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School-Based Services for Traumatized Refugee Children

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Putting Pieces Together for Ohio Students

School-Based Services for Traumatized Refugee Children

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In 1991, civil war raged in Somalia and the country's infrastructure began to disintegrate. Since then, millions have fled the violence and instability. Many Somali refugees have settled in the United States; Ohio now has the second largest settlement of Somali refugees in the country. Most of these refugees reside in the Columbus area, where numerous outreach services have been developed. The Somalis are one of many refugee populations that have enrolled children in Ohio schools. In such cases, there is often little or no warning of the children's arrival and thus little time to prepare a comprehensive school-based service delivery plan. The purpose of this article is to inform school psychologists of specific stressors faced by refugee children and to describe school-based plans that can help meet their needs.

Stressors Faced by Refugees

According to the United Nations High Commissioner for Refugees (UNHCR), there are approximately 16 million refugees worldwide, almost half of whom are children (2007). An additional 51 million people are classified as internally displaced people (IDPs), individuals forced to migrate within their own countries because of war and conflict, human rights violations, and natural and human-made disasters. Refugee children are often traumatized from pre-migration and resettlement experiences. They come from war-stricken environments or areas with political violence. Children who are refugees may have been exposed to violence and combat, home displacement, malnutrition,

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detention and torture. Many have been forced to leave their country and cannot safely return home. Psychological stress and trauma are often inflicted upon these children.

Traumatized refugee children often have difficulty negotiating a new school and fitting into peer groups. Refugee children and families may not understand how schools function in terms of the role that parents play in education or even how to open a locker. As students adjust to a new school, they may face discrimination from teachers and peers; they may also experi-



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ence difficulties integrating and making friends, developing romantic relationships, having academic success, and making language adjustments (Vinokurov, Trickett, & Birman, 2002). Further, children who have been exposed to violence are at risk for lower grade point averages and more days of school absence (Hurt, Malmud, Brodsky, & Gianetta, 2001).

One of the biggest challenges of a refugee child is the language barrier. To function in a society, communication through language is a necessity. Many refugee children's native language is different from their new country's language, which causes problems in a traditional school setting. School systems are set up in such a way that students learn through instruction, by collaborating with peers, and by completing homework. If the language is not understood, the educational system is not fully effective and the child is not learning up to his or her capability.

Refugee children tend to understand and speak new languages more quickly than their parents. This may seem advantageous for students in a new school; however, a language gap is often formed between the student and the parents (Gonzales, Dumka, Deardorff, Carter, & McCray, 2004). This gap may lead to conflict between parents and children. Parents may think that their children should hold on to cultural traditions from their native country, while the children may deviate from these traditions as they adjust to new social groups and culture (Kwak, 2003). As children struggle with two identities, parents often depend on their child to be a language interpreter. The child has to translate during school conferences, meetings with the school psychologist or counselor, or with a school nurse. Also, slow parental cultural acclimatization does not promote strong guidance and supervision over children (Gonzales, Dumka, Deardorff, Carter, & McCray, 2004).

In addition to stressors at school and at home, many traumatized refugee children develop clinical disorders, such as Post-Traumatic Stress Disorder (PTSD). Refugee children and adolescents have shown symptoms of PTSD that vary by age (Thomas & Lau, 2002). In preschoolers, PTSD symptoms include social withdrawal, anxiety, and regressive behaviors. School-aged children experience poor concentration, sleep disturbance, flashbacks, startle responses, and conduct problems. In adolescence, PTSD symptoms include aggression, nightmares and sleep disturbance, delinquency, and guilt over one's own survival. All age ranges report feelings of guilt, sadness, fear, and anger.

Children are less likely to develop PTSD when the parents are not traumatized (Daud, Klintberg, & Rydelius, 2008). In fact, children are better able to adapt to a new culture when their parents are mentally healthy. Having a stable and supportive home environment lessens stress and reduces the risk of psychological disorders. This may be difficult for some families as they try to meet basic needs during the transition. Worries of finances, employment, integration, and social networking may cause stress in the home.

