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Child refugees, trauma and education: interactionist considerations on social and emotional needs and development

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This paper focuses on the social and emotional needs of children and young people who are refugees. It was inspired by casework undertaken by the author involving a 13-year-old boy who was a refugee from Montenegro. A vignette of the case is presented in addition to a review of relevant literature to illustrate and discuss the various sources of trauma experienced by children and young people who are refugees, and the potential impact of these on psychological functioning and emotional wellbeing. Child refugees' experiences of trauma are seldom restricted to experiences of loss, violence or persecution in their country of origin. Rather, there are multiple experiences in the country of origin, during migration and on arrival in a country of "refuge" that are potentially traumatic, and can have adverse effects on a child or young person's development. Drawing on research with children and adults who are refugees, as well as research into post-traumatic stress disorder and into the educational effects of trauma, the paper advocates interactionist and ecosystemic perspectives for understanding the difficulties encountered by refugee children, and considers possibilities for therapeutic intervention.

Keywords: child refugees; trauma; education; emotional needs; development

Introduction

The focus for this paper was inspired by casework undertaken by the author involving a 13-year-old boy, B, who was a refugee, having fled Montenegro during the conflict in the former Yugoslavia. The term "refugee" will be used generically in this paper and will therefore include those who are seeking asylum as well as those who have been granted refugee status or leave to remain in the country. The boy had experienced significant trauma while in Montenegro, and considerable adversity both in and out of school since being in the UK. This case is outlined further later and the author will go on to discuss the extent to which B's experiences are typical or atypical of the experiences of refugee children. Specific questions that will be addressed in the following sections are: what are the sources and psychological effects of refugees' experiences of trauma?, what can educational psychologists (EPs) do to assess the impact of trauma in refugees?, what support or therapeutic interventions are there? This discussion will be approached from what can broadly be described as an interactionist perspective. That is to say that the analysis considers multiple levels of description – specifically individual characteristics, thought processes, ontogenetic factors and behaviour as well

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as social and environmental influences. In particular the author will draw on Ecological Theory (Bronfenbrenner, 1979), Social Cognitive Theory (Bandura 1986), and Interactive Factors Model (Morton & Frith, 1995).

Currently, while there is a developing literature on the work of EPs with refugees (see e.g. Iszatt & Price, 1995; German & Ehntholt, 2007), there is not an extensive research literature on the psychological or educational impact of trauma on children and young people who are refugees (Dyregrov, 2004; Hodes, 2000). This paper therefore tries to draw on what research there is, as well as research pertaining to trauma experiences more generally, and research with adult refugees, exposure to violence and Post-traumatic Stress Disorder.

Context: refugees in the UK

Being a refugee, fleeing persecution and seeking asylum is not a new phenomenon; it has gone on for centuries (Iszatt & Price, 1995; Wilkinson, 2003). One need only consider the Old Testament Book of Exodus, with the Israelites' flight from slavery in Egypt to remind oneself of oppression, displacement and migration as an enduring feature of human history. According to the United Nations High Commissioner for Refugees (UNHCR) in 2007 there were approximately 11.4 million refugees worldwide (UNHCR, 2008). Most refugees are in countries in the developing world, which accounted for approximately 68% of the world's refugee population in 2002 (IPPR, 2005). In the UK numbers of asylum applications have increased dramatically over recent decades.

In the period from 1985 to 1989 there were 28,549 asylum applications to the UK. This increased almost ten-fold for the period from 2000 to 2003 to 284,874 (IPPR, 2005). Levels of applications have fallen over recent years, since peaking in 2002, and in 2007 there were 23,430 applications for asylum (Home Office, 2008). About a quarter of asylum applications are granted some form of leave to remain (IPPR, 2005). The remainder may either return voluntarily, be deported, move to another country or remain in the UK illegally. In 2007 13,705 failed asylum-seekers and their dependants left the UK due to removal, voluntary returns programmes or assisted returns (Home Office, 2008). Among UK refugee communities at least 40% of the people are under 18 years of age (Hodes, 2000).

This demographic profile and the increase in the number of refugees has implications for education generally as well as the work of EPs in particular. As Rutter says, "Almost every English local authority now has refugee pupils attending its schools. About 4.5% of the school population in Greater London are refugee children, something that could not have been predicted 15 years ago" (Rutter, 2003, p. 4).

Since 2000 the Home Office has operated a system of dispersing asylum-seeker families requiring accommodation to authorities throughout the UK, with a view to easing pressures on London and the south-east of England. The result of this, coupled with the rise in the numbers of refugees, means that refugee children are a group that all EPs can increasingly expect to come across in their work.

The legal rights and entitlements of refugees and refugee children are set out in a number of Acts and Conventions at an International, European and UK level. A comprehensive overview of these and how they affect EP practice at a local authority, a group and an individual level is provided by German (2004). It is worth noting that the United Nations Convention on the Rights of the Child refers to refugee children as a group worthy of specific consideration:

> States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties. (United Nations, 1989, Article 22)

Any psychological work should be done against a backdrop of ethical standards. The United Nations Convention reminds us that refugee children are a specifically identified group whose interests merit special attention. On the level of a school as a system Osler and Starkey (1996) suggest a number of questions that can be asked of a school to assess whether or not it takes children's rights seriously. These include: "What steps have been taken to ensure that refugee children can benefit fully from the education available? What provision is made for their induction, language tuition, and teacher training?" (Osler & Starkey, 1996, pp. 24–25).

