ORIGINAL ARTICLE

STRESSFUL EVENTS AND PSYCHOLOGICAL IMPACT OF HIDDEN TRAUMA AMONG REFUGEE CHILDREN AGED 3-6 YEARS IN GERMANY: A QUALITATIVE STUDY

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ABSTRACT

Refugee children face multiple traumas before, during and after forced displacement. In early childhood, these experiences can include masked trauma, which are emotional, behavioral and developmental adaptations that are not obvious to the naked eye, as children do not have the capacity to talk about their internal feelings of distress. This study aimed to investigate the perceptions of caregivers about stressful experiences and the psychological consequences of invisible trauma in refugee children (ages 3-6) in Berlin, Germany. The study was a qualitative descriptive study that employed purposive sampling with six parents/primary carers of refugee children. The information was gathered by means of semi-structured interviews with twelve open-ended questions at refugee centers in Berlin. Thematic analysis was used to identify common themes in the interview data concerning the emotional, behavioral and developmental outcomes of displacement among children. Six themes were identified: disrupted communication and emotional expression, emotional distress and dysregulation, emotional withdrawal and social isolation, structural barriers to psychological support, disrupted sleep patterns and family stress, developmental regression and increased dependence. Persistent fear, emotional insecurity, communication difficulties, behavioral changes, sleep disturbances, and social adaptation difficulties in children consistently appeared in the reports of caregivers regarding the impact of forced migration. The impact of forced migration was consistently reported by caregivers in terms of persistent fear, emotional insecurity, communication difficulties, behavioral changes, sleep disturbances and difficulties in social adaptation of children. Children from refugee backgrounds have experienced trauma that is hidden and can be seen in the way they behave, in their emotions and in how they learn, think and act. To ensure refugee children are resilient and healthy, early signs of trauma, trauma-informed mental health services, culturally appropriate services and support, and early childhood education services are all important.

key words: *Refugee children, early childhood, psychological distress, forced displacement, hidden trauma.*

INTRODUCTION

Global displacement cases have also increased significantly in the past decade creating significant humanitarian as well as public health issues on a global platform. It has been estimated that there are 100 million people currently displaced by armed conflict, persecution, violence and human rights violations; approximately 40 per cent of this group is made up of children[1]. Refugee children can be discussed as one of the vulnerable groups that must face a variety of stress factors that can be disrupted by exposure to the armed conflict, forced migration, family turbulence, and social instability. All these conditions have dramatic effects on their mental health, emotional development and future health.

Early childhood is a critical period of development where neuroanatomical architecture, executive affect regulation, and social learning go through a quick maturation process. This stage of life may be disrupted by traumatic exposure to alter neurobiological stress-response mechanisms and result in developmental pathways that predetermine people with long-lasting disorders in cognitive, behavior, and affective levels [2]. The links between childhood exposure to adversity in the early years and increased vulnerability to anxiety-based disorders, depressive disorders, and

behavioral disorders, as well as impaired cognitive processing, have been repeatedly proven to exist[3]. The Adverse Childhood Experiences (ACE) framework is used to explain how those stressors that occur during childhood, such as violence, lack of parental care, and separation in the home, have a cumulative impact on later health outcomes[4]. However, the traditional ACE model might be insufficient in summary of the multifaceted exposure patterns of refugee children, who frequently experience other types of stressors like war, displacement, long-term uncertainty, and difficulties linked with cultural adapting. Hidden trauma is psychological distress characterized by invisible symptoms often not expressed verbally by young children. Rather, trauma is manifested as emotional, behavioural, and developmental changes observed by caregivers. As previously noted, there have been high rates of psychological distress in refugee children such as post-traumatic stress disorder (PTSD), anxiety, and depression as compared to non-refugee groups[5].

Childhood trauma can be poor in expression through words; hence, psychological stress can be reflected in behavioral and emotional alterations, including withdrawal, sleeping disorders, developmental regression, and an increase in the level of fear[5]. Caregivers are also instrumental in identifying such early signs of trauma since they are the closest to children in terms of behavioral and emotional changes in normal situations. While several studies have found high prevalence rates for mental health issues among refugee children, little qualitative research has looked at the hidden trauma of refugee children ages 3-6 years from the perspective of the caregiver, especially in Germany. This study will help address the gap by increasing the understanding of hidden trauma to better facilitate the early identification and trauma-informed interventions. This study aims to explore the perceptions of caregivers on stressful experiences and psychological effects of hidden trauma in refugee children aged 3 to 6 years living in Berlin, Germany.