Mental health treatment is an option for refugee children with PTSD or other clinical disorders. However, refugee families rarely use mental health services (Yule, 2000). During the resettlement period, families have immediate needs that often do not include mental health. Further, families may not have health care or may be hindered by a language barrier. Research in this area is sparse and the statistics are not straightforward; however, it is clear that mental health services are underutilized and not fully effective. Interventions that are comprehensive service models and focus on educational, social, and economic outcomes are more effective than clinical treatment alone (Yule, 2000).

School-Based Services for Refugee Students

The purpose of a school-based plan for traumatized refugee students is to protect life, reduce emotional trauma, and to assist in recovery from emotional trauma. The school is an excellent setting to provide comprehensive services for these children because it can be a secure and predictable environment. The first step of a school-based plan is for the school staff to recognize those refugee students who may be traumatized. Traumatized refugee children are at a high risk for mental health problems, so students' progress should be monitored through consultations with school psychological services, mental health services, local child guidance, and refugee advocacy groups (Yule, 2000). This crisis plan requires a supportive school and community and collaboration between school and community resources. Observations, interviews with the parents and student, and knowing the signs of PTSD will help in recognizing these students. If a language barrier exists, an interpreter should be employed.

The second step is for the at-risk traumatized refugee students to talk with a school counselor or school psychologist. Basic principles should be kept in mind when talking with a traumatized refugee student because they may be particularly sensitive to a new school and culture. The Center for Victims of Torture (CVT; www.cvt.org, 2004) has established guidelines for school staff when talking with traumatized refugee children (see Appendix A, pg. 10). The guidelines discuss issues such as re-traumatization, reliving memories, speaking on a collective level, and establishing trust over time. It is common for traumatized refugee children to not talk about their experiences. Refugee families may have participated in illegal activities to get out of their country and told their children not to talk about what happened with people of authority (Yule, 2000). It will

take time to build trust with the student. The importance of a supportive, stable home life should be stressed when talking with the family.

The third step is to provide an intervention for refugee students who may be traumatized. School-based interventions are an effective and practical way to help traumatized refugee children and families. This is particularly true if the school-based efforts are coordinated with outside agencies and resources.

Intervention in Resettlement

Comprehensive service models for traumatized refugee children and their families are proposed through the National Child Traumatic Stress Network (NCTSN; Birman et al., 2007). The NCTSN mission is to "raise the standard of care and to improve access to services for traumatized refugee children, their families and community throughout the United States." They argue that there should be a collaborative effort to provide services to traumatized refugee children. The NCTSN has proposed that comprehensive service models include four components: (1) trauma-informed treatment; (2) strategies for providing access for refugee children to mental health services; (3) providing culturally competent services; and (4) strategies for helping refugee children and families cope with stresses of resettlement. The following interventions can be used in school systems.

Cognitive Behavioral Therapy (CBT) is a traditional treatment for traumatized refugee children (Foa, 2000). CBT has been shown to be an effective intervention in reducing symptoms of PTSD, including anxiety and depression (Paunovic & Ost, 2001). A subset of CBT, the Cognitive Behavioral Intervention for Trauma in Schools (CBITS), is recognized by the U.S. Department of Education as a program that can be used for refugee and immigrant children

in school systems. This intervention first identifies students who have been exposed to trauma and have signs of PTSD through a self-report questionnaire. Ten group CBT sessions are administered in the school system. In these sessions, students are educated about the common symptoms of trauma, undergo relaxation training and cognitive-behavioral therapy, learn how to face trauma, and begin to build skills to get along with peers. Further, parents are given the opportunity to participate in sessions that educate them about trauma and how to support their children, and teachers have in-services to learn how to detect traumatized students in the classroom. CBITS has been developed in several languages and is sensitive to multicultural communities.

Narrative Exposure Therapy (NET) is an intervention for PTSD that was developed for treatment of organized violence. NET asks an individual to describe what happened to them, including details explaining what they heard, smelled, and felt. Onyut and colleagues (2005) did a pilot study that investigated the effectiveness of NET when applied to 6 teenage refugees who had been identified as having PTSD. When NET is applied to children, it is called KIDNET. In the first step of KIDNET, children are asked to draw any picture that came to mind. Next, the children are given flowers, stones, and a rope to construct his or her lifeline. Flowers are used as positive life events, stones are used as negative life events, and the rope is the lifeline. The children in this study were asked to narrate their lives according to the lifeline. The events each child described were written down, and questions were asked that delved deeper into the child's emotional, physiological, cognitive, and behavioral reactions. The sessions progressively delved deeper into the child's life. Each child received 4-6 sessions of KIDNET, each lasting 1 to 2 hours. The results showed that after 9 months, 4 children no longer had symptoms of PTSD and 2

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children were on the low borderline level of PTSD. This intervention may be useful in a school setting with counselors and/or school psychologists. CBTIS is recognized by the U.S. Department of Education as an effective intervention for PTSD and for recognizing PTSD in children. It requires a collaborative effort between social workers, school psychologists, clinicians, and educators.

