Deportation and despair in context

by HANNAH BRADBY Dec 6, 2017

Assessments of the health needs of refugees and asylum seekers in Europe tend to focus on trauma suffered prior to exile and during the flight to the host country. Less attention has been paid to the ill effects of the process of applying for asylum in the host country. An exception to this generalisation is the documentation of the devastating effects of being denied asylum for young people in Sweden.

Some children whose asylum-applications are denied become withdrawn, and unable to eat, walk or communicate, are tube fed in bed, wearing nappies. The bed-bound young people have no obvious pathology causing their withdrawal from the world, except that their family’s application for asylum has been denied by the Swedish Migration Board.

These extremely withdrawn children started to be seen in Swedish clinics in the late 1990s. By the year 2005 a child psychiatrist working in Stockholm, reported that a couple of hundred children from traumatized asylum-seeking families in Sweden have developed severe loss of mental and physical functions without evidence of underlying disease.

Almost all of these children had emigrated from former Soviet Union and Yugoslav states, and a disproportionate number were Roma or Uyghur minorities. Many of their families had suffered violence precipitating their flight. Parallels were drawn with ‘pervasive refusal syndrome’ recognised as a psychological response to severe trauma.

The term ‘apathy syndrome’ appeared in Swedish media in 2005 referring to child asylum seekers exhibiting extreme apathy or hopelessness, both mentally and physically, and requiring clinical care to preserve life. These children’s health was restored after they, together with their families, were granted legal residency in Sweden.

There was a suggestion that families of these ‘apathetic’ children were engaged in a cynical manipulation of the migration system in order to gain legal residence. In 2006 a family with children suffering from this total withdrawal were due to be deported to Azerbaijan. The Migration Board commissioned expert testing of the children for evidence of poisoning. No such evidence was found.

By 2014, ‘uppgivenhetssyndrom’ (which translates as ‘severe withdrawal’ or ‘despair syndrome’) had been recognized as a new psychiatric diagnostic code in Sweden. Clinicians described these children as having ‘severe loss of activities of daily living’ in the absence of underlying disease, pointing instead to numerous psychosocial factors including...
In 2015 and early 2016 unprecedented numbers of asylum seekers arrived in Sweden, then with the introduction of tighter border controls in 2016, the number of arrivals dropped. Over a similar period of time (2014-2016) the National Board of Health and Welfare reported a sharp increase in numbers of asylum seeking children receiving psychiatric care.

Usually referred to as ‘resignation syndrome,’ the controversy about children who are affected has not subsided. Writing in the New Yorker, Rachel Aviv describes the gothic spectacle of adolescent Roma sisters from Kosovo, frozen for years in their beds in the North of Sweden since their family’s application for residency was rejected. Doctors caring for these unresponsive ‘Snow White / Sleeping Beauty’ figures have suggested that the only cure for resignation syndrome is the security of their family being granted a residence permit. A retired ear nose and throat doctor who cares for children on a voluntary basis, sometimes encourages families to “get their tubing”—the feeding tube—as quickly as possible, in order to emphasize their suffering to the Migration Board.

Specialist reports have stated that children can be cured with a favourable decision from the Migration Board.

Rachel Aviv notes the possibility of an inadvertent nocebo effect by doctors who are supporting refugees refused residency. The so-called evil twin of placebo, nocebo occurs when a supposedly neutral medical intervention brings about unwanted side-effects or iatrogenesis. Well-meaning doctors reinforce the necessity for refugee children’s extreme suffering in order to persuade the Migration Board to grant residency permits. A self-fulfilling prophecy is established whereby the families expect that unless they are granted residency—the only medicine—their children will waste away.

