


Spring 2019

Prevalence, Nature, and Prevention of PTSD in Refugee Children

Leah Metzger

Follow this and additional works at: <https://pillars.taylor.edu/ovc-student>

 Part of the [Child Psychology Commons](#), [Higher Education Commons](#), and the [Social Welfare Commons](#)

Prevalence, Nature, and Prevention of PTSD in Refugee Children
Leah Metzger
Taylor University

Introduction

The world today has the highest number of refugees ever recorded in history. At the end of 2017, there were 68.5 million individuals who were displaced across the globe due to persecution, conflict, violence, or human rights violations. There are three main categories of individuals within this statistic: refugees, internally displaced people, and asylum-seekers. By the end of 2017, there were 25.4 million refugees in the world (the highest ever), 40 million internally displaced people, and 3.1 million asylum seekers (UNHCR). It is currently estimated that over half of the world's refugees are children, and 28 million children have been forcibly displaced from their homes (UNICEF, 2016). The following sections will first examine what post-traumatic stress disorder (PTSD) is and how it manifests and presents itself differently within children versus adults. Next, the prevalence of PTSD in refugee children will be discussed, along with comorbidity with other mental illnesses. Afterwards, risk factors, treatment methods, and protective factors will also be mentioned. Finally, children refugees are looked at through a biblical lens.

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) wasn't formally recognized as psychiatric disorder until 1980. For some time, it was thought children and adolescents couldn't develop PTSD, but today we know that is not true. Although it hasn't been studied as in depth, researchers are now developing a framework for how PTSD may manifest itself in children across developmental stages. An individual is at risk for developing PTSD when they experience "an event that involved a threat to one's own or another's life or physical integrity and that this person responded with intense fear, helplessness, or horror" (Hamblen & Barnett, pg. 1, 2003). Traumatic events can include a variety of things, including natural disasters, violent crimes, community violence, war, abuse, and more (Hamblen & Barnett, 2003). It is also important to note that exposure to a traumatic event can be indirect and vicarious, such as learning about or hearing the details to something violent (APA, 2017).

Prevalence

According to the American Psychological Association (APA) (2017), PTSD affects approximately 3.5% U.S. adults, and 1 in 11 people will be diagnosed at some point in their life. However, there is no consensus on the exact percentage of children in the United States who are dealing with PTSD. These studies indicate that approximately 15 to 43% of girls and 14 to 43% of boys experience a trauma within childhood. Within these populations, 3 to 15% of girls and 1 to 6% of boys develop PTSD (Hamblen & Barnett, 2003). Overall, girls are more likely to develop PTSD than boys. The variation in these statistics could be due to different manifestations of symptoms and a lack of awareness. Symptoms generally fall under three categories: anxiety, stress, or depression. This can include intrusive thoughts or memories of the event, avoidance of any reminders of the traumatic event, continued anxiety, and physical reactions such as changes in sleep and personality (Hasan, 2018).

Manifestation in Children

The way PTSD manifests itself in children and teens can look vastly different than it does in adults. Because very young children are unable to verbalize their emotions and fears, PTSD may manifest itself in more generalized fears, including separation anxiety and avoidance of situations that remind them of the trauma. They may also experience sleep disturbances and a

regression in developmental skills, such as potty training. Young children may become occupied with certain words or symbols, and their trauma will most easily be seen in their play (Hamblen & Barnett, 2003).

Elementary school children are not likely to experience flashbacks or amnesia, but they often skew the timeline of the trauma and believe there were warning signs of impending danger. Because of this, they may be likely to believe that they should have been able to predict the trauma, engage in self-blame, and will become hyper aroused in an attempt to predict future trauma. School-aged children are also likely to engage in post-traumatic play or reenactment which can be seen in drawings, play, and behaviors. The manifestation of PTSD in adolescents will be the most similar to adults, and they are more likely to become aggressive and impulsive as a result of their trauma (Hamblen & Barnett, 2003).

If an event is unpredictable and uncontrollable, the event is much more likely to be traumatic and destructive. We now know that exposure to trauma can directly impact the developing systems in children and adolescents. This includes brain development, cardiovascular development, along with changes hormonal and immune system development. These can result in emotional dysregulation, behavioral impulsivity, increased anxiety and startle response, and sleep abnormalities. (Schwarz & Perry, 1994). This poor development and the presence of dysregulated systems can also make them more vulnerable when exposed to psychological stressors later in life. The most common symptoms of children suffering from PTSD are intrusive recollections (81%), distressing dreams (80%), being upset by reminders (80%), and flashbacks (74%) (Thabet, Ibraheem, Shivram, Winter, & Vostanis, 2009).

