HOW TRAUMA-INFORMED CARE CAN BE USED IN A SCHOOL SETTING TO BETTER SUPPORT REFUGEE STUDENTS WITH POSTTRAUMATIC STRESS DISORDER

by

Kelli H. Langford

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APPROVED BY: Maria Stella, PhD, RCC

Dedication

This capstone is dedicated to all of the refugee children and adolescents who have had to adapt to new communities and schools while dealing with loss and trauma. You are often the ones helping support your parents in learning about a new language and culture while also learning yourself. I admire your resilience and bravery. I hope that we can do a better job supporting you through these immense changes in your lives.

I want to acknowledge my partner Rob, who supported and encouraged me in more ways than I can count through the completion of my degree and the writing of this paper. I also want to acknowledge my children, Jack and Harper who are the reason that I did this degree. And to my sister and parents who have always supported me and helped take care of my children and allowed me the time I needed to work on this project, I couldn't have done it without you. Thank you.

Abstract

Millions of people have been forcibly displaced from their home country and had to start over in new countries (UNHCR: The UN Refugee Agency, 2023). Many of these refugees are children and adolescents who are arriving in school facing many barriers to their success including language barriers, less time spent in Canadian schools and racism (Brewer, 2016). There is a lack of policy surrounding how to support refugee students in schools (Ratković, et al., 2017). Some studies show that as many as 90% of refugee children and youth suffer from posttraumatic stress disorder (PTSD UK, 2023). PTSD can cause symptoms of altercations in arousal and reactivity which can include difficulty concentrating, insomnia, hypervigilance, and irritability (Bryant R. , 2022)**.** Exposure to trauma is associated with lower odds of achieving educational milestones (Zhou, et al., 2022). Trauma-informed care can help support the unique needs of individuals dealing with trauma (Reeves, 2015). Trauma-informed care in schools may be the key to improving the emotional and physical safety of students (Walkley & Cox, 2013). Implementing trauma-informed care in schools requires a buy-in from the entire school community (Thomas, Crosby, & Vanderhaar, 2019), therefore training for the entire staff in trauma-informed care is recommended for successfully implementing strategies and procedures that could help avoid re-traumatization and encourage the success of refugee students suffering from posttraumatic stress disorder.

Keywords: refugees, posttraumatic stress disorder, trauma, students, trauma-informed care

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Chapter 1: Introduction

"Childhood trauma can lead to an adulthood spent in survival mode, afraid to plant roots, to plan for the future, to trust and to let joy in. It's a blessing to shift from surviving to thriving."

- Unknown

Introduction

In a perfect world, students would leave school with the skills necessary to thrive in the world. They would feel confident in not only their academic abilities, but in their sense of self. They would feel ready to take risks, explore and create meaningful connections with others. Unfortunately, students come to school having experienced various traumas, including the trauma experienced by refugee students who have been forced to leave their home countries. Trauma can significantly impact a student's ability to succeed at school. This capstone looks at how refugees who suffer from posttraumatic stress disorder could benefit from a trauma-informed care approach in their school environments in order to help them thrive.

Background Information

There are a growing number of refugees in Canada and in 2019, Canada was the world leader in the resettlement of refugees (UNHCR: The UN Refugee Agency, 2023). Helping to integrate refugees into their new communities is essential for their success, however there is limited in data in how this integration is accomplished (Donato & Ferris, 2020). Refugees face a lot of unique challenges when they arrive in their host countries (Desloges & Sawicki, 2021).

Some studies show that as many as 90% of refugee children and youth suffer from posttraumatic stress disorder (PTSD UK, 2023). Exposure to trauma is associated with lower odds of achieving educational milestones (Zhou, et al., 2022). Children and adolescents with history of trauma can struggle with self-regulation and impulse control which can result in an increase in high-risk behaviors such as self-harm, substance use and violence towards others (NCTSN: The National Child Traumatic Stress Network, 2023).

While doing my internship at the secondary school where I work as a French Immersion teacher, I was required to participate in a lot of meetings, such as School-Based Team, Counsellor/Administration meetings and many parent meetings. I quickly learned that a lot of the students that were exhibiting externalizing problematic behaviors at school and in the community were our refugee students. There were issues of violence, vandalism, substance use and even gang affiliation. I started to look into if there were protocols or strategies in place to help support the refugee students when they first arrived at the school, and I found very little at the school as well as the district level. When it comes to refugee students, I found that there is a reactive approach to dealing with any behavior or issues that arise instead of a pro-active approach to helping support them from the start.

There is a lack of policy surrounding how to support refugee students in schools (Ratković, et al., 2017). Support programs should be put in place to help support refugee students before problems occur and to help make all students feel welcome and safe at their school.

Statement of the Problem

There is not enough support for refugee students in school. Refugee students are arriving at Canadian schools with a high likelihood of having posttraumatic stress disorder (PTSD UK, 2023). Children and adolescents who have experienced trauma may react defensively and

aggressively in response to a perceived threat or blame (NCTSN: The National Child Traumatic Stress Network, 2023). Many refugee students feel marginalized because of language barriers and a gap in their learning because they often spent less time in school (Brewer, 2016). Refugee children and adolescents often struggle to make connections and they can experience bullying and discrimination from their peers (Guo, Maitra, & Guo, 2019). Adolescents that are marginalized or feel alienated from their community are at a greater risk of participating in high-risk activities and in being involved with the criminal justice system (Chrismas, & Chrismas, 2017). There is a lack of procedure in Canadian schools devoted to the specific support of refugee students (Brewer, 2016). Schools have limited resources to promote social integration which is so essential for refugee students (Lundberg, 2020). Teachers, administrators, and support staff are struggling to support the unique and challenging needs of refugee students in their schools.

