



Equity by Design:

Supporting Social-Emotional Needs
of Students Who Are Refugees

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Supporting Social-Emotional Needs of Students Who Are Refugees

The changing demographics of the United States is spurred by immigration from throughout the world and the network of Equity Assistance Centers, including the Midwest and Plains Equity Assistance Center, is dedicated to supporting school systems' capacities to receive and educate students of national origins other than the U.S. These new Americans include an influx of refugees from countries undergoing severe and persistent upheaval.

KEY TERMS

Refugee - a person outside their country of nationality due to well-founded fears of persecution because of their race, religion, nationality, political views, or social group and are unable or unwilling to return; or a person displaced due to certain events and are unable or unwilling to return to their country of nationality (UNHCR, 1951).

Mental Health - a state of well-being in which a child realizes his or her own potential, can cope with the normal stresses of life, can learn and work productively, and is connected and makes positive contributions to his or her community (World Health Organization, 2014). In this way, students develop optimal mental health when they are supported by compassionate and nurturing adults, socially connected and competent, emotionally resilient in the face of adversity, and engaged in and succeeding in school.

School-Based Mental Health Services - a continuum of mental health services delivered in the schools that vary by targeted group and intensity of need. Services include primary prevention initiatives, targeted intervention, and intense intervention (Werthamer-Larsson, 1994).

Cognitive Behavioral Therapy - a form of psychological treatment that combines psychoeducation, somatic management, cognitive restructuring, exposure, and relapse prevention to mitigate the impact of chronic anxiety-related disorders (Albano & Kendall, 2002).

Multi-Tiered and Multimodal Interventions - a method of service delivery that provides individualized treatment based on severity of needs.

Because of the trauma that often precedes such migration, appropriately supporting the mental health needs of refugee children and youth can be considered a public health concern (Weine, 2011). Even though the post-migration lives of many refugees are characterized by resiliency and adaptation (Bronstein & Montgomery, 2011; George, 2012), it is necessary for educators and school-based mental health providers to understand that the process of migration, resettlement, and accumulative stress leaves refugee youth susceptible to various types of psychological distress (Bronstein & Montgomery, 2011). As the largest provider of mental health services to children (American Academy of Pediatrics, 2004), schools are uniquely positioned to enact practices that support the social-emotional needs of students who are refugees who have experienced social upheaval, trauma, war, and uncertainty. Given the centrality of mental health to the overall wellbeing of individuals, families, and communities (Alegria, Green, McLaughlin, & Loder, 2015) and ongoing disparities in access to mental health services (Alegria, Valles, & Pumariega, 2010), educational systems should help ensure that all children receive the necessary social-emotional supports to lead healthy, productive lives. In this brief, we provide an introduction to the refugee population, describe common experiences of trauma and resultant treatment, and offer an overview of research-based school supports for students who are refugees. This discussion is applicable to individuals with formal refugee status, as well as others who have been exposed to war or conflict and fled their home countries as a result.

A Global Perspective on the Refugee Population

The refugee population represents a broad diversity of individuals and communities who share the experience of fleeing their home countries due to fears of persecution because of their identity, social status, or beliefs. Such fears characterize the experience refugee groups and sets them apart from other migrant and immigrant groups who have also left their countries of origin. Refugees constitute a substantial portion of all globally-displaced persons along with asylum-seekers, internationally displaced persons, and persons of concern, among others. Of great concern to public and mental health service providers is the consistent increase in the number of refugees over the last five years, a trend heavily influenced by continued conflict in the Middle East, most notably, Syria. According to the United Nations High Commissioner for Refugees (UNHCR), 2015 saw the highest number of displaced individuals worldwide. Globally, over 65 million people were forcibly displaced (nearly 6 million more than the previous year); approximately one-third of whom are refugees. Developing regions account for the greatest number of refugees including countries such as: Syria, Afghanistan, Somalia, South Sudan, Sudan, Democratic Republic of the Congo, Central African Republic, Myanmar, Eritrea, and Colombia.



