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Therapy Approaches Provided to Traumatized Refugee Children

Esther Ekeh
SIT Study Abroad

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Esther Ekeh

Gettysburg College, Psychology Department

SIT, Middle East, Jordan, Amman

Academic Director: Dr. Ashraf F. Alqudah

Project Advisor: Dr. Ahmad S. Alsheikh, Clinical Psychologist, University of Jordan

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Abstract

The study examined various trauma treatments provided to traumatized refugee children and evaluated their effectiveness. Interviews were conducted with five mental health professionals, comprising two males and three females. The professionals included a psychologist at Caritas, a coordinator at Syrian American Medical Society (SAMS), a manager of an international non-governmental organization (NGO), a clinical psychologist at the Happiness Again Project, and a psychologist at an NGO. All interviews were conducted in person. Thematic analysis was employed to analyze the interview data. The findings revealed that play therapy and group therapy emerged as the most effective trauma treatments for traumatized refugee children. These findings hold significance for mental health professionals and clinicians in diagnosing young refugee children or any child who has experienced a traumatic event. While post-traumatic stress disorder (PTSD) is frequently diagnosed, it is crucial not to overlook other coexisting mental health disorders such as depression, anxiety, and grief.

Key words: Psychology, Mental Health, Guidance and Counseling

Therapy Approaches Provided to Refugee Traumatized Children

Introduction

The issue of increasing numbers of refugees is one of the biggest challenges of the modern era. A refugee is defined as “someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion” (UNHCR, 2002). Most often, they have encountered a multitude of challenges in their home countries, such as torture, sexual assault, political oppression, terrorism, scarcity, massacres, or natural disasters (UNHCR, 2021). Based on the UNHCR's report in 2021, over 90 million individuals have been forced to leave their homes due to conflict or persecution, and of that number, nearly 21 million are refugees.

The UNHCR recognizes three solutions for refugees: repatriation (where they work with the origin of the country to allow refugees to go back home), integration (where refugees will have to integrate themselves into the host community), and resettlement (where refugees resettle into a different country giving them the opportunity to become a naturalized citizen of the country). Although resettlement may appear to be the optimal choice for refugees seeking a safe environment, multiple challenges present themselves including displacement, difficulties adapting to the new country, prejudice, lack of access to resources, and exposure to trauma. Due to these challenges and traumatic events many refugees suffer from post-traumatic stress disorder (PTSD) and other psychological disorders such as anxiety, depression, and suicidal ideation.

Over half of refugees in resettlement countries are children and adolescents, making refugee children the most vulnerable and at risk. Young refugee children face many issues in both their home countries and host countries. Before resettlement, many young refugees have

experienced traumatic events in their home countries from wars to violence, and even poverty. When fleeing from their country, and resettling in a different country, they are faced with many challenging problems, such as separation from family, loss of loved ones, lack of resources, and physical or sexual abuse. Younger refugees, particularly unaccompanied minors, are at a high risk of experiencing traumatic events during their migration journey (Unterhitzenberg et al.,2015). These children migrate alone or are accompanied by someone other than a parent or legal guardian. Many of these unaccompanied and separated children must live with the trauma of seeing graphic killings in front of them. Without being able to cope/express their emotions, refugee children are dealing with the experiences of loss and grief which can lead to them suppressing their feelings. These issues become more severe once they are resettled in a new country, dealing with limited access to education, healthcare, and employment opportunities, making it harder to have hope for the future.

Refugee minors may encounter numerous challenges at school, making it hard for them to adjust to the host country. Children are confronted with negotiating a new school environment and integrating into new peer networks. Children and adolescents struggling with identity formation may experience psychological difficulties in the context of dual cultural membership (Phinney, 1990), particularly if they are discriminated against and receive negative messages about their race and culture (Portes & Zhou, 1994). Many refugees often experienced discrimination from students and teachers, making it hard to form long-lasting friendships (Vinokurov et al., 2002). For children whose education have been interrupted because of war or extended stays in refugee camps, the transition to school may be particularly problematic. Educational delays can have lasting consequences on a child's academic achievement, employment opportunity, and even future socioeconomic status. These limitations also affect a

child's ability to receive secondary and post-secondary education, resulting in only 1% of refugee children going to university compared to 34% of people globally (UNHCR, 2016).

