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# Understanding Trauma in the Refugee Context

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For a school counsellor or classroom teacher, working with newly arrived students from refugee backgrounds can be daunting, particularly with the awareness that these students have likely experienced significant and potentially horrific trauma. There is now a wealth of evidence showing that traumatic experiences can significantly impact our neurological development, resulting in difficulties in areas such as learning, behaviour, relationship building and emotion regulation, meaning newly arrived refugee students will often arrive at school with some significant challenges. While there is an extensive amount of literature on trauma, there is very little that focuses specifically on the refugee population, and even less on young people from refugee backgrounds. Predominantly, the research looks at chronic or developmental trauma such as child abuse and neglect, or acute trauma such as natural disasters. The following article looks at the refugee context specifically, breaking down the difference between acute, chronic and developmental trauma; and describing the neurological effects of trauma and suggesting some practical classroom-based strategies that can be employed to support and facilitate the recovery of students from refugee backgrounds.

■ **Keywords:** school counselling, refugee, education, trauma

*Maya was the first child born into her family in Aleppo, Syria. When Maya was six years old and in her first year of school, a group of five men came to the front door. They forced her father to kneel down and they shot him in the back of the head, to the horror of his watching family.*

*Two months after this event, Maya, her younger sister Liliane and their mother left Syria with a small bag each, bound for a refugee camp in Turkey.*

Trauma is, unfortunately, something that will affect the majority of us at some point in our lives and is a significant part of the refugee experience, almost without exception (Joseph, 2011; Shukoor, 2015). Our experiences may be something as dreadful as Maya's, or may be less dramatic, but by their very definition, traumatic experiences are 'deeply disturbing and distressing experiences' and can leave us

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feeling helpless and hopeless (Oxford English Dictionary, 2018; National Child Traumatic Stress Network [NCTSN], n.d.). We now know that traumatic experiences can actually change the way both our brains and our bodies function, significantly impacting the way we interpret and interact with the world around us (Porges, 2011; van der Kolk, 2014).

There has been a great deal of research into the effects of trauma and there have been several types of trauma identified in the literature, leading to many terms, definitions and buzzwords used to describe the experiences and symptoms. Because most of the available literature explores childhood trauma outside of the refugee context, it can be quite confusing as a school counsellor to try and unpack a referral for a refugee student. Similarly, for a classroom teacher, it can also be overwhelming and daunting to know how to support a newly arrived refugee student in the class. It will be helpful to discuss some of the commonly used terms from the trauma literature, with specific reference to the refugee context, before we begin to look at some of the effects and recovery techniques that can be used within the school environment.

## Acute Trauma

Experiences of trauma and the resulting impacts vary greatly. Researchers and clinicians often divide trauma into two separate types — acute trauma and chronic/complex trauma (NCTSN, 2016). Acute trauma occurs when a person is exposed to a single event trauma such as a car accident, an assault, a natural disaster or a terrorist attack. These events are terrifying for the individual and will often have far-reaching implications for stress levels, mental health and everyday functioning. These effects can range from uncomfortable to life controlling and can include ongoing fearfulness, nightmares, impaired concentration and memory, depression, anxiety and posttraumatic stress disorder, and can last weeks, months or years following the event (van der Kolk, 2014). In the case of an event such as a natural disaster or a terrorist attack, these effects can filter through entire communities. Evidence of this was seen in people living in close proximity to the September 11 terrorist attacks in New York. Researchers found many were still experiencing heightened fear responses three full years after the attack (Ganzel, Casey, Glover, Voss, & Temple, 2007).

While trauma is very common among people from refugee backgrounds, acute trauma is a less common experience than chronic trauma as, sadly, many people who become refugees will have experienced ongoing and multiple traumas (NCTSN, n.d.; Shukoor, 2015).

## Chronic Trauma

*In the months before her father was killed, Maya would lie awake in bed each night, listening to missiles being dropped on the city, wondering who might be getting hit. Several of her friends had left the city after their homes had been destroyed and members of the family had been killed. Her friend Soraya had lost an arm in a blast and Maya had seen dead bodies in the street on more than one occasion.*

For some people, experiences of trauma will not be a single event; traumatic events will occur repeatedly and over long periods of time, including experiences such as war, ongoing community violence, parental neglect, ongoing sexual abuse and repeated domestic violence. These types of repeated, life-threatening experiences are typically understood to result in symptoms of chronic trauma (NCTSN, 2016). Often when psychologists discuss chronic trauma in a local context, they are referring to children who have experienced ongoing abuse or neglect, such as children in out-of-home care. However, countries that are at war or are in great political turmoil perpetrate many of the risk factors that can lead to the development of chronic trauma, meaning that many individuals and families from refugee backgrounds have experienced chronic trauma.