For refugee children specifically, children in the Gaza strip who experienced trauma experienced difficulty eating and going to bed, sleeping with their parents, poor concentration, attention seeking, dependency, tantrums, and disruptive fears. Overall, preschool children who are suffering from PTSD are likely to manifest their symptoms in forms of anxiety and behavior problems, while adolescents are more likely to have flashbacks and depression (Thabet, Karim, & Vostanis 2006).

Refugee Children

Refugees are “individuals who have been granted protection in another country because of a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinions” (Beise, Grojec, Hansen, Matthes, Rosengaertner, & You, 2017). As of 2015, there were 10 million child refugees and 1 million child asylum seekers. Children may migrate for a variety of reasons, including the need to escape violence, persecution, climate change, poverty, a desire for a better life, and more. Most likely, refugees cannot return home or are afraid to do so. War, ethnic, tribal, and religious violence are the leading causes of refugees fleeing their homes (The UN Refugee Agency (UNHCR), n.d.). These reasons frequently overlap, and many children will travel on their own because their chances of success are estimated to be greater on their own. Between 2015 and 2016, 300,000 unaccompanied and separated children either applied for asylum or were apprehended across the world, but in reality this number is probably much higher. When a child travels alone, they face an increased risk for exploitation and abuse. For example, 75 percent of children who crossed the Mediterranean in 2016 experienced abuse amounting to trafficking (UNICEF, 2016). The events and experiences these children witness in their home countries, while migrating, in refugee camps, and in their country of refuge can increase their risk of developing PTSD.

Prevalence and Comorbidity

With more than 28 million children forcibly displaced from their homes in 2016, there is a pressing need to understand the effects being a refugee has on a child. It has already been established that children who have lived in war zones and become refugees are at a higher risk of developing different types of psychopathology (Thabet, et. al, 2009). Studies have shown that children who are refugees are at a higher risk for developing PTSD, anxiety disorders, sleep disorders, depression, and emotional and behavioral disorders (Fazel & Stein, 2002). Specifically, exposure to traumatic events has been connected to oppositional defiant disorder, conduct disorder, and attention deficit hyperactivity disorder (ADHD) (Pine, Costello, & Masten, 2005). Khamis (2012) studied the impact of war on PTSD in children and discovered high comorbidity with anxiety and depression. In addition to this, a study from 2004 focused on the relationship of PTSD and depression among refugee children in a war conflict and found high levels of comorbidity (Thabet, Abed, & Vostanis, 2004).

However, one limitation in this field is that it is difficult to estimate the exact prevalence of these disorders due to the nature of the population and cultural barriers that are in place. Even so, several studies continue to show significantly raised levels of these disorders when compared to a control population (Fazel & Stein, 2002).

Among newly arrived refugee children, the rate of anxiety is between 49% and 69% (Fazel & Stein, 2002). Studies from the Middle East, the former Yugoslavia, and Palestine have all established high rates of PTSD in refugee children and comorbid disorders. A longitudinal study of Palestinian children found the prevalence rate of PTSD to be 40.6%. High prevalence of PTSD was found to be correlated with children being displaced from their community (Thabet, et al., 2009). Cambodian refugees are another group that has been widely studied. In a longitudinal study, they found PTSD rates in children to be 40%, depression at 21%, and anxiety at 10%. After three years, the levels were still shockingly high, with the rate of PTSD and depression actually increasing over time. Even after six years, PTSD was still prominent in their sample and researchers suggested children who are diagnosed are more vulnerable to traumatic events later on (Fazel & Stein, 2002). All of these studies point to not only shockingly high levels of PTSD among refugee children, but also the increased risk of other mental disorders such as depression, anxiety, and behavior difficulties. In addition to this, these levels have been shown to stay fairly constant years later, making children more vulnerable to future trauma.

Risk Factors

Exposure to trauma can happen to a refugee child in three main stages. The first is in their country of origin, where they may have been forced to flee their homes, witness or experience violence, lose close family and friends, and lose their sense of stability/normalcy. Children can be exposed to even more trauma in the second stage, when they make the journey to a new country in search of refuge. Trauma in this stage can include separation from parents, trafficking, exploitation, and life threatening situations. The final stage is when they arrive in a new country, and face the struggles of integrating into a new way of life, settling down, establishing community, and possibly experience hate from others (Fazel & Stein, 2002).