Trauma during early childhood can significantly affect a child's developmental trajectory. Properly addressing and dealing with childhood trauma is crucial for children to overcome their experiences and prevent future mental health problems. As an aspiring clinical psychologist who wants to work with children, it is very important to recognize the signs of trauma early and find the best modalities to treat it. This interest stems from my current research interests on the best characteristics of an effective and successful trauma prevention program for young children.

This topic not only pertains to mental health professionals, but the mental health care system. Investigating different trauma treatments can help identify effective methods for treating and preventing the negative effects of trauma early on before it reaches adulthood. This is very important because trauma that is left untreated can affect a child's brain development, leading to a lifetime of learning and behavior difficulties. Researching effective treatments can help inform interventions to help mitigate negative outcomes. This information can be useful for mental health professionals/clinicians when diagnosing young refugee children or any child dealing with a traumatic event. Even though PTSD is frequently diagnosed, other mental health difficulties, such as depression, anxiety, and grief, commonly coexist and must not be overlooked. By taking these necessary steps, we can help raise awareness to mental illness but also start the conversation about the importance of addressing trauma in young children.

While there have been studies done on the effectiveness of trauma treatments, it is crucial to investigate the different types of trauma treatments used for refugee children to minimize any psychological harm. This research study will address the different therapy approaches provided to refugee traumatized children. Through interviews, the research study will attempt to

understand the different trauma modalities used for traumatized refugee children and how effective these therapy treatments are.

Literature Review

Refugee children are particularly vulnerable to trauma, because of the violence and persecution they have faced in their home countries or during transit to their host communities. Studies have shown that refugee and asylum-seeker children typically present with higher rates (approximately 50%-90%) of post-traumatic stress disorder when compared to the general population (Lustig et al., 2004). For example, 53% of refugee children who settled in European countries suffered with PTSD, 33% suffered with depression, and 32% suffered with anxiety (Kien et al., 2019). This suggests that there is a need to implement trauma therapy treatments targeted for adolescents and children. Trauma therapy treatments, such as trauma-focused cognitive behavioral therapy (TF-CBT), eye-movement desensitization and reprocessing (EMDR), narrative exposure therapy (NET), expressive ert therapy (EAT), and child-centered play therapy (CCPT) have been commonly used for PTSD treatment in the general population but not as much for refugees. Investigations into the effectiveness of such therapy treatments are limited due to difficulties associated with conducting ethical research with this vulnerable population (Clark-Kazak, 2017). Although much research has not been done on the different therapy approaches provided to refugee children, some studies have demonstrated their effectiveness for treating refugee trauma (Pfeiffer et al., 2019). This review will examine literature addressing the effectiveness of trauma approaches provided to refugee traumatized children.

Therapy Treatments

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a short-term manualized treatment that uses cognitive-behavioral principles and exposure techniques to prevent and treat posttraumatic stress, depression, and behavioral problems (de Arellano et al., 2014). TF-CBT encompasses three phases: Stabilization, Trauma Narrative and Processing, and Integration and Consolidation (Cohen and Mannarino 2015). Even though TF-CBT is one of the most and frequently used treatment methods for traumatized youth, there has been limited research targeting refugee youth. Unterhitzenberg et al., 2019 conducted a pilot study to evaluate the effectiveness of TF-CBT with 26 unaccompanied minors from Afghanistan. At the post intervention, results indicated a statistically significant reduction in PTSD (d = 1.08) depressive symptoms and behavioral symptoms in refugee minors. Even after six weeks and six months, the results stayed consistent with PTSD symptoms being decreased. Gormez et al. (2017) conducted a pre-post-test study without a control group of eight sessions of TF-CBT in a school setting for 32 traumatized Syrian refugees. The reports indicated significant decreases in emotional and trauma-related symptoms, including anxiety and intrusive thoughts. Even though the study was effective in reducing PTSD symptoms among Syrian refugee students, the sample size was small and there was no control group to compare the outcome with, so the results should be carefully considered. Finally, Unterhitzenberg et al. (2015) conducted a case series study to evaluate TF-CBT effectiveness with six unaccompanied young refugees. Results indicated a statistically significant reduction in PTSD symptoms for all cases at posttest. Since TF-CBT is regularly conducted with parents or caregivers in an equal number of sessions, the effectiveness of TF-CBT wasn't as strong among refugee children, due to low levels of parental involvement