The sections that follow attempt to consider particular issues that pertain to EPs in working with children who are refugees, with particular reference to the impact of trauma on their social and emotional development.

Case vignette

B is a 13-year-old boy who was referred to the Educational Psychology Service (EPS) by a social worker from the Child and Adolescent Mental Health Service (CAMHS). He and his family are ethnic Albanians who came to the UK in 2000, having fled Montenegro during the conflict in the former Yugoslavia, and after having experienced substantial trauma and brutality there. Since arriving in the UK he and his family have endured considerable adversity. As asylum seekers they initially lived in London in cramped, poor quality accommodation, before being moved to Glasgow, and then moving to Birmingham. These relocations, along with moving between London boroughs, have meant that their access to support services has often been disrupted and fragmented. In 2003 a Clinical Psychologist saw B, while he and his family lived in London, and expressed concerns about his cognitive, social and emotional development, noting that his learning was significantly behind other children of his age and stating that he had longstanding learning difficulties and complex learning needs.

B's mother was also receiving treatment for symptoms of depression and post-traumatic stress. A little later when they had moved to Glasgow, one of his teachers reported that B was one of the most traumatised children the school had ever seen. At this stage B was seen by an EP, but his family moved to Birmingham before any assessment could be completed. At his school in Birmingham he was not identified as having any Special Educational Needs. The only support that he was deemed to need was as a speaker of English as an additional language, which involved attending a regular withdrawal group for additional language instruction. B did however access support from CAMHS. Initially B was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and a CAMHS social worker made efforts to contact the school about assessing and supporting his learning needs. After repeatedly trying and failing to involve the school through communications to the Special Educational Needs Coordinator (SENCO) and the head teacher, the social worker contacted the EPS direct to request involvement. By this stage the diagnosis of ADHD had been rejected and B was receiving treatment for Post-traumatic Stress Disorder (PTSD).

The author's involvement with B's case was brief and limited to conducting an assessment and formulation of his needs in order to advise other professionals. B's academic achievement was significantly below the level that would be expected for a child of his age, and he was in need of additional support, particularly in literacy and numeracy. His experience of school more generally was of some concern. He regularly experienced bullying and perceived much of the school environment as being unsafe. He found it difficult to trust many of the teachers. Things had got worse, in this respect, since his sister left the school to go to college, as he had relied on her for support and protection. B had a cousin in the Sixth Form who also provided protection and security, and B was dreading him leaving at the end of the year. Also, B regularly experienced nightmares that prevented him from sleeping. As a consequence he was always tired, had difficulty concentrating, and would often fall asleep in lessons.

The experience of trauma

The vignette above highlights some of the sources of trauma and distress to which refugee children are exposed. B and his family fled a war zone where they were members of a persecuted minority group. His traumatic experiences were not, however, limited to this. Having arrived in the UK he had to cope with poor living conditions, unexpected relocations, family members with mental health problems, bullying, and he felt unsafe at school. Such experiences are not untypical for children and young people who are refugees in the UK.

Between 1999 and 2003 the 10 main countries of origin for asylum seekers to the UK were Somalia, Iraq, Afghanistan, Serbia and Montenegro, China, Iran, Turkey, Zimbabwe, Pakistan and India. These accounted for 55% of all applications (IPPR, 2005). It is, of course, the norm that refugees are fleeing from countries where there is conflict and/or abuse of human rights. As Rutter (2003) recognises, however, the exposure of refugee children to traumatic events will vary widely, although only "a small number will have no direct experience of persecution" (p. 6). The typical or characteristic types of traumatic experiences that refugee children have experienced before fleeing to the UK include: persecution or fear of persecution; experience of or witness to violence or war; loss or murder in family or community (Hodes, 2000).

It is not just a child's experiences before flight from their country of origin, however, that are a potential source of trauma and/or distress. There are numerous experiences that can have adverse effects on a child, both during migration, such as prolonged and dangerous journeys, and on arrival in the UK, such as poor accommodation, separation from family and community, persecution and racism (Hodes, 2000; Rutter, 2003; Anderson, Hamilton, Moore, Loewen, & Frater-Mathieson, 2004). Uncertainty concerning asylum and legal status can also be a major source of anxiety (German & Ehntholt, 2007). Hodes (2000) also makes the point that the experiences of refugees are usually very different to those of other immigrants, with greater social instability, fewer opportunities for planning, more socio-economic adversity, as well as increased exposure to traumatic incidents.

It is perhaps natural for others, such as professionals working with refugee children, to perceive their experiences before coming to the UK as the greatest, or only, source of trauma, and that, in seeking "asylum" they have found a place of safety and sanctuary. A timely and apposite riposte to such ethnocentric complacency is found in research by Gorst-Unsworth and Goldenberg (1998) who found that refugees often viewed their experiences in the UK as more detrimental to their mental health than the

atrocities that they endured in their countries of origin. As Webster and Robertson (2007) put it: "Most asylum seekers and refugees have escaped conditions of discrimination, domination and exploitation in their home countries, only to confront similar experiences in their host country" (p. 158).

