Working Clinically with Traumatized Refugee Children and Families

Kate Porterfield, Ph.D.,

Bellevue/NYU Program for Survivors of Torture

portek01@med.nyu.edu

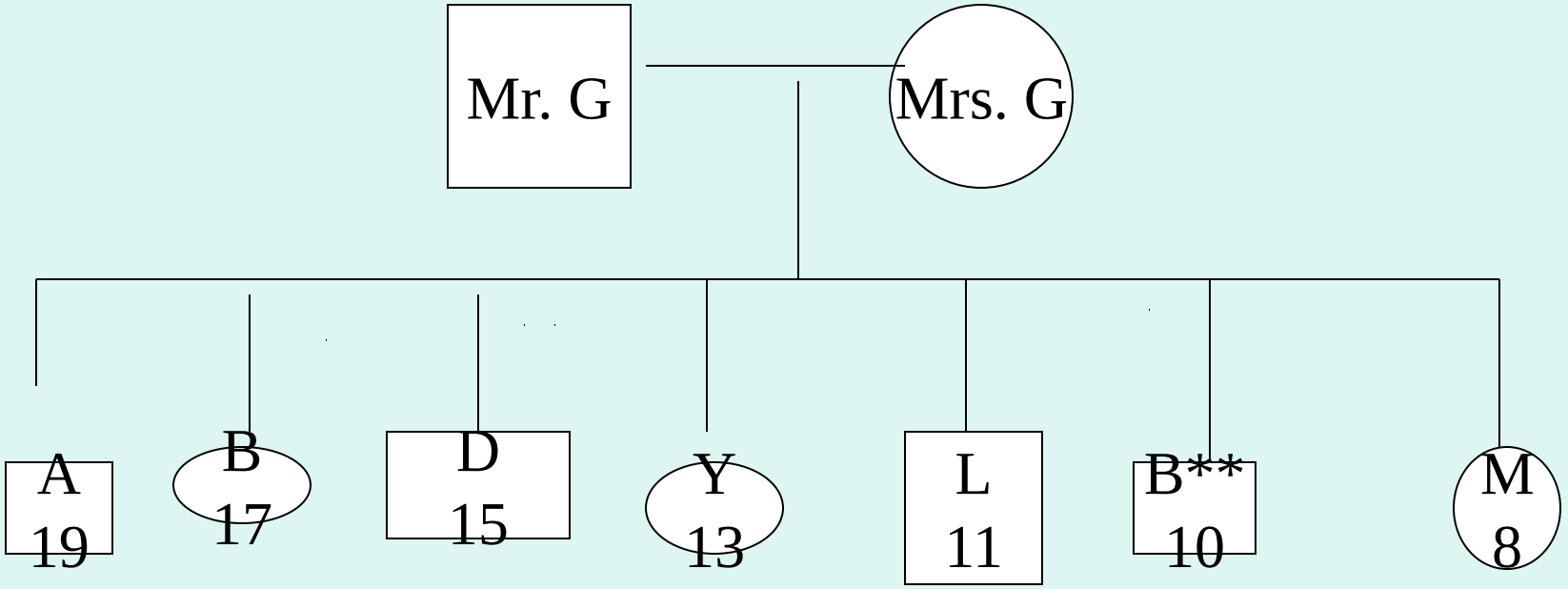
Case Example

-In small groups, look at case description and decide together:

-what areas need intervention and why?

-in your current professional role, would you be directly able to address any of these issues or would you refer?

The G Family



G Family: Chronology

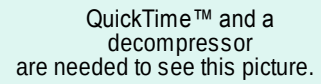
- Since 1989: Intimidation of Mr. G by Serbian authorities; Loss of job
- 1997: Oldest son leaves
- 1997: Attack in the home by paramilitary, now 10 year old burned
- 1998: Forced evacuation, flight on foot
- 1999: 5 months in Macedonian camp
- June, 1999: Family arrives in New Jersey

Family history

- The G family was resettled in New Jersey from Kosovo in 1999. They lived in refugee housing and quickly drew the attention of the resettlement agency because they were a “nuisance” in the apartment building where they lived. The complaints were that they were loud, disorganized and not clean. This led the agency to call a therapist from a program for survivors of war trauma and torture.
- The therapist was told the family’s history: They had survived years of persecution in Kosovo because they were Muslim. The father had been threatened and attacked and lost many jobs during periods of time when Muslims were persecuted. In 1997, as the conflict between muslims and Serbians was escalating, the G family decided to send their eldest son to Macedonia, fearing he would be drawn into violence as a young man. A year later, when the family was in their home, Serbian paramilitary came into their home and began threatening the family. One of the men took a pot off of the stove that had hot oil in it and threw it on the 8 year-old son’s face. The boy was badly burned and the entire family witnessed the event. The family sought help at a nearby clinic where his burns were superficially treated. Several months later, Serbian military overran the family’s village and the family fled from their home with almost no belongings. They walked on foot with hundreds of other refugees until they reached the Macedonian border. They then stayed in a refugee camp for about 8 months.

- The family was resettled to New Jersey and placed in an apartment with other refugees. At the time of the referral to treatment, the children were in a New Jersey public school and the boy who had been burned (who was now a full year older) was being aggressive and oppositional at school. He was particularly disruptive on the bus, where he had gotten into several fights.
- Mrs. G, during interviews, was unable to speak without crying profusely. She was particularly distressed about the eldest son who was now living apart from the family. She said the other children were “fine” and hadn’t seen anything bad during the flight to the refugee camp.

How does war trauma and torture affect children and families?



Ripple effect

- 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

Assessment

How do we determine what a family needs?