Purpose of the Paper

The purpose of this capstone is to explore the literature on refugees, posttraumatic stress disorder, and trauma-informed care and to provide recommendations on how to implement trauma-informed care principles in a school setting. This capstone will explore:

- Challenges most often faced by refugees when they arrive in host countries
- Supports or lack thereof for refugee students in schools
- How posttraumatic stress disorder (PTSD) is diagnosed and the effects that it can have on a person
- How trauma-informed care can help people suffering from PTSD
- How trauma-informed care can be implemented in a school setting to help support all students

The intent of this capstone is to provide information and support to school counsellors who are interested in implementing trauma-informed care practiced into their school in order to help support refugee students suffering from PTSD.

Research Question or Thesis Statement

This capstone aims to answer the following question: How can trauma-informed care be used in a school setting to better support refugee students suffering from posttraumatic stress disorder? In order to answer this question, the capstone will focus on exploring the ways in which trauma can impact refugee students and how a trauma-informed care approach can help support not only the refugee students, but all of the people in a school community.

Significance of the Study

Conflicts around the world continue to displace families and increase the number of refugee students in schools across Canada. These students have unique needs and struggles that can be challenging for the school to support. A lack of knowledge in trauma and how it effects students, will result in these students continuing to feel alienated and potentially engaging in high-risk activities that can be harmful to the individual student as well as the school community (Chrismas, & Chrismas, 2017).

This capstone aims to educate counsellors on the importance of supporting refugee students and understanding trauma and how it can impact the students at school and in the community. This will allow for counsellors to help educate the greater school community on how to implement trauma-informed care strategies in the classroom and throughout the school. This could significantly help support the integration and general well-being of not only the refugee students but will help support the entire school community.

Outline of the Remainder of the Paper

In this chapter, I presented the problem guiding the research, which is how there is a growing number of refugee students in schools who are suffering from trauma and how their needs are not always being supported within the school system. In chapter two, I will look at the research surrounding refugees. I will also review the research literature on posttraumatic stress disorder. Finally, I will review the research around trauma-informed care and ways that it can support students facing trauma. In chapter three I will present a professional development program that can be presented to staff and teachers to help give them the tools implement trauma-informed care practices within their classrooms and in the greater school community.

Chapter 2: Literature Review

Introduction

Millions of people have been forced to flee their home countries for reasons of war, genocide, religious or political beliefs, just to name a few (Desloges & Sawicki, 2021). Refugees arrive in host countries with a lot of unique challenges including difficulty obtaining employment, access to health care, including mental health support, and struggle to integrate into their new community (Capps, et al., 2015). Refugees can experience stressors and trauma before, during and after migration to a new country, which has them at a higher risk of mental health problems such as posttraumatic stress disorder (PTSD) (van der Boor & White, 2020). Some studies show that as many as 90% of refugee children suffer from PTSD (PTSD UK, 2023). This means that most refugee students that are arriving in our schools are suffering from trauma. We will not always know which students are and which are not, but implementing trauma-informed care in schools can help promote healing and connection for all students (Bath, 2008). This literature review begins with an exploration of experiences refugees encounter, followed by a discussion of post-traumatic stress disorder—one of the dominant struggle refuges face, and ends with a description of the need for trauma informed care practices to support refugees in school settings.

Refugees

A refugee is an individual who has fled from their country of origin to escape war, violence, or oppression and who cannot or does not want to return there due to fear of persecution (Reyhani, 2022). Refugees are not simply people seeking better living and economic conditions, but are people that are fleeing war, genocide, or threat of death (Desloges & Sawicki, 2021). Refugees often have to leave their country with very few possessions and will often be

forced to leave behind close family members (UNHCR: The UN Refugee Agency, 2023). According to the IRPA (Immigration and Refugee Protection Act), a person may apply for refugee status if they are being persecuted for one of the following: race, religion, nationality, membership in a particular social group, and political opinion (Desloges & Sawicki, 2021).

Anyone fleeing their country of origin is able to seek asylum in another country, this is a human right (Amnesty International, 2023). Once an individual has entered the country where they are seeking asylum, they are able to submit a claim for refugee status (Government of Canada, 2023). In Canada, in order to be eligible for refugee status, an applicant must have a referral from the UNHCR, or have a private sponsorship (Desloges & Sawicki, 2021).

According to the UNHCR, by the end of 2019 there were 70.8 million forcibly displaced from their home country worldwide (UNHCR: The UN Refugee Agency, 2023). People generally seek refuge in countries close to their country of origin, which is why the Middle East and North Africa host the largest number of refugees (Desloges & Sawicki, 2021).

Malala Yousafzai is a well-known refugee who had to flee her home in Pakistan to seek refuge in the UK after being targeted and shot for speaking out against the Taliban (Yousafzai, 2019). Luol Deng is another well-known refugee who was forced to flee his home country of South Sudan to the UK to escape the civil war and later became a professional basketball player (UNHCR: The UN Refugee Agency, 2023).

Challenges Faced by Refugees

Regardless of their country of origin or their reason for leaving, refugees face a lot of unique challenges (Desloges & Sawicki, 2021)**.** Three of the top challenges that refugees face are obtaining employment, access to health care, including mental health support, and social and cultural integration into their new community (Capps, et al., 2015).

