Working Clinically with Traumatized Refugee Children and Families

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The G Family

Mr. G

Mrs. G

A 19
B 17
D 15
Y 13
L 11
B** 10
M 8
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?
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


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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