While the majority of the global refugee population resettles in other developing regions (i.e., Turkey, Pakistan, Lebanon, Islamic Republic of Iran, and Ethiopia, among others), approximately 273,000 refugees and 286,000 asylum-seekers (pending cases) currently reside within the United States (UNHCR, 2015). In the United States, refugee and asylum status are forms of protection defined under the Immigration and Nationality Act initially authorized in 1952 and currently administered by the U.S. Department of Homeland Security (USDHS); individuals must be referred for official status and approved for admission to the country following extensive application and interview procedures, health screening, sponsorship by U.S. resettlement agency, and, often, culture training (USDHS, 2015; US Department of State, 2017). Many other immigrants hail from countries and regions deeply affected by violence and political disruption (e.g., certain South American countries) that may result in similar experiences to refugees and, as such, warrant similar supports to promote wellbeing (Fortuna, Porche, & Alegria, 2008). Supporting the academic, behavioral, and social-emotional needs of refugees in the United States is a concern for schools since over half (51%) of refugees are children (UNHCR, 2015) many of whom experienced severe and repeated victimization and trauma, both direct and indirect, such as intergenerational trauma (Baker & Shalhoub-Kevorkian, 1999) that can shape their experiences and outcomes after resettlement.

Trauma and Treatment

Although many children and youth nonetheless demonstrate resiliency and positive outcomes, negative experiences like war, active combat, family separation, fleeing one's home, and deprivation (Lustig et al., 2004; UNICEF, 2016), increase the risk of social-emotional and academic difficulties (Kirmayer et al., 2011). Again, it is important to emphasize that the above experiences do not necessarily lead to

negative mental health outcomes as there are a plurality of environmental factors and family characteristics that increase resiliency among refugee youth and protect against additional trauma; one protective factor relevant to educators is school attendance (Montgomery, 2010).



To better understand the ways in which the experiences of refugee youth impact functioning later in life, it is important to understand the migration trajectory of refugees as well as the direct and indirect trauma commonly experienced. A useful model to represent migration experiences divides the process into three phases (pre-migration, migration, and post-migration) each associated with unique stressors (Kirmayer et al., 2011). Pre-migration is typically characterized by social, political, cultural or economic upheaval (George, 2012) which alters or damages existing social roles and networks (Kirmayer et al., 2011). The limited research available indicates that the majority of refugee youth experience or witness multiple violent incidents, nearly one-third experience sexual assault and/or death of a family member, and 10-20% experience imprisonment, hiding, forced combat, or sexual slavery (Thomas, Thomas, Nafees, & Bhugra, 2004). Later social-emotional difficulty is most common among those who lost parents or other family members (Kia-Keating & Ellis, 2007).

During migration, refugees may traverse multiple countries, often living in refugee camps where communities, friends, and families are separated (George, 2012). These journeys are often characterized by uncertainty, danger, and deprivation of basic necessities. Although the initial stages of post-migration bring about hope and optimism as individuals escape persecution, these feelings may give way to disillusionment, loss, anxiety, culture shock, isolation, and depression, as well as barriers to advancement due to current policy, racism, or discrimination (George, 2012; Kirmayer et al., 2011). Thus, the entire process of migration may expose refugees to significant cumulative trauma.

Students exposed to such trauma can present with a variety of psychological symptoms including, but not limited to: sadness, irritability, separation anxiety, reduced concentration, fears, apathy, irritability, restlessness, somatic symptoms, paranoia, heightened awareness of death, and limited engagement and progress in school (American Academy of Child and Adolescent Psychiatry, 2010; American Psychological Association, 2008; Bronstein & Montgomery, 2011). Studies of refugee youth have demonstrated elevated prevalence of post-traumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD), depression, conduct disorders, and anxiety (Bronstein & Montgomery, 2011; Daud & Rydelius, 2009; Lustig et al., 2004). Taken together, it is clear that the exposure to trauma and the resultant symptoms experienced by refugee youth should signal need for screening and intervention to promote wellbeing.

Unfortunately, refugee youth and their families encounter barriers that limit their access to beneficial services resulting in increased mental health disparities between refugee communities and non-refugee communities (Rousseau & Guzder, 2008). Broadly, mental health services include various forms of counseling,

psychoeducation, family and peer support, as well as psychopharmacological assistance. These services can be delivered by a number of qualified and trained individuals such as clinical, counseling, or school psychologists; psychiatrists; physicians; and social workers to support individual needs and reduce the impact of traumatic experiences. Several factors have been identified that perpetuate the trend of underutilizing mental health services including stigma, cost, language proficiency, and competing cultural practices (Saechao, Sharrock, Reicherter, Livingston, Aylward, Whisnat, Koopman, & Kohli, 2012), as well as demographic and psychological factors like population age, symptomology, and the racial/ethnic minority status of most refugees that are related to service barriers.

