Working Clinically with Traumatized Refugee Children and Families

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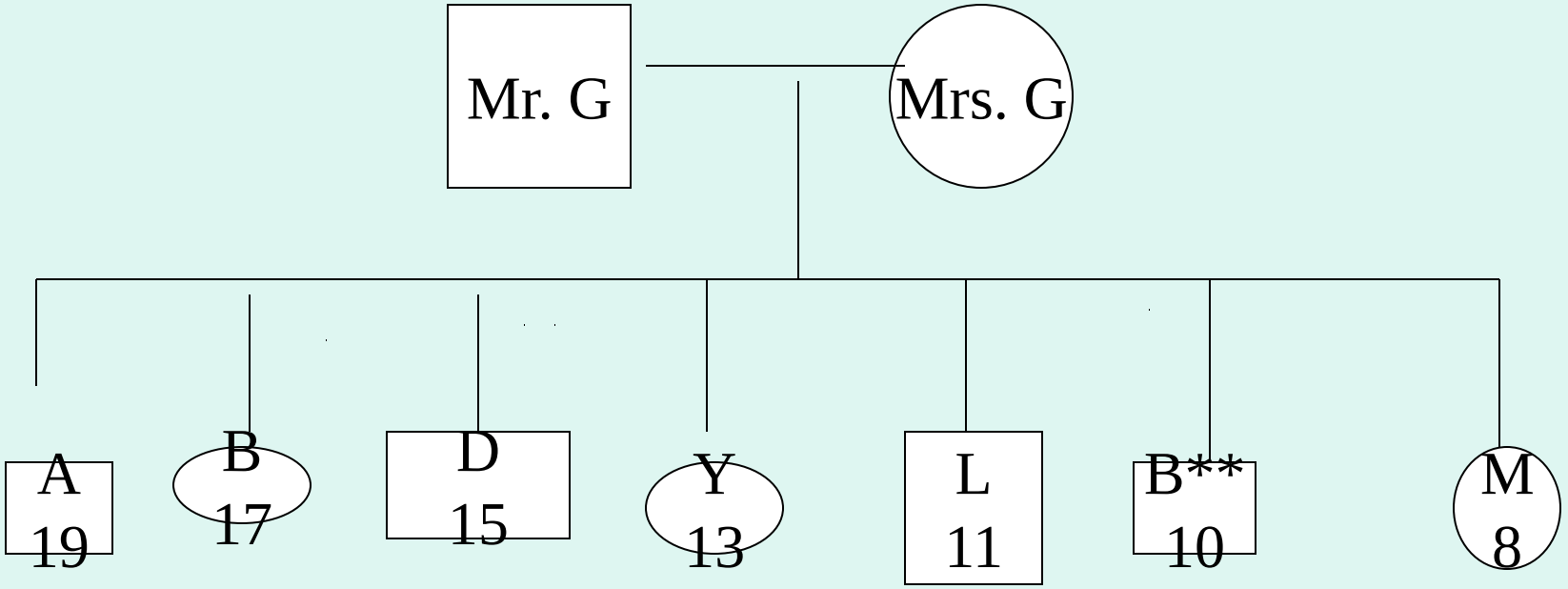
The G Family



G Family: Chronology

- Since 1989: Intimidation of Mr. G by Serbian authorities; Loss of job
- 1997: Oldest son leaves
- 1997: Attack in the home by paramilitary, now 10 year old burned
- 1998: Forced evacuation, flight on foot
- 1999: 5 months in Macedonian camp
- June, 1999: Family arrives in New Jersey

G Family: Referral issues

- Nuisance behavior in apartment complex-loud, “dirty,” uncooperative
- Mother-depressed, not functioning
- 10 year-old boy-aggressive on bus and at school

How does war trauma and torture affect children and families?

QuickTime™ and a
decompressor
are needed to see this picture.

Ripple effect --Even one family member's experience of trauma impacts the whole system

- Direct exposure to violence and threats of violence
- Witnessing violence, threats
- Fleeing from home, community due to danger, either with or without parents
- Living as a displaced person in a refugee camp
- Going to another country as a refugee

Understanding this ripple effect and intervening requires:

- Careful assessment
- Community-based services
- Culturally competent care provision
- Resilience, strength-based service provision
- Intervention for the most symptomatic/distressed

How do trauma reactions manifest themselves in kids?

- Preschool
  - Acting scared, separation problems
  - Regressive behaviors including loss of milestones (toileting, motor skills, language)
  - Dysregulated sleep, routine
  - Repetitive play
  - Aggression
  - Social withdrawal

School age:

- Irritable, jumpy, agitated
- Aggression, conduct problems
- Poor concentration
- Sleep problems
- Somatic complaints
- Fear of events occurring again
- Phobias
- Bad memories

Adolescents:

- Aggression/Anger/Wish for revenge
- Withdrawal/Isolation
- Nightmares/Flashbacks
- Feelings of guilt, shame
- Depression
- Lack of motivation/energy
- Disillusionment with adults/authority

Assessment

How do we determine what a family needs?