Every experience of trauma is unique, but there are many common traumatic threads seen in refugee experiences across cultures and continents. These include sexual assault (particularly for women), witnessing extreme violence, being forced into becoming a child soldier, and witnessing the effects of bombs and missiles (NSW Centre for Refugee Research, 2007). The refugee journey and the experience of living in a refugee camp can also include assault and violence and often also includes having a lack of physical safety and basic necessities such as food and water.

Experiences of chronic trauma have an enormous impact on the way our brains and bodies function and react to the world around us. Although everybody is different, there are some commonalities in the responses that we have after experiencing ongoing traumatic events, including an impact on two of the most fundamental things in our life: our ability to build trusting relationships with other people, and our ability to feel safe (Blaustein & Kinniburgh, 2010; NCTSN, 2016). Chronic trauma also often produces strong feelings of fear, shame and guilt (NCTSN, 2016).

## Developmental Trauma

Developmental trauma is a term that is being used a lot in the current literature and around young people's experiences of trauma. In order to understand developmental trauma, it is first important to understand the theory of attachment.

Attachment theory was developed in 1958 by John Bowlby, further developed by Mary Ainsworth over the next two decades, and continues to be regarded as fundamental to understanding human relationships (Ainsworth, 1973; Bowlby, 1958). In psychological terms, the word 'attachment' refers to the physical and emotional bond that a child forms with their primary caregiver(s), usually their mother and/or father (Ainsworth, 1973). Attachment theory suggests that the type of bond that an infant develops shapes the way that they will then interact with their environment and the types of relationships they will build with others (Blaustein & Kinniburgh, 2010). For example, if a child develops a healthy, 'secure' attachment with their caregiver, they will feel safe to explore the environment and people around them, knowing that they have a safe place to return to (Ainsworth, 1973; Blaustein & Kinniburgh, 2010). This attachment also helps the infant to learn how to regulate and control their emotions.

Alternatively, there may be situations in which the primary caregiver is unable or unwilling to consistently respond to the infant's needs of safety, security and

protection, so this secure attachment does not form. This could be for many reasons, such as the caregiver lacking basic parenting skills or having an abusive caregiving style, or because the parent has a mental or physical health issue that prevents them from providing ideal parenting. In the context of refugee families, factors such as war, poverty or conditions in refugee camps or immigration detention may mean that ideal, safe parenting conditions are simply unavailable.

Developmental trauma is chronic trauma of an interpersonal nature, often (although not exclusively) involving an attachment figure, including abuse and neglect (van der Kolk, 2005). Developmental trauma is sometimes referred to as complex trauma in the literature (van der Kolk, 2005). An example of this might be a parent who is drug affected and does not consistently respond to their child's needs for food, water, safety, shelter and love, or a family member who engages in ongoing sexual or physical abuse of a child. In Maya's case, it may be that while her mother has the understanding and knowledge of good parenting practices, her own grief, mental health issues related to her own traumas, and the availability of resources in the refugee camp mean that she is unable to fully provide for Maya. Maya's trauma would also be compounded by the sudden and unexpected loss of her father, who she was likely also attached to.

Developmental trauma disrupts or damages the development of a secure attachment to that caregiver and tends to be ongoing (as in chronic trauma) rather than tied to a single traumatic event (as in acute trauma; van der Kolk, 2014). The nature of the trauma (e.g., abuse, neglect) often means there is a lack of predictability and safety in the child's environment. As with chronic trauma, developmental trauma has a myriad of potential unpleasant effects, including our ability to build trusting relationships with other people and our ability to feel safe (Blaustein & Kinniburgh, 2010; van der Kolk, 2014).