Eye movement desensitization and reprocessing (EMDR) is an evidence-based trauma treatment for processing traumatic memories in children and adults (Shapiro et al., 2017). The core feature of EMDR is that an individual recalls a distressing memory while also performing a secondary task, usually engaging in sets of saccadic eye movements. Oras et al. (2004) revealed that engagement in the EMDR intervention was associated with significant reductions in PTSD and depressive symptom severity, and with improvements in overall functioning. Lempertz et al. (2020) conducted a pilot study that evaluated EMDR with refugee children in German daycare centers in a pre-test and post-test with ten preschool refugee children aged 4-6 years with PTSD symptoms. Based on teachers score ratings, a decrease in PTSD symptoms was seen more with boys than girls. These findings suggest that EMDR may be an effective intervention when used with both younger children and adolescents.

Narrative exposure therapy (NET) is a short-term manualized intervention program for the treatment of trauma. NET is based on the principles of CBT but is heavily influenced by exposure therapy (individuals repeatedly talk about their traumatic exposure to achieve habituation) and testimonial therapy (individuals construct a chronological account of their life to reconsolidate and integrate traumatic events into their biography) (Neuner et al., 2004). There is a child version of NET, which is known as KIDNET. KIDNET helps children create a narrative of their whole life focusing specifically on the traumatic events. During this therapy, the therapist will ask the child to describe their feelings, thoughts, and sensory information they remember. Even though NET has been proven to be effective for adults (e.g., McPherson 2012), only two studies have conducted the effectiveness of KIDNET with refugee children. Onyu et al. (2005) used 4-6 sessions of KIDNET with six Somali children aged 12-17 with PTSD. Participant's symptoms were significantly reduced and remained consistent at the 9-month follow-up.

Similarly, Peltonen and Kangaslampi (2019) randomly assigned fifty children and adolescents aged 9-17 from Finland, Iraq, Afghanistan, and various other countries (from other Middle Eastern countries and from African countries). Participants were randomized into KIDNET group or other treatment group (TAU). KIDNET was significantly more effective than TAU in reducing PTSD symptoms.

Expressive art therapy (EAT) refers to a form of psychotherapy that aims to provide individuals with outlets to explore feelings, process emotions associated with traumatic experiences, as well as to facilitate growth through emotional expressions such as art, music, and drama (Dieterich-Hartwell & Koch, 2017). Art therapy has been implemented with young children, especially because it allows children to express themselves through artistic drawing or creative materials. Previous research has shown the effectiveness of art therapy in improving children's physical and psychological health as well as their quality of life (Aguilar 2017). However, there are few studies on this model that show the effectiveness with refugee children. Of these studies, Ugurlu et al. (2016) conducted art therapy interventions, including music movement and drawing, with 64 Syrian refugee children in Turkey. Participants were divided into three age groups. There was a significant decrease in trauma and depression symptoms but the reduction in anxiety symptoms was not statistically significant. Quinlan et al. (2016) assessed a school-based creative art therapy program for 42 adolescents from refugee backgrounds. Two groups were generated: a creative arts group and control group. Participants were provided with art therapy activities such as: clay, play-doh, painting, drawing, and drama and music therapy activities such as: lyric analysis, songwriting, guitar, and vocal sounds. There were significant reductions for behavioral difficulties, emotional symptoms, hyperactivity, and peer problems.

These results are consistent with Durà-Vilà et al., (2013), who worked with a similar group (refugee young people) and demonstrated a decrease in peer problems.

