From Being at risk to Being a Risk: welcoming refugees in challenging times

- Second Part -

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Stavanger, June 2019

Presentation Outline
Second Part

- Adopting clinical models to the growing uncertainty : A phased approach
- Phase 1: holding and addressing survival needs
  - Through programs
  - In clinical intervention
- Phase 2: working through trauma and grief
  - Considering a continuum of stress-related disorders
  - Paying attention to developmental variations
  - Fostering resilience
- Taking care of the clinical team

Clinical implications of the present context

- Questioning the focus on pre-migratory trauma and the use of the PTSD category as an explanatory model
- Trauma may not be “post” rather it is ongoing: acute trauma syndrome
- Cumulative trauma or sequential trauma may better represent the refugee trajectory
- Establishing emotional safety is the first step (NICE phased approach)

Phased Approach: Phase 1

- Ensuring survival (basic, relational and security needs): psychosocial interventions
- Seeking to comfort: targeted interventions to address symptoms without aiming at working through trauma or grief (for example to relieve nightmares)
  - CBT and/or medication, or medically unexplained symptoms
- Supporting asylum claim: being heard and believed (individual level advocacy)

Developmental specificities of stress related disorders in DSM 5 and ICD 11

- The recognition of attachment disorders as stress related disorders
- A conceptualization of stress as a continuum from normal stress to extreme/cumulative stress
  - Criterion A questioned
- The recognition of developmental differences in symptom presentation
- The problem of massive comorbidity (with conduct/ODD/ADHD/depression and other anxiety disorders)

Developmental specificities of stress related disorders in DSM 5 and ICD 11

DSM 5

- Younger than 6 years old: developmental subtype for PTSD
- Traumatic play and reenactment in children and adolescents
- Risk-taking in adolescents

ICD 11

- No subtype – less symptoms needed for PTSD but more specific
- Complex PTSD (differential diagnosis with Borderline personality disorder)
- Prolonged grief disorder

Adjustment disorder vs. sub-threshold PTSD?

Stress related disorders in immigrant and refugee children

- Overall, more exposure to stress for children with precarious immigrant status. Well-documented in refugees but also undocumented children.
- Increasing number of immigrant children have undergone extreme stress (i.e. Syrian immigrant children in Montreal)
- Type of stressors may be specific of premigratory period (war- separation) and of postmigratory period (hunger, discrimination, fear of authorities)
- Because of stigma and cultural competence issues, mental health services are underutilized by immigrant and refugee families
- Schools, family doctors and pediatricians on the frontline

PTSD guidelines for immigrant and refugee children (Canadian task force)

Screening for PTSD is not recommended in immigrant and refugee children, but should be ruled out in children presenting with:

- Mental health symptoms (internalized or externalized)
- Medically unexplained symptoms
- Learning/cognitive difficulties

Hussein a 9 year-old Somali boy

- Referred for hyperactivity and violence
- Treated with methylphenidate and considered as delinquent
- Behaviour deteriorates with placement in special class
- Assessment in transcultural psychiatry demands a long negotiation around interpreters
- Reveal massive exposure to trauma
  - Wounded by Grenada
  - Caught in cross-fire
  - Food deprivation to the point of Vitamin A blindness in brother

Medically unexplained symptoms and stress related disorders

- Most common idioms of distress:
  - Headaches
  - Stomachaches
- Frequent neurological symptoms:
  - Dizziness
  - Fainting
  - Pseudoseizures
  - Absences

Désiré

- 8 year-old boy from Rwanda
- Presenting at the E.D after fainting repeatedly in school
- Neurological exam and EEG normal
- Good social and academic adjustment
- No emotional or behavioral symptoms
- Trauma exposure before immigration
- Protecting pregnant mother
- Passing out to forget?

Ange-Marie

- 14 year old girl from Haiti
- Sent by ambulance from her school to E.D
- School refuses to take her back
- DYP signaled because of her father "Lack of cooperation"

Ange-Marie

- Recent immigration from Haiti in context of reunification with her father
- Early childhood abuse
- Subsequent emotional dysregulation interpreted as "possession" in country of origin
- Cultural misunderstanding an aversive but effective treatment?

VICTOIRE

- A 13 year-old Congolese girl
- Sent by her school to E.D after unpredictable attack (strangling) toward a peer
- Has no memory of the event. Epilepsy is evoked.
- After some time, begins to disclose former sexual abuse
- PTSD symptoms blurred by massive dissociation-avoidance
- Satanic possession evoked by peers

Implications for clinical work with immigrants and refugee children

- Think of trauma when faced with medically unexplained symptoms in immigrant and refugee children
- Absence of "typical" PTSD symptoms (nightmares-flashbacks) do not rule out trauma in children
- Invite disclosure, but do not push it
- Reassure the child environment (family, schools/day care) to restore a safe holding milieu

Usefulness of cultural formulation

- Cultural dimensions of symptoms' expression
- Cultural meaning of disorder/distress
- Coping and social network
- Cultural appropriateness of intervention-treatment
- Cultural element of patient-clinician relationship

Learning to do a cultural formulation

- Asking for a cultural consultation (C.C.S at the JGH)
- Working with an interpreter/cultural broker
- Case discussion seminars:
  - Cultural consultations and case discussion seminars associated with shift in diagnosis, with increased recognition of stress related disorders

Aggression: the blind spot
Mounir story

- Spent 4 years in “the street”
- Multiple exposure to witnessing war horror, losses of family members, suffering direct physical trauma
- Probable involvement as perpetuator (in self-defense situations?)
- Sleep with knives – very impulsive, hit when feel threatened
- Severe dissociation with CPTSD

