

One often forgotten element of the refugee crisis is mental disorders amongst infants, children, adolescents and their families.

Many individuals and organizations are stepping forward to assist with the settlement of Syrian refugees. Planning is under way to provide refugees with needed medical care and access to housing, social services, legal advice and education with the hope of leading refugees to success in school and meaningful job opportunities. One often forgotten element in the midst of macro level settlement activities is the need to identify the supports required by each individual refugee, including those needed for mental health and psychological wellbeing. Survivors may have witnessed atrocities including the death of loved ones, famine and sexual violence. Resources to address the psychological impact of exposures to traumatic events will be required. People of all ages with Post Traumatic Stress Disorder (PTSD) or Acute Stress Disorder require and deserve the specialized treatment that only those with adequate training and experience can provide. Refugees suffer, as well, from co-morbid disorders such as severe depression, all of which can impact upon cognitive functioning. The combined result of these conditions often interferes with educational and vocational planning and community integration.

53% of the Syrian survivors are children and adolescents who may not have the cognitive and emotional skills to process complex trauma. While most children are incredibly resilient, frequently parents and healthcare professionals fail to recognize the responses in infants and pre-school age children that are indicative of suffering from PTSD. Almqvist and Branell-Forsberg interviewed forty-seven Iranian families living as refugees in Sweden. Parental interviews focused on the exposure of their pre-school age children to organized violence and post-traumatic symptomatology. Information provided by the children increased the prevalence of PTSD from 2% to 21% for 42 of the children with traumatic exposures through war and persecution. The stability of the prevalence of PTSD symptomatology was high with 23% of these children meeting the full criteria for a diagnosis of PTSD two and half years later (*Refugee Children in Sweden; Post Traumatic Stress Disorder in Iranian Preschool Children*). Other studies of child refugees from various war zones have found rates of PTSD amongst children and adolescents of between 21% and 50%.

Young victims of trauma may present in the classroom with symptoms that appear as behavioural or attention problems (i.e. Conduct Disorder or Attention Deficit Hyperactivity Disorder). Since 70% of severe persistent mental disorders begin in childhood or adolescence, children deserve to be understood and cared for adequately and given the tools necessary to process trauma, develop coping strategies and the resiliency skills that are necessary to overcome their mental disorders. School psychologists and community-based paediatric and clinical psychologists are uniquely positioned to provide such tools. Our schools will need added resources to ensure that these children do not go untreated, labeled, wrongly diagnosed, inappropriately medicated or left un-medicated and sent on a negative life trajectory.

What is clear from the research is not everyone exposed to traumatic events develops PTSD. This disorder results from some combination of personal vulnerability factors, the characteristics of the traumatic event(s), the individual and family members' appraisal of the events and post-trauma factors. In accepting responsibility for 10,000 Syrian refugees, the Ontario government has a moral obligation to ensure that the appraisals of traumatic events are put into a proper context through psychological interventions, where necessary.

Such support will provide refugees with a sense of safety and security, leading to a positive settlement in Ontario. Poor parental adjustment following traumatic events has been shown to be associated with PTSD symptoms in young people. Children have less prior knowledge of how the world works. Their view of traumatic events is influenced by parental appraisal of the same events. While it will be important to address the psychological reactions of each young person, it will be equally important to provide their parents with similar psychological support to prevent undue distress in children (*Handbook of Interventions that Work With Children and Adolescents: Edited by Paula Barrett and Thomas Ollendick, 2004*).

It is recommended that, prior to any treatment intervention such as trauma informed Cognitive Behavioural Therapy (CBT), a proper assessment must be conducted. The assessment of PTSD is a potentially threatening experience. Comprehensive assessments are required - this is not the work that should be conducted by anyone who does not understand PTSD. A proper psychological assessment, conducted by psychologists with expertise in both psychological trauma and cultural sensitivity, will identify co-morbid disorders such as depression, behavioural or adjustment disorders, autism spectrum disorder, as well as learning or developmental intellectual disabilities. In turn, the psychologist will prescribe the appropriate psychological intervention that will enable the child to achieve his or her full potential. Assessments are often also needed in more complex cases to understand the root cause of mental health disability, as well as cognitive-functional impairments. Assessments provide rich histories through in-depth interviews and are combined with psychometric testing to identify personal strengths and weaknesses. They are the stepping-stones to the development and implementation of individualized treatment and settlement plans that can then be used to meet all of the challenging requirements of each refugee.

Trauma research during the past 20 years has heavily emphasized cognitive-behavioural models from both etiology and treatment perspectives. These models stress the role of maladaptive cognitive strategies in the development and maintenance of PTSD. PTSD sufferers often attach dysfunctional meaning to their symptoms. Intrusive thoughts may be interpreted as a sign of a mental illness and stigma may prevent the individual from acknowledging the need for psychological supports. PTSD sufferers hold dysfunctional beliefs, such as their life has been ruined by an unsafe world. They may experience “mental defeat” (hopelessness - a risk sign for suicidal ideation), and alienation from others. To address these symptoms, refugees often develop maladaptive coping strategies such as avoidance, thought suppression, rumination and distraction that block the individual’s ability to fully process traumatic events. In turn, these beliefs contribute to the individual’s sense that the traumatic events will continue to have damaging implications in the present and generate a sense of a “current threat” (*Ethlers & Clark, 2000*). Cognitive-Behavioural approaches have proven effective in assisting the individual to develop more effective emotional processing of the events. Cognitive-Behavioural Therapy (CBT) is the most frequently studied psychological treatment. In rigorously controlled investigations of its efficacy in the treatment of PTSD in adults and children, it has been found to be effective in preventing PTSD from becoming a life long chronic psychological disorder (*Cohen, Berliner & March - review of the literature, 2000*).

Psychologists are stepping up to the plate to provide the necessary level of expertise needed to assess each refugee and to provide the psychological treatments they may need. In spite of government’s best efforts, Ontario’s publically funded mental health system is still struggling to meet the acute mental health needs of young people and their families. Ontario will be hard pressed to address the mental health needs of Syrian refugees. The OPA’s network of trained trauma psychologists was established to provide the psychological expertise to deliver the evidence-base trauma interventions to children, adolescents, adults and their family members will need to successfully settle into the fabric of Ontario’s communities. The extensive work of the OPA to address PTSD amongst refugees, veterans, active military personnel and first responders has uniquely prepared our Members to deliver evidence-base trauma interventions through the supports provided by members of the OPA.

Contact: **Jan Kasperski**, Chief Executive Officer, at jan_kasperski@psych.on.ca