Child Centered play therapy (CCPT) is another model that helps children express their feelings, thoughts, and desires through play (Ray, 2011). During this therapy, toys are like the child's words, through which the child is encouraged to explore his feelings, to understand and accept them and process them using his imagination and creativity. Schottekorb and her colleagues (2012) evaluated CCPT in comparison with CF-CBT with 31 traumatized refugee children aged 6–13 years living in the USA and randomly assigned to each treatment group. Both treatment models significantly reduced trauma symptoms, with no significant differences in their effectiveness. Kwon and Lee (2018) applied CCPT to four North Korean refugee children in a group setting. After 35 sessions, the parents and teachers report indicated a significant reduction in PTSD symptoms and an improvement in expressing emotions.

Methodology

Participants

Although the study was originally planned to involve six participants, one individual cancelled last minute, resulting in only five participants – three females and two males. Participants were recruited through professional staff contacts from SIT and the University of Jordan and were required to have experience working with traumatized refugee children. No compensation was provided for their participation.

Design

The study utilized a qualitative design, using interviews as the primary method of data collection. This approach was chosen due to its ability to gather more detailed and comprehensive insights, including nonverbal cues and emotional responses.

Materials

Seven interview questions, categorized by theme, were utilized in the study, with all questions presented and answered in English (refer to Appendix B). Interviews were conducted over a two-week period, with four occurring at non-government organizations and one taking place over Zoom. Each interviewee was contacted via phone or WhatsApp, with time and location determined by their availability. Interviews varied in length from 30 minutes to one hour.

Procedure

Five individuals were interviewed, including a coordinator at Syrian American Medical Society, a psychologist at Caritas, a psychologist at an NGO in Jordan, a manager of an international NGO in Jordan, and a clinical psychologist at the Happiness Again Project. To enhance communication and ensure understanding, participants were given interview questions before the interview, effectively preventing misunderstandings caused by language barriers.

The first interview was conducted with Rowida Tailakh, a coordinator at Syrian American Medical Society (SAMS). This interviewee was chosen because of her knowledge about trauma treatments provided to traumatized refugee children.

The second interview was conducted with Faten Ziadat, a psychologist at Caritas. This interviewee was chosen because of her strong knowledge of trauma programs for refugee children at Caritas.

The third interview was conducted with a psychologist who works at an NGO in Jordan. This interviewee was chosen because of their positionality within the organization and first-hand experience working within this population.

The fourth interview was conducted with a manager of an international NGO in Jordan. This interviewee was chosen because of the previous experience and thorough knowledge on the topic researched.

The last interview was conducted with Mohanad Abci, clinical psychologist at the Happiness Again Project. This interviewee was chosen because of their children's program that incorporated trauma treatments at their organization.

To ensure ethical integrity, questions were asked in a sensitive manner, to offer anonymity when asking particularly personal questions, and to follow up diligently on surprising answers. After the interviews, each interviewee was asked to sign the informed consent form (refer to Appendix A). Interviewees were informed of the way the research data was going to be used. If participants preferred their names not to be mentioned in this study, their identities were fully protected.

Obstacles

During the research process, various obstacles presented themselves, with the most significant being the time constraint of only five weeks for the study. This allotted time frame was further affected by several holidays that impeded the scheduling of interviews. The first two weeks of the research period coincided with Ramadan, and Eid Al-Fitr provided employees with a four-day break during the third week. These circumstances made it exceedingly difficult to arrange appointments and secure reliable contact with interviewees. Despite cancellations and unreturned communication attempts, obstacles were overcome. However, due to these setbacks, the number of interviews had to be reduced from six to five, limiting the amount of data collected on the research topic.

Findings

Interview Results

The data is analyzed using a thematic analysis. The analysis led to the development of an overarching theme: 'The use of trauma informed care with traumatized refugee children, as well as four interpretive themes. A list of the themes and codes are shown in table 1 below.