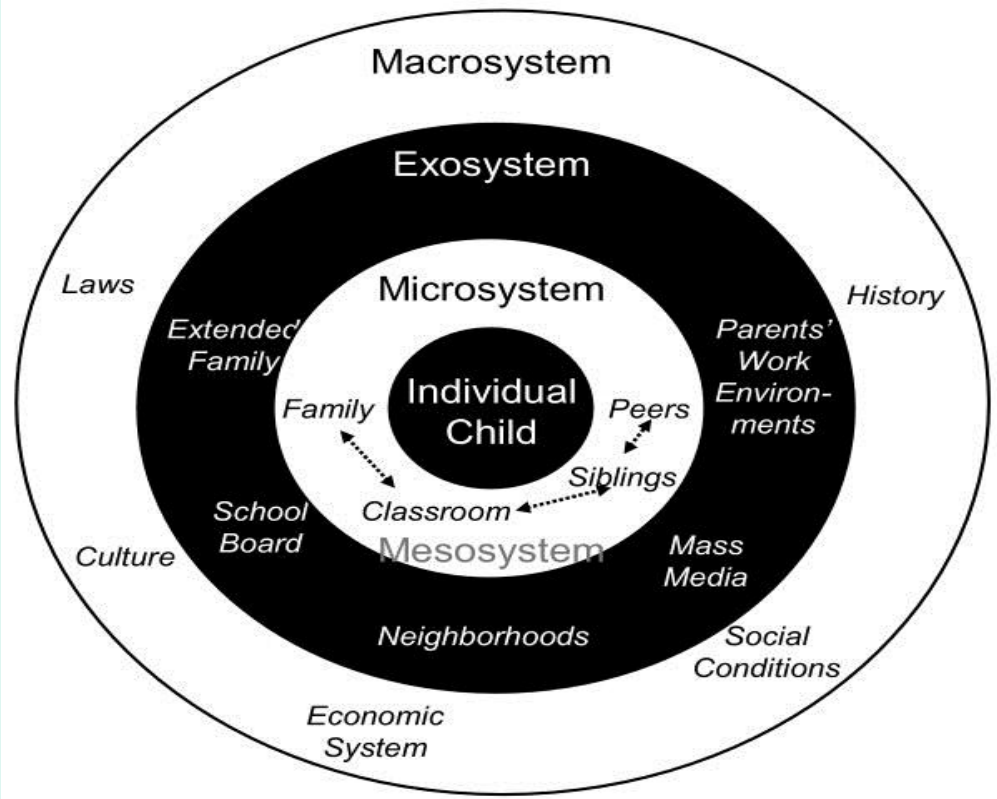
Understand the predictors of functioning for war-traumatized children

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.

Katherine Porterfield, Ph.D.
Bellevue/NYU PSOT

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

So, build these predictors into your assessment of the child. How?

Parent functioning: Don’t be afraid to find out how the parents are doing—ask and observe!

Note: Parents’ avoidance of traumatic material may hinder this goal.

Exposure: Find out what the child experienced without retraumatizing (this may take time.)

Note: You may need several reporters in the family

Strategies when 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.”

Disruption: Spend time learning about their pre-trauma lifestyle and the stress of resettlement.

Note: You should be able to picture the family's life and routine before the trauma

Social Supports: Who else matters to this child and are they available to him/her?

Resilience/Competence:What was this youngster like before this? Get a thorough developmental history.

Note: Vulnerable kids do worse after a trauma.

What do trauma symptoms look like in children?

- Rates of PTSD sx 20-80% depending on country
- High co-occurrence with depression and anxiety
- Understanding PTSD as a manifestation of the effects of fear/terror on the body and the mind

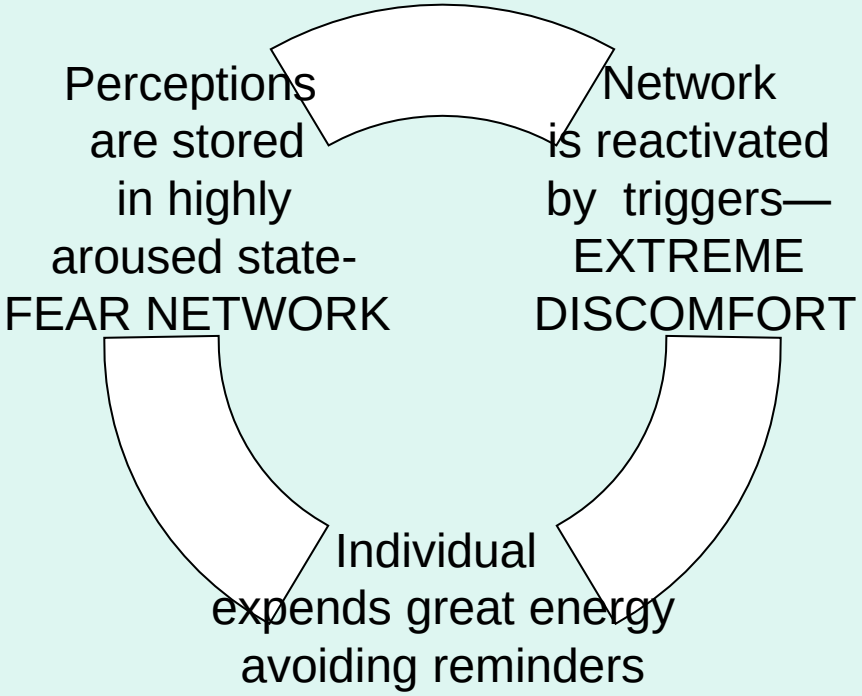
PTSD – A disorder of memory and arousal

- Amygdala and hippocampus- involved in:

  1. registering danger (“fight or flight”) and

  2. formation of memories

- Fear Network (cognitive, sensory, physiological, emotional experiences) is established with “faulty” connections –arousal linked to memory



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

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