Working Clinically with Traumatized Refugee Children and Families

The effects of war on children and families

The events of war and conflict in the victim's home country may have exposed the victims to:

- chronic persecution
- violence: psychological/physical
- Trauma, dislocation
- Collapse of social infrastructure: i.e. lack of basic housing, health, nutritional, educational needs

Ripple Effect: One family member's traumatic experiences affect the whole system.

- Direct exposure to violence and the effects of violence
- Witnessing violence
- Fleeing from home/community due to danger (with or without parents)
- Living as a displaced person in a refugee camp
- Going to another country as a refugee

PTSD: "Occurs after a traumatic event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (Bisson 2007).

- PTSD is a mind-body reaction; memories of traumatic events are linked to a state of fear, and physical manifestations of it. Depression and anxiety are common symptoms in persons suffering from PTSD.
- PTSD is exhibited differently in children than in adults: See list below for different developmental indicators of trauma reactions.

How do trauma reactions manifest themselves in children?

Preschool:

- Exhibit fear, suffer from separation anxiety
- Loss of milestones (toileting, motor skills, language)
- Deregulated sleep
- Repetitive play
- Aggressive behavior

School age:

- Irritability, anxiety
- Aggression, misconduct
- Lack of concentration
- Trouble sleeping
- Stomach pains
- Fear of events occurring again
- Emergence of phobias
- Recurring nightmares

Adolescents:

- Outburst of anger/feelings of revenge
- Detachment
- Intrusive thoughts, nightmares, flashbacks
- Feelings of guilt, shame
- Depression
- Lack of motivation/energy
- Disillusionment with adults/authority

This information sheet is based on an NPCT webinar on this topic, presented by Kate Porterfield, Ph.D., a Program Psychologist at the Bellevue/NYU Program for Survivors of Torture. The webinar was originally aired on April 17, 2012 and is archived on our website, www.gcjfcs.org/refugee under Webinars.

"This information guide is adapted from Kate Porterfield's presentation at the NPCT national conference in New Orleans, LA. Special thanks to the note taker from that workshop, Tulane University student Shannon O'Neil."

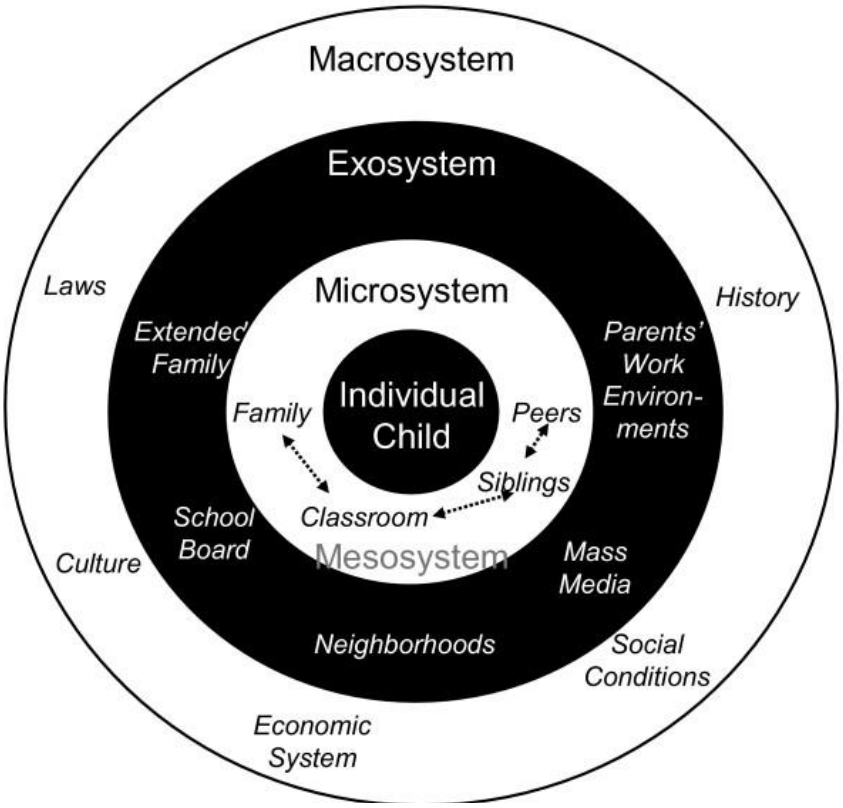
Refugee Services
National Partnership for Community Training
Gulf Coast Jewish Family & Community Services

ASSESSMENT: HOW DO WE DETERMINE WHAT A FAMILY NEEDS?

Understand predictors of child functioning after war and other trauma:

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

It is important to note that a child's environment influences them both physically and psychologically, therefore it is necessary to assess the child's relationship to each system in his/her environment. Bronfenbrenner's Social-Ecological Model depicts the different social subsystems that influence a person's development and growth. Disruption in any of those subsystems can significantly affect the child's development. In this case in order to conduct a careful assessment of the child, one must look at his/her environment, close family, support groups, community, etc.



Bronfenbrenner, U. (1979). *The ecology of human development*.

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Build predictors into assessment of the child

- Parental functioning – How are they doing?
- Exposure – What did you experience and see?
- Disruption of family life – What was it like before?
- Social support – Who mattered to this family and where are they now?
- Resilience – What was this child like before the traumatic experience?

(Gibson, K. (1989) Children in political violence. *Social Science and Medicine 28* (7).)

Strategies for asking/talking about trauma:

- Reflect back what you hear: "I can see how important it is for you to tell me."
- Give control: "Where would you like to begin?"
- Anticipate: "Today we will be talking about your application. That means we will be talking about the war"
- Normalize: "People who have been through hardships 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."

COMMUNITY BASED SERVICES

Utilize organizations and services with which the refugee family is already connected. This can decrease stigma, prevent redundancy of services, and enhance a sense of belonging. Services should be centrally coordinated when possible.

- schools
- community organizations
- refugee centers
- religious organizations
- youth groups
- athletic groups

RESILIENCE, STRENGTH-BASED CARE: Focus on family's survival and coping strategies that were effective as a starting point for all discussions of where they are having trouble currently.

- recognize achievements
- explore effective coping strategies
- normalize current stressors
- collaborate with family to solve problems

Psychoeducation: Educate survivors on what PTSD is, how it manifests itself, what triggers the trauma and how to overcome it.

CULTURALLY COMPETENT CARE:

Create a treatment plan that involves culturally competent services

- services that are reflective of the family's priorities and goals
- services that are respectful of the family's concepts of well-being and distress
- services that utilize culturally syntonic values, as much as possible

WHEN TO REFER:

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

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Kate Porterfield received her Ph.D. in Clinical Psychology from the University of Michigan, where she specialized in child and family treatment. She received the Power Fellowship at the University of Michigan to focus her clinical and research training on the needs of children who have suffered loss, either through death, divorce, or other trauma.

Dr. Porterfield was a postdoctoral fellow at the NYU Child Study Center. Since 1999, in her work at Bellevue/NYU Program for Survivors of Torture, Dr. Porterfield has provided individual and family therapy to children, adolescents and adults and supervises trainees working with survivors of torture.

Dr. Porterfield has worked as a clinical evaluator on several cases of young people held in detention at Guantanamo Bay and frequently consults with attorneys handling cases involving torture and maltreatment. She has also presented extensively in the New York area and nationally on topics such as the effects of war and refugee trauma on children, clinical work with traumatized refugee families, and the psychological effects of torture. Dr. Porterfield is the Chair of the American Psychological Association's Task Force on the Psychosocial Effects of War on Children Residing in the United States.