While much research has focused on the experiences of adult refugees (e.g. Gorst-Unsworth & Goldenberg, 1998), it is worth reflecting that children's experiences may differ. It is possible that they may be insulated from some of the stresses that adults experience, such as the direct experience of persecution or the stresses associated with, say, unemployment. Indeed parents, carers and others may try to protect children by not talking to them about traumatic experiences or telling them about what is going on. It should be remembered that such children are still likely to experience stress and trauma vicariously, and the intention to protect children may be counter-productive. A child who is not given the opportunity to talk about their experiences may find it more difficult to deal with their emotional consequences (this is discussed further later in this article), and a child who is not made aware of what is happening may struggle to understand what they are experiencing, leading to greater, not less, anxiety.

Refugee children will often experience regular and sudden upheavals such as being re-housed or changing schools. These are surely more difficult to process and understand if a child is less aware of how these decisions are made and less aware of them as possibilities. Also, whereas adult refugees are often able to live among others from their own communities and control the pace of their integration with wider society, refugee children have to cope with adapting to schools where there may be no-one from a similar background or even who talks the same language. One might imagine that school offers an environment of stability and safety for refugee children. Would that it were so. B's experience of bullying is common among refugee children. Adverse media coverage and unsympathetic attitudes in society have increased hostility towards all refugees, including refugee children, from adults and children alike (Rutter, 2003).

The effects of trauma

Post-traumatic Stress & Post-traumatic Stress Disorder (PTSD)

It is worth noting that the experience of trauma will not inevitably have adverse effects on a child refugee's emotional well-being, nor will all children be affected in the same way. Rutter (2003) emphasises that many refugee children are resilient, cope well with adversity and do well in school. Indeed Hodes (2000) states that "the majority of young refugees will cope well with the terrible events to which they may have been exposed and the very difficult circumstances in which they and their families have to live" (p. 62). Nonetheless the literature on PTSD suggests that between 15% and 90% of children exposed to traumatic incidents go on to develop PTSD, and that the rates for children developing PTSD are higher than those reported for adults exposed to traumatic events (Perry, 2002). The variation in rates depends on the nature of the traumatic event, as well as the presence of a number of risk and protective factors. Table 1 summarises some of the factors that affect whether or not a child refugee may suffer long-term stress in response to the experience of trauma.

PTSD is a clinical diagnosis that describes symptoms that may occur following exposure to a traumatic event. Diagnostic criteria for PTSD define a traumatic event as one where two key features are present. Firstly, the event involves a threat of death, serious injury, or physical integrity, to oneself or others who are around. Secondly, the

Table 1. Factors that increase and decrease risk of child refugees experiencing adverse psychological responses to trauma.

	Increased risk	Decreased risk
Feature of traumatic experience	• Multiple events or repeated exposure (1,2) • Physical injury to child (1) • Involves physical injury or death to loved one (1) • Overwhelmingly intense or long-lasting events (1,2) • Perpetrator is a family member (1) • Loss caused by disappearance where there is uncertainty about death (8)	• Single event (1) • Short duration (1) • Perpetrator is a stranger (1) • No disruption to family or community structure (1) • Presence of family during trauma (9)
Child characteristics	• Age of child at time of trauma – pre-school children (1,3,4) and early adolescence (5) are most vulnerable ages • Subjective perception of physical harm (1) • History of previous exposure to trauma (1) • Lack of shared experience with peers or being isolated from others from home country (1,2) • Low cognitive ability or academic problems at school (1,2) • Experience of bullying or isolation at school (2) • Low self-esteem and pessimistic outlook (2) • Pre-existing psychiatric diagnosis – especially anxiety related (1) • Viewing exile as inexplicable (2) • Being unable to talk about events (2) • Using withdrawal or anger to deal with adversity (2) • Having a learning disability (2) • Unrealistic expectations about life in new country (7)	• Cognitively capable of understanding abstract concepts (1) • Good coping skills (1) • Aware of normal post-traumatic responses (1) • Strong ties to cultural or religious belief system (1) • Understanding reasons for exile (2) • Remembering good things about life in country of origin (2) • Optimistic outlook (2) • Self-esteem (2) • Being able to talk about events (2) • Feeling able to ask for help when things go wrong (2) • Having interests and hobbies (2) • Being happy in school and making friends (2)
Family and social factors	• Trauma directly impacts caregivers (1) • Anxiety in primary caregivers (1) • Continuing threat and disruption to family (1) • Absence of caregivers (1)	• Intact, nurturing family (1) • Non-traumatised caregivers (1) • Caregivers educated about post-traumatic responses (1) • Strong family beliefs (1)

(*Continued.*)

Table 1. (*Continued*.)

