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Post traumatic withdrawal state in children seeking asylum: a case report and analysis of existing literature

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Abstract

Refugee and asylum-seeking and children experience wide range of difficulties during the migration process. A number of non-organic syndromes (Resignation Syndrome, Pervasive Refusal Syndrome and Depressive Devitalisation) presenting with potentially life-threatening refusal in eating, drinking, speech, mobilisation, and personal care accompanied with social withdrawal and apathy have been reported in this population following witnessing or experiencing a traumatic event. The majority of cases have been reported in Sweden. We present a case from the UK. Our patient, a Middle Eastern adolescent boy, went into a state of withdrawal after witnessing a fatal beating in 2018. We have offered robust social care in addition to medical and psychological interventions. We analyse the literature to understand the complex interplay of moderating and mediating factors in the socio-political context of this population and how this affects the management. In our opinion, this group of rare but debilitating and neglected syndromes should be recognised and treated, given the severity of symptoms.

Keywords: Refugee; Asylum seeking; Migration; Withdrawal; Resignation Syndrome; Pervasive Refusal Syndrome; Depressive Devitalisation; Children

Introduction

The numbers of refugee and asylum-seeking populations continue to rise, especially given the recent conflicts in Afghanistan, Syria, and Ukraine and the increasing incidence of climate-related disasters (Knights et al., 2022). Nearly a third of refugee and asylum-seekers are children (defined as people below age 18) (UNHCR, the UN Refugee Agency, n. d.). Displaced people may be more vulnerable to poor mental health than other migrants for several reasons. We aim to explore the presentation and management of post-traumatic withdrawal state in an asylum-seeking child seen in our Child and Adolescent Mental Health Services (CAMHS) clinic and analyse the understanding and treatment in the current literature.

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Background

Stressors can occur at any of the three stages of the migration journey of displaced people. The first stage is the departure from home countries where many have been forced to flee because of political unrest, violence, or environmental catastrophes. The second stage is the journey to a country of refuge. This can take months and may involve travel through different countries, and individuals are often exposed to life-threatening dangers. The final stage is the attempted settling in the host country. This is commonly accompanied by uncertainty and fear of deportation back to the crisis that has been fled (Hodes & Vostanis, 2019).

Refugee and asylum-seeking children have a higher prevalence of psychiatric symptoms compared with non-refugee populations. High rates of trauma symptoms, depression, and anxiety have been reported. Additionally, increased aggression and hyperactivity may be displayed by these children (Parviainen et al., 2022).

A number of non-organic syndromes presenting with a potentially life-threatening refusal in eating, drinking, speech, mobilisation, and personal care accompanied with social withdrawal and apathy have been reported in refugee and asylum-seeking children who have witnessed or experienced a traumatic event. Diagnostic nomenclature for the presentation in this demographic includes resignation syndrome (RS) (Figure 1), pervasive refusal syndrome (PRS) (Figure 2), and depressive devitalisation (DD) (Figure 3) (Ngo & Hodes 2020). There is significant overlap with various psychiatric disorders, including depression, post-traumatic stress disorder (PTSD), selective mutism, anxiety disorders, chronic fatigue syndrome, anorexia nervosa, somatization disorder, conversion disorder, factitious disorder, and catatonia. However, none of these diagnoses fully explain the specific group of symptoms observed (Jarbin et al., 2022).

Figure 1. Diagnostic criteria for pervasive refusal syndrome

a)	Partial or complete refusal in three or more of the following domains: a. Eating b. Mobilization c. Speech d. Attention to personal care
b)	Active and angry refusal to acts of help and encouragement
c)	Social withdrawal and school refusal
d)	No organic condition accounts for the severity of the degree of symptoms
e)	No other psychiatric disorder could better account for the symptoms
f)	The endangered state of the patient requires hospitalization

Note. Taken from Jaspers et al. (2009).

Figure 2. Assessment scale for resignation syndrome

Symptom	**Grade 1**	**Grade 2**
Ability to communicate	Non-verbal response	No response at all
Ability to fulfill daily routines	If motivated/reminded	Not at all
Ability to move	Is able to walk with help	Lies down, unable to stand No facial expression
Basic survival skills	Is fed, chews, or swallows on his/her own	Tube fed
Awareness about the world	Can hear or react to certain sounds. Can open eyes	Totally detached

Note. The grading system for resignation syndrome according to Swedish Government Official Reports. Reprinted from Makris (2021). Original source: 'Asylum-seeking children with Resignation Syndrome—trauma, culture and the asylum process' (Asylsökande barn med uppgivenhetssyndrom-trauma kultur, asylprocess, SW, No. 49 ISBN 91-38-22 573-7), SOU Report.

