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Psychotrauma of Terrorist Attacks Among Displaced Children Aged 3 to 7 in the Town of Bourzanga, Burkina Faso

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Abstract: Since 2015, terrorists in Burkina Faso have caused the loss of relatives in families, resulting in widows, injuries and orphans. Also, there is an increase in Internally Displaced Persons (IDPs), including children and their mothers who show signs of major psychological distress. The objective of this research-intervention was to assess the situation of children, to identify the symptoms of post-traumatic stress and to apply projective therapeutic methods aimed at mitigating the consequences of violence and brutal separation from parents over children. We adopted a quantitative and qualitative cross-sectional study of a sample of 97 children aged 3 to 7 years who were victims of terrorism in Bourzanga, a town in northern Burkina Faso. The majority of participants were orphans who witnessed their fathers being murdered by terrorists. We opted for the game, the family drawing and the clinical interview as methods of investigation of the psychopathology of the child, at first. Then, the parents and the social workers were received in a second time for a semi-directive interview on the psychopathological signs and manifestations of the children. The results of the clinical evaluation identified 30 out of 97 children, or 30.93%, with symptoms of Post-Traumatic Stress Disorder (PTSD). Psycho-projective therapeutic techniques, such as psychodrama and musicodrama have had restorative effects in these children, we recommend them for the care of child victims of terrorism.

Keywords: Child Victims, Terrorism, Child Psychopathology, Post Traumatic Stress

1. Introduction

The world, in general, is increasingly affected by disasters of all kinds. From a definitional point of view, a disaster or event can be either its origin or its effects. Thus, the United Nations defines a disaster as a serious disruption of the functioning of a society causing widespread human, material and environmental losses which exceed the ability of the affected society to cope using its own resources [28]. As for Alexander [1], a disaster is an exceptional event that exceeds the normal capacity of the resources and organization available to deal with it. The result of such an event is dangerous, damaging or fatal.

The obvious plurality of disasters leads us to their classification according to a double source namely natural and human. Contrary to the natural origin of the disaster which results from environmental shocks, the human source of the event, resulting from human action, is subdivided into subcategories taking into account the technological, social and complex disasters including a certain State fragility [20].

Explicitly, natural type disasters cover geophysical events such as volcanic eruptions or earthquakes. Those events are often very localized, and their effects are felt in a restricted area. This category of disasters also covers hydrometeorological events. Those are felt over much wider areas and include: storms (hurricanes, typhoons, cyclones); heavy rain or snowfall; drought; and excessively low or high temperatures. Biological events are also a category of natural disasters. They include: insect invasion; and epidemics. On the

other hand, it should be noted that in turn, those natural events can trigger: floods; tsunamis; landslides and mudslides; avalanches; excessive erosion; forest fires; and crop failures.

As a subcategory of human disasters, those described as technological refer to industrial or technological accidents involving radiation, chemical emissions or explosions; accidents occurring during the transportation of hazardous materials; structural failure of bridges, buildings, power lines, dams or mines; train or vehicle accidents; and unexploded devices.

In addition to those technological disasters, the so-called social disasters are those resulting from social failures of order when a deterioration of group behavior occurs in an order, for example, of increasing magnitude such as demonstrations, crowd movements, riots, terrorist action, conflict and war.

As for complex disasters and failed States, which constitute the last sub-category of human disasters, the importance of good governance and the rule of law is recognized for a stable society. When these fail, for example because of conflict or a large-scale natural disaster, a complex set of failures with economic, social, physical or environmental consequences occurs, all within a general context of insecurity.

To date, so-called human disasters have not failed to make the headlines, not only because of their recurrence, but also because of the harmful and damaging consequences they cause. Considering their frequency and the extent of the inconveniences caused, they come to constitute a public health problem. In this respect, terrorist attacks focus much more attention in the sense that they, by their human, media, symbolic and societal intentionality, have a strong traumatic potential [25].