Obtaining Employment

Employment is essential to refugees as it offers opportunities for sustainable income, self-autonomy, socialization, and recovering a sense of worth (Mencutek & Nashwan, 2020). It is one of the most important steps in integrating refugees into their new country (Lee, Szkudlarek, Nguyen, & Nardon, 2020). Seeking employment can be very difficult when arriving in a new country especially when a new language needs to be learned and developed (Desloges & Sawicki, 2021). Approximately 45 percent of Government Assisted Refugees (GAR) report income from employment in their first year in Canada (Capps, et al., 2015). Many refugees are unemployed, under-employed or dependent on public assistance (Lee, Szkudlarek, Nguyen, & Nardon, 2020). A 2019 study on the employment integration of refugees in Canada, showed that jobs or recent refugees often had poor working conditions and that the refugees employed, did not have accurate knowledge about their rights and workers, including knowing what to do if they were being mistreated or asked to perform unsafe labor (Kosny, et al., 2020). Unlike other migrant groups, refugees did not choose to leave their country of origin and therefore can have many socio-economic, language, legal and psychological barriers that make employment difficult to obtain (Lee, Szkudlarek, Nguyen, & Nardon, 2020).

Access to Health Care/Mental Health Support

Access to quality health care is essential for everyone including refugees (Brandenberger, et al., 2019). Studies show that refugees have important health care needs and that they often face inequalities when trying to navigate the health care system (Brandenberger, et al., 2019). A study from 2018 showed that 42% of Syrian refugees in Canada had unmet health care needs (Oda, et al., 2018). Three specific challenges that exist for refugees are communication, confidence, and continuity of care (Brandenberger, et al., 2019). Language barriers and a lack of familiarity with

the health care system are major challenges for anyone new to the country (Salami, et al., 2020). For refugees, having trust in their healthcare provider and health literacy education about the county's health care system is key for their confidence (Brandenberger, et al., 2019). Refugees tend to be placed in suburban areas where public transit infrastructure is less developed making it difficult to make and keep appointments for those that do not have a car, which is common for new refugees (Salami, et al., 2020). According to the World Health Organization, improvement in health care for refugees needs to include patient-centered and intercultural approaches (World Health Organization , 2017).

The high number of asylum seekers and refugees that are arriving in host countries put added pressure on mental health services that may already been limited in many countries (van der Boor & White, 2020). There is significant research that shows mental health inequalities among visible-minority immigrants and refugees in Canada (Salam, Odenigbo, Newbolt, Wahoush, & Schwartz, 2022). Specific challenges in migrant mental health include communication problems, cultural differences in views on mental health and difficulties in adapting to the dominant culture (Kirmayer, et al., 2011). Refugees can be subject to intense stressors before, during and after migration to a new country, exposing them to higher risks of mental health problems such as posttraumatic stress disorder (PTSD) (van der Boor & White, 2020). Refugee women seen in clinical settings have higher rates of exposed violence and PTSD that have gone undiagnosed (Kirmayer, et al., 2011). Reduced access to mental health services leads to decreased mental health in a group of people that are already at a higher risk for mental health problems (van der Boor & White, 2020). Studies have shown high levels of distress and depression among younger refugee populations settled in high-income countries including Canada (Kirmayer, et al., 2011). In general, visible minority migrants are an at-risk group that

are clinically underserved (Salam, et al., 2022). Assessment and treatment of refugee's mental health can be improved by having trained interpreters at appointments who understand both cultures (Kirmayer, et al., 2011).

Social and Cultural Integration

There is a need for asylum seekers and refugees to develop close relationships in order to feel integrated into the society of their new country (Strang & Quinn, 2021). Unfortunately, in many high-income countries, refugees face social (van der Boor, et al., 2020). Dispersal policies that exist in many countries for placing refugees can amplify the feeling of social isolation (Gambaro, Neidhofer, & Spress, 2020). A study from 2021 on single refugee men from Iran and Afghanistan, shows that these men have very little contact with family and local friends after arriving in their host country (Strang & Quinn, 2021). These men struggled to establish trust and there were limited opportunities for relationships to develop (Strang & Quinn, 2021).

Having established social networks and social integration is associated with a higher quality of life for asylum seekers and refugees (van der Boor, et al., 2020). Social integration in formal and informal settings is up to the individual to take the initiative and this is an unfair burden for refugees who are already dealing with multiple stressors (Lundberg, 2020). Refugees need support in building knowledge and trust of resources and services (Strang & Quinn, 2021). Newly arrived individuals long for security, friends, and practical assistance (Lundberg, 2020). The education system in an important part of a refugee's social integration into a new society (Donato & Ferris, 2020). Early Childhood Education and Care programs can help both refugee parents and their children with both language acquisition and social inclusion by providing opportunities to connect with others and create meaningful contacts (Gambaro, Neidhofer, &

Spress, 2020). Social integration is not only an individual pursuit but a shared responsibility that should be supported by both the school and greater community (Lundberg, 2020).

Supports for Refugees in Schools

Education is key to the integration of refugee children because it can bring about a sense of normalcy, routine, and emotional and social support (Guo, Maitra, & Guo, 2019). Unfortunately, there is a lack of policy in Canadian schools dedicated to the support of refugee students (Brewer, 2016). Schools also have limited resources to promote social integration which is so essential for refugee students (Lundberg, 2020). In British Colombia it is the policy for schools to create and maintain an environment where all students are treated equitably (Government of British Colombia, 2023). This inclusive environment means that different beliefs, customs, and languages from all learners are to be valued and respected (Ghosh, Sherab, Dilimulati, & Hashemi, 2019).

Many school districts in British Colombia do have settlement workers to help support refugee families navigate the new school system (School District 43 , 2023). They provide translation and facilitation between the school and the parents, help with cultural differences within the educational system, and they provide help with accessing community resources (School District 43 , 2023).