Figure 3. Depressive devitalization grading definition

Grade 1: This level of severity includes children at risk of developing severe depressive devitalization who are showing clear signs of depression but who are not in need of somatic care interventions.
Grade 2: The child is withdrawing in terms of communication and contact and has reduced mobility and appetite.
Grade 3: The child is in a state of complete function loss, which means that the child is unresponsive, his or her mobility is extremely limited, and feeding needs to be provided either through a nasogastric tube or through spoon feeding. The child needs help with all daily routines including hygiene and getting dressed and is often unaware of bodily signals (such as hunger or going to the toilet).

Note. MAST grading of depression deviation according to Blight et al. (2012). MAST grading is a description of symptoms used to assess the child's level of functioning/extent of devitalization in order to decide on the level and type of health care intervention needed. MAST grading was developed by the Stockholm County Council and has not been used in other countries.

Quantifying the total number of cases globally is challenging due to the different nomenclature used and the varying quality of reports. Cases of RS have been reported in asylum-seeking children in Sweden since the late 1990s. There was a peak prevalence of RS in Sweden from 2003 to 2005, with 424 cases identified (von Knorring & Hultcrantz, 2020; Sallin et al., 2016; Sallin et al., 2021). DD was diagnosed in 25 cases in a 2011 Swedish ethical report (Blight et al., 2012). According to Sallin (2021), RS has been diagnosed in Sweden until as recently as 2020. Very few cases of children with the same or similar symptoms have been reported from other countries and none in the UK that we are aware of. A 2018 study reported that 15 refugee and asylum-seeking children developed PRS in Nauru (Newman et al., 2020). A case for which RS was included as a diagnostic differential was identified in Greece in 2019 (Makris et al., 2021).

Case presentation

Our patient, Khaled (pseudonym), a 15-year-old Middle Eastern boy seeking asylum in the UK, was referred to our outpatient CAMHS from primary care in January 2020. On presentation, he was withdrawn and apathetic. He spoke minimally and selectively and required heavy prompting and encouragement with activities of daily living, some of which his parents were simply doing for him.

According to his father, Khaled was born via normal vaginal delivery without birth trauma or neonatal support. His father described normal developmental processes in childhood without deficits in social, motor, and cognitive function. Khaled was not permitted to attend school due to the family's stateless status and as such did not learn to read or write. Otherwise, his father labeled him a 'normal, healthy, happy child'.

The family fled from their home country to Greece in 2017 due to political persecution. While in a refugee camp in Greece in 2018, Khaled and his family witnessed the beating and death of a stranger in their tent. His father reported that he became withdrawn from that moment onwards; he stopped speaking, making eye contact, and most spontaneous movements. The rest of the family was also traumatized by what they witnessed. They continued their migration journey and arrived in the UK in December 2019.

Once under our care, Khaled was initially treated with art and behavioral therapy, but progress was poor, so he was referred for medical review to rule out catatonia or underlying organic dysfunction. Physical examination and investigations, including blood tests, electrocardiogram (ECG), and electroencephalogram (EEG) were unremarkable. He did not meet the diagnostic criteria for psychiatric illnesses such as depression, anxiety, anorexia nervosa, or PTSD. It was not deemed appropriate to utilize psychotropic medication.

The multidisciplinary team (MDT) has taken a holistic approach to managing Khaled's case, with a particular focus on the social and psychological aspects of his care. We referred Khaled to a program through which he attends school for an hour a week. We have encouraged the family to attend community cafes to meet families from similar backgrounds and to access English lessons. The family was referred to Social Services for Early Help as tensions were noted in the relationship between Khaled's parents. His father has also been supported to self-refer for psychological treatment as he is bearing the burden of caring for Khaled. We have implored the local MP to prioritize their asylum claim as the case has been delayed due to the COVID-19 pandemic, but as of yet, they have not been granted residency. We are noticing very slow and gradual improvements in Khaled's ability to participate in psychological therapy as he is now able to participate in Eye Movement Desensitisation and Reprocessing (EMDR), and he demonstrates a greater variety of spontaneous movements.

Literature analysis

We analysed systematic reviews and case series of refugee and asylum-seeking children who developed social withdrawal symptoms (including RS, PRS and DD). Different articles highlight a complex interplay of moderating and mediating factors within the formulation.

Almost all children across the studies had experienced traumatic events before the onset of the withdrawal state. This was seen as typically gradual with a prodromal presentation of a 'variety of psychiatric disorders' but most commonly depression in girls and PTSD in boys. Suicidal thoughts or attempts were also common in these cases. Some children went straight into a withdrawal state after being a victim of trauma or witnessing a traumatic event (Ngo & Hodes 2020).