	Increased risk	Decreased risk
	• Prolonged experience of lack of stability and disruptions to family routines (e.g. in transition camps) (5) • Loss of family support and pre-migration culture (6) • Intra-familial violence (11)	• Good parenting skills and parents who give attention (1,2) • Extended family network (2) • Access to friendship and support from outside family, especially within own community (2) • Access to permanent housing, immigration status and a reasonable standard of living (2) • Being able to maintain some links with home country (2) • Migration accompanied by family members (10) • Family cohesion and adaptability (12)

Numbers in parentheses refer to sources: (1) Perry (2002); (2) Rutter (2003); (3) Bowlby (1980); (4) Montgomery (1998); (5) Ahearn and Athey (1991); (6) Kinzie, Sack, Angell, Manson, and Rath (1986); (7) McKelvey and Webb (1996); (8) Quirk and Casco (1994); (9) Germazy and Rutter (1985); (10) Felsman, Leong, Johnson, and Felsman (1990); (11) Garabino and Kostelny (1996); (12) Laor et al. (1996).

event is one that elicits a response of intense fear, helplessness or horror (or in children, disorganised or agitated behaviour). These diagnostic criteria identify three types of symptoms: re-experiencing (e.g. nightmares, flashbacks, intrusive thoughts), avoidance (e.g. avoiding thoughts, feelings, conversation about the trauma, or persons and situations that might evoke these, inability to recall events, changes in range of affect), and increased arousal (e.g. disturbed or reduced sleep, irritability, poor concentration) (American Psychiatric Association, 2000). Refugee children who experience adverse psychological reactions to trauma may experience some of these symptoms without meeting the full diagnostic criteria for PTSD or may experience symptoms of other disorders such as depression. Children with PTSD are often misdiagnosed with other disorders, such as ADHD (as was the case for B), major depressive disorder, oppositional-defiant disorder, conduct disorder, separation anxiety or a specific phobia (Perry, 2002).

Community Consultation Research with adult refugees has suggested that depression is a more common problem than PTSD (Webster & Robertson, 2007). However research in which Bosnian refugee children were assessed using standardised diagnostic instruments reported that 68% were in the clinical range for PTSD symptoms, compared to 47% for depression and 29% for anxiety (Papageorgiou et al., 2000). The difference between such findings may be due to differences in ages or other factors, such as the nature of traumatic experience, the amount of exposure to trauma, the ethnicity and cultural background of the refugees, or the availability of post-migration social support. Another possibility is that it reflects a difference between the perceptions of refugees themselves, which is what the community consultations elicited, and how refugees' symptoms are interpreted by standardised diagnostic instruments. Indeed it has been argued that PTSD is a Western construction with limited applicability to people from other cultures (German, 2004). As such it is criticised for pathologising "normal" responses to adversity and not accounting for cultural variation in these. Eisenbruch (1991) argues that the refugee experience should be understood from the point of view of "cultural bereavement", where the loss of home, family, social networks, institutions and routines can result in the symptoms of PTSD, but these are viewed as a normal response. Against this Hodes (2000) contends that "substantial evidence now exists regarding the cross-cultural validity of PTSD" (p. 59).

Undoubtedly it is important for EPs and other professionals who work with refugee children to be aware that adverse reactions to stress and trauma may have different cultural meanings to those given by Western medical models of mental illness. One notable shortcoming of PTSD as a means for understanding refugees' experiences is that it focuses attention on discrete trauma experiences so that professionals might think that trauma is in the past and was restricted to experiences in the country of origin. As was outlined earlier, child refugees experience considerable adversity and stress after fleeing their country of origin which may have a negative impact on their psychological well-being. Consequently, the kinds of support and intervention that such children may benefit from are likely to be more than simply focusing on the individual and their post-traumatic stress symptoms (although this is, of course, important), and may necessitate a broader focus on school and family ecology and systems, as is discussed further at a later stage. Hodes (2000), defending the use of PTSD diagnosis for refugee children acknowledges this point:

> The suggestion that a diagnostic approach will lead to ignoring social causes is as illogical as arguing that for people living in insanitary conditions a diagnosis of cholera

> should not be made because the source of infection, typically drinking water, would then not be improved. A psychopathological perspective can easily be linked to social action. This may include the provision of community interventions including the primary prevention of distress, perhaps building on existing community resources and strengths. (Hodes, 2000, p. 59)

Hodes' response here is well made, and he is correct to say that a diagnostic approach does not necessarily entail ignoring social factors. Nonetheless it should equally be noted that consideration of social factors is not necessitated by such an approach either. The analogy with cholera is somewhat spurious, as the epidemiology of cholera is more obvious and direct (i.e. poor drinking water) than that of the psychological symptoms of a child refugee who might be diagnosed with PTSD, and the social actions to remedy it are more obviously identifiable.

Educational and other effects of trauma

Research on non-refugee children highlights a number of effects of the experience of trauma on children's educational functioning and experience at school. As mentioned earlier, trauma can have the potential to induce psychological disorders such as anxiety disorders and depression (Yule, 1998). Trauma can also affect a child's ability to function effectively at school, from the point of view of attainment, attendance and maintaining effective relationships (Dyregrov, 2004). In particular, memory and concentration are negatively affected by traumatic experiences (Streeck-Fischer & van der Kolk, 2000). This, allied to the observation of increased incidence of poor behaviour in children who have experienced trauma (Mallon & Best, 1995), may go some way to explaining why the initial diagnoses of ADHD or conduct disorders mentioned earlier are not uncommon.