Many refugee students feel that there are many barriers to their success including language barriers, less time spent in Canadian schools and racism (Brewer, 2016). A 2019 study on the integration of Syrian refugee children found that any of these students struggled to make connections and that they experienced bullying and discrimination from their peers (Guo, Maitra, & Guo, 2019).

There appears to be a gap in the Canadian educational policy when it comes to supporting refugee students (Ratković, et al., 2017). Teachers and school administrators often lack cross-cultural competencies and an understanding of the refugee experience when working with refugee students (Ratković, et al., 2017). The experiences of refugee children and youth are diverse therefore the policies should reflect that diversity (Ghosh, et al., 2019). Future policy should include specific features of refugee students' needs such as supporting language learning, recognizing academic blocks, identifying identity issues, recognizing power imbalances and being aware of discrimination (Brewer, 2016). Refugee students should not only be seen as victims but be recognized for their strengths and resilience (Ghosh, et al., 2019). More research is required to develop a universal approach to the education of refugee students (Ratković, et al., 2017).

Refugee and asylum seekers are at a much higher risk of developing post-traumatic stress disorder (PTSD) and other mental health problems than the general population (Knipscheer, Sleijpen, Mooren, ter Heide, & van der Aa, 2015) Studies show that approximately 40% of refugees, and as many as 90% of refugee children suffer from PTSD (PTSD UK, 2023). Human rights abuses, traumatic loss, a lack of necessities and the separation from others were some of the main factors leading to a refugee developing PTSD (Knipscheer, et al., 2015).

Posttraumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a psychological and behavioral disorder that can develop in reaction to a traumatic event (American Psychiatric Association, 2013). PTSD is a common reaction to intense trauma, such as severe accidents, disasters, and abuse (Ehlers & Clark, 1999). It can either develop after a single traumatic event, such as a car accident, or be the result of a prolonged exposure to trauma, such as domestic abuse (Bisson, et al., 2015).

Symptoms of post-traumatic stress disorder can develop soon after the traumatic event, however it is also possible for symptoms to show up months or even years after the trauma; this is referred to as "delayed expression" (American Psychiatric Association, 2013). Some of the more common symptoms can include, but are not limited to, intrusive memories about the traumatic incident, dissociation, avoidance of triggers related to the trauma, and changes in mood (Bisson, et al., 2015). Although a large percentage of people will experience a traumatic event in their lifetime, most will return to "normal" psychological functioning and will not suffer from PTSD (Bonanno, Romero, & Klein, 2015).

Post-traumatic stress disorder was first introduced in the DSM-III in 1980, however, a similar disorder had already been included in the 1952 DSM-I under the term "gross stress reaction" (Andreasen, 2010). Historical accounts and literature also provide numerous examples of trauma victims displaying symptoms like those of PTSD, notably, the character of Achilles in Homer's, "The Iliad" and Job in the Holy Bible (Jones, 2013).

The Neurobiology of PTSD

There have been many studies that have helped advance our understanding of PTSD since its introduction in the DSM-III in 1980; however, there is still a fair amount of controversy surrounding the neurobiology of PTSD (Bryant, 2019)**.** There are several general conditions that appear to be correlated with symptoms of PTSD. The first is low levels of cortisol, the stress hormone. Many sufferers from PTSD show lower levels of cortisol in their urine than those who do not show symptoms (Heim, Ehlert, & Hellhammer, 2000). There is also some evidence that low levels of cortisol can increase the likelihood of someone developing PTSD. A 2001 study (Aardal-Eriksson, Eriksson, & Thorell, 2001) found that soldiers that had lower cortisol levels before military service were more likely to develop PTSD symptoms after being subjected to war

trauma. As cortisol plays an important role in resetting emotional states after stress, the authors hypothesized that those with low cortisol might experience distress with more intensity and for longer periods of time, which can cause symptoms (Aardal-Eriksson, Eriksson, & Thorell, 2001).

Another general condition seems to be the dysfunction and hypersensitivity of the HPA (hypothalamic-pituitary-adrenal) axis, which determines the body's hormonal response to stress. (Radley, et al., 2011) This results in enhanced activity in the amygdala, where emotionally charged memories come from, and reduced activity in the prefrontal cortex, which performs functions of cognitive control (Etkin & Wager, 2007). The hippocampus, an important center for memory, learning and time and space recall, seems to be a lot smaller in people with PTSD symptoms, however, just as with the low cortisol levels, it is still unclear if this is a result of the exposure to the traumatic experience, or if this is a risk factor for developing PTSD (Sherin & Nemeroff, 2011).

The prefrontal cortex may function less effectively when someone is experiencing a traumatic event or when they are exposed to similar stimuli from previous trauma, forcing the brain into survival mode and impacting decision-making abilities (Giustino & Maren, 2015). Understanding the neurobiology of PTSD is the key to developing the proper treatments for those suffering from the disorder (O'Brien, 2022). The Neurobiology of trauma helps explain common behaviors and experiences of trauma and the understanding of how trauma affects the brain can help undo common misconceptions about PTSD and help normalize the responses of trauma survivors (Assult Survivors Advocacy Program, 2023).

Causes of PTSD

Although a large percentage of people will experience a traumatic event in their lifetime, most will return to "normal" psychological functioning and will not suffer from PTSD (Bonanno,

Romero, & Klein, 2015). According to World Mental Health Surveys done by the WHO in 2017, approximately 70% of the world's population will experience some trauma in their lifetime, but only 6% will develop PTSD (Kessler, et al., 2017). People exposed to prolonged trauma are more likely to develop PTSD, and studies also show that interpersonal trauma, such as sexual assault has a greater chance of resulting in PTSD then a group lived experience, such as a natural disaster (Brewin, Andrews, & Valentine, 2000).

