Trauma and PTSD in Children Who Are Refugees or Immigrants

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Introduction

Children in humanitarian emergencies are at risk of experiencing further trauma of several types, including physical or mental abuse. Studies have shown that a majority of children will have experienced at least one significant trauma by age 18, regardless of whether or not they are in a humanitarian emergency [1, 2]. An estimated 10–15% of these will develop PTSD [3]. If children experience repeated traumatic events, they are more likely to develop PTSD. A systematic review of psychological distress of refugee children found prevalence rates of PTSD between 19% and 54% [4]. The higher rates could reflect multiple or complex trauma.

The PTSD prevalence figure varies significantly with the type of trauma, age, and sex of the child. PTSD may evolve from the horrifying experiences leading to family displacement, from the abuse experienced in a refugee setting or in transit, from traumas experienced during resettlement, and even from medical or surgical procedures experienced in clinics or hospitals. Whether or not a child manifests PTSD after a traumatic event will depend on the child's innate personality, the adult support received immediately after the event, and whether or not the child receives appropriate psychological assistance. The traumatic events that are most likely to lead to PTSD include the death of a parent, loss of a home, repetition of displacements or physical and mental abuse. The children at greatest risk for both abuse and PTSD are unaccompanied minors [5]. If relief workers fail to recognize or intervene early, the negative impacts on displaced children may lead to lifelong psychiatric illness.

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C. Harkensee et al. (eds.), *Child Refugee and Migrant Health*,
https://doi.org/10.1007/978-3-030-74906-4_5

How to Recognize the Trauma from Child Abuse

Children who are displaced may experience several types of abuse after the initial trauma of leaving a home and being part of family uncertainty. Even in a well-organized refugee camp children may experience mental or physical (including sexual) abuse sometimes perpetrated by family members or teachers, traffickers, or even relief workers. Young children may have left home carrying precious toys that are stolen by other children. This can be significant trauma to a child who has already lost nearly everything. Child bullies may inflict both physical and mental abuse. Parents who are stressed by many aspects of a disaster may be more likely to beat their children or criticize them. The loss of supportive connections with relatives, friends, religious leaders, and teachers may lead to increased abuse by parents or caretakers [6]. Childhood maltreatment, including neglect and physical, emotional, and sexual abuse, is the leading risk factor for mood disorders and psychiatric disorders, according to a review by Lippard and colleagues [7].

Relief workers should be alert for signs of abuse such as unexplained bruises, strange descriptions for injuries, evidence of fear, the child clinging to a relative stranger, hyperventilation, frequent frightening nightmares, recurrent abdominal pain without a clear diagnosis, anxiety about attending school, or violent or graphic drawings. Some children will have elevated blood pressure for prolonged periods after experiencing abuse.

If physical abuse is suspected, a thorough skin examination should be done. A mnemonic for remembering when to suspect that bruises were caused by physical abuse is TEN-4-FACESp. TEN refers to bruising on the torso, ears, or neck. 4 refers to bruising in a child less than 4 years or ANY bruising in a child 4 months or younger. FACES refers to physical injury to the frenulum of the tongue, angle of the jaw, cheek, eyelid, or sclera. P refers to a pattern of injury, e.g., bruise that is in the shape of a hand or a belt.

Abusive head trauma may manifest as the shaken baby syndrome. If severe, the infant may be unconscious, have seizures or apnea. If less severe, the infant may manifest vomiting, poor feeding, or rapid increase of head circumference. Such infants should have head imaging and a skeletal survey if available.

The Child Protection App developed by Children's Mercy Hospital, Kansas City, and the University of Texas Health Sciences Center is available for free download from Apple or Google Play stores. It provides realistic animations of how childhood injuries may happen, photos of various injuries, history-taking tools, descriptions of medical findings, decision trees for use in determining the likelihood of abuse, appropriate medical evaluations, and further investigative needs [8].

How to Recognize PTSD

The term PTSD is in general casual usage today, and it is probable that there are children and adults who are incorrectly labeled as having PTSD. It is best to make the diagnosis of PTSD based on the rather complex diagnostic requirements as

described in the DSM V that were published in 2013, by the American Psychiatric Association [9]. Keep in mind that the listed criteria must be present for more than 1 month in order to qualify for a PTSD diagnosis.

Diagnostic Criteria for PTSD

The following are the specific criteria for the diagnosis of PTSD for adults, adolescents, and children *6 years of age or older.*

Criterion A: Stressor (one required)

- Direct exposure.
- Witnessing the trauma.
- Learning that a relative or close friend was exposed to trauma.
- Indirect exposure to aversive details of the trauma.

Criterion B: Intrusion Symptoms (one required)

- Unwanted or upsetting memories.
- Nightmares.
- Flashbacks**.**
- Emotional distress after exposure to traumatic reminders.
- Physical reactivity after exposure to traumatic reminders.

