Working in early childhood settings with children who have experienced refugee or war-related trauma

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Between 1992 and 1997, Australia accepted approximately 11500 immigrant children under the humanitarian refugee program. Many of these children attend early childhood settings while their parents attend English classes and then go on to seek employment. Children who have experienced trauma develop behaviours that help them cope with the stress and fear of the trauma. In Australian early childhood settings, such coping behaviours are often perceived as maladaptive and undesirable. Until children feel safe in their new environments, they are unable to change their behaviour. The project reported in this paper examined caregivers’ and teachers’ responses, in Australian early childhood settings, to a range of coping behaviours commonly demonstrated by children who have been traumatised. It was concluded that caregivers and teachers are skilled in drawing from a range of options and in developing a repertoire of appropriate strategies with which they can support each child’s healing and provide a safe environment for all children.

In recent decades, war has affected many civilians. More than 24 million people worldwide were displaced from their homes because of wars in 1996 (Machel, 1996). Half of all displaced people are children, who are particularly vulnerable to increased risk factors associated with displacement. Risk factors include physical danger (shelling, sniping, land mines), limited access to food and water, separation from parents, high levels of violence, substance abuse, illnesses, rape, prostitution, sexual molestation and mutilation, trafficking, and conscription. Such risk factors continue to exist in refugee camps. The arrival of peacekeeping troops does not lessen all the risk factors. Increased rates of child prostitution, and subsequent HIV infection, are often the result of living in areas occupied by peacekeeping troops (Machel, 1996).

Children who have experienced these traumas learn to adjust in order to survive. The extreme nature of their experiences results in adjustments that are developmentally dangerous (Marans & Adelman, 1997). Children learn to think of the world as a dangerous place where no-one can be trusted, especially not adults. They learn to act aggressively before they themselves are hurt. They learn to be hyper-vigilant, always on the lookout for danger and never relaxing. They often re-enact their trauma, playing out scenes of extreme violence and even involving other children in their play. Conversely, children may react to trauma by repressing all effect. They become unresponsive and close down emotional senses.

These behaviours are seen as maladaptive and inappropriate in Australian early childhood settings.
Children displaying them often become labelled as aggressive or withdrawn/shy by both staff and other children. This results in their social isolation from the peer group. Bloom (1995) argues that usual adult responses to the range of maladaptive behaviours displayed by traumatised children result in reinforcement of the trauma. If we react in a way which conveys to the children that they are ‘different’ (bad) we are, in effect, telling them they are at fault for their behavioural problems. If we react towards them as if they are ‘sick’ we are also implicitly identifying a deficit in the child. Either way, we are reinforcing their powerlessness and the hopelessness of change.

Bloom (1995) suggests that we need to think of the children as injured, through no fault of their own. We need to understand that repetitive re-enactment of their trauma is triggered by outside stimuli and is not something children are able to easily control. Their coping behaviours are triggered by stress and anxiety and are also automatic responses to danger. These children are used to rejection, hostility, abuse, harsh discipline, unrealistic expectations, and pain. We have to persuade children that their usual behaviour for coping with these feelings can be changed. We have to persuade children it is safe for them to change their coping behaviours.

It is crucial to note that the impact of trauma is not limited to those who experienced it directly. Children born in Australia to families from a traumatised background experience a form of secondary trauma which impacts on their long-term developmental outcomes in similar ways (Gallagher, Leavitt & Kimmel, 1995). Families adopt parenting styles and survival strategies in order to accommodate their traumatic experiences. Siblings share play experiences and interactions within the family. Thus the trauma is passed on to Australian-born children.

Children who do not receive appropriate support in their early years have a much higher risk of developing post-traumatic stress disorder (Garbarino, Dubrow, Kostelnly & Pardo, 1992; Karcher, 1994). Children can develop extremely aggressive behaviours, somatic illnesses, depression and/or learning difficulties (Demaree, 1994; Lawson, 1995). Long-term mental health problems are likely to occur, even in those children whose early behaviours appear relatively unaffected (Garbarino et al., 1992). Supportive and appropriate early childhood environments have a significant impact on children’s long-term development. Studies indicate that children who are able to access appropriate early childhood environments are less likely to need specialised therapy or intervention (Rutter & Hyde, 1998).