Long spared by attacks, the countries of West Africa, including Burkina Faso, have been affected by this phenomenon since 2015, with its procession of deaths and injuries, both physical and mental [15]. The terrorist attacks were caused on May 31, 2020, according to the Observatory for Democracy and Human Rights (ODDH) [18], at least 1,219 civilians and 436 Burkinabe FDS agents killed by terrorists, 310 wounded, 530 orphans and 215 widows. As for Internally Displaced Persons (IDPs), the number increased from 1.85 million to 1.90 million, between March 31, 2022 and April 30, 2022; an increase of 2.8%. It was at 1.21 million in April 2021, an increase of nearly 46% over the 12 months.

The consequences of terrorism affect not only adults, but also babies, children and adolescents. On the other hand, it was after the Second World War that studies on the childhood trauma of consumption took off [22]. Beyond, apparent and manifest aspects of potentially traumatic disasters intertwine with those inherent in the psychic injury likely to result. This acceptance inspires the need for an exploration of the underlying mechanisms presiding over the resilience of, among others, survivors of potentially critical events.

Our research focuses on orphans aged 3 to 7 years old, as a result of terrorism. It aims to examine and understand the devastating consequences of the trauma they have suffered. This concern leads to the following general research question:

What exactly are the symptoms of children traumatized by the terrorist attacks in Burkina Faso?

The DSM-5 introduces a diagnostic subcategory of Post-Traumatic Stress Disorder dedicated to this still very fragile category of people, entitled "Post-Traumatic Stress Disorder in Children Aged 6 or Less". This new subcategory is indicative of the recent interest in child psychotrauma [13]. Currently, the criteria for the DSM-5 algorithm for the diagnosis of post-traumatic stress disorder in young children (under 6 years old) revolve around 4 dimensions:

1) Reliving or intrusion symptoms. These are recurrent intrusions of memories that may present themselves in the form of repetitive play, traumatic nightmares, dissociative reactions with re-enactment through play, distress upon exposure to signs reminiscent of the event, marked physiological reactions after exposure to stimuli reminiscent of the trauma;
2) Avoidance symptoms. These include avoidance of signs recalling the trauma, avoidance of thoughts, emotions, and conversations reminding the trauma;
3) Symptoms of negative cognitive and mood changes. These include frequent increases in negative emotions, decreased interest in play, social withdrawal, and restriction of the expression of positive emotions;
4) Symptoms of hyperarousal. They consist of hypervigilance, exaggerated startle response, difficulty concentrating, disturbed sleep, irritability with anger [16].

Since the impact of a stressful event depends on both the disaster and the characteristics of the person undergoing it, it appears that the child's fragility, both physically and psychologically, is not necessarily greater, but different. Children are fragile both physically and psychologically, but their fragility is not necessarily greater, but it is different. Indeed, events different from those that can traumatize an adult can have a major traumatic effect on them, and the development of their personality will be affected [3].

In a study, Olliac [19] describes the symptomatology of traumatized children. His work shows that children aged 5 or less will have common reactions such as crying and fear of being separated from their parents. Regressive behaviors are also common (fear of the dark, thumb sucking, return of bedwetting). Children in this age group may be influenced by the parents' reactions to the traumatic event. For the author, slightly older children, between 6 and 12 years old, show social withdrawal, agitation, attention difficulties, regressive behaviors, sleep problems, nightmares, irrational fears, aggressiveness or irritability. The child may also generally complain of stomach aches or other symptoms without somatic origin. Sometimes, a decline in school performance, a refusal of school, expressions of hyper anxiety or depression may remain.

A similar description of childhood trauma according to Lamia [12] indicates that preschool aged children, 3-6 years old, may show repetitive behaviors and drawings, avoidance behaviors, regressive behaviors (enuresis and/or secondary encopresis), sleep disorders (nightmares, night terrors),

phobias (fear of going to the bathroom alone), clinging reactions and separation anxiety, sadness, somatic manifestations (abdominal pain, headaches). Delays in language and psychomotor development may also be noted. With children in the latency period, symptoms of anxiety, depression or inhibition as well as the expression of guilt may be encountered. Hypervigilance, changes in plays, loss or change of habitual interests, and difficulties in concentration are more marked at this level than in the young child.