Criterion C: Avoidance of trauma-related stimuli after the trauma in the following way (one required)

- Trauma-related thoughts or feelings.
- Trauma-related external reminders.

Criterion D: Negative alterations in cognitions and mood (two required)

- Inability to recall key features of the trauma.
- Overly negative thoughts and assumptions about oneself or the world.
- Exaggerated blame of self or others for causing the trauma.
- Negative affect**.**
- Decreased interest in activities.
- Feeling isolated.
- Difficulty experiencing positive affect.

Criterion E: Alterations in arousal and reactivity. (These symptoms began or worsened after the trauma) (one required)

- Irritability or aggression.
- Risky or destructive behavior.

- Hypervigilance.
- Heightened startle reaction.
- Difficulty concentrating**.**
- Difficulty sleeping.

Criterion F: Duration (required)

– Symptoms have lasted for more than 1 month.

Criterion G: Functional significance (required)

– Symptoms create distress or functional impairment in social interactions or in work.

Criterion H: Exclusion (required)

– Symptoms are not due to medication, substance use, or other illness.

Two Additional Specifications for PTSD Diagnosis

Dissociative Specification. In addition to meeting the criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

- Depersonalization. Experience of being an outside observer or detached from oneself (e.g., feeling as if one is in a dream or "this is not happening to me").
- Derealization. Experience of unreality, distance, or distortion (e.g., "things are not real").

Delayed Specification. Full diagnostic criteria are not met until at least *6 months* after the trauma, although onset of symptoms may occur immediately after the trauma.

Diagnostic Criteria of the DSM V that Apply Specifically to Children *Younger than Age Six* Include the Following

Exposure to actual or threatened death, serious injury, or sexual violation:

- Direct experience.
- Witnessing the events as they occurred to others, especially primary caregivers *(Note: Does not include events witnessed only in electronic media, television, movies, or pictures.)*
- Learning that the traumatic events occurred to a parent or caregiver.

The presence of one or more of the following:

- Spontaneous or cued recurrent, involuntary, and intrusive distressing memories of the traumatic events *(Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.)*
- Recurrent distressing dreams related to the content and/or feeling of the traumatic events *(Note: It may not be possible to ascertain that the frightening content is related to the traumatic event.)*
- Reactions as if the traumatic events are recurring; the most extreme being a complete loss of awareness of present surroundings. *(Note: Such trauma-specific reenactment may occur in play.)*
- Intense or prolonged psychological distress at exposure to internal or external cues.
- Marked physiological reactions to reminders of the traumatic events.

One of the following related to traumatic events:

- Persistent avoidance of activities, places, or physical reminders.
- People, conversations, or interpersonal situations that arouse recollections.
- Diminished interest or participation in significant activities such as play.
- Socially withdrawn behavior.
- Persistent reduction in the expression of positive emotions.

Two or more of the following:

- Irritable, angry, or aggressive behavior, including extreme temper tantrums.
- Hypervigilance.
- Exaggerated startle response.
- Problems with concentration.
- Difficulty falling or staying asleep or restless sleep.

Clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers, or with school behavior not attributable to another medical condition.

PsySTART Rapid Mental Health Triage System

In many settings where families are displaced by man-made or natural disasters, symptom-based screening tools have been used to identify those with disorders. However, in the immediate aftermath of traumatic events, these screeners are problematic because they do not differentiate children with transitory distress from those with more permanent distress. During the first weeks after displacement, we recommend the use of the PsySTART rapid mental health triage system which was developed to address the limitations of early screeners [10].

As opposed to symptom-based PTSD screening tools, PsySTART is an evidence-based rapid mental health triage system that can be completed by non-mental health workers. It relies on evidence-based, objective risk factors such as deaths of family members, displacement from home, and exposure to mutilated bodies. Relief workers can apply PsySTART in a matter of seconds (see Appendix). Those identified with high scores in the aftermath of a disaster should be monitored closely and referred for mental health evaluation and treatment if they meet the criteria for PTSD or have other psychological symptoms of concern.

After more than a month following a disaster, relief workers can consider using a PTSD screening tool such as the UCLA PTSD Reaction Index for Children and Adolescents (PTSD-R). This widely used assessment tool can be administered to children and adolescents or to parents [11]. It is available in many languages including Spanish, Japanese, Simplified Chinese, Korean, German, and Arabic.

Appropriate Interventions for a Traumatized Child

We do not recommend that relief workers ask specific questions about the trauma. However, if a child wishes to talk about the specifics, the relief worker should listen and express empathy to the child [12]. Some children will reflect fear and anxiety in their play or in their drawings. For example, a 5-year-old child who had lost a parent in the Asian tsunami of 2004 kept playing with a toy boat and tipping the boat. The father had been a fisherman who was lost in the tsunami. Relief workers should make efforts to provide paper, crayons, pencils, and markers for children. They should also identify coaches and teachers who can guide adolescents to organize games and activities for younger children.