Table 1: Themes and Codes

1. Theme #1: The Manifestation of Trauma.	• Emotional instability • Behavioral Problems
2. Theme #2: Thinking Processes	• Art/Drawings • Denial/Avoid Trauma
3. Theme #3: Assistance and Treatments	• Play Therapy • Group Therapy
4. Theme #4: Social and Academic Impact of Trauma	• Academic achievement is poor due to stress and anxiety • Bullying/Harassment due to not being from the host country
5. Theme #5: Advice on Effective Programs to Improve Social Functionality of Traumatized Children?	• Involve the family

The Manifestation of Trauma

Trauma can manifest in various ways among refugee children due to their exposure to significant adversity and violence. Emotional instability emerged as a major theme, as traumatized refugee children may struggle with intense and overwhelming emotions such as sadness, fear, anxiety, or depression. An interviewee highlighted how refugee children, unable to comprehend their traumatic experiences, may resort to expressing their feelings and thoughts in a negative manner. This often results in behavioral problems, another theme that was highlighted. Refugee children may exhibit behavioral problems, including aggression, withdrawal, or biting, as they struggle to express themselves effectively. They often perceive anger as the most suitable outlet for their emotions.

Thinking Processes

Many refugee children lack the skills to express themselves verbally, so they express themselves creatively. They draw to communicate their thoughts and feelings, allowing them to construct their own visual narratives. Another significant theme is denial/avoidance, as these children lack coping skills and use denial to protect themselves from remembering their traumatic events. Mohanad Abci, a clinical psychologist from the Happiness Again Project, asserts that many refugee children currently lack the time to process their trauma. When refugees leave their home country and resettle in a host country, they often arrive with nothing and must immediately begin working. They gradually come to perceive their emotional experiences as normal.

Assistance and Treatments

When it comes to trauma treatments for refugee children, only a few have proven effective in reducing PTSD symptoms. One commonly mentioned treatment is play therapy,

which provides children with a safe and unrestricted space for play. Rowaida Tailakh, SAMS coordinator, emphasizes that allowing children to have control over their play choices empowers them, as opposed to being told what to play with. This approach helps children regain a sense of control in their lives. Another treatment option is group therapy, where one or more therapists guides a group of patients. Group therapy allows young children to realize that there are others facing similar challenges, creating a sense of comfort and shared experience. According to one interviewee, when a child speaks up, it encourages others to express their emotions more comfortably.

Social and Academic Impact of Trauma

Young refugee children face social and academic challenges because of trauma. Whether it's the experience of resettling in a new country, the loss of loved ones, or constant exposure to violence, these children are unable to reach their full potential. One interviewee highlighted that in their home countries, schools served as shelters during the war, leading children to associate school with the war and feel unsafe. Additionally, many refugee children experience harassment and bullying due to being outsiders in the host country. This further complicates their integration into the community and hinders the development of lasting friendships.

Advice on Effective Programs to Improve Social Functionality of Traumatized Children

It is crucial to provide young refugee children with the necessary assistance and treatments to minimize psychological harm. One recurring theme is the involvement of the family. Keeping the family informed about treatments and treatment plans is of utmost importance. Faten Ziadat, a psychologist from Caritas, emphasizes the significance of including the family in the process. Parents should be aware of workshops that can aid their child's progress and continue the therapeutic work at home.

Discussion

The research was conducted to examine different trauma treatments for traumatized refugee children and their effectiveness. While prior studies have identified KIDNET as the most effective treatment for reducing PTSD symptoms (Genç, E. 2022), the results of this study do not support this statement. Instead, it was concluded that play therapy and group therapy were the most effective treatments. The findings from the interviews support this conclusion.

Trauma is often experienced by refugee children, and its effects can manifest in emotional instability and behavioral issues. These manifestations are a direct result of the distressing experiences and challenges they have encountered before and during resettlement. In a study conducted by Fadhila et al. (2022), the key emotions experienced by refugees during the pre- and post-resettlement period were evaluated, and the most common emotions reported were fear, sadness, worry, and feeling unsettled. These emotions can fluctuate, leading many refugees to display behavioral problems, which often serve as coping mechanisms. For example, one participant in the study mentioned that he had been displaced more than 13 times, and there was never a day he didn't feel angry or feel like hitting something. This demonstrates that behavioral problems may be a way for young refugees to express their emotions.