As for Reveta & al [21], the exposure of a child or an adolescent to a traumatic event can be accompanied by very diverse reactions ranging from minimal disruptions in the life of the subject to very severe clinical pictures strongly interfering with his/her development. The child or adolescent exposed to a potentially traumatic event expresses his or her suffering either in the form of nonspecific symptoms or through a defined disorder that is different from Acute Stress Disorder or PTSD.

Like the data in our study, not all individuals exposed to the same trauma develop PTSD (post-traumatic stress disorder). Moreover, the evolution of the trauma consequences on the psychological health of children includes 4 phases:

1) *phase one:* It is called the *shock phase and lasts from 0 to 4 days*. This first phase is the acute reaction. It occurs when the child, under the initial shock, thinks that the world has become his/her enemy imposing pain and death;
2) *phase two:* when *symptoms persist beyond 4 days, it is called an acute stress disorder (ASD)*;
3) *phase three:* when *symptoms persist beyond 30 days*, the diagnosis *becomes that of post-traumatic stress disorder (PTSD);*
4) *phase four*: This phase corresponds to the *child's adaptation to the situation of the DSM-5*.

The cardinal symptoms of stress reactions are exhaustion, panic, paralysis (sometimes catatonia), grief, despair, paralyzing guilt, amnesia, overexcitement, paranoia, dissociation as well as loss of speech, bowel and bladder control.

Cardinal symptoms of post-traumatic stress disorder (PTSD) are nightmares, insomnia, flashbacks, intrusive thoughts, inability to concentrate, flight/fighting responses, bedwetting, depression, self-harm, anorexia, lack of empathy, coldness, apathy, impulsivity, aggression/identification with the aggressor, repetitive plays that re-enact the trauma, altered states of consciousness, catatonia, extreme fatigue and weariness, stuttering and mutism.

Reactions in all phases are related to the developmental stage of the child at the time of the attack, the severity of the perceived threat, the violence witnessed, and the aggression experienced, etc. [14]. On the other hand, other child victims suffer without showing any visible signs. This is frequently the case for the youngest children (under 5 years old) and for children under chronic intrafamilial or extrafamilial violence (physical or sexual), whose reactions to danger (stress reactions) have become blunted [10]. Some of them, however, immersed in a situation of prolonged threat, war or terrorism, transform the terrifying reality into a protective denial, facilitating survival. Yet, looking back, this protective denial can lead to doubts about the reality of what was experienced [29]. Especially, the question that guides this research is established as follows:

What are the symptomatic signs resulting from the psychic injury induced by the potentially traumatic context of the security crisis among the children of Bourzanga (Burkina Faso)? What are the therapeutic recommendations to be implemented?

The purpose of this article is to study the signs and psychopathological manifestations in child victims of terrorism in order to better understand the symptoms of post-traumatic stress, and to recommend an adapted approach to the management of psycho-trauma in children in Burkina Faso.

2. Methods

The particularities of the child's psychic reality require adjustments to the clinical framework and the adaptation of certain tools [24]. To this end, the intervention framework is designed as an interlocking group and individual intervention.

2.1. Study Population

The study was conducted among a sample of 97 children aged 3 to 7. It involved internally displaced persons in the town of Bourzanga in northern Burkina Faso and ran from May 16 to September 23, 2020. All the children were living in the refugee center and the majority were orphans who had witnessed the killing of their fathers by terrorists.

2.2. Instruments

The psychic life of the child is constituted in a preferential way through the meeting and the use of the object. At this stage, the child needs to project himself/herself into something. This specificity of psychic functioning then leads to the use of mediations in the child clinic [24]. In order to respect this specificity of the child clinic, we opted for observation, interviews with parents and social operators as diagnostic tools, while psychodrama and musicodrama were used as both diagnostic and therapeutic techniques.