METHODS

Study Design and setting

This study employed a qualitative descriptive design to explore caregivers' perceptions of hidden trauma among refugee children aged 3–6 years living in Berlin, Germany.

Study populations and Participants:

This study sample included parents or primary caregivers of refugee children aged 3–6 years in Berlin, Germany. The selection of parents and caregivers was since young children may not be able to tell their traumatic experiences in words. The researcher used purposive sampling to recruit the participants. The eligible caregivers who fulfill inclusion criteria were invited to participate in the study voluntarily and given consent forms for data collection. The children who were included were aged 3-6 years and whose families had been forced to flee because of war, armed conflict or political unrest, and had been residing in Germany for over one year. The study excluded children below 3 years of age, those above 6 years, children who have not been displaced because of the conflict and families living in Germany for less than one year.

Sampling Strategy and Sample Size

Purposive sampling was used to ensure that the participants have first-hand experience in taking care of the young refugee children who are displaced by selecting ten to fifteen parents. Finally, 12 parents were interviewed, which is considered sufficient to reach thematic saturation.

Data Collection and analysis

The data was gathered through semi-structured online interviews with twelve questions that were open-ended. The interviews were conducted for about 30-45 minutes in Arabic or English depending on the interviewee's preference. The researcher recorded key responses and observations in the interviews. The interviews focused on caregivers' perceptions of stressful experiences and the emotional, behavioral, and developmental signs and symptoms of hidden trauma in refugee children.

Thematic analysis method proposed by Braun and Clarke was used for analyzing the data. Interview notes were reviewed numerous times, coded systematically, and arranged thematically into themes in accordance with patterns that emerge in the responses across the various participants. Data collection continued until thematic saturation was reached and no new themes arose from the last few interviews.

Trustworthiness

The interview notes were used to build on and repeat coding and theme development to ensure consistency and trustworthiness of the findings. Emerging themes were discussed to further strengthen the credibility and confirmability of the analysis with the research supervisors.

Reflexivity

The researcher conducted all interviews and remained aware of the potential influence of personal perspectives throughout the research process. Reflexive notes were maintained during data collection and analysis to minimize bias and support objective interpretation of the findings

Ethical Considerations

The University of Cyberjaya Research Ethics Committee gave the present investigation the ethical approval. The involvement of the participants was voluntary and information about the aims of the study was provided to the participants before the data was collected. Each of the parents provided a written informed consent that was informed before they took part in the investigation. Respondents were also informed that they have the right to quit the study any time without being subjected to any penalty. All data were anonymized and stored safely to protect confidentiality. Personal identifiers were removed in the transcripts and the data used in the research only.

RESULTS

Description of participants

The table presents the demographic and social characteristics of the 12 participants included in the study. The participants ranged in age from 31 to 54 years, indicating representation across a relatively broad adult age range. There was an equal distribution by gender, with 6 females and 6 males. Regarding educational level, most participants had completed secondary education or college-level education, while 1 participant reported having a diploma. Specifically,5 participants had secondary education, 6 had college-level education, and 1 had a diploma. The duration of living in the camp ranged from 3 to 7 years, demonstrating variation in participants' length of exposure to the camp environment. Most participants had been living in the camp for 4–6 years, while only a smaller number had lived there for shorter or longer periods. In terms of living arrangements, participants reported living in different families or caregiving settings. These included living with parents, mother only, father only, relatives, or caregivers. Living with parents and relatives was relatively common arrangements, while fewer participants lived with only one parent. The participants originated from several countries and regions affected by displacement, including Syria, Yemen, Iraq, Libya, Sudan, and Palestine. Syrian participants represented the largest group, with four participants, while Yemen, Iraq, and Palestine were each represented by two participants, and Libya and Sudan by one participant each.

