

## Session 4 BACKGROUND READINGS

### Some Impacts on Children and Young People

#### Section a

#### CHILDREN'S REACTION TO THE REFUGEE EXPERIENCE

Becoming a refugee is always a traumatic experience for children, no matter what their circumstances. When working with refugee students, it is important that we understand that they have all suffered serious trauma as a result of the experiences they have lived through. These experiences may include:

- loss of physical ability through injury
- loss of loved ones
- exposure to conflict/bombing
- displacement
- loss of home
- loss of parental support and protection
- living with distressed adults
- loss of traditional way of living
- lack of educational structure
- poor physical environment
- poverty
- malnutrition
- social disintegration

Numerous studies have demonstrated exceptionally high levels of mental health problems among resettled refugee children, including serious psychiatric conditions and post-traumatic stress (PTS) symptoms at rates two and three times those of the mainstream population. The consequences of torture and trauma have profoundly negative impacts on the psychological wellbeing of refugee children and young people (Almqvist and Broberg, 1999; Fazel and Stein, 2003; Hjern et al, 1998; Lustig et al, 2004).

Trauma reactions display themselves in a variety of ways, such as anxiety, helplessness and loss of control; conflict with parents, family and community; shattered assumptions about human existence; and guilt and shame concerning their traumatic experiences. Common internalised behaviors include eating disorders, depression, and social withdrawal. Acting out behaviors such as irritability and aggression are typical of delayed reactions or late onset symptoms (Angel et al, 2001; Hjern and Angel, 2000). All of these indicate a serious reaction to traumatic experiences.

Other reactions include:

- lack of confidence and trust
- problems with attachment and bonding

- heightened sense of responsibility
- difficulty having 'fun'
- thinking a lot about experiences of violence
- feeling ill and having pain
- difficulty sleeping
- lack of concentration and interest
- getting angry easily
- not trusting other people
- lack of self confidence

It is very important that those working with refugee children understand that these are *normal* reactions to *abnormal* situations. They do not necessarily indicate mental illness, but rather they do indicate poor mental health and very high mental health risks. The impact of refugee trauma on children should not be underestimated. Refugee children will need significant support to recover from their experiences. However, treating their reactions to trauma as medical problems or 'pathologies' is often not the best way to help (Rousseau and Drapeau, 2003). Rather, we need to holistically address the emotional, social and physical needs of the child and their family in the resettlement process.

## Section b

### THE IMPACT OF SOCIAL VIOLENCE AND ARMED CONFLICT

Witnessing and experiencing organised violence and living through times of war can have devastating impacts on children. Refugee children and young people who have been exposed to chronic high levels of community violence commonly experience anxiety and depression, anger and violence, psychic numbing, paranoia, insomnia, and a heightened awareness of death. They are also likely to respond to these experiences by adopting high-risk behaviours including alcohol and drug use, carrying knives and guns, defensive and offensive fighting, all of which can lead to trouble in school.

The severity of the impact of social violence and armed conflict on children depends on additional factors. In particular, social support, especially from parents, has been found to be the most important factor in children's psychological vulnerability or resilience during wartime (Adjukovic and Adjukovic, 1998; Almqvist and Broberg, 1999; Brough et al, 2003; Lustig et al, 2004). Long-lasting post traumatic stress symptoms are usually displayed in children who had high vulnerability when exposed to organised violence (Almqvist and Broberg, 1999).

Other risk factors relate to the secondary causes of conflict such as the loss of family, inadequate care, poverty and displacement. Long-term mental health problems have been found to be more associated to these factors, rather than the violence and the trauma of the initial conflict (Adjukovic and Adjukovic, 1998; Angel et al, 2001; Lustig et al, 2004).

## Section c

### IDENTIFYING POST-TRAUMATIC STRESS SYMPTOMS

In some cases, the traumatic experiences have been so extreme or the reactions are so severe that the child may need psychiatric assessment for post-traumatic stress disorder (PTSD) or mental illness. However, there is reason for great caution when diagnosing PTSD, for several reasons.