Considering the kinds of traumatic incidents that refugee children may have been exposed to it is worth noting research by Schwartz and Gorman (2003) into the effects of community violence exposure. They studied primary school aged children from the Los Angeles area, and found that exposure to community violence was associated with poor academic performance, poor self-regulation, depressive tendencies, and disruptive behaviour. They noted that both depression and disruptive behaviour mediated the effects on academic performance. They also found that children exposed to community violence were more likely to be victims of bullying. It has been hypothesised that this is due to the detrimental effects of exposure to violence on social functioning (Schields, Cicchetti, & Ryan, 1996). Such results are, of course, only indicative and one might question whether it is appropriate to generalise from the experiences of children in Los Angeles to those of refugee children. Nonetheless, their findings are convergent with other research reporting negative effects on academic performance in survivors of the sinking of the cruise ship *Jupiter* (Yule & Gold, 1993) and survivors of a Gothenburg discotheque fire (Broberg et al., cited in Dyregrov, 2004). The effects of trauma on school performance appear to be most significant on those subjects requiring high levels of concentration, such as maths, physics and grammar (Dyregrov, 2004) and there appears to be a positive relationship between the severity of trauma and magnitude of school performance impairment (Saltzman, Pynoos, Steinberg, Eisenberg, & Layne, 2001).

Dyregrov (2004) offers a number of possible explanations for the links between trauma and a decline in academic performance. These include: intrusive material making it hard to concentrate; PTSD altering information-processing systems,

especially where attentional resources are associated with focusing on perceived threats; the effects of depression slowing down cognitive functions; loss of motivation; effects of stress making it hard to differentiate relevant from irrelevant information; and mood states that overwhelm the ability for self-regulation leading to behavioural problems. As mentioned earlier, Schwartz and Gorman (2003) identified depression and disruptive behaviour to be mediating factors. Yule and Gold (1993), however, emphasise the loss of motivation of participants in their study. As Dyregrov puts it, children might ask: "What is the use of investing in schoolwork when you can be dead tomorrow?" (2004, p. 80). Another possible factor might be teachers' perceptions and expectations. It is possible that teachers might either not wish to pressurise children who have experienced trauma out of concern for their emotional well-being, or they might lower their expectations of them given their experiences of trauma. This could act as a self-fulfilling prophecy leading to children performing poorly at school. Also of importance when considering refugee children would be the difficulties many encounter as a consequence of having English as an additional language.

Interactionist perspectives on assessing and understanding the effects of trauma

The preceding sections of this paper have discussed and emphasised the multiple sources of stress, trauma and adversity that refugee children may experience and complex effects on their psychological functioning and emotional well-being. Given such a complicated picture it is helpful for EPs to adopt an interactionist approach to understanding the problems encountered by refugee children.

Anderson et al. (2004) refer to the work of Urie Bronfenbrenner and advocate an ecological approach to understanding the experiences of refugee children (see, for example, Bronfenbrenner, 1979; Bronfenbrenner & Morris, 1999). That is to say that to give a full picture of the influences on refugee children it is necessary to consider the child's microsystem (school, home/family, support services, peer groups), mesosystem (interactions between, say, home and school), exosystem (government agencies and religious community) and macrosystem (the society's ideology, laws and customs). Thus, Anderson et al. (2004) construe the experience and development of refugee children in terms of three phases of changing ecologies; pre-migration, trans-migration and post-migration. From this perspective the challenge for children who are refugees and their families is to manage these transitions and establish adaptive ecosystems.

EPs' work with refugee children is, *ipso facto*, within the post-migration ecology, but they need to be aware that such children carry with them past experiences and expectations of their ecosystems and roles within them. The ability of an individual to adapt and cope within their current ecosystem will be dependent on factors at different levels:

> The extent to which a child's family manages to adapt to its new surroundings and circumstances will impact on the extent to which the child can successfully adapt to the new school. In addition, unresolved emotional issues associated with displacement and trauma in the past can interfere with the child's ability to learn and develop within school. Also, the extent to which a subset of the familiar social environment has come intact with the child (family, extended family, friends and neighbours) will clearly impact on the child's ability to thrive within school. Support services available in the host country, and the degree to which they are coordinated to help children and families, can either facilitate or present a barrier to the process of adaptation. (Anderson et al., 2004, p. 10)

Bandura's concept of "triadic reciprocal determinism" can also help EPs to understand the significant interactions that involve refugee children. Bandura (1986) has proposed that behaviour should not simply be viewed as being a product of the person, their environment or a function of the two. Rather there are two-way reciprocal causal relations between person and environment, environment and behaviour, and behaviour and person. So, for example, a child refugee may develop PTSD in response to events that they experience in their environment. This will affect their behaviour, but also the label and perception of PTSD will affect the way in which others interact with them, as will being identified as a refugee, so altering their experience and environment. The child's behaviour may include symptoms of PTSD as well as some of the other effects of trauma outlined earlier, such as poor behavioural control and low academic attainment. These may, in turn, affect his or her sense of self-esteem, motivation and optimism, further perpetuating any difficulties.