Table 1: Descriptive analysis for the participants

Participant code	Age (years)	Gender	Education level	Duration living in camp	Living arrangement	Country/region of origin*
P01	32	Female	Secondary	3 years	With mother only	Syria
P02	39	Male	Collage	4 years	With parents	Syria
P03	31	Female	Secondary	3 years	With father only	Yemen
P04	45	Male	Secondary	5 years	With relatives	Iraq
P05	43	Female	Collage	4 years	With caregivers	Libya
P06	52	Male	Collage	5 years	With caregivers	Syria
P07	36	Female	Secondary	5 years	With relatives	Iraq
P08	42	Male	Diploma	7 years	With mother only	Sudan
P09	54	Female	Collage	5 years	With parents	Syria
P10	41	Male	Collage	6 years	With relatives	Palestine
P11	37	Female	Secondary	4 years	With parents	Yemen
P12	48	Male	Secondary	6 years	With caregivers	Palestine

Overview of Thematic Findings

Thematic analysis of caregiver narratives identified multiple interconnected themes reflecting the emotional, behavioral, and developmental impacts of early childhood displacement among refugee children aged 3–6 years. Caregivers reported notable changes in emotional regulation, communication, social interaction, and daily functioning following resettlement. Overall, the findings highlight patterns of emotional insecurity, developmental disruption, and limited psychosocial support within this population, summarized across six key themes.

Theme 1: Disrupted Communication and Emotional Expression.

Parents consistently reported changes in children's communication after displacement. Children, especially when they were younger when displaced, exhibited a significant decrease in speech or even muteness. Children used crying and non-verbal actions to express their needs and feelings. Caregivers understood this to be an emotional rather than a language delay, in response to trauma, fear and insecurity. One caregiver explained: “After we arrived here, he stopped talking completely. Before, he could say simple words, but now he just cries when he wants something.” (Caregiver 3).

Another caregiver shared: “He doesn’t say what he wants anymore. He just refuses everything or becomes stubborn. I know it’s because he cannot express himself.” (Caregiver 1).

Theme 2: Emotional Distress and Dysregulation.
Emotional distress emerged as a dominant theme across all interviews. Caregivers described frequent and prolonged crying episodes, often occurring without clear triggers. Children were also reported to display intense fear, irritability, and emotional reactivity when exposed to unfamiliar people or environments. These reactions were interpreted as signs of ongoing anxiety and difficulty perceiving safety after displacement. As one caregiver noted: “She cries a lot, even when nothing seems wrong. It’s like she cannot calm herself anymore.” (Caregiver 7). Another caregiver described fear responses in social situations: “Whenever we meet new people, he becomes very scared and angry. He holds onto me and starts crying.” (Caregiver 2).

Theme 3: Emotional Withdrawal and Social Isolation.
Several parents reported a withdrawal from emotional and social interaction after resettlement. Children were observed to be avoiding eye contact, physical contact, and engaging with family and other children. This behavior was interpreted as a loss of emotional bonding and was seen as a potential concern for future social development. One caregiver reflected: “Sometimes I feel like he is not really with us. He stays quiet and avoids talking or playing with anyone.” (Caregiver 9). Another caregiver noted social withdrawal: “He doesn’t like to play with other children. He prefers to stay alone and doesn’t respond when others try to talk to him.” (Caregiver 6).

Theme 4: Developmental Regression and Increased Dependence
Caregivers observed regression in children’s developmental progress, including loss of independence and return to earlier behaviors. One caregiver stated, “He was already out of diapers, but after everything we went through, he went back to using them.” (Caregiver 5). Another caregiver explained: “He cannot sleep alone anymore. He needs me all the time, even for small things.” (Caregiver 4). This was commonly interpreted as a sign of emotional insecurity.

Theme 5: Disrupted Sleep Patterns and Family Stress.
Sleep problems were common and had a major impact on families. Parents reported inverted sleeping patterns, trouble falling asleep and night-time wakings. Caregivers felt these sleep issues were likely related to children's emotional distress and anxiety, and they increased levels of caregiver stress and fatigue. One caregiver shared: “At night he doesn’t sleep at all, and during the day he is exhausted. It affects the whole family.” (Caregiver 4). Another caregiver noted: “Even when he sleeps, he wakes up crying and scared. None of us rest properly.” (Caregiver 11).