There are very few existing diagnostic tools which have been specifically designed for refugee children and young people. Instead, existing diagnostic tools for young people relating to post traumatic stress, depression and anxiety are used. However, while these tests have proven scientifically reliable and consistent when used on refugee children, they are not necessarily appropriate or helpful. Risk factors are exceptional for refugee children and young people, because they have survived multiple traumatic events rather than the single traumatic incident which the majority of trauma scales are used to measure. Diagnostic tools such as these pathologise the normal response of refugee children to grossly abnormal experiences (Brough et al, 2003; Lustig et al, 2004; Rousseau and Drapeau, 2003).

In addition, focusing on post traumatic stress (PTS) responses often leads to the assumption that if refugee children do not have PTS symptoms, then they are not seriously affected. Checklists or structured interviews focusing on PTS symptoms may fail to capture the variety of refugee children's stress reactions, such as of grief, loss, or readjustment difficulties (Brough et al, 2003; Hjern and Angel, 2000).

As well as this, the PTS model is a Western cultural framework which treats reactions to trauma as a medical condition. It may be irrelevant for refugee children, who may have different cultural expressions of trauma as well as different cultural knowledge about how to work through it (Angel et al, 2001; Lustig et al, 2004).

However, it is important to be able to identify when children are showing PTS symptoms. Most importantly, these can indicate that the child needs special support or care, and can also point to other aspects of the child's resettlement experience which may be contributing to the trauma. Conversely, PTS symptoms leave children more vulnerable to experience subsequent stress in resettlement. If a refugee student is displaying PTS symptoms, teachers and counsellors can assume that the child is having trouble with the resettlement process, and aim to address this with holistic interventions that aim to support the entire resettlement process.

If you suspect that a child is displaying PTS symptoms it is essential that they be referred to a specialist counselling service.

## **Section d**

### ***Identifying PTS symptoms in preschool-age children***

- exhibit anxious attachment – clinging, whining, tantrums and attachment to security objects
- regression – reverting to early childhood behaviour patterns
- thematic play – recreating struggle, trauma and abuse with dolls, toy guns and playmates
- traumatic dreams and nightmares
- obsessive telling of story
- withdrawn, avoiding playmates and adults
- mutism - refusal to talk
- illness or tiredness

## **Section d**

### ***Identifying PTS symptoms in school-aged children***

- elaborate re-enactments of trauma
- moodiness as they attempt to deal with feelings of inadequacy and attempt to establish control
- aggressive and bossy behavior in order to establish control
- decline in school or work tasks
- perfectionism in tasks and performance
- continual and/or obsessive talking about their feelings and the traumatic events they survived
- if they are not free to openly express their feelings they may develop psychosomatic complaints such as headaches, stomach aches, etc

## **Section d**

### ***Identifying PTS symptoms in adolescents***

- may exhibit all or any of the previous behaviours described
- remaining withdrawn and isolating themselves
- compliance and always trying to please
- anger and rebellion
- acting out behaviors by arguing with adults
- disobeying rules
- drug taking
- inappropriate sexual activity
- vandalism
- extremes in risk taking behavior
- pre-occupation with self

## Section e

### **THE IMPACT OF FAMILY STRESS AND POOR PARENTAL MENTAL HEALTH**

The two factors that have been found to most contribute to poor mental health amongst refugee children are family stress and parents' emotional well-being (Hjern et al, 1998). These factors are highly dependent on the resettlement environment, which, as we have seen, places many pressures on parents and families.

From this we can understand why it is necessary to treat refugee trauma among children holistically rather than focusing only on the clinical aspect. The best way to promote happy and healthy refugee parents and families is to support them in their resettlement process. This includes delivering a wide range of support services, and also welcoming them into the community. When parents and families are able to learn the language, find work, adapt to the new culture and regain control over their lives, then they will be able to move on and find a new sense of belonging. This is the single most important factor for the emotional well-being and successful adaptation of refugee children.

### **CONCLUSION**

Many of the symptoms listed above are similar to those experienced by Australian children who are sexually abused, or have experienced violence in the home. There is overlap between the problems experienced by some young people from CALD backgrounds and some refugees. We are looking at cases of 'compounded risk', at children who are vulnerable for a range of different reasons, and each additional risk compounds their vulnerability and lessens their resilience.

Our challenge as professionals working with refugee students is to learn to identify the symptoms which indicate that they are more than just "naughty children" or "difficult adolescents". Many of them are vulnerable and they have very few support networks.