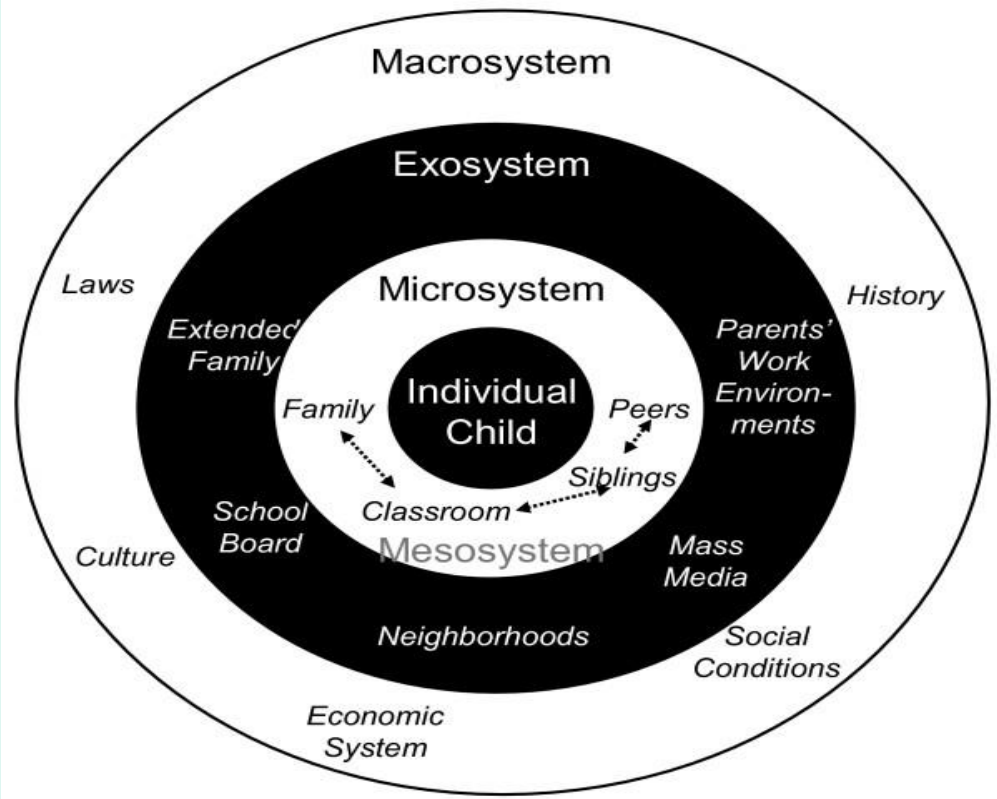
Understand the predictors of functioning for war-traumatized children

i.e., What variables help you to understand how the child in front of you is coping?

Predictors of child functioning after war and other trauma

- Parental reactions to the trauma
- Degree of exposure to traumatic events
- Degree of disruption of family unit and routine in the aftermath of trauma
- Availability of positive social supports (i.e. school, community organizations, extended family)
- Overall resilience and competence of child

Bronfenbrenner's Social-Ecological Model



Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.

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So, build these predictors into your assessment of the child

- ASK about:
  - Parental functioning--How are they doing?
  - Exposure--What did you experience and see?
  - Disruption of family's life--What was life like before?
  - Social Supports--Who mattered to this family and where are they?
  - Resilience-What was this child like before the war?

Strategies when asking/talking about trauma

- Reflect back what you hear--”I can see how important this is for you to tell me”
- Give control-”Where would you like to begin?”
- Anticipate- “Today, we will be working on your application. That means we will talk about the war.”
- Normalize-”People who have been through hardship like you often feel the same way.”
- Contain-”It seems like this topic is making you feel very bad. Maybe we should take a break from talking.”

How did the G family look on these predictors?

- Parental functioning
- Degree of exposure
- Degree of disruption of family unit and routine
- Availability of social supports
- Overall resilience/competence of each individual

Once you have assessed, are there community-based services available?

Community based--what and why?

- What--systems and organizations that the family is involved with, connected to, or has a relationship with. (Schools, refugee agencies, ethnic organizations, faith-based organizations)
- Why--to decrease stigma, normalize, prevent redundancy, and enhance belonging

Using a community based model with the G Family

- School based intervention
  - Empathy enhancing
  - Behavioral intervention
- Holding family sessions at the refugee agency
- Educating their resettlement team

Culturally competent care: What is it?

- Provide services in ways that are “acceptable, engaging and effective with multicultural populations”*
- Not an on/off switch
- “Rules” are less helpful than skills in communicating about culture.
- Teaching cultural competence is as much a process-based endeavor as a content-based one
- We are not the “experts”

Culturally competent assessment looks at what the *client's* concerns are as much as what the professional's concerns are

G family: Cultural issues

- Gender issues
- Parents' focus on external behavior and not on internal experience of their children
- Lack of knowledge of therapy, medication

Resilience, strength-based care

- What: A focus on family's survival and coping strategies that were effective as a starting point for all discussions of where they are now having trouble

  -recognize achievements

  -normalize current stressors

  -collaborate with family to solve problems

G Family: Strength-based focus

- Family meetings-not pathologizing one person
- Sharing memories of home
- Modeling praise/empathy for the mother
- Giving advice to a little girl from their country

When do we refer?

- Stabilization of family's situation does not lead to stabilization of an individual in the family
- Symptoms are highly disruptive or frightening, out of control behavior or suicidal feelings
- School or other care providers seeing problems

G Family: Referrals

- Mother--psychiatry
- Son-plastic surgery

Unexpected ending

- Decision to return to Kosovo
- Goodbye and anticipation
- Incomplete parts of the treatment
- Countertransference