Refugee children engage in creative activities like drawing to process their trauma. Sigmund Freud's Psychoanalytic Theory describes two parts of the mind: the conscious and the unconscious. According to Freud, dreams serve as a pathway to accessing unconscious thoughts. Drawing can visually represent dreams, enabling individuals to recall and analyze different types of dreams, which may offer clues to their hidden desires. Another way in which children process trauma is through denial and avoidance. Freud explained that the mind consists of three components: the id, ego, and superego (Rennison, 2015). Freud argued that when faced with

psychologically dangerous or threatening situations, individuals are likely to employ defense mechanisms for protection. He further mentioned that individuals may be unaware of their use of defense mechanisms, with denial being one mechanism. By denying or avoiding certain aspects of reality, individuals prevent these thoughts and emotions from entering their conscious mind. Traumatized refugee children lack the words to verbally express their emotions, which is why narrative exposure therapy is ineffective.

Play therapy and group therapy are the most effective treatments for reducing PTSD symptoms in refugee children. Play therapy, primarily used with children, aligns well with Sigmund Freud's Psychoanalytic Theory. Freud's model of the mind describes its features and functions, using the analogy of an iceberg. The visible tip of the iceberg represents the conscious mind, while the vast hidden portion represents the unconscious mind, which we are unaware of and cannot directly access. According to Freud, the unconscious mind communicates through symbols and dreams. Play therapy allows children to engage in symbolic play, using toys and objects as representations of their inner world. Through play therapy, children can express and explore their unconscious conflicts, desires, and fears. Group therapy also supports Freud's psychoanalytic theory. The unconscious mind consists of thoughts and emotions outside of awareness. In group therapy, individuals can share their thoughts, emotions, and experiences with others. When a member shares their traumatic experiences, it may help another member uncover one of their own unconscious thoughts, bringing it into conscious awareness.

Refugee children who have experienced trauma face many challenges in their academic and social lives. Many of them face interrupted education due to frequent relocations. A recent study conducted in Norway found that compared to their Nordic counterparts, children from refugee families had lower average grades during compulsory schooling and a lower percentage

of individuals achieving upper secondary education (Dunlavy et al., 2020). This indicates that a significant number of refugees struggle to attain secondary education, which can lead to employment difficulties later in life. In addition to academic obstacles, refugee children also face community-related challenges. When resettling in a host country different from their own, many young refugee children become targets of bullying and harassment by their peers. Samara et al. (2020) conducted a study examining the psychological well-being and behavior of refugee children in comparison to British-born children. The findings revealed that young refugees experienced more peer problems, functional impairment, physical health issues, and psychosomatic problems compared to both British-born children and older refugee children's groups. Thus, future research should investigate the well-being of young refugees and develop tailored interventions to address their unique needs.

When it comes to improving social functionality for young refugee children, there are many things that should be taken into consideration. One thing that should be taken into consideration is the involvement of the family. Involving the family can increase the likelihood of the treatment working long-term. When family members are actively involved in the treatment process, they gain knowledge and skills to support the child outside of therapy sessions. When aiming to improve social functionality for young refugee children, several factors should be taken into consideration. One crucial aspect is the involvement of the family. Family involvement can enhance the effectiveness of treatment in the long term. When family members actively participate in the treatment process, they acquire knowledge and skills to support the child beyond therapy sessions.

Conclusion

Findings have revealed that play therapy and group therapy are the most effective and commonly used treatments for reducing PTSD symptoms in traumatized refugee children. Although these results do not support recent studies, it is still crucial to continue researching this topic. The research on this topic has been obtained from case studies, pilot studies, and cross-sectional studies. Therefore, it is vital that we conduct longitudinal and randomized control trial studies with a follow-up to investigate the long-term effects of these interventions.

