Facing the challenge of regulation problems in 0-5 year olds from refugee backgrounds

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Introduction

Regulation, in 0-5 year olds from refugee backgrounds, is affected by many interconnected factors. Unhelpful labels can be given to the child and their behaviour, when the refugee experience is not taken into account, and this can affect the responses of caregivers and professionals.

Clinical observation and assessment at STARTTS, which are consistent with the trauma studies of Perry (2011), Porges (2011) and Van der Kolk (2010), show that children who come for therapy present with health issues, sensory processing problems, aggression, irritability, controlling behaviours, lack of focus, and speech delays. These presentations can all stem from the brain's survival system.

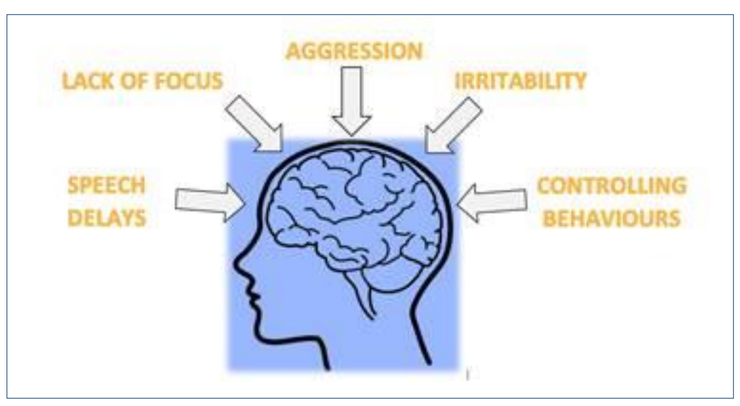

Fig. 1 Some areas of brain associated with dysregulation

Background

These children have not just faced one adversity but several layers of traumatising experiences. Of the ten adverse childhood experiences - ACEs (Curran, 2016) some of the children seen at STARTTS have each experienced all ten of them, in addition to displacement, organised persecution, and deprivation. Post traumatic signs and symptoms can also be passed from one generation to the next.

Their lives have been chaotic and unpredictable from the moment of their birth. Because it is earlier than their language development - the common triggers are at an unconscious and nonverbal level. The impact of these layers of experiences means that normative development does not occur so they are continuing to rely on earlier skills. Rather than developing new competencies, their energy is invested in survival.

Interventions

A mix of therapeutic interventions is used, to include such modalities as play therapy, music and movement, sensory motor activities and mindfulness. Repetitive, patterned, sensory, rhythmic activities (Perry, 2011) and other non-verbal techniques are particularly helpful.

References

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Complex interactions

Due to the early experiences of the children we see that they may react differently to other children. For one child, putting a boat on the belly, and observing it move up and down with the in breath and outbreath, may be a fun activity. For another it may remind them of the frightening boat journey.

These children may have dual diagnosis, and they may have sensory processing dysfunction where the sense of the world is distorted.
An oversensitivity to sound, taste, touch or sense of movement may cause the child to feel unsafe, because of implicit traumatic memory of bombings, crowds on the boat, the sense of the boat's movement or other traumatic experiences. Is the child's behaviour defiance or impairment? When a child looks physically perfect, it's easy to assume that his or her negative behaviour is intentional.

The parents who come to see us are suffering from their own trauma. They are emotionally and physically exhausted. In this state it is difficult to respond attentively to the child's distress. The child's crying may trigger the parent's implicit memory of massacres or escape situations.

There are many dynamics, so we have to make decisions about the most appropriate way to work in each situation.

The children referred to the STARTTS Early Childhood programme are generally considered to be a problem for others, such as care givers, child care or schools. Sometimes behaviours are not recognised to be within normal developmental challenges.

Conclusion

Our aim is not just to improve the child's symptoms but to also enhance and build on safe care giving systems, by working respectfully with the parent, who is then informed and empowered to work with their own children.