The "Interactive Factors" (IF) framework for causal modelling (Morton & Frith, 1995) can be used by EPs to help make sense of the interactions and reciprocal processes affecting refugee children. This framework uses three levels of description to explain developmental or psychological problems: the biological level, the cognitive level and the behavioural level, as well as recognising the influence of a child's environment at all three levels. The IF framework can be used to create a simple visual representation of the model of a child's difficulties. Figures 1 and 2 show models of some of the potential difficulties faced by a refugee child, such as B, with hypothesised causal processes. Figure 1 represents problems that B experienced relating to the causes and impact of sleep difficulties, while Figure 2 represents some of the factors affecting his behaviour within school.

The IF diagram shows the web of inter-relations between factors and effects. Of course there are other factors and causal links that could be added. Figures 1 and 2 show that any assessment of the emotional well-being of a child refugee must be holistic. Although there are standardised measures of symptoms, such as the Impact of Events Scale, that can be used to assess the severity of clinical symptoms, a full assessment will involve assessing the familial, social and community supports available to the child; their perceptions, feelings and constructions; their academic functioning; experiences in and out of school; language needs, and so on.

Intervention and support

The considerations outlined earlier suggest that child refugees may encounter difficulties in a variety of domains – social, educational, mental health – and may require support from a variety of sources. Thus, intervention with refugee children is unlikely to be done by an EP in isolation. Work with refugee children lends itself to a multi-agency, consultative approach with information sharing and appropriate divisions of labour.

There are a number of different approaches that have been used to treat symptoms of PTSD. These include family therapy, group therapy, eye-movement desensitisation and reprocessing (EMDR), "play" therapy and art therapy (Perry, 2002). EMDR involves clients holding in mind an image of the trauma, negative emotions and self-cognitions (i.e. thoughts or statements about oneself that feel true when the client focuses on the target image), and related physical sensations, while moving their eyes

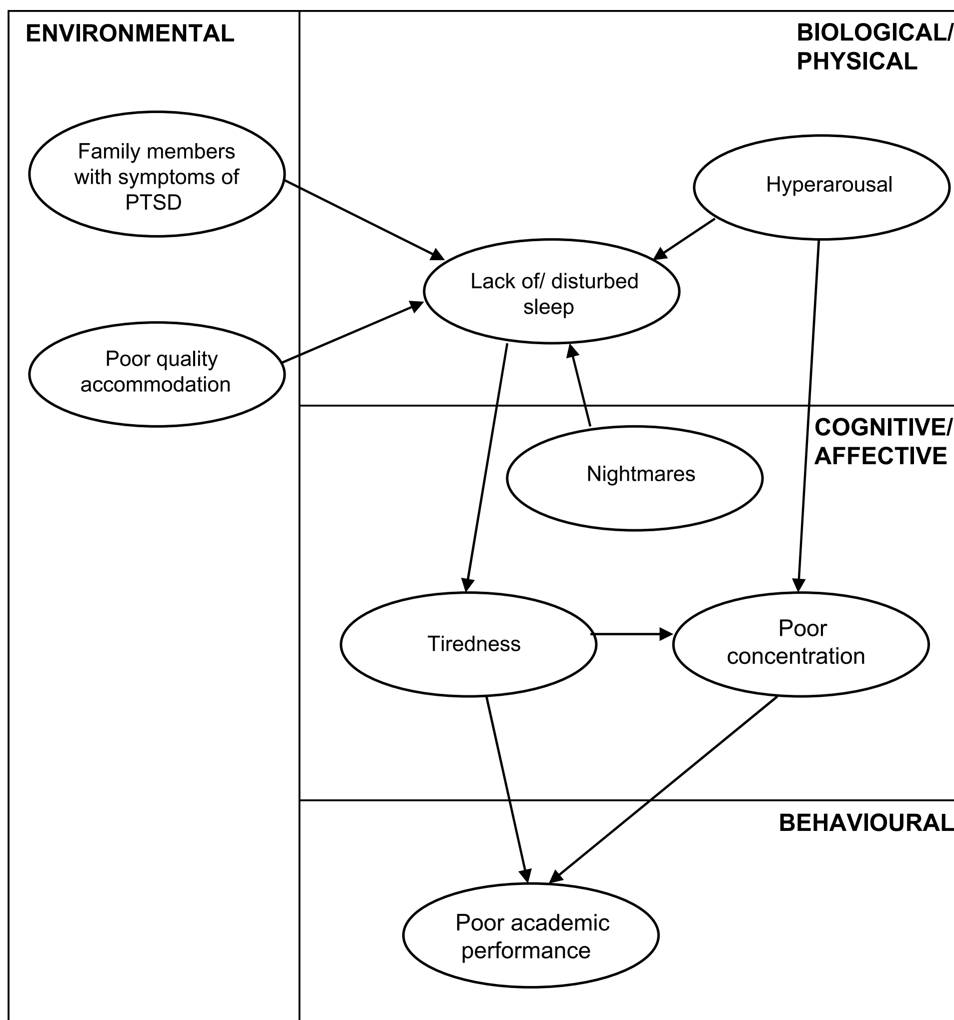

Figure 1. IF framework for some of the effects of trauma on a child refugee – the impact on sleep.

quickly following the therapist's finger moving back and forth. This is continued until the client becomes desensitised to the thoughts and memories, and has been shown to be efficacious in reducing PTSD symptoms and anxiety (Wilson, Becker, & Tinker, 1995). Similarly there is evidence that Cognitive Behavioural Therapy (CBT) can reduce post-traumatic problems in children and adults (Dyregrov, 2004; Cohen, Mannaniro, Berliner, & Deblinger, 2000).