Limitations of Study

`The research spanned five weeks, which proved lack of exploration of the topic and real-time monitoring of changes. Numerous holidays fell within this period, impacting my ability to conduct interviews. The initial two weeks coincided with Ramadan, a holy month during which Muslims fast throughout the day. As a result, individuals were tired, unavailable, or disinterested in participating. Following Ramadan, Eid Al-Fitr granted a four-day break during the third week, further complicating communication and scheduling. Another limitation was the small sample size of only five participants, which was not enough to assess the effectiveness of trauma treatments for refugee children accurately. As a result, the obtained results did not provide an accurate representation of the target population.

Recommendations for Future Study

As this study provides a brief overview of trauma treatments provided to traumatized refugee children, a relevant direction for future research on this topic, might include detailed investigation into categorizing refugees based on the types of trauma experienced, duration of exposure, age, and nationality. This would assist in determing the most effective treatments for various refugee groups rather than grouping all refugees together. Further areas of research could

center on developing culturally sensitive interventions for refugee trauma, considering the cultural aspects that many refugees may confront

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Appendices

Appendix A: General Consent Form

Informed Consent Form

SIT Study Abroad
a program of World Learning

Study Title: The Therapy Approaches Provided to Refugee Traumatized Children

Your Name/Homeschool: Esther Ekeh/Gettysburg College

School for International Training—Jordan: Psychology, Well-being, and Mental Health

1. The purpose of this study is to investigate the different therapy treatments provided to young, traumatized refugee children to see what the most effective therapy approach is.
2. **Rights Notice**
   If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop the interview. Please take some time to carefully read the statements provided below.
   a. ***Privacy*** - all information you present in this interview may be recorded and safeguarded. If you do not want the information recorded, you need to let the interviewer know.

   b. ***Anonymity*** - all names in this study will be kept anonymous unless the participant chooses otherwise.

   c. ***Confidentiality*** - all names will remain completely confidential and fully protected by the interviewer. By signing below, you give the interviewer full responsibility to uphold this contract and its contents. The interviewer will also sign a copy of this contract and give it to the participant.
3. **Instructions:**

Please read the following statements carefully and mark your preferences where indicated. Signing below indicates your agreement with all statements and your voluntary participation in the study. Signing below while failing to mark a preference where indicated will be interpreted as an affirmative preference. Please ask the researcher if you have any questions regarding this consent form.

I am aware that this interview is conducted by an independent undergraduate researcher with the goal of producing a descriptive case study on the different modalities that are used with traumatized refugee children.

I am aware that the information I provide is for research purposes only. I understand that my responses will be confidential and that my name will not be associated with any results of this study.

I am aware that I have the right to full anonymity upon request, and that upon request the researcher will omit all identifying information from both notes and drafts.

I am aware that I have the right to refuse to answer any question and to terminate my participation at any time, and that the researcher will answer any questions I have about the study.

I am aware of and take full responsibility for any risk, physical, psychological, legal, or social, associated with participation in this study.

I am aware that I will not receive monetary compensation for participation in this study, but a copy of the final study will be made available to me upon request.

I [do / do not] give the researcher permission to use my name and position in the final study.

I [do / do not] give the researcher permission to use my organizational affiliation in the final study.

I [do / do not] give the researcher permission to use data collected in this interview in a later study.

Date:
_____

Participant's Signature:
_____

Participant's Printed Name:
_____

Researcher's Signature:
_____

Thank you for participating!

Questions, comments, complaints, and requests for the final written study can be directed to:
Dr. Ashraf Alqudah, SIT Jordan Academic Director

Appendix B: General Interview Questions

1. Theme #1: The Manifestation of Trauma.

   Q1. How does trauma manifest for refugee children?

2. Theme #2: Thinking Processes

   Q1. How do young refugee children process their trauma?

3. Theme #3: Help/ Assistance

   Q1. What kind of modalities do you use to help children manage/overcome their traumatic experiences?

   Q2. What do you do as a professional?

4. Theme #4: The Social and Academic Impact of Trauma

   Q1. How are children socially impacted when experiencing trauma?

   Q2. How are children academically impacted when experiencing trauma?

5. Theme #5: Advice on Effective Programs to Improve Social Functionality of Traumatized Children?

   Q1. What are the best practices/characteristics of a successful trauma prevention program?