2.3. Observation

We opted for active participant observation, which implies the participation of the observer. In this case, it is possible for the observer to intervene in the process by introducing modifications in the studied operation [5].

2.4. Interview with the Parents and the Social Workers Present on the Site

The child's clinic is most often a group therapy (the child with his/her family or at least with one of his/her parents), and the follow-up involves a systemic and family approach. The child's symptom and suffering must therefore be considered within the more global framework of the family and educational system in which he/she emerges [2]. In view of these aspects, we subjected the parents and the social

workers to a semi-structured interview. To this end, an identification form containing demographic data and a questionnaire inspired by the PCLS (Posttraumatic stress disorder Checklist Scale) containing psychopathological manifestations related to post-traumatic stress syndromes was constructed and used.

2.5. Musicodrama and Psychodrama

We chose to apply the Analytical Musicodrama in the therapy of traumatized children in order to facilitate the expression of emotions and the staging of the scenario of the horror they witnessed in a well-defined framework [6]. The principles of role-playing and date of the children's psychic experience that we implement in our technique are inspired by psychodrama. Moreover, Moreno, the inventor of classical psychodrama, was already interested in its application to music therapy, even if it was his nephew, Joseph Moreno, who was to take the question further [26].

The musicodrama protocol was applied in 2 phases as follows:

First: we proposed a familiar piece of music to the children. The music proposed had the objective to bring out the children's unconscious problematic that will be worked on during the session. We invited the children to express themselves freely in response to the music by drawing. The material obtained is analysed as projective material to indicate to us the unconscious issues that are troubling the children at the time of the session. A round of verbalization follows this graphic expression, where each child presents his/her achievement. This verbalization time was carried out in small groups to allow all the children, at least those who wished to, to express themselves.

Second: This second, more active time, called the staging phase, is experienced in these small groups. Each group was followed by a psychology undergraduate student previously prepared to conduct the musicodrama session. At this stage, one of the drawings is chosen by the group to be dramatized. This is the integration of psychodrama into musicodrama, which is an adaptation inspired by the article by Dakovanus [7].

The roles to be played are related to the drawing, and can be characters, emotions, thoughts, scenarios, etc., related to the children's psychic reality, as they showed it during the first part of the session. Then, the children are invited to express themselves by free association on their experiences through a play. This is a moment that allowed us to have access to the subjective feeling of each participant, in relation to their experience.

2.6. Procedure

We opted for the group therapeutic approach as a privileged way of accessing the psychic and relational reality of the children while favoring the support of their experience in a containing and reassuring framework [9]. This choice is justified by the fact that the individual therapeutic framework alone could amplify or maintain the fear of the other, social withdrawal, avoidance, etc. This is the reason why the group was used as an intervention approach and technique. However, this did not prevent moments of individual follow-up, as the intervention framework was conceived as an interlocking of group and individual interventions. Children who did not want to join the group were received individually and, as far as possible, other children were joined in the refugee camp.

3. Results

An evaluation or review by pencil paper was performed on the data collected. It should be noted that all 97 children in our sample participated in all psycho-pedagogical and therapeutic activities. After analysis of the data, 67 or 69.07% of the children showed a good awakening level, a good prosocial index and normal development. Moreover, they do not show any signs or psychopathological manifestations related to post-traumatic stress. Moreover, for the social workers in permanent contact with the children, the latter follow the didactic activities with attention, assiduity and motivation and are less disturbed and less disruptive.

On the other hand, 30 children (30.93%) showed symptoms of Post-Traumatic Stress Disorder (PTSD). We noted avoidance, dissociative, dysphoric and hyperactivation symptoms. Also, irritability, aggressiveness and a tendency to self-destruct and to reproduce the scenario of violence in a good number of children (insults, punches, lack of mutual aid and empathy between them, setting fire to the tents, etc.) were observed. Indeed, parents are worried about their children who have fun setting fire to the tents without any fear. These children are also part of a scripted reproduction of the tragic events they experienced.