Given that over half of the refugee population is comprised of children (UNHCR, 2015), it is important to consider how age impacts service-seeking behavior. Overall, as children age they are more likely to use mental health services and have their needs properly identified (Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006). However, young age may also serve as a protective factor for refugee youth when predicting future mental health problems. Research suggests that younger children are less likely to report both a need for mental health services and an unmet service gap when other factors are taken into consideration (e.g. whether a family member lives in the country of resettlement as well as the absence of internalizing symptoms; Bean et al., 2006). The importance of properly identifying young children in need of mental health services is underscored by the fact that most children seek services after being referred by an adult. For refugee children, these adults may include teachers and other educational professionals (Howard & Hodes, 2000). Therefore, educators play a crucial role in supporting access to treatment through early and accurate identification of young refugee children in need of mental health services even

when the school is not the provider of those services.

Symptomology is a second key factor that may exacerbate the gap in service receipt for refugee youth. Generally, children are referred for mental services at higher rates due to externalizing disorders and behavioral challenges as opposed to internalizing difficulties (Bean et al., 2006). Unfortunately, the predominant mental health needs of refugee youth fall under the category of internalizing difficulties; most notably PTSD, depression, and anxiety, thus necessitating preventative screening and referral procedures to identify students whose more subtle difficulties may interfere with wellbeing and academic engagement.



Finally, trends in mental health service utilization indicate that racial and ethnic minority communities have lower rates of access to psychological support when compared to peers in dominant cultural groups (Bean et al, 2006). Some of the differences in mental health access may be attributed to logistic and cultural barriers like language and cost (Saechao et al., 2012), but disparities persist even when access is equalized indicating that other important barriers like stigma, or prioritizing basic needs, may reduce access treatment (Lustig et al., 2004).

Taken together, the barriers associated with access to mental health support indicate that service providers should shift their thinking

regarding the environments in which services are provided, the methods used to identify children in need, and the overarching social factors that lead to persistent inequities. By working collaboratively to address the needs of refugee youth, service providers may help reshape attitudes towards seeking psychological support while simultaneously strengthening both school and neighborhood communities.

School-Based Social-Emotional Support

Schools remain the primary provider of mental health services for children and youth, and can serve as vital conduits to treatment for students who are refugees. School-based mental health providers in areas with large refugee populations should recognize this need for additional services as well as the school's position to implement effective screening and intervention programs (Rousseau & Guzder, 2008). Schools are likely the first space in which refugee youth are introduced to the culture of the country in which they resettle (Wilkinson, 2002) in addition to providing structure, predictable routines, and opportunities to interact with peers and form friendships—all features often absent in war-exposed areas (Werner, 2012). Even though schools serve as protective environments for refugee youth, academic performance may be hindered by social-emotional difficulties that result from their pre-migration and migration experiences. Schools are considered the optimal setting in which to identify and intervene on anxiety and depression given teachers' ongoing interactions with students and other personnel and resources to support screening and intervention in an environment that is engaging and accessible to students and families (Huberty, 2014). Notably, families may feel that there is less stigma associated with school-based mental health services that emphasize prevention or resilience (Weine, 2011) and are delivered community settings

(Roussaeu et al., 2012). Further, individual and group intervention provided by trained school personnel is a low-cost and efficient means of providing mental health services to refugee youth (Werner, 2012).



Overall, research on the effects of school-based interventions show that they may help reduce symptoms of trauma experienced by refugees and war-traumatized youth. Two types of social-emotional support that may benefit refugee youth are cognitive behavioral therapy (CBT) and multi-tiered or multimodal frameworks for intervention. These types of interventions show the strongest and most consistent positive results for reducing social-emotional difficulties of children and youth who are refugees. (A note of caution: Creative expression therapies, such as those utilizing music, drawing, theater, or stories have shown mixed, and sometimes harmful, effects so should be avoided in the absence of strong research support for specific interventions with this population).

Cognitive Behavioral Therapy

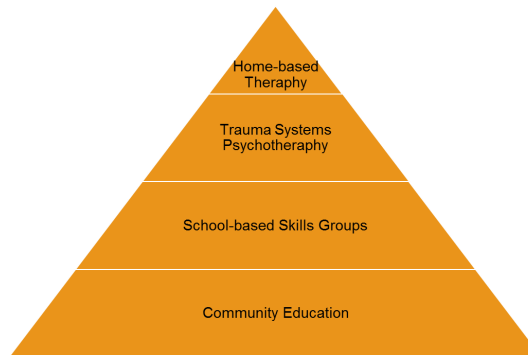
A cognitive behavioral perspective acknowledges that anxiety and depression are common emotions with adaptive physiological, behavioral, and cognitive components. However, persistent and extreme feelings of anxiety or depression may result in significant stress and impairment- impacting functioning within home, school, and community settings.

