Medical and psychological airport reception and care of children from Haiti adopted in France

By

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Abstract

Following the earthquake of January 12th 2010 in Haiti, the French government decided to proceed to the emergency evacuation to France of children for whom a legal decision for adoption had been reached. An unprecedented care and prevention operation was established in the Paris airports. Our first objective was to ensure medical and psychological care provision immediately on arrival for these mentally poly-traumatised children, often also affected physically. Our second objective was to ensure satisfactory conditions for the encounter with the adopting parents, while 88% of the children had never met them. This article presents the operation specifically set up for these transfers, and describes the clinical characteristics presented by the first 363 children received, in particular the acute states of stress presented by these very young children. Finally the ethical issues relating to this operation will be broached.

On Tuesday January the 12th 2010 at 16h53 an earthquake registering 7.3 on the Richter scale hit Haiti, causing more than 220 000 deaths. The political context in the country was unstable, with violence and poverty rife in the everyday life of the population. In view of the resulting chaos, France decided to set up an operation for the repatriation of its nationals, with reception organised in the Paris airports comprising medical and psychological care provision. Since 2004, France has systematically organised reception operations in airports by way of the Cellule d'Urgence Médico-Psychologique (CUMP), part of the SAMU (French emergency medical system). This care provision, which has been activated for numerous situations of crisis (the civil wars in Ivory Coast and Lebanon, the tsunami of 2004, the 2006 Lebanon war, the crash of the Rio-Paris Air France airliner etc) [Baubet et al, 2006], provides for separate areas for children and families. From January 16th, following the earthquake, an operation of this type was established in the Paris airports.

Alongside this, the French government also decided to evacuate all the children involved in an adoption process for whom a legal decision had been pronounced, which concerned around 476 children. This led us to design an original, specific care provision operation comprising psychiatric and paediatric care, which will be described below[1].

From January 22nd the operation was in place in the Paris airports: in Orly it was supervised by the SAMU 94[2] CUMP unit, and in Roissy by the SAMU 93 CUMP unit.

Presentation of the operation

The operation was in two stages: first the emergency reception in the airports when the flights landed, and subsequent follow-up of the child and the receiving family, mostly by telephone and email, since adopting families were from all over France. On arrival in the airport, each family received a written document explaining the reasons for our presence and the meaning of our intervention, referring to the emotions and symptoms that they were likely to encounter, both for the children and for themselves; it also gave names, addresses and contacts for subsequent follow-up.

1 This operation for adopted children and their receiving families was coordinated by Hélène Romano in Orly airport, and by Dr. Thierry Baubet in Roissy Charles de Gaulle airport.

2 This figure refers to the Paris-area département to which the SAMU unit belongs

Medico-psychological airport reception operation

The operation mobilised a medical team (paediatricians and emergency physicians) and an emergency medico-psychological team (psychiatrists, paedo-psychiatrists, psychologists and nurses all specialised in catering for psycho-trauma). Each flight arrival required the presence on average of 25 care providers for 45 children.

The operation was designed so as to optimise medical and psychological care provision in the reception setting (airport terminal) with the added constraint of the necessary administrative procedures, conducted by the relevant Foreign Ministry department. Five zones were defined:

- Reception and waiting zone for the children: each child arrived from Haiti (via Guadeloupe or Martinique) with an accompanier (a volunteer, generally healthcare or first-aid worker). When the plane landed French Red Cross volunteers boarded the plane, each becoming the referee for one child. This person established the link between the accompanier and the child as far as the terminal. On arrival the child was settled in a dedicated zone where the Red Cross volunteers relayed until the encounters with the parents (a time lapse of around 2 hours). The zone comprised a play area, a nursery for changing, and a meals facility. The accompanier separated from the child and was able, (if the parents agreed) to meet the parents receiving the child whom he/she had taken care of over the journey.