Several predisposing factors were featured across the literature. A premorbid personality of shyness and anxiety with high levels of conscientiousness, perfectionism, drive to achieve, and inability to cope with perceived failure was commonly described. History of trauma, personal pre-existing mental disorder, family history of mental disorder, and neurodevelopmental disorder or intellectual disability were also listed as predisposing factors (Ngo & Hodes 2020). Published studies demonstrate an age range of 7-19 years at onset, with a slight female majority of cases (von Knorring & Hultcrantz, 2020). Patients in most reported cases had fled from Central Asia or the former Soviet Republic. However, cases from Iraq, Syria, Afghanistan, Bangladesh, and Africa have been reported (Ngo & Hodes 2020; Makris et al., 2021).

The precipitating factors identified included the asylum-seeking process (particularly the rejection of leave to remain), family relocation, and witnessing violence. Physical illness, sexual abuse, bereavement, problems at school, parental divorce, bullying, and perceived failure were also noted to precipitate the development of symptoms (Ngo & Hodes 2020; Otasowie et al., 2020). Overlap with the perpetuating factors identified included family relocation, stress associated with the asylum-seeking process, bullying, unresolved grief, and chronic physical

illness. Additionally, illness was maintained by enmeshed parent-child relationships, mental disorder in parents, difficult home life, and parental discord (Ngo & Hodes 2020; Otasowie et al., 2020).

Neurological symptoms were described only in a few cases, as well as some secondary symptoms such as tachycardia, pyrexia, weight gain, oedema, profuse sweating, reactivation of latent viral infections, skin ulcers, and muscular atrophy. Physical health investigations ruled out organic explanations for these symptoms. Most reported cases required inpatient admission with a multidisciplinary approach. Almost all cases reported required nasogastric (NG) feeding. Pharmacological management has been utilized in several cases; however, it appears to play a very limited role in the treatment and is more useful for comorbid disorders (Jaspers et al., 2009). Several authors stress the necessity for permanent residency, although there is disagreement about the importance of this (Makris et al., 2021; Ngo & Hodes 2020; Otasowie et al., 2020. Controversially, a recent retrospective cohort study showed that environmental therapy with patients separated from their parents and distanced from the asylum process resulted in remission (Sallin et al., 2016).

Discussion: our patient and the wider socio-political context

We propose that our patient presented with a moderate version of a post-traumatic withdrawal state. He comes from a similar age group and ethnic demographic to those reported in the literature and developed symptoms following the witness of a traumatic violent attack. His family relocated and he has not been able to acclimatize to the new culture, with the COVID-19 pandemic interrupting usual social activities and causing delays in the asylum-seeking process. We are not overly concerned about the specific nomenclature of his diagnosis, but rather with his management in the wider socio-political context. We involved social care and governmental and non-governmental organizations in his care, in addition to our standard psychiatric practice.

With the increasingly hostile geopolitical climate and the growing impact of global warming, the threat of more widespread conflict seems imminent. Children are at an increased risk of adverse physical, mental, and social health outcomes. Multidisciplinary and multilayered approaches is needed in supporting displaced communities, families, and children (Liu, 2017). Treatment must involve 'tender loving care' and carers must be patient and sensitive (Jaspers, 2009). Liu (2016) highlights the importance of trauma-focused techniques in treating children affected by war. Parenting practices play an important role in the wellbeing of children. Hence, focusing on individual and family-based approaches could break the vicious circle of war trauma, psychopathology, and dysfunctional family dynamics (Samara et al., 2020).

Conclusion

We are aware that the concept of post-traumatic withdrawal states in refugee and asylum-seeking children has been the subject of public dispute. Malingering or Munchausen syndrome by proxy have been proposed as alternative explanations (Makris et al., 2021). However, research has shown that the most significant determinants of mental health are structural: discrimination, poverty, social exclusion, and exposure to violence and conflict (Samara et al., 2020). The social and cultural context in which mental illness and distress take place must be acknowledged.

In our opinion, this group of rare but debilitating and neglected syndromes should be recognized and treated given the severity of symptoms. The focus of diagnosis and treatment must be less individualistic and should consider our current political context. Policymakers in the UK and in interim countries that host refugees should be explicitly aware of the potential consequences of trauma experienced as part of the migration journey and must consider how this process can be improved for refugee and asylum-seeking children and their families.

Further research is required into the management of this presentation as an unprecedented number of children are displaced from their homes, and it is likely that we will encounter further cases in the UK and worldwide.