Perry (2002) also suggests that there is evidence from clinical experience, if not clinical trials, that psychotropic medications can be used successfully to reduce symptoms of PTSD. Examples include using depakote or lithium to treat aggressive symptoms, fluoxitine for depressive symptoms, and clonidine for hypereactive symptoms (Perry, 2002). Such types of therapy are interventions that EPs are unlikely to employ for a variety of reasons. These include: professional competence, practical

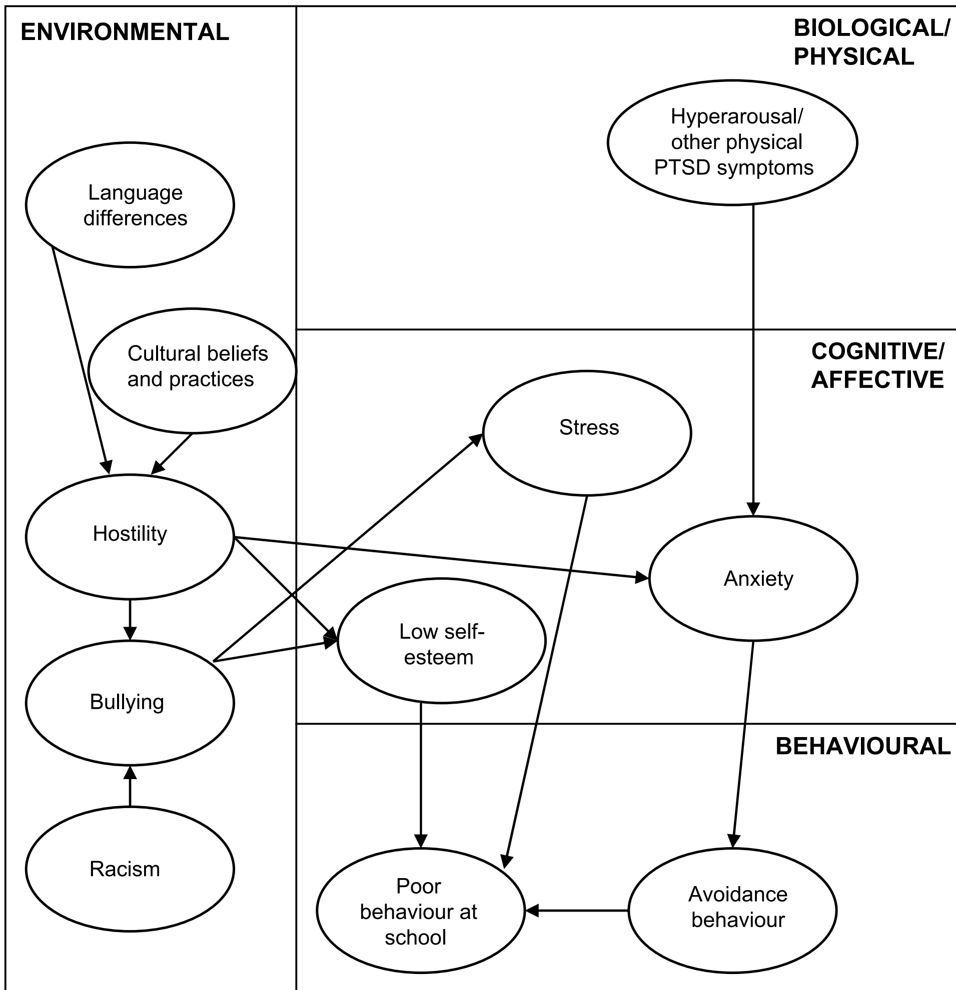

Figure 2. IF framework for some of the effects of trauma on a child refugee – the impact on behaviour.

considerations about time and resources, and judgements about the appropriateness of such approaches. Nonetheless it is important for EPs to be aware of such interventions as examples of support that refugee children may be offered or receiving, or support that they may have access to if referred to appropriate agencies.

In addition to such clinical/medical interventions there is research that suggests that school-based interventions can be used effectively to address post-traumatic stress symptoms in children. One such intervention is the Teaching Survival Techniques programme produced by the Children and War Foundation (Smith, Dyregrov, & Yule, 2002). This programme was devised by researchers with expertise in child clinical psychology and psychiatry. It is designed to be delivered by people who do not have significant experience of working within mental health, or working with children who have experienced trauma. The programme should, however, be conducted under supervision from someone with greater mental health expertise