As highlighted earlier, our primary attachment shapes the way that we interact with others and build relationships throughout our lives. When traumatic experiences damage this fundamental primary attachment, it usually means that the way we form future relationships will be altered or damaged, meaning it may be much harder for someone to trust adults, for example, or harder to feel safe and secure in a friendship or romantic relationship (Blaustein & Kinniburgh, 2010; van der Kolk, 2014). It may also mean that when a young person begins to feel a close bond building with someone that they may push hard against that bond in an attempt to stop it from forming. In the school environment, we may receive referrals for students who display behaviours of concern, who are struggling to make friendships, or who display defiant behaviours when faced with authority or school rules. A classroom teacher may feel frustrated that their efforts to bond with the student are seemingly fruitless. It may also be very difficult for a positive relationship to be built in the therapeutic context.

The recovery process for someone who has experienced developmental trauma is often more complex and challenging, particularly if the young person is still living in the situation that is causing the trauma. For Maya, while she is living in the refugee camp and while her mother is still struggling to provide consistent love and care due to her own grief, she is likely to continue to experience the effects of developmental trauma and recovery from these effects may be hampered.

## Effects of Trauma on the Brain

It is very common to hear people say that children are resilient, that they will bounce back from traumatic events, that perhaps they will not even remember them (Perry & Szalavitz, 2006). The evidence that we now have about the impact of trauma on the brain effectively shows that, in fact, exactly the opposite is true. Childhood trauma can have a significant impact on brain development and can have long-lasting impacts on the way individuals interact with their environment and build relationships, as well as potentially affecting physical development as well (NCTSN, 2016; van der Kolk, 2014). It is helpful to explore some basics about the way our brain develops in order to understand the potential impacts that trauma can have on the brain and how these might be having an impact on the refugee students we work with.

As described by Bruce Perry, the brain develops from the bottom up, and the inside out (Perry, 2011). The most essential and primitive parts of the brain develop first: first, the brain stem, which connects the brain to the spinal cord, heart and lungs and is the part of the brain responsible for our most primitive survival mechanisms, such as our heart beat and breathing (Perry, 2011; Perry & Szalavitz, 2006; Porges, 2011). After this, we develop our midbrain, responsible for things such as vision, hearing, movement, balance and body temperature; then our limbic system, responsible for raw emotions and, importantly, our threat and danger responses, sometimes referred to as the fight or flight response (Perry, 2011; Porges, 2011; van der Kolk, 2014). The cortical region of the brain, responsible for complex processes like thinking, reasoning, attention, perception, awareness, thought, language and consciousness, is the very last part of the brain to develop and continues developing well into our twenties (Perry, 2011; Porges, 2011; van der Kolk, 2014).

When exposed to trauma, the brain adapts its functioning in many ways in order to best ensure our survival (Porges, 2011; van der Kolk, 2014). The extent to which our brain adapts its functioning depends on the extent to which the individual perceives threat. To simplify the explanation, we can say that when the brain perceives a serious threat, the parts of the brain responsible for some of our more advanced abilities, such as the cortex, ‘switch off’ to allow the more primitive survival functions of our brain to take over and attempt to ensure our survival (Porges, 2011; van der Kolk, 2014). The parts of the brain responsible for things like detecting threat, increasing alertness and engaging the flight/fright/freeze response (i.e., the limbic system) become engaged in order to provide the body with the best possible conditions for survival (Porges, 2011; van der Kolk, 2014).

The response that our bodies have to the brain functioning like this can vary, depending on how the individual perceives the threat. Often, it will result in a person becoming ‘hyper-aroused’, meaning that their brains become highly alert and hyper-vigilant to all the sensory information around them, searching for any further threat (NCTSN, 2016). During hyper-arousal, the fight/flight response is often engaged (NCTSN, 2016). This is a very common response and something that most of us can relate to with personal experience. A good example would be after being in a car accident — you may find that because your cortex was not functioning well your memories of the event are a bit patchy and that you were quite jumpy for a few hours afterwards. If the car accident was quite traumatic,

these effects may have lasted for days, weeks or even months. We would expect that for Maya, after she witnessed her father's murder, her brain would adapt in a way that would make her hyper-vigilant for a long time afterwards, well after her arrival in Australia.