In general, there are three main risk factors that help predict how likely a child is to develop PTSD. This includes the severity of the traumatic event, parental reaction, and physical proximity and exposure. As a rule of thumb, the more severe the traumatic event the more likely the child is to develop PTSD (Hamblen & Barnett, 2003). Parental support has been shown to be a major factor in whether or not a child develops PTSD. If a parent is killed or psychologically

unavailable, a child has a much higher risk of developing PTSD. Other factors that can be considered to predict the potential impact of a trauma is the amount of life disruption (such as fleeing home, becoming an orphan, etc.), and the amount of social disorganization that follows (such as social order and emergency systems collapsing into chaos) (Pine, Costello, & Masten, 2005).

It is important to note that exposure to a traumatic event does not have to be experienced first-hand in order for a child to develop PTSD. A child could be exposed to a traumatic event in the event of hearing about a horrific event or seeing/learning about events on the television (Parekh, 2017). Terrorism and war add unique dimensions to this discussion, because children may become targets for political or ideological reasons. This fear and uncertainty against the child's identity and family can result in PTSD even if it is not experienced directly (Pine, Costello, & Masten, 2005). War also opens the door to a variety of risk factors a child may experience. They may directly witness violence and experience trauma, but they may also suffer problems of malnutrition, physical ill health, displacement, and loss of support networks (Thabet, et. al, 2009). Economic struggles have also been shown to indirectly impact the psychological well-being of refugee children. Adolescents from the Gaza strip who were experiencing "economic pressure were at the highest risk for psychological distress including PTSD, depression and anxiety" (Khamis, pg. 7, 2012). This may be because it is a source of stress in their lives while simultaneously decreasing resources a child has access to, which may serve as a buffer from trauma.

Additionally, researchers have been able to identify which traumatic events are the most likely to result in the development of PTSD. Events that threaten the safety and health of self and parents are more likely to lead to PTSD than events such as forced removal from home (Pine, Costello, & Masten, 2005). Furthermore, interpersonal traumas, such as rape and assault, are more severe than indirect traumas. Studies have found that as many as 100% of children who witness parental homicide develop PTSD, along with 90% who are sexually abused (Hamblen & Barnett, 2003).

A group of children that are particularly vulnerable to trauma are those who are traveling unaccompanied. As mentioned earlier, between 2015-16, there were at least 300,000 unaccompanied children trying to find refuge. Unaccompanied or separated children have no social or support system to guide them along this journey, which puts them at an automatic disadvantage. In addition to this, children who are unaccompanied are at an increased risk of neglect, sexual assault, and other abuses (Fazel & Stein, 2002). Likewise, due to the increased lack of opportunities for families and children to migrate legally, many are placing their hands in the fate of smugglers. In survey of migrants from Africa, 68% reported that they used smuggling services, increasing the risk of economic, physical, and sexual exploitation and abuse (Beise, Grojec, Hansen, Matthes, Rosengaertner, & You, 2017).

Overall, refugee children and their families face an increased risk of exposure to traumatic events that can lead to the development of PTSD. These can be experienced directly or indirectly, and can occur at any point in their migration and search for refuge. Children who lose parental support (through death, separation, or parental incapacity) and experience direct interpersonal attacks are the most likely to develop PTSD. However, it is well established that trauma can be a long and complex process, with the effects of events accumulating over time. The most dangerous situation for children occurs when there is repeated exposure to violence and an undermining of civil society (Pine, Costello, & Masten, 2005). As the number of risk

factors and experiences increases in a child's life, so does the likelihood that they will develop psychological disturbances, including PTSD (Fazel & Stein, 2002).

What can be Done?

It is important to note that, in general, children tend to be resilient and recover quickly from exposure to traumatic events unless they or their families are directly involved in harm (Pine, Costello, & Masten, 2005). The problem arises when there is a direct threat to themselves or family, or violent events happen repeatedly and the effect of these traumas is compounded. There are certain things that can and should be done immediately in order to lessen the effects of trauma that refugee children experience, which will be briefly mentioned here.

The first is making attempts to combat the devastating effects of parental separation and loss of parental support. Once children develop attachments to their caregivers, they are sensitive to a loss in this area, and separation from a parent can be more traumatic than the event itself. Due to social referencing, children will gauge threats based on the response of parents, so if a parent is terrified and irrational, children will follow suit (Pine, Costello, & Masten, 2005). If an adult behaves calmly, this has been shown to mediate distant trauma and the fears of children. Because of this, there is a call for interventions to target parents and teachers to teach them how to be a buffer, as well as teaching them how to limit exposure of traumatic events to children. It has been shown repeatedly that adults can serve as protective factors, so intervention targeting this population can theoretically be very helpful (Pine, Costello, & Masten, 2005).