One recognized method of treating anxiety is CBT which contains the following components: psychoeducation, somatic management, skills training, cognitive restructuring, exposure, and relapse prevention (Albano & Kendall, 2002). Given the concern about the high prevalence of anxiety and PTSD symptoms within refugee populations, CBT is a promising, yet preliminary, avenue of treatment (Ehnholt, Smith, & Yule, 2005). Research evaluating CBT interventions in schools yielded several benefits including an alignment with the American Academy of Child and Adolescent Psychiatry's (2010) recommendations of treating children with trauma, consistent results, and efficient methods of resource distribution as interventions can be delivered by those without clinical training. One CBT program developed to fit within the school setting is Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Nadeem, Jaycox, Kataoka, Langley, & Stein, 2011). A meta-analysis of school-based CBT, including CBITS, found substantial reductions in PTSD symptoms and depression and anxiety (Rolfesnes & Idsoe, 2011). Schools can mobilize qualified staff (i.e., school psychologists, social workers, counselors, etc.) to support the social-emotional needs of refugee youth through implementation of manualized CBT programs such as CBITS that provided detailed structuring of the intervention process.

Multitier and Multimodal Interventions

Multitier and multimodal methods of service delivery individualize treatment based on the severity of need. The four-tier model implemented by Ellis and colleagues (2013) provided services at the community level, targeted support for English language learners, trauma support to enhance emotional regulation, and intensive care/home-based therapy. Moreover, services were implemented by cultural brokers in order to align with Somali

culture. Overall results were promising, but preliminary (Ellis et al., 2013).



There are several strengths to a multitier approach to mental health support for students who are refugees. First, because the multitier approach focuses on levels of need and universal supports, it is an efficient approach to service delivery in schools with large populations of refugee youth who may have been exposed to trauma and the primary prevention efforts of tier one services can address multiple barriers to service for refugees and other culturally and linguistically diverse youth. Efforts tailored towards refugee communities can also be integrated into broader social-emotional supports within common multitier systems of support such as schoolwide positive behavior supports and response to intervention for behavior to expand screening, to address internalizing difficulties, and incorporate CBT or other trauma-focused services into the upper tiers of service delivery. Likewise, psychoeducation for teachers and families can be incorporated into the universal tier or primary prevention in order to raise awareness about social-emotional development, difficulties students may experience, and potential resources within the school and community to support wellbeing. Schools can partner with local agencies and community organizations to facilitate services within and outside of schools (e.g., referral lists, cultural brokers or liaisons, collaborative planning and service delivery in school).

Conclusions

As the refugee population within the United States continues to grow, mental health providers are called upon to support the myriad needs of refugee youth. It is important to understand the stressors impacting the lives of refugee communities as they begin to rebuild their lives in a new country while simultaneously coping with the loss and trauma that preceded resettlement. Given the importance of schools as socializing agents and support networks for refugee youth, educators and school-based practitioners should make concerted efforts to understand the experiences and culture of local refugee communities, identify children in need of intervention, and provide mental health support based on individual needs.

The suggestions above provide a basis for supporting the social-emotional needs of refugee youth, but their unique experiences may require that existing and manualized interventions are tailored to fit the cultural background of community members. School-based mental health providers should undergo training and self-study regarding the history, culture, and experiences of war-traumatized and refugee youth to better serve children in need. Finally, the school itself is an excellent environment in which to support the social-emotional needs of refugee children, but efforts should be made to extend services to family and community settings. By bringing together various stakeholders and developing close community partnerships, educators and practitioners can reach a broader audience and ensure that their practices are culturally-informed. Through collaborative partnerships, educators have the means of supporting the social-emotional needs refugee youth in U.S. schools.



About the Midwest & Plains Equity Assistance Center

The mission of the Midwest & Plains Equity Assistance Center is to ensure equity in student access to and participation in high quality, research-based education by expanding states' and school systems' capacity to provide robust, effective opportunities to learn for all students, regardless of and responsive to race, sex, and national origin, and to reduce disparities in educational outcomes among and between groups. The Equity by Design briefs series is intended to provide vital background information and action steps to support educators and other equity advocates as they work to create positive educational environments for all children. For more information, visit <http://www.greatlakesequity.org>.

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