(e.g. an EP). It involves working with groups of children and the programme describes various activities that can be used to address some of the effects of post-traumatic stress. The tasks and activities are organised into three sessions, each focusing on one of the three main sets of PTSD symptoms: Intrusion [e.g. activities dealing with imagery, dual attention (based on EMDR), and dreams], Arousal (e.g. muscle relaxation), and Avoidance (e.g. graded exposure). The principles underlying these tasks are drawn from CBT as well as other psychological therapies, and the programme has been shown to be effective, reducing traumatic stress and depression in children in Greece who had survived an earthquake (Giannopoulo, Dikaiakou & Yule, 2006), as well as with survivors of the Bam earthquake in Iran, and Finnish children who had experienced sexual abuse (Children and War Foundation, 2008). It has also been used with refugee children in the UK and observed to have positive effects in reducing distress, although the effects were not as large as those observed in post-disaster studies. The authors hypothesised that this may be due to complexities in the lives of these children, including uncertainty about their future. Nonetheless, there was a significant decrease in PTSD symptoms such as recurrent thoughts and nightmares. Children enjoyed the groups and teachers reported improvements in participants' behaviour and emotional well-being (Ehntholt, Smith, & Yule, 2005).

Within the literature there is also evidence that more generic counselling-based interventions have been successfully employed by EPs to reduce symptoms of PTSD following a traumatic incident within a school (Mallon & Best, 1995). This research highlighted the importance of early intervention following a single acute traumatic incident (a violent, hostage situation within a school). Such early intervention may not be possible in work with refugee children, whose experience of trauma may have occurred some time before they arrive in the UK. Nonetheless, given the various, protracted and ongoing difficulties that refugee children have often experienced it is likely that they would benefit from such support. Moreover, evidence suggests that it helps refugee children to talk about their experiences, but teachers and family members often have concerns about this and may actively discourage it (German & Ehntholt, 2007). In such situations the opportunity to access school counselling services or individuals with counselling skills to talk in a non-directed way may well be helpful.

There is a strong case to be made for these types of school-based interventions because children and families may be somewhat reticent about accessing mental health services in a clinical setting. Given cultural beliefs and attitudes as well as language issues such services may not be perceived as particularly inviting. Moreover, parents may wish to focus on the future and their children's academic progress and may be reluctant to do things that interfere with these, such as removing them from school for clinic appointments (Hodes, 2000). Also schools can often offer the first place of security, consistency and emotional containment for refugee children (German & Ehntholt, 2007): although it is worth repeating the caveat, mentioned earlier, that schools can be threatening and stressful places for refugee children, and any assumed sanctuary may in fact be illusory.

In addition to interventions focused on PTSD-type symptoms, EPs can also target interventions at a level of secondary prevention. One example of such work would be interventions and support to increase the resilience of refugee children. Resilience does not refer to an individual trait or characteristic. It "involves a range of processes that bring together quite diverse mechanisms operating before, during

or after the encounter with the stress experience or adversity that is being considered" (Rutter, 1999, p. 135). Such a view is consistent with the ecosystemic and interactionist perspectives outlined earlier. Indeed, the promotion of resilience can be conceptualised as occurring at systemic levels or ecologies – individual, home/family/school, and community/environment – and in different domains of a young person's life – participation in education, promotion of positive values, life skills, care and security, maximising talents, and pro-social bonding (Newman & Blackburn, 2002; Daniel, 2003). A number of specific interventions and supports have been identified that can promote resilience in refugee children. These include: ensuring a caring adult is available and there is a nurturing environment; programmes to develop self-esteem, social skills and internal locus of control; teaching host language to both children and adults to help develop social networks; ensuring counsellors and teachers are aware of children's needs; using group processes in class to facilitate development of friendships; and making local information available to alleviate stress of relocation (Anderson, 2004). In work with adult refugees Webster and Robertson (2007) argue for the application of Community Psychology approaches to support refugees, challenge injustices and empower them. Such an approach can not only draw on the many existing social resources that exist within refugee communities, it can be more sensitive to cultural understandings of refugees' experiences and hopefully lead to more sustainable improvements.

Conclusion

These approaches and the issues discussed in this paper emphasise the importance of considering the breadth of the challenges and difficulties that refugee children encounter, and the importance of focusing interventions at appropriate levels of systems. Schools and services need to adapt to be more supportive of and welcoming to refugee children. But this may involve generic approaches targeted to support all children and young people, such as whole school anti-bullying and anti-racism policies and initiatives. Not only is it appropriate to act at such levels from the point of view of an interactionist or ecosystemic stance, but it makes sense given the increase in numbers of refugee children that schools are encountering and can expect to encounter in the future. There is an existing literature with recommendations for good practice for local authorities and EPSs in responding to traumatic incidents (e.g. Mallon & Best, 1995; Cameron, Gersch, M'Gadzah & Moyse, 1995). Lessons can be drawn from this and from the literature on supporting refugee children to develop policies and guidance tailored to the needs of this group of vulnerable young people.

This paper has highlighted some of the issues that EPs need to consider when working with children who are refugees. There is much that has not been discussed in depth, for reasons of limited space, such as issues surrounding language and cultural beliefs. However the author has endeavoured to explore the various sources of stress and trauma that refugee children might experience, and the different effects that these might have on their psychological functioning and emotional well-being. It has also been argued that interactionist and ecosystemic approaches afford the most appropriate frameworks for conceptualising the difficulties experienced by refugee children as well as for considering appropriate therapeutic intervention.

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