Studies show that many people with post-traumatic stress disorder also suffer from comorbid disorders, most notably, depression, anxiety, and substance abuse (Rytwinski, Scur, Feeny, & Youngstrom, 2013). The environment in which a person lives can play an important role. If the environment includes exposure to a high amount of stress, has a lack in social support and has limited access to resources there is an increased risk for developing PTSD (Bryant, 2019). There are also certain professions that have a higher risk for developing PTSD. Some of these professions include, but are not limited to, police officers, firefighters, paramedics, and heath care professionals (Skogstad, et al., 2013).

Children and adolescents are also at risk of developing post-traumatic stress disorder (Bisson, et al., 2019) Similar to adults, children and adolescents were more likely is develop PTSD when exposed to interpersonal trauma. Gender, however, was shown to be a factor, with females at a greater risk for developing the disorder then males (Alisic, et al., 2014)

Symptoms of PTSD

The main symptoms of PTSD can be divided into four categories: intrusive symptoms, negative altercations in cognitions and mood, avoidance, and altercations in arousal and reactivity (American Psychiatric Association, 2013). One of the most prevalent symptoms in the category of intrusive symptoms is the repeated and unwanted reexperiencing of the traumatic

event (Ehlers & Clark, 1999). Other symptoms in this category are recurrent distressing dreams relating to the traumatic event, and dissociative reactions, where it can feel as if the event is reoccurring (Bisson, et al., 2015).

Some examples of negative altercations in cognitions are mood include but are not limited to memory loss, persistent negative beliefs of oneself, feelings of detachments from others, and a persistent negative emotional state (American Psychiatric Association, 2013). Avoidance of any activity, person, places, objects, or conversations that might trigger a traumatic event is a very common symptoms of PTSD (Bisson, et al., 2015).

Finally, symptoms of altercations in arousal and reactivity which can include difficulty concentrating, insomnia, hypervigilance, and irritability (Bryant R. , 2022)**.** The combination of the symptoms in these categories can have a negative impact on a person's physical health (Pacella, Hruska, & Delahanty, 2013).

Diagnosis of PTSD

Post-traumatic stress disorder was classified as an anxiety disorder in the DSM-IV but is now classified as a trauma and stressor related disorder in the DSM-V (American Psychiatric Association, 2013). According to the DSM-V, to receive a diagnosis of PTSD there must have been an experience of real or threatened death, serious injury or sexual violence from either direct exposure, witnessing the event, learning that the event occurred to a close friend or family member, or finally, from severe or repeated exposure to details of traumatic experiences (American Psychiatric Association, 2013). One or more symptoms need to be present in each of the categories: intrusive symptoms, negative altercations in cognitions and mood, avoidance, and altercations in arousal and reactivity (Bisson, et al., 2015).

The ICD-11 (International Classification of Diseases) which came into effect in January of 2022 has slightly different criteria for diagnosis (World Health Organization, 2022). The ICD-11 has three symptom groups instead of 4, which include: re-experiencing, avoidance and heightened sense of threat (Brewin, et al., 2017) One of the important differences from the DSM-V is that when re-experiencing the traumatic event, it needs to involve the feeling of experiencing the trauma again in the moment, and cannot simply be remembering the event (World Health Organization, 2022).

There are several tools that can be used to screen for PTSD and one example is the Posttraumatic Stress Disorder Checklist for DSM-V which is used as a self-report measure to PTSD symptoms in adults (Blevins, Frank W. Weathers, Witte, & Domino, 2015). The Child PTSD Symptom Scale for DSM-V (CPSS-V SR) is a self-report screening tool to measure symptoms of PTSD in children and adolescents (International Society for Traumatic Stress Studies, 2013). Clinicians use various approaches to provide an official PTSD diagnosis which can include the self-report screening tools mentioned above as well as structured and semi-structured interviews. (Weathers, Marx, Friedman, & Schnurr, 2014).

Post-traumatic stress disorder shares symptomology with a number of other disorders, most notably, adjustment disorder, which is another trauma related disorder used when responses to the trauma do not meet PTSD criteria and acute stress disorder, however here, the symptoms should resolve within a month of the trauma exposure (American Psychiatric Association, 2013).

Treatments of PTSD

Trauma-focused psychotherapy is considered to be the first choice in the treatment for PTSD (Forman-Hoffman, et al., 2018). The specific types of therapy that are most recommended by the American Psychological Association are cognitive behavioral therapy (CBT), cognitive

processing therapy (CPT), cognitive therapy (CT), and prolonged exposure therapy (PE) (American Psychological Association, 2017). Current studies support the use of CBT and CT in treating both acute and chronic PTSD in adults, children, and adolescents (Kar, 2022). CBT helps individuals with cognitive restructuring, which focuses on identifying dysfunctional thoughts and thinking traps and can helps the person to see alternative thoughts and beliefs such as differentiating the trauma in the past and what is happening now (Watkins, Sprang, & Rothbaum, 2018). A clinical trial from 2018 showed the exposure therapy can be an effective and successful treatment of PTSD (Sloan, Marx, Lee, & Resick, 2018). For this study, individuals with PTSD wrote down their traumatic experiences and then worked through what they had written with a psychologist (Sloan, Marx, Lee, & Resick, 2018). CPT, like CBT and CT is used to help sufferers of PTSD identity and then challenge maladaptive beliefs to achieve accommodation for the new reality (Watkins, Sprang, & Rothbaum, 2018). Studies show that between 30-97% of individuals who participated in CPT no longer meet the criteria for PTSD after their treatment (Watkins, Sprang, & Rothbaum, 2018).