Traumatized refugee children may also benefit from school-based expressive therapy. For students with language barriers, using art interventions is a popular way to communicate their experiences. In a study by McArdle and Spina (2007), art was used as a language for refugee children instead of a form of therapy. Art was seen as a way to build identity and tell their stories. Three 1-hour workshops were given to 9 children, approximately age 8. The students had little to no English skills and no previous experience with art. The results showed that during the art session, the students were able to share, connect with others, and show joy in engagement and persistence. The students did not depict war and killing in their artistic representations but bright, vivid portraits of family and themselves. Although using art interventions with refugee children is a popular practice, the methods and results are too vague to be used alone. Sufficient evidence is not available to support the effectiveness of expressive therapy alone as a research-based intervention at this point. The researchers suggested that art in conjunction with an intervention such as CBTIS may show promising results.

Research has also shown that the playground setting and playground activities can be a source for intervention. Government and community-supported playgrounds have been shown to provide protective environments for traumatized

refugee children (Jackson, 2006). In this study, both parents and children participated. The children were either not yet school-aged or they had withdrawn from school. During the 2-hour playground sessions each week, the children and parents played together under the guidance of the program facilitator. The child and parent were asked to stay together to reduce separation anxiety. Results from the study showed that the playground provided a stable and predictive environment that was socially inclusive, and the playtime helped to develop a strong relationship between parent and child and it promoted higher self-esteem. By slowly adjusting to a new environment the students were then able to make a smooth transition to school. The parents reported that the playground served as a social group for their own transition into a new community. A final step in comprehensive service delivery is to provide ongoing services for refugee students and their families. The symptoms of PTSD may resurface for many years after a traumatizing incident. Additionally, problems associated with the complexities of navigating the academic and social environment in older grades may develop. School psychologists can be a key resource for this population by monitoring the students' academic and behavioral progress, providing contacts for community resources, consulting with teachers and families, and developing appropriate intervention plans. Such activities on the school and district level can improve education for refugee children and help us step toward alleviating the plight of forcibly displaced people.

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Appendix A

Center for Victims of Torture: Basic Guidelines for School Staff When Talking with Traumatized Refugee Children

- Talking about what brought a survivor to this country or what happened in the home country can be highly distressing for the survivor, especially after s/he leaves the interview and is alone with the memories. There is high potential for re-traumatization, whether or not the survivor gives any indication of this.
- There is great variability in the physical and psychological effects of war and torture trauma, as well as tremendous variability in how survivors present themselves and their stories. There is also high variability in the ability to remember what happened and put it into words. Many war and torture traumas are considered “unspeakable acts.”
- Be prepared to talk at the collective (vs. individual) level, depending on the culture (e.g., what happened to us vs. what happened to me; use of pronoun we instead of I).
- Recounting what happened is a gradual process that unfolds over time, often years, as trust is slowly and carefully established. Expectations about the amount of time needed to learn a survivor’s history must be calibrated accordingly.
- Some survivors present a chronological account of what happened; others may move around in time. The story may be remembered differently on different occasions. There may also be apparent gaps, inconsistencies or incongruencies.
- Listening to the story and enduring the corresponding emotions with the survivor has healing value in and of itself.
- Be prepared to refer the survivor to appropriate professional and community resources. Trauma disclosure is often rare and presents a unique opportunity to provide information and referral services.
- Allow plenty of time for closure after emotional wounds have been re-opened by talking about trauma. Talking about more ordinary, everyday activities or, alternatively, talking about the survivor’s strengths can provide a way to wind down the interview.
- Listening to survivors’ stories often elicits unexpectedly strong feelings in the interviewer that can impact the interview and the relationship. It is essential that interviewers have access to professional consultation.