Interestingly, another response that our brain and bodies can have during threat can result in a state of hypo-arousal rather than hyper-arousal. Hypo-arousal occurs when our brain perceives a very extreme threat, potentially with the risk of death — the cortex also switches off, but the focus of the brain's drive is on the brain stem rather than the limbic system, slowing the heart rate and breathing (Perry & Salavitz, 2006). The reason for this is to enhance chances of survival during severe injury — if our heart rate is slower we will bleed more slowly (Perry & Salavitz, 2006). A person who is hypo-aroused may become unconscious or fall asleep when the threat is imminent rather than having the more typical fight/flight response. Young children are sometimes found among dead bodies after traumatic events, seemingly unconscious, but are potentially in a state of hypo-arousal.

It can take days, weeks or months for the brain to recover from using the threat response (Porges, 2011; van der Kolk, 2014). You may be able to recall a time where after a dangerous situation you were quite jumpy for several days, or you may have found for years afterwards that something like a particular colour, image or smell reminded you of the event and made you tense all over again. For people who have to endure ongoing war, abuse or neglect, this threat response can potentially become their 'new normal', changing the resting state of the brain (Blaustein & Kinniburgh, 2010; NCTSN, 2016). This is particularly true for the younger, still developing brain, which is still learning how to respond to new situations (NCTSN, 2016).

If a young person is chronically exposed to trauma, their brain is likely to 'learn' that the trauma/threat response is important and adaptive, resulting in the brain's response, as described above, becoming the 'normal' state of functioning (NCTSN, 2016). As a result of this, young people who have experienced chronic exposure to traumatic events can become perpetually hyper-aroused or hypo-aroused, with brains that are constantly scanning the environment for threat, often perceiving threats in the environment that may not even be present (NCTSN, 2016).

In Maya's case, she was lying in bed and listening to missiles dropping on houses, wondering when they might drop on her own house. This threatening situation would likely mean that her brain would be hyper-aroused, ready to engage in the fight/flight response each night. Because this happened so often, and there were many other threats in her daily life, her brain may have then adapted to this constant hyper-vigilance and begin to stay in this state. By the time she arrives in Turkey, or even when she finally settles as a refugee in Australia, Maya may still be experiencing this hyper-arousal, which can be easily triggered by loud noises like airplanes, lawn mowers, a knock on the classroom door or the school bell. To a classroom teacher, it may look as if Maya is inattentive, hyperactive or potentially even aggressive with little warning, whereas it will likely be Maya's brain responding in a very adaptive way, in survival mode. If Maya ever falls into hypo-arousal at school, to a classroom teacher it may look as if she is just lazy, daydreaming or tired.

On top of these neurological difficulties, Maya will also be dealing with a new language, a new school environment and culture, new food, a new social culture,

a new community, new housing and learning new skills, all of which is likely to be very overwhelming, exhausting and is likely to take considerable time. Some students will also have the added experience of having lived in an immigration detention centre, which evidence has shown has the potential to add an extra, significant layer of trauma (Mares, Newman, Dudley, & Gal, 2002).

It is important to acknowledge that while traumatic experiences can be quite neurologically damaging, we now know that the brain is plastic, and that provided with the right conditions, a great deal of reparation can occur (Doidge, 2010; van der Kolk, 2014).

## Facilitating Recovery

*After spending 18 months in the refugee camp in Turkey, Maya and her family are granted a refugee visa for Australia and make the journey by plane to Sydney. Just two days after they arrive, Maya and Lilliane, who has just turned 5, are enrolled and start attending their local primary school.*

*Maya feels scared — it is the first time she has had to leave her mother's sight since her father was killed. She doesn't speak any English and doesn't understand what is happening most of the time. The teacher seems kind and doesn't ever hit the kids like her teacher in Syria, but she can't explain to Maya what is happening. Maya desperately wants to learn English but keeps forgetting the things she just learned.*

What can we do to support a family or a child that is experiencing the effects of trauma? Classroom teachers and school staff are often overwhelmed and turn to the school mental health expert — the school counsellor — for support and guidance. As a school counsellor, receiving a referral for a refugee student may sometimes feel overwhelming when hearing of the enormity of the trauma that a student has experienced, and it can be hard to imagine what steps we can take to help a young person recover. Evidence suggests, however, that in a school environment, there are many simple factors that can make an enormous difference to begin recovery after trauma, regardless of whether someone is struggling from acute, chronic or developmental trauma and whether they are from a refugee background or not. The first step will often be to provide psychoeducation around all of the issues discussed in this article, particularly the neurological impacts of trauma, which can provide a way for behaviours of concern to be seen in a different (and less personalised) light. Once there is a basis for understanding the origins of behaviour, a focus on providing the conditions for recovery can begin.