- Medical zone: advanced medical post set up in two marquees where doctors from SMR 94 and paediatricians from SMUR 92 (Béclère) provided medical care for the children who had been signalled when they boarded the plane, and those who were identified by the Emergency medical services on arrival or in the reception zone. Another marquee was set aside for the parents when referral of their child to emergency department was envisaged, to provide them with a quieter environment away from the other family groups. 42% of the children required medical care, and 6% were hospitalised (denutrition, dehydration, bronchiolitis, injury during the

earthquake).

- Reception zone for adopting parents: this was located at the far end of the setup, in a separate room, visually and phonically apart from the other areas. The parents were invited to arrive a hour before the arrival of the flight. Many of the parents came accompanied (brothers and sisters, relatives, friends), and it was not always possible to find room for all of them in the limited space allocated. For each family, a CUMP professional contacted the parents and any adopting siblings present. They had the task of answering questions and worries. It was also important to assess how much the family new about what the child had been through, and how far they actually knew the child (some had already met the child, while others (88%) had only ever seen photographs. After this interview, a document was given to each family with the contact details for specialist consultations, and a link was established with facilities in their home area (specialised adoption consultations, and local government follow-up departments)

- Administrative zone (local government authority (préfecture), family allowances department, Foreign Ministry international adoption department, ADP) located between the parents' waiting area and the meeting area. Before being able to meet their child, the parents had to go through the different formalities for international adoption. Depending on the advancement of the case files, the time required was sometimes very long on account of the verifications required. To facilitate the different administrative procedures, various government departments were present.

- Meeting area for parents and children: this was materialised by a few armchairs and screens, and aimed to provide parents and children with as much privacy as possible when they met, mostly for the first time. Certain families stayed as long as 8 hours in this area on account of the difficulty in establishing contact between parents and child. The accompanier was not present at the time of the encounter: this was not just for reasons of time (they had to take the return flight), it was above all to avoid conflicts of loyalty for the child between an accompanier he had known for several hours and parents who were frequently complete strangers.

These areas as a whole were set up in a dedicated zone well away from any passenger transit throughout the operation, and protected by police to avoid any intrusion, particularly by journalists.

Over the entire operation, which lasted as long as 10 hours for some families, a child mental health professional accompanied the child and the family, preparing and accompanying the encounter, and intervening where necessary.. The task of these professionals was to detect states of mental distress, and to provide emergency care measures for the infants and children. Each professional took charge of three families, and all were supported by a senior clinician (H.Romano or T.Baubet). We noted that the presence of professionals had a containing role that was very reassuring for the families, and parents questioned us a lot about the meaning of what was happening for the children: "why do you think he did that?"

Provisions for follow-up

On account of the specific features of this care provision (multi-trauma, precipitated international adoption procedures, and families from all over France) from the outset we established a follow-up system for these children and their adopting families:

- A telephone contact within the week following, and then envisaged at one, three and six months, and one year

- Availability for any parent wishing to call the coordinators of the two operations (worries about the child, consultation relays, difficulty obtaining appointments with specialists, etc)

- An information letter to specialised departments and facilities (COCA, local government, education authority) explaining the context so as to raise their awareness towards these young children and their new families.

- Debriefing of the teams who had taken part: an intervention of this sort is not easy for those taking part, and requires an elaboration of counter-transfer effects, sometimes felt particularly strongly (words of the adopting parents, refusals on the part of certain children to leave with their new parents).

Clinical observations

Thus 363 children were cared for, brought in on 9 flights, and 240 of them were under the age of 3. All the families (parents, brothers and sisters, close relatives), amounting to 1105 individuals, were also attended to.

Psycho-traumatic impact among the children

This intervention in the airport terminal environment used to receive these children is quite specific compared to other operations that have been organised in other airport crisis situations, on account of the numerous trauma, and the young age of children :

- certain children already had a traumatic past, prior to the earthquake – abandonment, violence

- the confrontation with a major traumatic event, the earthquake and its consequences: chaos, disorganisation of the adult world, loss of all landmarks and references

- different levels of exposure: certain children were in places that were spared, while others had been buried under rubble

- numerous losses suffered in the space of a few days: their attachment figures, their references, their roots, their habits, and also the actual death of attachment figures or other children

- very young children with great difficulty expressing their distress

- the language barrier (most spoke Creole)

- cultural shock: leaving a world of black people for a world of white people; shifting from living in a group to situations where the child was cared for individually by numerous different people; and also thermal and dietary shock, and so forth

- a violent confrontation , not allowing for the individual pace and ability of each to elaborate this new world and new family.