Other therapies that can be effective in the treatment of PTSD include eye movement desensitization and reprocessing (EMDR), brief eclectic psychotherapy (BEP) and narrative exposure therapy (NET) (American Psychological Association, 2017). Recent studies have shown the EMDR therapies can be just as effective for treating PTSD and symptoms of anxiety as CBT (Moreno-Alcázar, et al., 2017). BEP can reduce the major symptoms of PTSD and help individuals learn from the trauma and develop new perspectives (Nijdam, Meewisse, Smid, & Gersons, 2022). NET can be effective for individuals who have been exposed to multiple traumatic experiences. The therapist will help the client create a timeline of their life and then

together they elaborate on events and find value and meaning for the individual (Lely, Smid, Jongedijk, Knipscheer, & Kleber, 2019).

Aside from psychotherapeutic interventions, some medications have proven to be helpful in the treatment of PTSD, including fluoxetine, paroxetine, sertraline, and venlafaxine (American Psychological Association, 2017). These are all SSRI's that are used most commonly to treat symptoms of depression and anxiety which are core symptoms of PTSD (Williams, Phillips, Stein, & Ipser, 2022).

Limitations in Knowledge

Although a lot of new information has been obtained about PTSD in recent years, there have been little advancement in the treatment of PTSD which still leads many individuals suffering because of ineffective treatments (Bryant R. , 2019). Treatments are also not always readily available for individuals or groups suffering from PTSD; therefore, outreach efforts are needed to help increase the numbers of people who obtain treatment and to help track the success of those treatments received (Kessler, et al., 2017). There is also insufficient evidence what medications may work best with which psychotherapeutic intervention, and therefore further research is required (Forman-Hoffman, et al., 2018).

Given the prevalence of PTSD in refuges and the need for supporting these individuals, especially in schools, culturally responsive trauma-informed approaches can help in the resettlement and integration of refugees (Im & Swan, 2020). Trauma-informed care can help promote healing and connection and these approached can be used in healthcare, the home, the community and in schools (Bath, 2008).

Trauma-Informed Care

The effects of trauma can be misunderstood by those experiencing them and by those involved in their lives, and this can contribute to re-traumatization, unhelpful interventions, and a negative labelling of the behavior (or the person) as “bad”, “angry”, or “defiant”. (Poole, Talbot, & Nathoo, 2016). Trauma-informed care changes the question from “what is wrong with you?” to “what happened to you?” and seeks to provide care and support for the person based on a complete picture of a person’s life situation (Center for Health Care Strategies , 2023). Being trauma-informed places a priority on a person’s safety and choice (Poole, Talbot, & Nathoo, 2016). Trauma-informed care involves understanding the impact of trauma, recognizing signs of trauma and, incorporating knowledge about trauma into policies and procedures (Center for Health Care Strategies , 2023). An essential aspect of trauma-informed care is intentionally avoiding re-traumatization (Poole, Talbot, & Nathoo, 2016).

The term trauma-informed care was first communicated by Harris and Fallot in 2001 (Harris & Fallot, 2001). The Substance Abuse and Mental Health Services Administration (SAMHSA) formed the National Center for Trauma-Informed Care in 2005 and identified 10 principles that were essential to trauma-informed care (Elliott, et al., 2005). In 2011 SAMHSA made a policy statement encouraging all mental health services, including homeless shelters, child welfare agencies and education, to apply trauma-informed care principles to their programs (Wilson, Fauci, & Goodman, 2015).

Principles and Best Practice of Trauma-Informed Care

According to the SAMHSA, trauma-informed care involves the 4 Rs: realizing the impact of trauma, recognizing the signs and symptoms, responding by integrating knowledge of trauma into policy, and resisting re-traumatization (Substance Abuse and Mental Health Services

Administration, 2014). Being trauma-informed means that trauma could possibly be the cause of any person's feelings or behaviors (Poole, Talbot, & Nathoo, 2016).

Depending on the source, there are different principles of trauma-informed care, however they mostly follow similar values. According to the Center of Health Care Strategies (2023), there are six core principles of trauma-informed care: safety, trustworthiness and transparency, peer support, collaboration, empowerment, and humility and responsiveness. Safety can include getting to know what elements and places help someone feel physically and psychologically safe, and including those in their environment and in the way they are treated (Flavin, et al. 2022). Safety can also mean focusing on the person's ability to control their autonomic nervous system's response to danger (Zaleski, Johnson, & Klein, 2016).

Trustworthiness comes from allowing someone to express themselves without fear or judgement (Poole, Talbot, & Nathoo, 2016). Transparency would involve predictable and clear explanations about what is going to happen (Center for Health Care Strategies , 2023). The core values of peer support are mutuality, reciprocity, being non-judgmental, and sharing power (Blanch, et al., 2012). Peer support means providing opportunities for those who have shared lived experiences to share and express themselves together in a safe space (Substance Abuse and Mental Health Services Administration, 2014). Peer support can challenge people to develop personally and make meaning of life experiences (Blanch, et al., 2012).

Collaborating with other family members and friends and well as community programs is an essential part of trauma-informed care (Poole, Talbot, & Nathoo, 2016). It is important to recognize that everyone in a building or organization has a role to play when it comes to having a trauma-informed approach (Substance Abuse and Mental Health Services Administration, 2014).

The community the surrounds a person and the policies and procedures that exist within institutions can all help support or hinder a person's recovery (Flavin, et al. 2022).

Trauma-informed care promotes resiliency and believes in strength-based approaches and skill building such as mindfulness strategies (Poole, Talbot, & Nathoo, 2016). The individuals learn that the mind and the body have adapted to trauma and that they can tolerate an increase in stress (Zaleski, Johnson, & Klein, 2016). People suffering from trauma have often had their voices diminished and their choices limited; therefore trauma-informed care aims at empowering people to make their own choices, set goals, and create their own plan to heal and move forward (Substance Abuse and Mental Health Services Administration, 2014).