Between 1992 and 1997 Australia admitted more than 34,000 refugees who had experienced discrimination amounting to a gross violation of human rights or who had suffered, or feared they would suffer, persecution. More than a third of these were children. Since 1998 the focus has been on people from the former Yugoslavia (including Kosovo), the Middle East, and Africa (Ruddock, 1998). These figures indicate that there is a small, but significant, number of families living in Australia who have experienced refugee or war-related trauma. Many of the children are attending our early childhood programs. Our interactions may prevent long-term debilitating effects resulting from their experiences—but how well are we prepared to deal with this phenomenon?

How can we, in regular early childhood settings, meet the needs of young children who have been traumatised by war and refugee situations which are foreign to anything we could ever know? The aim of this research project was to identify how caregivers in early childhood programs are coping with the needs of these children, and to identify supports and strategies for teachers who are more and more likely to encounter refugee children and families.

**Methodology**

Teachers’ and directors were interviewed with a semi-structured schedule developed for this project. The questions referred to teachers’ familiarity with symptoms and strategies for dealing with children who display evidence of trauma. Some participants were chosen from the pool of child care centres who have known refugee children—often referred through Department of Immigration and/or community groups. Other centres were chosen because of their location in areas with high

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1. In this paper the terms ‘teachers’ and ‘caregivers’ are used interchangeably to refer to those professionals who work with young children in group settings.
percentages of migrant residents. Data was collected from 47 centres across Queensland, New South Wales, and Western Australia.

Results and discussion

Unusual withdrawn behaviour

To some extent, caregivers felt that onlooker play was to be expected when children did not understand the language. They saw their role as important in helping children play, and facilitating parallel, and eventually interactive, play with other children. They also talked about the importance of their presence as a reassuring safety net for children. One caregiver explained how she would cuddle a child, perhaps tell a story, then gradually involve other children. Once the child was happily engaged she would ease herself out of the interaction.

Several caregivers emphasised the importance of giving children time and space; allowing the children to come to them when they were ready. They felt the need to be warm and caring, but also respect children’s signals of comfort and discomfort in interactions. One caregiver mentioned that she worked with a child who still felt he needed to withdraw on occasions, even after a year in the centre. She felt it was important to allow him the space to do that.

One caregiver talked about a child she had worked with who spent three months in the corner of her room with his bag on his back. She said he would start to warm up by the end of the week but would regress to total withdrawal at the start of each new week. Other caregivers talked about children not liking to be touched at all, and children who spent all their time in onlooker play and not joining in with other children.

In these situations caregivers attempted a range of strategies. One caregiver described how she used a handle for attachment (Hutchins & Sims, 1999). She tried hard to find one thing the child liked, and shared that with him regularly. The experience of enjoying each other’s company with this one thing gradually developed into a trusting relationship. She rated this as very effective, although it took a long time to effect major change.

Caregivers talked about children whose withdrawn behaviour involved hiding. It was not uncommon in their experience for children to seek out quiet spaces where they could be alone. Sometimes they felt this was appropriate as, in large groups of children, there are times when all children want to be alone. However, there were occasions when they were concerned about children who were constantly hiding. One caregiver explained how she brought toys to the child’s hiding-place and invited him to join her in play. She also described how she had amused the child by using different voices in telling stories to make the child laugh.

One little child would crawl into a corner and hide—we would move the mat session near her so she could see everyone, place toys near her, and roll a ball to her.

These strategies all focus on developing a handle for attachment: a shared experience that can be used to build a relationship (Hutchins & Sims, 1999). Caregivers created a special event, game, or activity that existed between themselves and the child. It is theirs, and theirs alone. This becomes a ritual they can share, and their mutual enjoyment of each other’s company during this shared time is the foundation upon which other interactions can be developed.

In using these strategies the caregivers are using a key person model. Their aim is to re-establish children’s trust in adults by having one key person as the initial attachment figure in the centre. Some indicated this was easier in a smaller centre than in a large one. However, in centres of any size they thought it important to have an anchor person who was on duty every day, and to use the same relief staff at all times to facilitate a sense of security and trust.