It is not so much the catastrophe of the earthquake, as the way in which the consequences were managed that is liable to leave an enduring traumatic mark on these children's histories. Adoption will not cancel out this traumatic debt, and particular vigilance is required for these children and their parents. The risk is that the parents, encountering serious difficulties, will not feel able to seek assistance because of denial, fear, embarrassment or guilt.

Disturbances presented on arrival

All the children received in-depth psychological attention (Romano, 2006), from their arrival up to the meeting with the parents. Prior to this in transit in Guadeloupe and Martinique medico-psychiatric teams had assessed the children and commenced care provision. Two thirds of the children were under three, 52% were girls and 48% boys.

There were 21 sibling pairs, including 7 cases of twins and 4 where the siblings were not biological: children adopted at the same time by the same parents, but not brothers or sisters and not necessarily from the same orphanage.

On arrival the children mainly presented disturbances specific to children having experience traumatic events. In particular we noted:

- inhibition of affects: 72% of the children were hypotonic, prostrate, with a blank look, and without any manifestation of emotion. They remained completely absent, not responding to solicitations from the people taking care of them. These children did not explore their environment, they did not play, chatter or babble. 32% of these children presented reactive hypersomnia (they had slept for the 9 hours of the flight and did not then wake despite numerous solicitations).
- disorders of attachment behaviours: for 85% of the children we noted difficulties in establishing interactions with the adults around them (first aid staff, adopting parents). They were either excessively compliant in the face of adult solicitation, allowing adults to take them in their arms, treat them like dolls, feed them with water and biscuits (15%) or, for the majority (85%) withdrawn and defensive, refusing any bodily contact, adopting avoiding behaviours and rendering any holding function (carrying) impossible (stiffened body, aching backwards, or too floppy, with major risk of injuring or dropping the child.
- control reaction: 66% showed constant hyper-vigilance, startled by any new event; these children struggled not to fall asleep, while they were obviously exhausted
- re-living: 35% manifested traumatic play sequences (Romano, Baubet, 2008), nightmares when asleep in the waiting area, and distressed reactions in case of reactivation (loud noises)
- regressive states: numerous children seemed to have lost abilities that were assumed to have been acquired – walking, speech, toilet training.
- manifestations of severe distress: on arrival all the children who were awake demonstrated extreme sadness, over and above control reactions, withdrawal and reliving described above. During the receiving period 11% of the children expressed their distress by screaming in desperation, some inconsolably for more than an hour. 8% cried quietly for the complete duration of the operation.
- traumatic contamination of the adults taking charge: the confrontation with these very young children mentally harmed by their many trauma and presenting signs of acute distress was difficult to endure. We noted, among both emergency staff and adopting parents (when they met their child) behaviours that indicated the traumatic contamination that was underway. The adults mostly remained silent, unable to find words in the face of the child's distress. They were overcome with feelings of powerlessness at their inability to soothe, reassure and console, or merely take the child in their arms. Some (25%) reacted by compulsive hyper-stimulation (tickling, forced play). They had great difficulty in apprehending the child's traumatic history, and this suggests that it is likely that, when confronted with post-traumatic manifestations, they will over-react or deny them. For example, such symptoms that can be interpreted as "tantrums" or "naughtiness", rather than as the signs of the mental trauma that these children have undergone. When confronted with post-traumatic manifestations, they will over-react or deny them. These symptoms that can be interpreted as "tantrums" or "naughtiness", rather than as the signs of the mental trauma that these children have undergone).

Psycho-traumatic impact among parents and siblings

The time spent with the parents in the waiting area enabled numerous questions to be answered reassurance to be given them as to their parenting abilities. 835 interviews were conducted. It also enabled us to detect distress among certain parents as well as their degree of perception of what their child had just been through.