For trauma-informed care to be effective, any biases, stereotypes, and historical traumas are identified and attended to (Center for Health Care Strategies , 2023). If organizations and caregivers have cultural humility, they will be able to recognize stereotypes based on race, ethnicity, sexual orientation, age, disability etc., and address it accordingly (Vinson, Majidi, & George, 2019). It is important that procedures and practices are included that are responsive to the cultural needs of all individuals (Substance Abuse and Mental Health Services Administration, 2014).

Benefits of Trauma-Informed Care

The application of trauma-informed care can make sure that the unique needs of individuals dealing with trauma care considered and that this population of people, that are often vulnerable, is protected from discrimination and re-traumatization (Reeves, 2015). A trauma-informed space or organization can create safety for everyone, including the caregivers, who may also have experienced trauma in their lives (Menschner & Maul, 2016).

May people with trauma struggle to maintain healthy relationships with care providers and trauma-informed care can help survivors of trauma engage in more trusting relationships with the people trying to support them (Center for Health Care Strategies , 2023). Other meaningful connections can also be developed between trauma survivors because of the peer-support that is provided (Menschner & Maul, 2016).

Trauma-informed care supports people in developing important life skills such as self-regulation and resilience (Leitch, 2017). Because empowerment is no essential to trauma-informed care, those experiencing trauma get to take part in decision-making processes which with often result in them being more actively engaged in their own healing process (Menschner & Maul, 2016).

Trauma-informed care can benefit many different sectors and institutions (Center for Health Care Strategies , 2023). For example, the health care system can greatly benefit by decreasing patient's symptoms, thus, shortening stays in medical facilities and decreasing emergency department visits (O'Malley, et al., 2023). The Centre for Youth Wellness in San Fransico is implementing trauma-informed care in their programs to help with toxic stress in youth (Center for Health Care Strategies , 2023). A trauma-informed care approach has even shown benefits for the inmates and staff at a women's correctional institution in the UK (Jewkes, et al., 2019).

Implementing Trauma-Informed Care in Schools

The justification for implementing trauma-informed care into schools is clear, as many children are affected by toxic-stress and trauma caused by neglect, family violence, and adverse childhood experiences to name a few (Walkley & Cox, 2013). Research has shown that exposure to trauma in childhood can cause social, emotion and cognitive delays, which can impact school

performance (Thomas, Crosby, & Vanderhaar, 2019). Traumatic experience are a predictor of poorer reading, math and science scores for elementary students and can make a student three times more likely to have an individualized educational plan (IEP) for leaning or behaviour concerns (Ridgard, et al., 2015). Childhood trauma can negatively affect a student's ability to self-regulate, organize, comprehend, and memorize (Thomas, Crosby, & Vanderhaar, 2019). Traumatic experiences can contribute to hypoarousal or hyperarousal in response to different routines or upsetting stimuli which can cause significant behavior concerns in students (Ridgard, et al., 2015).

Trauma-informed care in schools may be the key to improving the emotional and physical safety of students, which will then improve behaviour and academic achievement (Walkley & Cox, 2013). A trauma-informed approach in schools makes certain that the needs of traumatized students are attended to and that students are unlikely to be re-traumatized (Ridgard, et al., 2015). Reports from uncontrolled studies on trauma-informed schools have reported drastic reductions in student suspensions (Overstreet & Chafouleas, 2016). Trauma informed care approaches have also been successful implemented into programs in schools aimed at preventing teen pregnancy (Martin, et al., 2017). There are elements of trauma-informed care that have been integrated into BC's new curriculum, such as teaching students how to understand the impacts of trauma (Government of British Colombia , 2023).

Implementing trauma-informed care in schools requires a buy-in from administration, positive and restorative responses to discipline, staff professional developments and a collaboration with mental health professionals (Thomas, Crosby, & Vanderhaar, 2019). People working to support children would benefit from a better understanding of how trauma affects childhood development and what interventions can help children heal (Walkley & Cox, 2013).

All adults that interact with students would need training in trauma-informed care, not just the teachers (Thomas, Crosby, & Vanderhaar, 2019). If the entire school community commits to trauma-informed care, it has the power to support the needs of all the students in the building (Ridgard, et al., 2015).

Cultural Considerations for Trauma-Informed Care

Attention to cultural context is a required element of trauma-informed care (Bryant-Davis, 2019). The implementation of trauma-informed care requires a collective approach to engaging with and from different communities in order to create a culturally safe space with both safe and effective practices (Poole, Talbot, & Nathoo, 2016). In order for trauma-informed care to be effective there needs to be a cultural awareness and people and organizations needs to focus on cultural humility (Bryant-Davis, 2019).

Many marginalized communities can benefit from a trauma-informed care approach because there is an emphasis on safety and collaboration (Substance Abuse and Mental Health Services Administration, 2014). Trauma-informed care creates a positive framework for the LGBTQ+ community who are at a greater risk of trauma and discrimination than heterosexual and cisgendered people by created a safe and empowering space for them to recover from trauma (Levenson, Shelley, & Ashley, 2023). Trauma survivors hold many different identities which all impact their trauma and recovery; therefore, attention needs to be made to the intersectionality that exists among the people suffering from trauma (Bryant-Davis, 2019). Trauma-informed care seeks to recognize the impact of historical trauma for indigenous communities and provide holistic and culturally appropriate interventions (Poole, Talbot, & Nathoo, 2016). Cultural considerations are essential in providing appropriate care because culture plays such a major role

in the vulnerability of a person to trauma as well as in their recovery from mental health challenges (Bryant-Davis, 2019).

