development disorders
- low social class
- lacking or insufficient availability of adults
- insufficient or no normalisation of life after the trauma
- physical injuries
- lasting injuries
- perpetrator and victim know each other
- affected person is themselves the perpetrator

Protective factors

- being religiously oriented
- healthy sense of self-awareness
- being in employment
- strong family and social support
- able to spontaneously express feelings

Role of resistance

- Resistance is the ability to continue living and developing despite adverse living circumstances (Rutter, 1985).
- Resistance is a potential that depends on
    - individual physical and psychological characteristics
    - family and social context
- Resistance must be addressed!

Trauma in child refugees

Risk factors which can increase the likelihood of PTSD in child refugees:

1. The type of trauma

- chronic: war, persecution, ethnic conflict
- often inter-personal violence
- often witness to the threat to life or the death of a care figure
- the child itself is the perpetrator, e.g. a child soldier

2. Parental support is only available to a limited emotional extent (or is evidently absent)

- as a consequence of war: separation of the family
- specific vulnerability of unaccompanied minors
- as a consequence of a personal trauma suffered by the child's parents or weakening of their parentage through
    - migration: raising a child means preparing a child to assume a place in the context, but parents are not always able to understand this context well.
    - institutionalisation in collective reception structures.

    - tension experienced by parents as a result of the lack of control.

3. The migration process

- an enormous experience of loss
    - of your socio-cultural frame of reference
    - your trusted network
    - your identity (you stay the person you were before and you have to become the person you are)
    - your role in society
- different integration rhythms of different family members (the circumstances sometimes cause a change in roles in the family)
- the image of the parents as protectors is often destroyed (e.g. they have nothing to say about the people smugglers)
- feelings of guilt regarding family who has stayed behind
- an extra development step as a result of the changing environment: children must form their own synthesis between the culture they live at home and the culture of the new environment.

4. An uncertain future/asylum procedure

5. Cultures which deploy fatalistic and self-accusatory coping mechanisms

All of these factors mean that

- life after trauma has not been normalised.
- officially recognised refugees often have a lower socio-economic status.
- care figures are not or insufficiently available.
- refugees exhibit a higher prevalence of PTSD, depression and symptoms of anxiety.

Treatment of PTSD in refugees

- Post Traumatic Stress Disorder is a diagnosis which has its roots in the Vietnam war years, when it was used to classify and treat symptoms witnessed in war veterans.
- It refers to a universal neurobiological response, with ethno-cultural variations in its manifestations. Above all, we witness symptoms of avoidance, "numbing" and manifold somatic complaints
- This is actually a Western vision of the disorder, 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 child refugees is a social pathology that features multiple instances of loss. It is a normal reaction to abnormal events.
- The treatment of trauma in child refugees must be conducted in two areas. Why? Because the stress factors resulting from the migration and acculturation process interact with the

trauma experienced prior to migration. They can have a mutually detrimental effect on one another or sustain one another.

Area 1: treatment by a professional trauma therapist

- Work is conducted in the native language
- Important of non-verbal communication: trauma-sensitive yoga, drawing, playing
- Importance of psycho-education:
  - not a case of the patients being crazy (which they often think) but they are demonstrating normal responses (flashbacks, somatic reactions) to abnormal, madness-inducing events.
  - no debriefing: considering the type of trauma (man-made, often repetitive, time that has passed since), you have to avoid addressing the trauma itself and forcing the refugee to discuss it. It is the traumatised refugee who must feel ready to talk about it, preferably in a professional setting with a qualified trauma therapist.

Area 2: support of the trauma therapist for the people around the child

(see also the PACCT fact sheet) Why?

- Address the child's resilience
  - Look for talents that can be encouraged and valued
  - Stimulate activities and schoolwork to bring more structure into the child's life:
    - the feeling of being in control of one's life
    - re-activate time that seems to have come to a halt by going to school and participating in activities
  - Create positive experiences with adults who do not cause harm, search for a positive role model.
  - Include activities which see the child assuming a role for another person.
  - Encourage the parents to assume their protective role as parents.
  - Create connections with neighbours, the community, the leisure club, ...
- Work in a culturally sensitive manner
  - Act as a bridge between the new environment in which the child must now operate. To be able to do this, you must first understand the parent's/child's frame of reference.
  - Create connections with the past, in particular positive memories/experiences.
- Early detection and referral if resilience does not appear sufficient and the child's development is at risk.

And finally

Of course, not all refugees are suffering from PTSD and require professional trauma support. Children are most certainly very resilient. It is important to mobilise this strength. The majority of children recover without professional trauma support.

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

All refugees (or child refugees) go through a grieving process. However, a normal grieving process does not require therapy: in fact, the outcome is often worse if they do receive treatment. Only in cases where the grieving process has stalled (e.g. the child is attracting attention in two out of the three areas of life) is therapy necessary.

Do you want to know more?

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