Network Collaborates to Help Refugee Children

In the past ten years, ten million children have been killed in war, many of them on the front lines as soldiers. From all over the world -- Afghanistan, Bosnia, Sierra Leone, Somalia, the Sudan -- the children who survived these wars have come to America for its promise of freedom. They come having suffered and witnessed unspeakably violent acts. Their experiences have left many of them with the signs and symptoms of post-traumatic stress, among which are anxiety, depression, flashbacks in which they re-experience the horrors of the event, overreacting to trauma reminders, a heightened state of vigilance, emotional numbing, and inability to concentrate. Yet, according to Dennis J. Hunt, PhD, Executive Director of the Center for Multicultural Human Services (CMHS) in Falls Church, Virginia, "the mental health problems of refugee children in the United States have been largely overlooked."

The Center that Hunt directs, now part of the National Child Traumatic Stress Network (NCTSN), was virtually alone in its mission when it was first established in 1982. It now provides a gamut of services in 34 languages to more than 6000 refugee children and their families each year. It is joined in the NCTSN by more than a dozen other centers that offer help to refugee populations. With the formation of the Network and funding provided by the Donald J. Cohen Traumatic Stress Initiative, through the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, these centers have formed the Refugee Trauma Working Group "to look more systematically at the impact of trauma on these children and their families," explains Hunt.

Wanda Grant Knight, PhD, Coordinator of another Network partner, the Center for Medical and Refugee Trauma at the Boston University School of Medicine, has been instrumental in organizing the collaboration. "We were really excited about the idea of a Network because it would give us the opportunity to work with other sites struggling with some of the same issues vis-a-vis refugee trauma."

Traumatized refugee children suffer additional stresses beyond their original traumas. They may feel exiled from their native cultures, from a home country that may no longer even exist as they loved it, having been devastated by war. They must look for safety in an alien culture, and ask for help in a non-native language. Families suffer not only the effects of post-traumatic stress, but, the added burdens of poverty, unemployment, stigmatization and bias, and the pressure to rapidly acculturate to a foreign environment or be further marginalized. As a result of having lived under authoritarian regimes, they may be reluctant to seek help from authority figures. Most important, perhaps, the very way they experience trauma may defy translation into another culture's terms. "Their own cultures may have very different notions of what is therapeutic following trauma and loss,' explains Grant Knight.

"If you miss the cultural aspects of the manifestations of traumatic stress, you miss understanding the case, and it becomes very hard to intervene," says Glenn Saxe, MD, Director of the Center for Medical and Refugee Trauma at the Boston University School of Medicine. "In some cultures, for example," he goes on, "emotional terms simply aren't used to express distress to the degree that they are in Western cultures." Culture, and how the culture delineates body and mind, determines how the child experiences discomfort. "Rather

than talking about emotional reactions," Saxe explains, "children might report stomach aches and headaches," feeling unwell in ways that we would regard as physical rather than emotional, a distinction that is itself cultural.

Wanda Grant Knight offers another concrete example. "People of Khmer origin, from Cambodia, might have what we would call in our Western psychiatric nomenclature, 'flashbacks,' but they would consider them appropriate responses to an intense longing for one's homeland." In the same culture, if someone has died and hasn't been buried according to ritual law, explains Grant Knight, as is the situation when masses of people die during war, the ghost of the deceased cannot rest and pays visitation to the bereaved survivor. Western clinicians might interpret such a 'visitation' as a symptom of PTSD, or even of psychosis, if they fail to view it through the lens of Khmer culture. "We need to be aware when our own cultural overlay is getting in the way of how we assess symptoms and signs of pathology," says Grant Knight. And understanding the patient's cultural overlays must inform treatment. Grant Knight explains that for the Khmer patient unable to work through the grief process because of ghostly visitations, what might be more therapeutic than psychotherapy or medication, would be some form of symbolic burial ritual.

The Khmer patient is suffering from a form of what trauma researchers and theorists call "traumatic bereavement." The survivor has become so preoccupied with the circumstances of the person's death – the way he or she died and what happened to the body – that the usual process of grieving the loss of a person has been derailed. The patient needs to work through the facts of how the person died in order to move through grief. For the Khmer patient, burying the loved one with the proper degree of ritual respect is a step towards processing the circumstances of the loss and being able to grieve and recover.

By looking together at cultural differences like these, the Refugee Trauma Working group will try to come up with some general truths about how to instill cultural meanings into treatment and assessment. How do you incorporate a culturally sensitive understanding into approaches that have been shown to be effective with traumatized kids?