Chapter 3: Summary, Recommendations and Conclusions

Summary

Refugee students are not receiving the support that they need to feel safe and connected in their school communities. These students are arriving from countries having fled war, persecution, natural disasters, or other traumatic events (Desloges & Sawicki, 2021). Refugee students are arriving at Canadian schools with a high likelihood of having posttraumatic stress disorder (PTSD UK, 2023). People suffering from PTSD can experience persistent negative beliefs of oneself, feelings of detachments from others, and a persistent negative emotional state (American Psychiatric Association, 2013). This can result in people who have experienced trauma may react defensively and aggressively in response to a perceived threat or blame (NCTSN: The National Child Traumatic Stress Network, 2023). Refugee students can feel marginalized because they do not speak the language, have different cultural practice and they often feel behind in classes because they have missed significant amounts of time in a school setting (Brewer, 2016). Students that are marginalized or feel alienated from the host community are at a greater risk of participating in high-risk activities such as violence, vandalism, and substance use (Chrismas, & Chrismas, 2017).

Although there seems to be a lack of policy on how to support refugee students in schools when they arrive in Canada (Ratković, et al., 2017), trauma-informed care in schools may be the solution to improving the emotional and physical safety of all students, including refugees, which will then improve behaviour and academic achievement (Walkley & Cox, 2013). Many marginalized communities, such as refugees, can benefit from a trauma-informed care approach because there is an emphasis on safety and collaboration (Substance Abuse and Mental Health Services Administration, 2014).

Recommendations

Based on the lack of policy and protocols in place in schools to help support refugee students as well as the obvious need to do so, I recommend that all school staff receive professional development training in trauma-informed care.

Rational

Teachers and support staff want to help all students feel safe, connected, happy, and be successful in school. It is why they got into education in the first place. They are not always provided with the information needed to help students with such unique challenges, such as refugee students. A professional development opportunity on trauma-informed care would help support refugee students at the school level for many reasons. Refugee students have a high chance of suffering from PTSD and would therefore would most likely benefit from a more trauma-informed approach in the school. Because of their exposure to trauma, refugee students are more likely to engage in high-risk activity which can have a negative impact on the individual as well as the greater school community. Trauma victims, including those with a PTSD diagnosis PTSD can struggle with academic abilities and making social connections which are both very important in a school environment. Trauma-informed care can help students feel safe and support in the school regardless of if they have suffered from trauma. It will not cause harm for students with no traumatic experiences. It is also important to note that we do not know which students have had traumatic experiences so it would allow for all students to be cared for. Trauma-informed care is culturally sensitive and considers the intersectionality of people suffering from trauma as well as the impact of historical trauma. Because school-based professional development days are already organized into the school year, having a school-based workshop would not require any supplemental time given on the part of the school or staff.

Finally, school counsellors are often already knowledgeable in trauma-informed care so could therefore help to run sessions if an outside expert could not be found.

Goals

An in-school professional development on trauma-informed care is meant to be a starting point in what would hopefully be a continued conversation on how to best support the students suffering from trauma. The goals of this professional development workshop are to create a safe environment for staff to discuss and learn about trauma-informed care. The purpose of this workshop is to teach staff about the impacts of trauma on individuals both on their mental state and how it appears in the body and to teach the 6 main principles of trauma informed care and how they can help heal a person who is suffering from trauma.

Another important goal of the workshop is to provide a space for staff to collaborate on ways to implement trauma-informed care in the school. This includes empowering staff, as they are probably already doing many of these things. This is not meant to make staff feel guilty about what they are not doing, but to simply help them learn more and therefore do better where they can.

Ideally the workshop will provide tools and strategies that would help implement trauma-informed practices within the school community. There will also be an opportunity to analyze case studies to understand more about how trauma-informed care can look while interacting with students. This professional development also aims to provide staff with resources so that they continue learning. Staff should also be encouraged to come and speak with the school counsellor if they have questions, concerns or need help in implementing ideas and strategies.

Expected Outcomes

The ideal outcome of a school staff receiving more training in Trauma-Informed Care is that the staff can then implement those principles in their classrooms, their interactions with students and in the school as a whole. This will hopefully result in refugee students feeling safer and more welcome at school. These students as well as others who have experienced trauma will also develop self-regulation and resilience skills which will hopefully result in less harmful externalized behaviours. This could then lead to a safer school community in general for everyone.

Because staff will have more knowledge about trauma, students who have experienced trauma will be less likely to feel re-traumatized in the school environment. This will also be beneficial to staff, as those who have suffered trauma will also end up feeling safer, connected and be less likely to be re-traumatized at work.

A trauma-informed school seeks to empower their students, so staff will include students in decision-making to help them feel more empowered and more a part of the greater school community. Staff and students will develop more trusting relationships which can result in students taking more risks and allowing for creativity in their work.

Another component of trauma-informed care is peer-support, so if the school can provide time and space for refugee students to connect with students with similar lived experiences, they can help support each other to heal and thrive.

Conclusions

A school should be a place where all students feel welcome and safe. For some students, their school is a more consistent environment than their home. For some students, it is where they can find a safe adult who will listen to them and accept them for who they truly are. It is

therefore essential that we take care of students who have experienced trauma, which includes our refugee students who have experienced so much. It is my hope that this capstone provides information and tools for school counsellors to help support their staff in creating a more trauma-informed school environment, to ensure that all or students feel the safety and support that they deserve.

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Appendix A: Building a Trauma Informed School Environment Workshop

Trauma-Informed Care Workshop.pdf