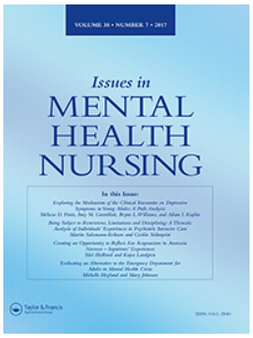

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FROM THE EDITOR

Resignation Syndrome: Is it a New Phenomenon or is it Catatonia?

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Have you heard of uppgivenhetssyndrom, a new syndrome affecting refugee children and adolescents in Sweden? The case of Georgi, a Russian refugee whose case is described in an article in *The New Yorker* (Aviv, 2017), provided my first glimpse of the syndrome and prompted me to search the scientific literature to learn more. Cases of refugee children becoming apathetic, then stuporous, and then unconscious, began to be reported in the early 2000's, the number of cases swelling to more than 400 by 2005 (Aviv, 2017). Most often, the children were from ethnic minorities, such as Roma or Uyghur, or fleeing persecution because of their family's religion (as in the case of Georgi). The children, generally between ages 8–15, who exhibited the apathetic syndrome began to require tube feeding and diapering; they were unresponsive to physical stimuli and did not appear to even react to painful stimuli (Bodegard, 2005). Electroencephalogram and computed tomography of the skull and brain revealed no striking abnormalities, nor did laboratory screenings such as toxicology (Sallin, Lagerkrantz, Evers, Engstrom, Hjern, & Petrovic, 2016).

The story of Georgi is illustrative. According to premorbid descriptions of childhood friends and family, Georgi was popular, athletic, and well integrated into Swedish society (having arrived from Russia at the age of 5). At the age of 13, just before he would have begun 7th grade, the migration board denied (for a second time) the family's petition for asylum in Sweden, after which Georgi became "sullen and aloof" (Aviv, 2017). Another blow was the deportation of a teammate from Afghanistan. The full-blown onset of his resignation syndrome occurred several months later when the migration board informed the family of upcoming deportation back to Russia: he stopped speaking, eating, and appeared to be in a deep sleep (Aviv, 2017). After a brief hospitalization, he was discharged to home care, bedfast and requiring tube feeding. Georgi's condition continued to deteriorate over the following months, with one doctor stating "the boy is alive but barely" (Aviv, 2017, p. 74).

As cases of this syndrome increased, vigorous debate about etiology and diagnoses occurred among Swedish physicians and psychiatrists, with consideration of anorexia nervosa, selective mutism, depression, malingering, and states of conversion and dissociation (Sallin, et al., 2016). The long and stressful migratory process of the refugee families gained favor as the etiology with the Swedish Board of Health and Welfare, which coined the term "resignation syndrome" and advised that "a permanent residency permit is considered by far the most effective treatment … the turning point will usually be a few months to half a year after the family receives permanent residence" (cited in Aviv, 2017, p. 72). A family system perspective appears useful, because resignation syndrome has not been diagnosed in unaccompanied minors (Sallin et al., 2016).

To date there has been little research on resignation syndrome, but Sallin et al. (2016) dispute that the condition is really new, pointing out that its characteristics fit with catatonia. Its clinical picture is consistent with the cardinal symptoms of pediatric catatonia (immobility, mutism, withdrawal, refusal to ingest). They also argue for culture-bound psychogenesis, since the syndrome has only been found in refugee children in Sweden whose families face deportation. Comparisons can be made to Amish girls displaying conversion disorder symptomatology and to hopeless concentration camp detainees who exhibited similar resignation behavior. Sallin et al. argue that if the standard treatment for pediatric catatonia were employed (benzodiazepines and ECT), a prompt response of the patient would validate their hypothesis that resignation syndrome is really catatonia. This treatment approach, however, has not been tried.

Some children with resignation syndrome have remained bedridden for as long as 4 years (Aviv, 2017). The available evidence, to date, indicates remission of the syndrome if the refugee families are not deported. In recovered children, neurological examination is normal with no apparent functional deficits (Sallis et al., 2016). New cases of resignation syndrome declined after the Swedish migration board, facing public outrage about the media stories on "apathetic children," revised its policies. Outcomes of deported children have not been systematically studied, but Aviv (2017) relates that one child who had been deported to Serbia was found still unconscious 6 months later.

To return to the story of Georgi, his family was granted permanent residence in Sweden. Two weeks afterward, Georgi opened his eyes; three days later, he took water from a spoon; four days later, he attempted to turn his body. Still later, he returned to school and began to interact normally with classmates—even joking with them. When visited by Rachel Aviv in his home in November, 2016, he conversed easily with her about topics such as sports. He described his many months in bed as feeling as though he had been trapped in a "glass cage" down in the ocean, which would shatter if he moved, causing drowning. When asked by Aviv if he was aware that Swedish residency had been granted to his family because of his condition, he replied, "I don't think that I wanted to do this. Not if I start to think about how I felt in the glass cage" (Aviv, 2017, p. 77).

No one contends that these children "resign" voluntarily. But there are many unanswered questions about this syndrome. Whether it is a new phenomenon or a permutation of catatonia, the suffering of these children and their families is profound. Further exploration of contributing factors such as traumatization and individual predispositions may shed light on preventive interventions for the syndrome. Manuscripts on any aspect of this topic would be welcome.

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