There are features of the group of young people diagnosed with resignation syndrome that offer clues to its genesis. Children who suffer from this syndrome tend to be from the USSR and the Balkans, disproportionately Roma or Uyghur, and more recently Yazidi, but there have been very few children from Asian families and none from African families. No unaccompanied asylum-seeking children have been documented with resignation syndrome. The mute, unresponsiveness of bed-bound youth, not eating or communicating, suggests a response to disempowerment and disenfranchisement. Unaccompanied child refugees have doubtless suffered before during and after exile and are aware of their own disempowerment and vulnerability as asylum seekers who may also be living under the threat of deportation. The suicide of young refugees who have been refused asylum has been linked to deportation decisions for those who arrived in Sweden as lone children, but never resignation syndrome. This suggests that the cultural and family context is important in understanding an extreme resignation response to a failed attempt to gain legal asylum. Normative expectations of the obligations between child and parent, before during and after exile, whether fulfilled or denied, may play a role in creating the devastation that results in total withdrawal.

Another striking feature of resignation syndrome is that it is confined to Sweden, not having been documented anywhere else. Young refugees, along with their families, apply for and are refused asylum in other parts of the world, but extreme withdrawal has never been documented as a response.

From the 1970s onwards, Sweden came to be known as a country that welcomed and integrated refugees from a range of states where civilians were fleeing conflict. Sweden no longer offers the welcoming sanctuary that it once did, with tightened border control and reduced residency rights for those who can cross into the country. Since 2016, a legal change means that nowadays asylum seekers are likely to get a 13 or a 36-month visa rather than permanent residency. Sweden’s reputation as a refuge doubtless persists despite recent changes and young people’s despair in the face of official refusal to grant asylum may be linked to their initially high expectations of a humanitarian response.

It is not only asylum-seeking families who have high expectations of Sweden’s humanitarianism towards refugees, but also parts of the Swedish population. Children suffering from resignation syndrome are embedded in a moral and political debate that is central to the country’s identity.

Children and their reasons for seeking refuge are entangled with Sweden’s sense of itself in the world. The deputy prime minister wept on camera as she announced the end of the open-door policy for refugees in November 2015: her party wanted to continue to welcome refugees but could not given the power-sharing arrangements that make government possible and the rise of anti-immigrant sentiment.

The reasons behind resignation syndrome being confined to children refused asylum with their
families in Sweden remain under-explored. But the causative factors are sociologically complex. A more psychological approach identifies the children's illness as caused by their witnessing of trauma prior to exile, followed by the insight that their parent/s cannot protect and care for them, leading to despair. Building on this insight, a group of therapists working at a home for troubled children in Skara in the South of Sweden, say they can cure the syndrome, providing they can remove the unresponsive child from her parents. While splitting up an already traumatised family may seem cruel, it is claimed this is central for recovery, since in order to rebuild the family relationship, the child must first recover from a state of unresponsiveness. The treatment involves being separated from their parents and pushed back into a daily routine.

“We keep the family informed about their progress, but we don’t let them talk because the child must depend on our staff. Once we have separated the child, it takes only a few days, until we see the first signs that, yes, she’s still there…”

No conversations about the migration process are held in front of the children, who get up every day and follow a routine around dressing, eating, playing. An experience therapist, Clara Ogren, is quoted in a BBC article as saying:

“We play for them until they can play on their own. And we goof around a lot and dance and listen to music. We want to bring all their senses to life. So we might take a little bit of Coca Cola, and put it in their mouth so they taste something sweet. Even if they are tube-fed, we put them in the kitchen so they smell food”.

Within days of being separated from their parents, children show signs of recovery. The longest recovery time has been six months. Of the 35 children that Annica Carlshamre, a senior social worker, has met over the years, all but one recovered before their asylum status was assured. This is taken as proof that the granting of a residency permit is neither the necessary nor the sole cure for resignation syndrome. One of the authors of a new book – ‘The Way Back’ (Vägen tillbacka) – worked at this children’s home for a number of years and sets out the therapeutic methods that were developed.

Persuading young people to respond to the world is an important therapeutic aim. A discussion about the politics and ethics of global migration, especially as it involves children, with or without parents, represents another urgent response to their suffering.