References

Blight, K. B. J., Anita, D., Wilks, E., & Hultcrantz, E. (2012). Children without a voice: Report on children with symptoms of severe depressive devitalisation who have been refused asylum and protection in Sweden.

Available at: https://kclpure.kcl.ac.uk/ws/portalfiles/portal/51734563/Children_without_a_voice.pdf (Accessed: 10 October 2022).

Hodes, M., & Vostanis, P. (2019). Practitioner Review: Mental health problems of refugee children and adolescents and their management. *Journal of child psychology and psychiatry*, *60*(7), 716-731. doi: 10.1111/jcpp.13002

Jarbin, H., Saldeen, A. S., & Forslund, C. M. (2022). Pervasive Refusal Syndrome: Three Case Reports—Autism as a Predisposing Factor and Gentle Coercion to Shorten Duration of Disorder?. *Case reports in psychiatry*, 2022. doi: 10.1155/2022/2258180

Jaspers, T., Hanssen, G. M. J., Van der Valk, J. A., Hanekom, J. H., van Well, G. T. J., & Schieveld, J. N. (2009). Pervasive refusal syndrome as part of the refusal–withdrawal–regression spectrum: critical review of the literature illustrated by a case report. *European child & adolescent psychiatry*, *18*(11), 645-651. doi: 10.1007/s00787-009-0027-6

Knights, F., Munir, S., Ahmed, H., & Hargreaves, S. (2022). Initial health assessments for newly arrived migrants, refugees, and asylum seekers. *bmj*, *377,* e068821. doi: 10.1136/bmj-2021-068821

von Knorring, A. L., & Hultcrantz, E. (2020). Asylum-seeking children with resignation syndrome: catatonia or traumatic withdrawal syndrome?. *European Child & Adolescent Psychiatry*, *29*(8), 1103-1109. doi: 10.1007/s00787-019-01427-0

Liu, M. (2017). War and children. *American Journal of Psychiatry Residents' Journal, 12*(7), 3-5. doi:10.1176/appi.ajp-rj.2017.120702

Makris, G., Papageorgiou, N., Panagopoulos, D., & Brubakk, K. G. (2021). A diagnostic challenge in an unresponsive refugee child improving with neurosurgery—a case report. *Oxford Medical Case Reports*, *2021*(5), omab020. doi: 10.1093/omcr/omab020

Newman, L., O'Connor, B., Reynolds, V., & Newhouse, G. (2020). Pervasive refusal syndrome in child asylum seekers on Nauru. *Australasian Psychiatry*, *28*(5), 585-588. doi: 10.1177/1039856220956251

Ngo, T., & Hodes, M. (2020). Pervasive refusal syndrome in asylum-seeking children: review of the current evidence. *Clinical Child Psychology and Psychiatry*, *25*(1), 227-241. doi: 10.1177/1359104519846580

Otasowie, J., Paraiso, A., & Bates, G. (2021). Pervasive refusal syndrome: systematic review of case reports. *European child & adolescent psychiatry*, *30*(1), 41-53. doi: 10.1007/s00787-020-01536-1

Parviainen, H., Kiviruusu, O., Lämsä, R., Skogberg, N., Castaneda, A. E., & Santalahti, P. (2022). Psychiatric symptoms and the association with parents' psychiatric symptoms among recently arrived asylum-seeking children in Finland. *Child Psychiatry & Human Development*. doi: 10.1007/s10578-022-01371-2

Sallin, K., Lagercrantz, H., Evers, K., Engström, I., Hjern, A., & Petrovic, P. (2016). Resignation syndrome: catatonia? Culture-bound?. *Frontiers in Behavioral Neuroscience*, 56-73. doi: 10.3389/fnbeh.2016.00007

Sallin, K., Evers, K., Jarbin, H., Joelsson, L., & Petrovic, P. (2021). Separation and not residency permit restores function in resignation syndrome: a retrospective cohort study. *European Child & Adolescent Psychiatry*, 32(1), 75-86. doi: 10.1007/s00787-021-01833-3

Samara, M., Hammuda, S., Vostanis, P., El-Khodary, B., & Al-Dewik, N. (2020). Children's prolonged exposure to the toxic stress of war trauma in the Middle East. *bmj*, *371,* m3155. doi: 10.1136/bmj.m3155

UNHCR, the UN Refugee Agency. (n.d.). UNHCR. Available at: https://www.unhcr.org/cy/wp-content/uploads/sites/41/2020/06/UNHCR-UNICEF-and-IOM_Refugee-and-Migrant-children-in-Europe-2019.pdf (Accessed: 10 October 2022).