- widely differing levels of elaboration of their parenthood: 12% had already met their child, 63% only knew the child from photos, and 25% had not even had a photo
- guilt expressed by 25% to be receiving child while for others the child had died in the earthquake: the risk is that they will minimise their difficulties and not dare to "complain" in case of difficulty
- some had thought that their child was dead: risk of tramautic encapsulation
- since the earthquake, these families had all been in an atmosphere of great insecurity and anxiety as to what had become of their child; this anxiety was compounded by statements by certain orphanages managers undergoing financial pressure : risk of vicarious traumatization disturbances relating to traumatic contamination
- all were in a state of extreme fatigue: little mental availability or energy, despite the fact that this was important to take over the children in the best possible conditions.
- 65% of the parents were adopting on an individual basis, 22% via associations, and 13% via OAA
- 32% of the parents were single
- certain parents stated they were "not ready", or "had not had time to get organised" to receive the child
- certain parents (15%) presented worrying mental disturbances: intellectual deficiency, immaturity, personality disorders, or acute disorders related to the context.

Clinical discussion

Despite the massive nature of the symptoms observed, it seemed to us that is was not easy to make a pronouncement on their clinical significance. The situation was indeed acute, and the clinical observation occurred at the time of a relational breaking-off, and at a time when the child was coming into contact with a new universe. In addition, we did not know exactly what events the children had experienced at the time of the earthquake (one to four weeks before examination), nor if there were pre-existing disorders. It is likely that the significance of the symptoms observed varies according to the child: acute stress disorder, post-traumatic stress disorder as defined in DC:0-3R (Zero to Three 2005Fenichel et al. 2005), affect disorder or again the evolution of a pre-existing condition as deprivation/ maltreatment disorder (Zero to Three 2005). Developmental and growth delays we observed in many cases supports the latter hypothesis.

Recent research concerning acute stress disorder in preschool children suggests the need for caution, beyond the emergency setting: it seems that acute stress disorders far more often evolve towards chronic states in preschoolers than they do among older children and adults; in addition, it also appears that these symptoms are often unrecognised by parents of preschool children (Sheeringa 2008).

Ethical issues

The emergency situation occurring in the aftermath of the earthquake led to the implementation of this operation (Balsari, Lemerey, Williams, Nelson, 2010). Providing care for these very young children enabled us to see the intensity of their mental distress. The risk of compoundede victimisation by hasty transfer and adoption is very real, entailing potential damage for both the children and the adopting parents and siblings. This risk of compounded victimisation should of course be weighed against the dangers that the child is liable to encounter if he stays where he is, as a result of destruction, lack of care and social disorganisation. In the chaos of the first days after the catastrophe, the balance was certainly in favour of the evacuation of these children.

The psycho-traumatic consequences are often minimised among the very young, and the risk is to think that these children are too young to realise, and that they will forget – this opinion being shared, as we sadly noted, by some professionals.

The trauma-generating consequences of this traumatic event and precipitated adoption process will depend on what the child can be told, and on the ties that the parents are able to establish with him to re-appropriate this history. If the parents, when they experience difficulties, try to cope on their own (for reasons of fear, embarrassment, guilt or shame) the outcome does not look good for these children.

It is for this reason that a close supervision of these families seems to us to be essential so as to be able to detect any individual distress (whether in the parents or the child) and family distress (siblings, parents/children)

Conclusion

The earthquake in Haiti led France to set up a completely new airport medico-psychological operation. The particular focus on very young children who had suffered numerous traumatic events went had in hand with the need to ensure a presence at the time of the first encounter between the child and his adopting parents, with whom he was frequently little or not at all acquainted.

This unprecedented care provision operation finds its place within a global approach to psycho-traumatic consequences for child victims, and also in the transmission of the trauma in the adoptive filiation procedure. The follow-up over several years of these children and these families will be necessary in order to evaluate the intensity of traumatic repercussions of a transfer in these conditions on filiation.

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