In this regard, the table below illustrates 3 clinical cases of all the children studied.

Table 1. *Presentation of some clinical cases.*

	Subjects		
	Subject 1	**Subject 2**	**Subject 3**
Age	**6 years old**	**5 years old**	**5 years old**
Traumatic experience	1Yacouba witnessed the execution of his uncle and father and the burning of his father's store in the village market.	2Fatoumata is accompanied by her mother. Her father was shot by the terrorists in their field. She did not witness the execution of her father but she heard the	3Géneviève lives with his mother and brother. Her mother tells us that her father has disappeared, but she hopes that he will find his way back to the village. Géneviève is inhabited

1 Assigned name in order to preserve the anonymity of the subjects studied.

2 idem

3 Idem.

	Subjects		
	Subject 1	**Subject 2**	**Subject 3**
Age	**6 years old**	**5 years old**	**5 years old**
Symptoms related to PTSD	fear of strangers; fear of places with many people; trauma relapse; mutism; social withdrawal; school refusal; regressive attachment of an anxious nature to the mother; aggressiveness and irritability; traumatic dissociation.	screams and saw the traces of blood. hyperactivity; agitation; refusal to join the group; isolation; recurrent nightmares; re-enactment of violent scenes (e.g., setting fires); verbal and behavioral aggression; irritability.	by the hope of seeing her father again. shyness and withdrawal; violence during music and psychodrama sessions; disproportionate emotional reactions; lack of involvement during sessions; signs of traumatic dissociation; aggressiveness and irritability.

4. Discussion

The present clinical study on childhood post-traumatic stress disorder (PTSD) in Burkina Faso, through the study of psychotraumatic signs and manifestations of child victims of terrorism, establishes that symptoms of trauma reliving (traumatic memory) associated with avoidance symptoms, dissociative symptoms, dysphoric symptoms and hyperactivation symptoms, are normal responses of a traumatized individual. Our results are in line with those of Salmona [25] who states that psychotraumatic disorders are normal and universal responses to major traumas. All victims, whatever their age, sex, socio-cultural background, origin, history or personality, can be affected by them. The violent event has an effect of paralysis of the psyche which will paralyze the victims, prevent them from reacting in an adapted way, and prevent the cerebral cortex from controlling the intensity of the stress reaction.

In the same vein, Reveta et al [21] describe a clinical trinity of the clinical picture of childhood psychotrauma, associating symptoms of repetition, manifestations of avoidance and neurovegetative hyperactivity. Given the evolutionary aspect, the symptoms of repetition may correspond in children to repetitive drawings of the traumatic scene or to compulsive games centered on the trauma, exactly as our study sample demonstrated during the music and psychodrama sessions.

In a systematic review of 35 studies for a total of 4365 young children aged 0-6 years, Slone & Mann [27] show that the effects of exposure of young children to war, terrorism and armed conflict include post-traumatic stress symptoms, behavioral and emotional symptoms, sleep problems, disturbed play, and psychosomatic symptoms. In addition, correlations emerged between parental and child psychopathology. Thus, the family environment and parental functioning appeared to be moderators of the exposure-response association in children.

The study of Klein et al [11], on the other hand, focuses on the reactions of young children aged 5 or less, and were living in the vicinity of "Ground Zero", during the September 11 attack in New York City, USA. Between November 2001 and May 2002, 67 New York City parents and 104 children participated in focus groups. Consistent with current understanding of trauma symptoms in children, parents reported chronic sleep disturbances, fearful reactions, development of new fears, and increased clinging and separation anxiety after the disaster. The authors note that on the day of the disaster, the children's reactions were described as ranging from calm and cooperative to difficult and panicked.