Glenn Saxe is hoping that by creating a large database the collaboration will be able to identify some factors that cross cultures and are common to the refugee experience. "We want to look at the problems of refugee children across different refugee populations, and consider the risk factors for their developing post-traumatic stress." His group is in the process of collecting data on the Sudanese and Somalian communities and assessing these populations in a systematic way that may lead to generalizable assessment techniques. Assessment of such variables as post-traumatic symptoms, coping skills, resilience, depressive symptoms, and self-esteem is the first step towards effective treatment. One variable that clinicians may need to look at more systematically, according to Wanda Grant Knight, is the child's degree of acculturation. Are there particular rituals that a child participates in that reflects his or her native culture? Does the child speak English or another language at home? Does the child identify with the US majority culture and is there a conflict with parents and older family members over acculturation?

All the sites in the Refugee Trauma Working Group agree that family and community involvement are key in the treatment of refugee children. "We all take a social/ecological perspective," says Glenn Saxe. "We look at the child embedded within a family and a community and a school. We focus treatment not just on the individual child but on the

broader social context. The community is extremely important for refugee children. Their community supports them and is a crucial vehicle towards recovery."

What happens to refugee children when they get to this country is also very significant since it can alleviate or compound their post-traumatic stress. The relationship between stigma, discrimination, and refugee trauma is another important topic the working group is poised to address, according to Glenn Saxe. When children come to this country and face new stigma and discrimination, these social stresses remind refugee children of their marginalized place in society and sustained lack of safety. "A child goes through a terrible trauma in his or her home country, witnessing violence at the hands of authority figures. They develop traumatic stress, and then they come into our country and are taunted about their religion or their appearance. They are yelled at, threatened, and that new threat serves as a reminder of past trauma, and worsens their symptoms," explains Glenn Saxe. Stigma also makes refugees feel that they cannot let down their guard, that they've got to "stay under the radar screen of authority," Saxe says, so stigma may also serve to keep people from seeking help for their traumatic stress symptoms.

Trauma researchers have seen from their work with World War II Holocaust survivors, as well as with survivors of familial sexual abuse, that trauma has multi-generational impact. That is, as Dennis Hunt says, "trauma passes on through families, from one generation to the next." Some of what is passed down are reactions to the trauma itself, a form of post-traumatic stress even in those who did not experience the trauma firsthand. But also communicated are certain post-traumatic ways of dealing with life, explains Hunt. "A parent comes from a world where he or she had no power, was betrayed by authority, and lost everything, and this profoundly influences their view of what to expect in the world. "For example," Hunt goes on, "the Cambodians went through what was essentially a Holocaust, and then no one here even acknowledges the fact that they've been through these experiences. They pass on very negative assumptions about the world to their children." Perhaps a father who served as a soldier has trouble regulating his own emotional responses. Maybe he was in prison, tortured, and as a result, has episodes of violent behavior. Or the parent has become so anxious, so mistrustful of other people that the message communicated is to not trust anyone. "We see more problem behaviors in second generation children, [children born here to parent survivors], than in first generation children," says Hunt.

Often the problem that first brings a child to the attention of clinicians is poor performance or "acting out" in school. Often the child has already entered the juvenile justice system before being identified for treatment. "These children have difficulty paying attention because of the effects of post-traumatic stress," explains Hunt. They're several years behind educationally, partly because of deprivation, partly because they don't speak the language, and partly because of the effects of post-traumatic stress. "Trauma has a very significant impact on the developing brain," Hunt says, "and children can have trouble concentrating, difficulty regulating their emotions. They may be contending with trauma reminders of which their teachers and peers are unaware." All these factors can have a negative impact on learning and classroom behavior.

One hope shared by the Refugee Trauma Working Group is that they will find ways of reaching traumatized refugee children sooner. Children need treatment before poor school performance or violent acting out has stigmatized them further.

To improve their outreach to the refugee communities, Network providers will need novel approaches to contend with what Hunt calls, the "conspiracy of silence "that operates in refugee communities. People don't talk among themselves about what happened. Trauma experts have learned from the adult children of WWII Holocaust survivors the destructive effects of their parents' silence. People may pretend to have forgotten, to have moved on. They may even deny that anything significant happened, but their behaviors, their nightmares, their bodies remember in dramatic ways of which their children are often exquisitely aware.

"Sometimes a child witnessed terrible atrocities," says Dennis Hunt, "a mother being raped, but the mother doesn't talk about it." There's tremendous denial of the trauma's impact on the child. The parents may tell themselves, Hunt says, "Oh, he didn't really see anything, he doesn't remember. If we don't talk about it he will forget." And sometimes parents engage in this form of denial, says Hunt, because they cannot bear the fact that they could not protect their own children. Those in the Refugee Trauma Working Group would like to counter this denial with interventions that help refugee families to acknowledge what they have survived, and to rally the strengths they will need to flourish in their new homes.