There are many different recovery models that are available for us to use in this context; for example, Hermann's Recovery Goals (Hermann, 1997), Blaustein and Kinniburgh's ARC model (Blaustein & Kinniburgh, 2010), UNICEF's STARS model (NSW Department of Education, 2016), and Foundation House's *School's In For Refugees* (Foundation House, 2016). While the various steps and factors for recovery differ, there are some consistent messages across all of these recovery models: building a sense of safety, building connections, and having a consistent and predictable environment. School counsellors may receive therapy referrals for newly arrived students from school staff who have heard of and are rightly concerned about the trauma a student has experienced. It is often not appropriate to start working on individual therapy with these young people; however, the evidence



does suggest that some of the most powerfully reparative steps can be taken in the school environment to help begin the recovery journey (Blaustein & Kinniburgh, 2010; Hermann, 1997).

These steps, and what they would look like in the classroom will be the focus of the following discussion.

### Safety

The clear and fundamental emphasis on restoring a sense of safety is the basis for all of the aforementioned models. When talking about safety in this context, we are referring to both physical safety and emotional safety (NCTSN, 2016). While physical safety may be easier to control through environmental modifications, feeling emotionally safe can be more complex. A child who is feeling emotionally safe will be calm, will feel that they can trust those around them, and will likely be open to learning. For children from backgrounds of chronic trauma, particularly those with refugee backgrounds, their experiences of trauma have almost always included being in unsafe environments and with people who did not make them feel safe. For these reasons, their brains and bodies may perceive threat in an environment that another person would feel quite safe and comfortable in.

In the school environment, there is much that can be done to assist young people in feeling safe. What will feel safe for each individual young person may be quite different depending on their experiences. Feeling physically safe will most obviously include attending school in a safe area (outside the war zone), but feeling emotionally safe may also include factors such as feeling welcome, understanding classroom and playground expectations and rules, having a 'safe space' to calm down, having a 'safe person' to check in with, having opportunities to relax and play, having predictable routines, and having a way of communicating needs. All of the factors discussed below will also contribute to a young person feeling safe.

For Maya, as it is the first time she has left her mother in over a year, it may be particularly pertinent to make sure she has a 'safe person' to check in with. Some visual communication cards and a visual timetable may also be useful, so that Maya understands what is going to happen and when, and so that she can ask for things she needs, such as water or a toilet break.

### Connections

In their reputable textbook on treating traumatic stress in children, Blaustein and Kinniburgh (2010) claim that 'across studies, perhaps the single most important predictor of resilience for high-risk children is a safe, nurturant bond with a single person' (Blaustein & Kinniburgh, 2010, p. 20). For many children from refugee backgrounds, their experiences with adults have been predominantly negative and often adults — particularly adults in positions of power — will have become associated with threat (NCTSN, n.d.). Previous experiences of schooling may even have included corporal punishment. One of the simplest and most powerful things that a school can do is help a young person to build at least one safe relationship with a trusted adult. As a school counsellor or school-based mental health practitioner, you may wish to consider your availability and how regularly you are on site when considering whether you are the appropriate staff member to become this 'safe person.' It may also not necessarily be the classroom teacher — to start with it



may be a teacher's aide who speaks the home language, a deputy principal, welfare teacher or school librarian who has some time off class and is willing to spend time building a relationship with the student. In this case, your role may include facilitating this relationship between another staff member and the student and helping the staff member to understand some of Maya's behaviours of concern, and to understand the importance of the consistency of this relationship. Even a 5-minute 'check-in' at the beginning and end of each day can be a fantastic way for a student to know that there is somebody who cares about them and how they are feeling. It may take some time, but the more connections a young person can make at school, the better. It may help you to map out the relationships that a young person like Maya has in their life, across family, school and community, to see which areas may benefit from strengthening.