In addition to parent-based interventions, there is also a need for a variety of treatments, including individual, family, group, and in schools. Cognitive behavioral therapy has been shown to be an effective treatment for PTSD, along with treatments including play, art, and music therapy (Fazel & Stein, 2002). School should also be targeted for refugee children specially because they can serve as a source of stability and education, as well as emotional and social development. There is a great need for professionals and organizations to come together in order to address the needs of refugees. These partners can include "legal/immigration teams, voluntary organizations, ethnic support groups, social services, and schools" (Fazel & Stein, pg. 3, 2002).

Biblical Lens and Conclusion

There are several passages and verses a Christian draw on when it comes to both treating psychological disorders as well as coming alongside refugee children. Deuteronomy 10:18 says, "He defends the cause of the fatherless and the widow, and loves the foreigner residing among you, giving them food and clothing." In addition to this, Matthew 25:35-36 talks about whatever we do for the least of these around us, we do for Christ himself. When we come alongside refugees, serve them, and provide aid, we are doing it for Christ. As Christians we are called to love and serve those around us because Christ first loved us. Psalm 82:3 says, "Defend the weak and the fatherless; uphold the cause of the poor and the oppressed." Refugee children and their families face countless traumas and exposure, and are at an increased risk for developing PTSD and other psychological disorders. These challenges and situations put children in extremely vulnerable positions, and power is often abused in these circumstances. Abuse, exploitation, false promises, and violence run rampant. Refugees are in need of a variety of professionals and organizations to come alongside them in service and in love to help combat all angles of this problem. Christians should do that they can, in whatever area they are available or passionate, to serve this population. The Church should become one of the largest and strongest defenses and support systems for refugees instead of ignoring injustice and suffering.

References

- Beise, J., Grojec, A., Hansen, C. B., Matthes, J., Rosengaertner, S., & You, D. (2017). A child is a child: protecting children on the move from violence abuse and exploitation.
- Fazel, M., & Stein, A. (2002). The mental health of refugee children. *Archives of disease in childhood*, 87(5), 366-370.
- Hamblen, J., & Barnett, E. (2003). PTSD in children and adolescents. *National Center for PTSD*
- Hasan, S. (2018, July). *Posttraumatic Stress Disorder (PTSD)*. Retrieved April 2019, from KidsHealth: <https://kidshealth.org/en/parents/ptsd.html>
- Khamis, V. (2012). Impact of war, religiosity and ideology on PTSD and psychiatric disorders in adolescents from Gaza Strip and South Lebanon. *Social Science & Medicine*, 74(12), 2005-2011.
- Parekh, R. (2017, January). *What is Posttraumatic Stress Disorder* . Retrieved April 2019, from American Psychological Association (APA) : <https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd>
- Pine, D. S., Costello, J., & Masten, A. (2005). Trauma, proximity, and developmental psychopathology: the effects of war and terrorism on children. *Neuropsychopharmacology*, 30(10), 1781.
- Schwarz, E. D., & Perry, B. D. (1994). The post-traumatic response in children and adolescents. *Psychiatric Clinics*, 17(2), 311-326.
- Thabet, A. A. M., Abed, Y., & Vostanis, P. (2004). Comorbidity of PTSD and depression among refugee children during war conflict. *Journal of child psychology and psychiatry*, 45(3), 533-542.

Thabet, A. A., Ibraheem, A. N., Shivram, R., Winter, E. A., & Vostanis, P. (2009). Parenting support and PTSD in children of a war zone. *International Journal of Social Psychiatry, 55*(3), 226-237.

Thabet, A. A. M., Karim, K., & Vostanis, P. (2006). Trauma exposure in pre-school children in a war zone. *The British Journal of Psychiatry, 188*(2), 154-158.

The UN Refugee Agency. (n.d.). *What is a Refugee?* Retrieved April 2019, from USA for UNHCR.

(UNHCR), T. U. (2016). *Refugee statistics*. Retrieved April 28, 2019, from UNHCR:
<https://www.unrefugees.org/refugee-facts/statistics/>

Unicef. (2016). *Uprooted: The growing crisis for refugee and migrant children*. UN.

UNICEF. (2017). *Child refugee and migrant crisis*. Retrieved April 2019, from UNICEF USA:
<https://www.unicefusa.org/mission/emergencies/child-refugees>