5. Clinical and Therapeutic Implications

We agree with El-Hage [8], that after this first phase centered on the symptoms description and diagnosis, adapted care is required in front of the frequency, the severity of the PTSD symptoms in the child. This assertion is justified because of their impact in terms of psycho-affective development and personality construction. This raises the unavoidable question of how to deal with PTSD in children following the terrorist attacks. The main techniques commonly used in the literature for the treatment of PTSD are EMDR (Eyes Movement Desensitization and Reprocessing), KIDNET (Narrative Exposure Therapy for Traumatized Children and Adolescents), CBT (Cognitive Behavior Therapy), PDT (Psychodynamic Therapy).

EMDR is designed to help a person process their memories of a traumatic event. The therapy consists of evoking images, beliefs and painful bodily sensations related to a trauma.

KIDNET is a narrative exposure therapy for traumatized children and adolescents.

CBT is a combination of cognitive-behavioral techniques involving focusing on the trauma through cognitive processing of trauma-related thoughts or teaching anxiety reduction skills using procedures that directly target the person's beliefs and behaviors.

TPD focuses on the integration of the traumatic experience into the life experience of the individual as a whole.

In general, findings suggest that psychological interventions (regardless of management technique) are successful in reducing PTSD symptoms. For Newman [17], Pfefferbaum, Kirlic, Tett & Nelson (2014), the effect of reducing PTSD following psychosocial treatment, results in a 74% improvement. In addition, children receiving psychological intervention fared significantly better with an average improvement of 66% over those not receiving treatment.

Better yet, current guidelines recommend CBT as the first-line treatment for PTSD. However, in addition to CBT, Brown al [4] in a meta-analytic review conclude that there are a number of effective psychosocial treatments for child and adolescent disaster survivors. Thus, EMDR is more

effective than CBT, which is more effective than KIDNET. From this same analysis, it appears that CBT and PDT produce significant improvements, but these are more marked and faster for CBT. However, there are reports of increased anxiety and distress associated with CBT treatment involving exposure therapy [4]. Romano [23] advocates much more attention to the psychic issues of trauma by using the psychodynamic dimension of treatment. For her, clinical research should start from the subject, in all its dimensions, and should not exist without the respect due to him.

According to Reveta et al [21], multiple therapeutic approaches are possible, but trauma-focused cognitive behavioral therapy, a time-limited therapy that combines exposure, cognitive remodeling, and coping and resilience building exercises, is the most validated and widely used. They maintain, however, that much remains to be done regarding the identification of risk and protective factors, the description of the different possible paths following a trauma, the development of psychometric instruments and their validation in French, and the evaluation and implementation of effective and accessible therapies.

In sum, psychotherapeutic approaches are to be preferred in the management of child trauma. The reference therapy is trauma-focused CBT. Other therapies have shown beneficial effects, such as narrative therapy and EMDR. The choice of therapeutic strategies depends on the age of the child, the type of trauma and especially the clinical manifestations. Parental involvement in the child's care, group therapy and school-based interventions improve symptomatology. Drug prescription is not recommended except in situations of severe, chronic, resistant symptoms or comorbidities [8]. However, the lack of professionals trained in these psychotherapies in Burkina Faso is a limit to the treatment of post-traumatic stress disorder (PTSD) in children.

6. Conclusion

The objective of this mixed-methods research is to assess and identify the symptoms of post-traumatic stress. As such, it focuses on 97 orphans, aged 3 to 7, who witnessed the murders of their fathers during the terrorist attacks in Burkina Faso. Thus, the town of Bourzanga, located in the north of the country, served as the setting for our study. The investigative techniques recommended for this purpose were, first of all, those of the play, the family drawing, and the clinical interview with the children. The parents and the social workers were then received for a semi-structured interview on the signs and psychopathological manifestations of the children.

The results of the clinical assessment identified 30 children out of 97, i.e. 30.93% with symptoms of Post-Traumatic Stress Disorder (PTSD). As a result of this assessment, psychodrama and musicodrama were used as therapeutic techniques to address the consequences of violence and the brutal separation of the parents on the children.

Childhood psychotraumatic disorder is a reality in Burkina Faso and its treatment is practically a public health emergency. These include trauma-focused CBT and other therapies with beneficial effects, such as narrative therapy and EMDR.

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