Theme 6: Structural Barriers and the Need for Early Psychological Support.
Caregivers identified barriers to accessing early childhood education and psychological support. Caregivers felt that many institutions were not equipped to support children with emotional and behavioral issues and/or communication difficulties. Caregivers strongly expressed the need for early, trauma-informed psychological and psychosocial support to facilitate recovery and development. One caregiver explained: “They told us they cannot accept him because he cries too much and doesn’t communicate.” (Caregiver 8). Another caregiver concluded: “These children need help early. They need someone who understands what they went through.” (Caregiver 12)

DISCUSSION

This research demonstrates significant emotional, behavioral and developmental disturbances in refugee children (3-6 years) after displacement and resettlement. As reflected in the themes, parents reported difficulties communicating, emotional distress, exaggerated fear, regression in development, isolation, and difficulties in daily life. Our results are in line with previous research showing that exposure to conflict and displacement during early life can have profound implications for children's mental health and development[6].
Notably, children reported losing or disusing speech, instead communicating through crying or behavior. This is consistent with trauma theories which postulate that extreme stress can interfere with children's emotional processing and language development, especially during critical periods of development[7]. Other work among refugee children has reported regression in communication, with more reliance on non-verbal forms of communication during trauma[8].

Distress symptoms, such as excessive crying, anxiety and emotional dysregulation were also reported. This is consistent with internalizing symptoms reported for refugee children exposed to adversity[5]. Sustained emotional dysregulation may be a result of both previous trauma and continued stressors associated with resettlement and environmental stressors[9]. Parents also reported that children were fearful and vigilant, with significant reactions to

new people and places. This is in line with trauma reactions, where children may perceive danger in situations that are not dangerous[10]. This response is well documented for children living in conflict and linked to long-term emotional and behavioral issues[11].

We also found evidence of regression and increased dependency, where children reverted to earlier skills. This resonates with studies showing regression is common among children exposed to trauma in the early years, to re-establish feelings of safety and security[12]. Likewise, the social disengagement seen in this study may reflect attachment disruption and challenges in social development, which are important in early childhood[13]. Impairment in functioning, including sleep problems, was commonly reported and led to family distress. Sleep disturbances are common among traumatized children and linked with anxiety, hyper-arousal and emotional dysregulation[14]. Finally, limited access to early childhood education also contributed to children's vulnerability. Early childhood educational settings provide a protective context for refugee children, enhancing their emotional regulation, social skills and resilience[15].

Parents noted younger children were especially affected by displacement, which is consistent with research identifying early childhood as a critical period for development of the brain and emotion regulation skills[2]. Adverse experiences in early life are linked to poor psychological outcomes in adulthood[16]. Overall, these results highlight the importance of early intervention for trauma-related symptoms and the need for trauma-informed approaches that are culturally sensitive. Improving access to mental health and inclusive early childhood education is critical to support recovery and ensure healthy development of refugee children during resettlement[17].

Limitations

There are some limitations to studying. First, the small sample size and purposive sampling approach restricts the transferability of the findings, as experiences of caregivers may not be universal across refugee groups and regions. Second, the study exclusively used caregiver reports without direct child measures, which may be biased by the caregiver's emotional well-being, cultural background or life experiences. Third, the study was conducted in one geographic location (Berlin), which may not be representative of other countries with different social and integration policies. Finally, the cross-sectional design limits the ability to evaluate longitudinal changes, suggesting the need for future longitudinal studies to better understand the long-term effects of early childhood experiences of displacement on children's development and mental health.

Implications for Practice and Policy

The study suggests early recognition of trauma symptoms in refugee children such as distress, language problems and social isolation. Early childhood services that are trauma-sensitive and have trained providers are needed to support refugee children. Early childhood education should be prioritized, as structured settings support emotional recovery and socialization. Parents should also be targeted through parenting and psychological interventions. Finally, coordinated mental health and psychosocial support services should be sought to minimize the long-term effects of early childhood trauma.

CONCLUSION

This qualitative research offers important insight into parents' views of hidden trauma among refugee children between 3-6 years of age living in Germany. The study highlights that early childhood displacement can result in emotional, behavioral, and developmental difficulties, such as impaired communication, emotional distress, fear reactions, developmental regression and social isolation. These trauma symptoms are often subtle and may not be identified by conventional support services. Caregivers' observations offer valuable insight into how trauma may manifest in very young children who are not able to verbalize their experiences. The study suggests the need for early detection, trauma-sensitive approaches, and supportive learning environments to support emotional well-being and development in refugee children. Building early childhood mental health programs and enhancing access to social and educational support programs may help mitigate the lasting effects of displacement on at-risk children.

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