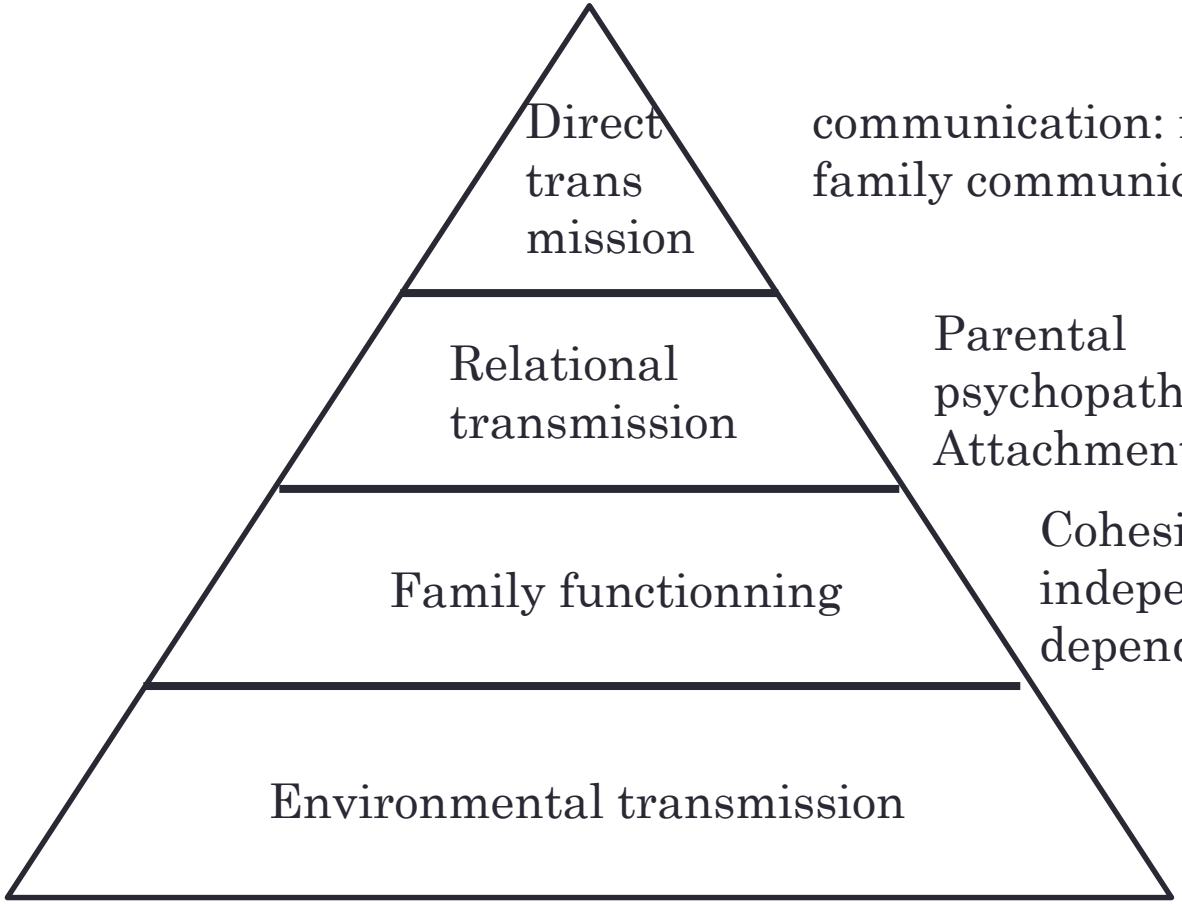
Mounir story

- The challenge of reenactment and risk taking at adolescence
- The perception of psychosocial professionals: the radical and dangerous other
- Navigating the fine line between perceived trauma repetition caused by institutional constraints and a firm and supportive environment

Formulating a treatment plan

- Ensuring safety, decreasing daily stressors
- Creating a holding network with the child life
- environments- restoring significant bonds
- Giving access to therapy (individual-family)
- Enhancing possibilities of expression
- Decreasing anxiety and depression through physical activities
- Medication is not recommended and should be the last resort

Infants and young children
The multiple layers of intergenerational trauma transmission



communication: intra family communication

Parental psychopathology
Attachment patterns

Cohesion – conflict – independence – inter-dependence

Chain of events after trauma
adversity/opportunities

Pseudo-autism?

- Mamadou 3 years olds
- ASD diagnosis – no speech
- The dyadic interview: sitting straight and still
- The summary to the child
- The long sight – the brief glance

The hibernation of the developping brain

- Cesaria from Haiti
- At 1 y.o. developp Kwashiorkor
- Separation from mother
- Mulitple traumas and deprivation
- At 9 y.o. moderate mental retardation
- At 18 y.o. repeating the IQ testing

Crying for life

- The unconsolable Carlitos – 8 months old
- Silencing the parents
- The untold betrayal
- The father political commitment
- The mother anger
- A place to calm down: the church

The (too) perfect baby

- Ali, six months old and so quiet, one could forget him
- The tortured father, the overwhelmed mother
- The needy siblings
- Ali serious gaze
- The consultation: the baby is fine, doing really well!

Taking care of the clinical team

- Institutional leadership: recognition and validation
- Training:
  - protecting continuous learning process
  - Balancing academic and experiential learning
- Addressing the structural challenges and the hidden curriculum

Taking care of the clinical team

- Team life:
  - Valuing and surviving dissent
  - Preserving case discussion time
  - Cherishing play and laughter
- Remembering we have bodies
  - Listening to them
  - Favoring non verbal expression among us

Conclusion

- We cannot give what we do not have…
- If we get hurt by our work, our patients become our aggressors
- We can learn from them how to survive and thrive……