Caregivers mentioned the importance of developing partnerships with parents. Some indicated that having a male member of staff available to interact with fathers was of great help in establishing relationships with families. They talked about their efforts to establish trust through being open, taking time to listen, and making an effort to understand. One caregiver said she thought no effort was too great in the first few weeks, as some families have had little reason to trust any other human being and this needed to be overcome if they were to establish a partnership which benefited the children.
Chronic fear

Some caregivers identified children who appeared to be constantly watchful. They did not observe this behaviour only in refugee children. Some indicated it was also a behaviour they had seen in children where they knew of violence in the home environment. This fear often became particularly evident at sleep times, and this is discussed separately below. Fear of benign items and objects was also identified, and this is also discussed below.

Caregivers emphasised the importance of having a key person who took responsibility for comforting children when they were fearful. Their aim was to build up an attachment between the key person and the child, thus creating a feeling of security and trust in the care setting. They talked about the importance of cuddling and physical contact in offering comfort and reassurance to children.

Fear of benign items and people

Not all caregivers had observed children who feared benign items or people. Those who had initially attempted to remove the feared object from the environment where possible. They then attempted to desensitise children to the object by telling stories, talking, and gradually exposing children to the object. One caregiver described a child who was scared of people in uniform. With the help of one of the parents of the other children (who was a policeman in uniform), she was gradually able to demonstrate to this child that not all uniforms were to be feared.

Fear of loud noises such as sirens, cars, or trains passing nearby were also mentioned, as was fear of the toilet. Caregivers tried to deal with this by helping children identify the benign nature of the objects. They told stories about cars and trucks, used small models as part of the children's play, and organised outings where children could see these objects as part of the normal environment.

Unnatural clingingness and over-dependent behaviour

Many caregivers indicated they had worked with children who were unnaturally 'clingy'. Some of them saw this as a cultural difference related to values about independence and dependence. They recognised that behaviours which were perceived in Australian centres as clingy and over-dependent were likely to be those valued and praised in children's home environments, and felt more information on child-rearing practices of specific cultures would help them here. However, a number of caregivers talked about behaviours which they perceived as clingy beyond the level they would expect in relation to usual cultural differences.

For the first few days, because of their experiences, these children are often more clingy than Western children when they are new to the centre. It is often difficult to get the child away from the parent.

In these situations caregivers described the importance of using a bilingual worker to explain, in the children's first languages, that their parents will return for them. They emphasised the necessity of establishing an attachment relationship between the children and a staff member. Children were encouraged to feel part of the group but not pushed to participate before they were ready. Above all, children needed to have access to a staff member willing and able to give reassurance when they felt they needed this. Caregivers observed that, when this occurred, the clinginess improved over time as children learned to feel safe in the new environment and to trust the caregivers.

Continual difficulties at sleep time and sleep disorders

Fear often arises at sleep time, as children are afraid to go to sleep in an unfamiliar environment. Caregivers mentioned that they found it useful to encourage the use of a comfort object at sleep time. Parents were asked to bring in an object from home so the children could have something familiar with them as they fell asleep. They found this worked quite well, even on occasions when children did not normally use a comfort object to sleep in the home.

Others indicated that it was important to have some degree of flexibility over sleeping arrangements. Some found that children were comforted when their beds were moved (in one case next to a sibling), when an adult paced them, or when an adult remained nearby. Others found that children preferred not to sleep at all, but rather to have some quiet activity as a substitute. Caregivers said that, as trust and attachments grew, children often overcame their difficulties with
sleeping and were more likely to relax. Even just knowing that sleeping was a choice helped some children to settle down quietly.

Aggression

Some caregivers felt that aggression was an understandable response in any children who were having difficulty in understanding the language used about them. Their experience suggested that the aggressive behaviour disappeared quite quickly.

Different caregivers varied in what they defined as unusually aggressive behaviour. For example, some felt that all children will naturally want to play with guns (perhaps the influence of television) and that the gun play of refugee children was no different from that of other children in this age group. However, a small number of caregivers did identify excessive gun and/or knife play amongst some refugee children. One caregiver talked about a little boy who would build guns and knives all the time. He had no English—we would show him how to use the equipment and direct him or redirect him to some other behaviour. This child never hit other children—just role play expressing feelings—but, as this is inappropriate in this setting, we needed to redirect him.