### **Predictability and Consistency**

Living in ongoing traumatic situations, such as war or domestic violence, is almost always chaotic and unpredictable. It may feel as if it would be beneficial for a traumatised young person to have fewer rules; however, evidence suggests that having consistent boundaries and clear expectations can be very beneficial, as it provides a predictable and consistent environment that is more likely to produce feelings of safety (Blaustein & Kinniburgh, 2010). As a school counsellor you can help schools to understand that events such as timetable changes, the absence of a 'safe' staff member, or an unusual event (e.g., fire drill) may make a traumatised student feel unsafe and unsettled, potentially leading to behaviours of concern and emotions. Where possible, these changes should be communicated in advance and, if they are likely to be particularly unsettling, the school counsellor can assist the school to produce a safety plan for these days (e.g., in the case of teacher absence, a plan for alternative 'safe' staff members to spend time with the student, an extra 'check-in' and a safe place to go to). For students like Maya who are still learning to speak English, use of visual timetables, visual cues, visual and/or translated class rules or an interpreter may be necessary to effectively and safely communicate these changes well. Maya, like many traumatised young people, is struggling with remembering what she is learning. It is important to remember that, as previously mentioned, traumatic experiences can have a significant negative impact on memory, so having classroom strategies such as predictable routines and consistent use of visuals that reduce reliance on memory can reduce cognitive load and stress.

### **Therapies**

As previously mentioned, it is not always appropriate to begin individual counselling in the school environment with students from refugee backgrounds who have a history of significant trauma. There are many factors to consider, particularly the appropriateness of being one on one in a small, closed room with someone who may have been imprisoned or had adverse experiences with adults. The cultural appropriateness of talking therapies should also be considered, as well as the appropriateness of the school environment (where a sense of safety needs to be built) for processing and integrating trauma. There is an emerging body of evidence suggesting that creative therapies, such as drawing, music, dance, art and

yoga may be viable therapeutic options for working with people from refugee backgrounds (Dieterich-Hartwell & Koch, 2017). Using evidence-based creative therapy programs can reduce the reliance on language, provide a safe method of communication, and promote positive relationships and safe spaces.

### Protective Factors

Each individual who experiences trauma will carry along with them a series of protective factors, things that may protect them or mediate the effects of trauma. These may be genetic factors, such as good mental and physical health, or environmental factors such as friends, family, wealth or access to medical care (NCTSN, n.d.). The research indicates that the most powerful of these factors is support — connections to family, friends and community (Blaustein & Kinniburgh, 2010). For many refugees, the support network that may have been protective is left behind during the refugee journey. For some, there will be family, friends and/or a community to connect with in the new country, but for many families, relocation often results in social isolation, financial difficulties, language barriers and an overall lack of support, all of which are likely provoke the effects of trauma.

Access to a school counsellor can definitely be a potential protective factor, as well as other factors such as access to case workers, community services, financial assistance, medical assistance and education, both before, during and after the journey. As a school counsellor it may useful to explore whether a family you are working with had any of these protective factors in the past or has access to them now, and explore the possibility of increasing these. Schools can often play a significant role in facilitating connections between families and the community by offering a space for parents and families to connect, such as a parent café, gardening club or English lessons, or by just providing a space for community groups to meet. Building a strong relationship between parents and the school will likely help a young person to feel safe at school as well.

### Posttraumatic Growth

When working with young people who have experienced trauma, especially those from refugee backgrounds, we can often feel overwhelmed by the enormity of their stories. How can someone like Maya who has experienced such horrors ever go on to experience a normal life? Will they ever recover? There is a growing body of evidence showing that although trauma can have a very significant effect on our brains, our bodies and our relationships, it is also possible to experience positive psychological growth after trauma — posttraumatic growth (Tedeschi & Calhoun, 2004). Many people report that despite the significant difficulties following a trauma, they also experience an improvement in at least one element of their life, such as a growth in self-understanding, positive relationships, personal strengths and/or a greater appreciation of life (Tedeschi & Calhoun, 2004). There are many examples in our society of young refugees with significant histories of trauma who flourish and thrive, becoming doctors, lawyers, actors and politicians, holding meaningful jobs and having productive, supportive relationships and families. The school environment is one of the most influential and adaptable environments that young people interact with and has a great deal of capacity to provide some of the conditions for recovery described above. These are likely to be the most positive and

reparative things that can be done to assist not just with recovery, but to promote positive growth, enabling students to flourish and thrive in the long-term.

## Free Resources/Suggestions for Further Reading

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