Treatment for Physical Abuse of Young Children

Children are often reluctant or unable to describe abuse from family members. If relief workers believe that physical abuse has occurred they should explain the significance of symptoms to parents or caretakers. Depending on the culture or language issues, it may be necessary to engage assistance from the medical staff of the same culture or from leaders in the refugee community. The perpetrator should be directly confronted if he/she is an older sibling or a classmate. Direct confrontation of parents or caretakers may be more complicated if, for example, the culture permits child-beating. International child protection laws should be explained as well as local child protection laws if they exist.

Treatment for Physical Abuse of Adolescents

Adolescents also may be reluctant to describe abuse or identify a perpetrator. Refugee camp leaders should assign persons to organize advocacy programs that

include safe shelters for abused women, adolescent females, and adolescent males. The program should include a system for notifying all persons about the safe shelters or names of persons whom they may contact about abuse.

Facilitating Resilience

Although the literature on refugee youth contains many examples of risk for mental health and educational challenges, researchers are increasingly documenting the importance of viewing the experiences of refugee children through a lens of recovery and resilience [13, 14].

It is helpful to remember that the majority of people, including children, are inherently resilient. Resilience can be facilitated by providing basic needs such as food, clothing, and shelter. For children, it is important to provide routines including reestablishment of schools as soon as possible following a disaster and to arrange for children to attend school wherever they are resettled. In refugee settings play tents or playgrounds that are closely monitored for safety are helpful and often therapeutic to children. The Nubader program [15] includes a variety of interventions, such as play therapy, parenting courses, and mindfulness, and has been used in a dozen countries.

When disasters happen children often cannot see the wider perspective. They see the world they once knew as coming to a standstill. Ideally, parents should lead by example and stay calm as the changed life circumstances evolve. Children who feel cared for and safe may find it easier to bounce back during challenging situations. Children reflect the mental health of their parents. If possible, mothers with several children should have access to a respite center. In some refugee camps, volunteers have organized "daycare" for children so that parents can get a break for at least a few hours [16]. This need may be even greater when the family is resettled in a new country and less likely to have close neighbors of the same ethnic group and experience.

There are a number of programs and activities that have helped displaced children to regain resilience. These include the Return to Happiness program originally developed by UNICEF and used in many countries (see Chapter on Return to Happiness). The Child to Child Programme [17] provides programs for teaching displaced older children how to help younger siblings. Culbert designed Comfort Kits with items appealing to children that have specific therapeutic benefit. Items include finger puppets, crayons, stress squeeze balls, bubbles or pinwheels, biodots, and small toys. He included instructions for parents or caretakers on how these benefit children in disasters. These have been translated into many languages and used extensively in disasters such as the tsunami of 2006, the Haiti earthquake of 2010, and the severe floods in Laos in 2018. Instructions for making comfort kits can be downloaded from the website of the International Pediatric Association [18]. Providing children with picture books is also comforting as demonstrated after a typhoon in the Philippines [19].

If there is access to the Internet or to a smartphone there are a number of apps designed to promote a sense of control and self-regulation in the children who use them. Examples include the following:

The Meg Foundation for Pain — www.themegfoundationforpain.org. This website provides excellent, free videos for young children about non-pharmacologic pain management. The videos have been translated into Spanish, Arabic, Chinese, and Thai.

Healing Buddies Comfort Kit — www.healingbuddiescomfort.org. This free app provides appealing guidance to help children who are anxious, afraid, or having sleep problems.

Heart Math — www.heartmath.com. This biofeedback system measures heart rate variability and has several formats including an app for smartphones (Inner Balance), a hand-held portable monitor (EmWave), and a computer program. The latter provides feedback for children as appealing games.

Promoting Resilience after Resettlement

In order to facilitate resilience children should be regarded as children, not as refugees. Factors that seem most important for children include meaningful involvement in school, social connections including some with people from the home culture, and family connectedness. If children develop an area of success in academics, music, art or sports, this facilitates feelings of belonging and adaptation to the new culture. However, it is also helpful for children to maintain contact with relatives or friends from the same ethnic or cultural group.

Conclusion

There is substantial data to validate the recommendation that relief workers should assess the trauma experiences of children. This should happen soon after a disaster. Those children at risk for PTSD or who manifest other psychological disorders should be treated as soon as possible to avoid lifelong mental illness. Programs in refugee camps should be alert to the possibility of continuing or recurrent trauma. Resettlement may occur years after a trauma. Once resettled, children should also be evaluated for mental illness and provided treatment if needed. And the remarkable resilience of humans should be respected and fostered.

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