Several caregivers identified this as an issue; the recognition that re-enactment is a necessary part of children’s healing but the inappropriateness of some such re-enactments in the group environment. No-one had any solutions to this dilemma. Rutter and Hyder (1998) argue that the therapeutic value of early childhood programs lies partly in the opportunities they provide for children to use play as a vehicle for re-enacting their experiences. These caregivers indicate that such re-enactments are not always appropriate.

The primary response to gun and knife play was redirection. Caregivers explained that gun and knife play is not appropriate in their centres, and required the toy be rebuilt. One caregiver said she had changed a gun into a helicopter with great success. Another said she had engaged in a problem-solving exercise with the children to determine what other ways they could use to catch people. All focused on the importance of not hurting other people. The majority of centres used a gun-free zone strategy, so children who brought these toys from home were gently asked to leave them in their bags or on a shelf as they could not be played with in the centre.

Several caregivers used a deliberate strategy to enhance children’s self-esteem in alternative areas to that of aggressive play. One caregiver talked about a young boy whose only play was extremely aggressive play with guns and sticks. She focused on emphasising how his play hurt the other children and made a huge effort to offer praise for any alternative, appropriate behaviour.

This child was very rough, playing with sticks and kicking other children. After the first few times we talked to the parent. After a while he stopped.

We talked to the child a lot and praised him for appropriate behaviour and tried to make him feel good.

Another caregiver said she acknowledged the child’s anger. She felt listening and demonstrating understanding was an important part of preventing repetition of the behaviour.

Caregivers mentioned rare occasions when children became too out of control that it was necessary to hold them to prevent them hurting other children. On other occasions they were able to get down to the children’s level and explain (one mentioned using sign language because of the limited understanding of English) that their behaviour had hurt others. Others mentioned separating children from others, giving them something to play with on their own and explaining that the aggressive behaviour was unacceptable. Others said that they simply went straight into a time out procedure in response to aggressive behaviour.

Alterations to moods

The literature suggests that children who have experienced trauma often present a range of mood disturbances such as irritability and depression. Some caregivers indicated that they perceived children’s desire to withdraw and be alone as similar to depression, but there was only one child in the research who was identified as showing extreme depression. This was a child with global delays in development.

Irritability is also recognised as a response to traumatic experiences. Some caregivers indicated that the irritability they observed in refugee children was no different from the irritability they associated with other children from non-English speaking backgrounds. They were not sure if this was a response to having to learn a second language.
quickly in order to function fully in the early childhood environment.

**Delayed development because of behavioural difficulties**

In this study caregivers rarely observed developmental delay as a result of children's trauma experiences, nor did they observe regression in development (probably because they would not have been made aware of children's achievements before starting at the centre in the first place). They did indicate that behavioural difficulties for some children extended over a considerable period. In these situations they believed it was important to work with family members. They felt a one-to-one focus with the child in the group setting was helpful, and some indicated they had employed additional staff for a set number of hours to help with this. They mentioned the importance of building up children's confidence as a longer-term strategy.

One caregiver described a little boy who was completely still and silent and did not talk, although he appeared to understand spoken English. He joined in activities only when he was physically assisted by staff, although he would sometimes perform a simple task in response to an adult's request. In this situation a primary caregiver system was attempted with little apparent success. Finally the centre referred the child to specialist services.

**Conclusion: What is best practice?**

Best practice in early childhood is also best practice for children who have experienced trauma. Best practice begins with an empathetic understanding of children and families. This starts with an awareness and an emphasis on establishing connections with families and children.

Once this foundation is laid, caregivers can build a range of strategies to support the development of children who have experienced trauma. Throughout the interviews caregivers consistently said that best practice depends on the individual situation. It appears there is no one right answer when it comes to best practice. Instead, best practice consists of having a range of options from which to choose and applying these options based on each individual child's needs. Caregivers try the strategy they believe will work in any individual situation. If that strategy does not work, then they attempt another. Caregivers need to develop a repertoire of strategies and be skilled in selecting from these in each situation. There are many indicators that refugee and traumatised children are being exposed to inappropriate and good practice which will result in long-term benefits for the children, their families, and society. Caregivers need reinforcement, support, and recognition in their important role of assisting refugee children.

**References**


