Can groups help refugee children with PTSD symptoms?

Investigating the pragmatics, effectiveness and participant engagement in psycho-social-educational groups.

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Overview:

Part One: Review Paper:
This review outlines the developing interest in post traumatic stress disorder (PTSD) in refugee children by considering general adult models of PTSD, ways these models have been adapted to children and the specific therapeutic needs of refugee children. The review will consider the existing evidence base for treating PTSD in children with particular emphasis on group treatments and the two published treatment studies involving refugee children. It will then consider the impact avoidant symptoms may have on refugee children’s response to treatment.

Part Two: Empirical Paper
This paper will highlight the need to develop evidence based treatments for refugee children and describe the evaluation of a manualised psycho-social-educational protocol designed to enhance coping in children who have been exposed to war trauma. It will describe the process of running these groups within a psychology service and secondary school and the evaluation of the pragmatics and effectiveness of the protocol using a range of self-report measures. It will also investigate whether an avoidant coping style moderates the effectiveness of the intervention.

Part Three: Critical Appraisal:
This appraisal will review the practicalities of running the groups and describe some insights gained from this process within both contexts. It will discuss the impact of the group and ways it is currently being used in both settings. It will end by considering the future possibilities and proposing additional ways that the group’s effectiveness may be enhanced and investigated in future studies.
Table of Contents:

Acknowledgements 4

Part One: Review Paper 5
  Abstract 6
  PTSD 7-9
  PTSD in children 9- 19
  Refugee children 19- 28
  PTSD treatment for refugee children 28- 40
  Factors affecting the effectiveness of treatment 40- 44
  Summary 44- 45

References 46- 53

Part Two: Empirical Paper 54
  Abstract 55
  Introduction 56- 66
  Method 67- 75
  Results 75- 91
  Discussion 91- 108

References 109-113

Part Three: Critical Appraisal 114
  Practicalities and process of the groups 116- 120
  Impact of the groups 121- 125
  Future directions 125- 130

References 131- 132

Appendices 132- 176.
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Review Paper

Can groups help refugee children with PTSD symptoms?
Abstract:

There is an increasing consensus about the potential impact of trauma on children and the need for more research into effective treatments. Refugee children are more likely to have experienced traumatic events yet are often under-represented in clinic populations and in the research literature, which remains small, recent and largely based in America. This review highlights what is known about treating PTSD in refugee children by considering general models of PTSD, ways these models have been adapted to children and some of the specific therapeutic needs of refugee children. It reviews treatment outcome studies with particular emphasis on group treatments and the two published treatment studies involving refugee children and suggests that psychosocial interventions warrant further use and evaluation. The challenge of facilitating access to services and considering factors that may moderate effectiveness of treatment (e.g.: avoidant coping style) are discussed.
Introduction:
The plight of refugees and their treatment in the UK has been the focus of much debate and media coverage. In 2000 there were an estimated 169,370 refugees in the UK (UNHCR, 2002b) yet accurate estimates of numbers needing psychological treatment are rare. According to the United Nations a refugee is someone who “owing to a well-founded fear of being persecuted” is “outside that country of his (sic) former habitual residence” and “is unable or, owing to such fear, is unwilling to return to it.” (UNHCR, 2005, p.13). These families have, by definition, been exposed to loss, disruption of lifestyle, high levels of violence and persecution. As all of these independently increase the risk of psychiatric disorders it is not surprising that 40% of refugee children meet diagnostic criteria, predominately for depression, posttraumatic stress disorder (PTSD) and other anxiety disorders (Hodes, 2000). Thus the number of people who would benefit from effective and culturally sensitive treatment presents a substantial challenge to services. Hodes’ (2000) estimate that 40% of the refugee community are under 18 years highlights the particular challenge for child and adolescent services that provides the background for this project.

Post Traumatic Stress Disorder:
There has been increasing research into PTSD since its introduction into the Diagnostic and Statistical Manual for mental health disorders following research into war veterans in the late 1970's (Wilson, 1994). The current DSM-IV (APA, 1994) definition represents a consensus that victims of events which threaten their sense of safety tend to experience unbidden memories, dreams, and feelings that are reminiscent of the original traumatic experience (criterion B) and that in an attempt to manage the overwhelming feelings caused by these memories they may try to
avoid all thoughts and reminders of the trauma or try to 'turn off' feelings more generally which can lead to a sense of emotional numbness, and social withdrawal (criterion C). The ongoing sense of threat results in prolonged chronic physiological hyper arousal (criterion D).

For PTSD sufferers the traumatic experience challenges their beliefs about the world, and more often than not, beliefs about others and themselves, particularly with regard to assumptions of safety and goodness (Janoff-Bulman, 1992). Horowitz (1986) proposed that it is precisely because such events cannot be assimilated into existing schematic representations that they are stored in active memory resulting in intrusions and overwhelming recollections. He argues that recovery involves integrating the trauma into a schematic representation that restores feelings of security. Over recent years understanding of PTSD has advanced through detailed cognitive models designed to explain how memories of traumatic events are stored differently to normal memories. Brewin, Dalgleish and Joseph’s (1996) dual representation model proposes that traumatic memories are represented in a ‘Situationally Accessible Memory’ system (SAMs). When triggered, SAMs cause the characteristic re-experiencing symptoms of PTSD including sensory, emotional, physiological aspects and the meaning of the experience. The model asserts these memories need to be integrated with other memories in the form of a ‘Verbally Accessible Memory’ system (VAMs) that is subject to deliberate retrieval. Integration can occur through processing as part of a natural habituation process to repeated experience of SAMs, however habituation may be inhibited by avoidance of reminders or prevented because of ongoing trauma, aversive secondary emotions, lack of social support and attentional and memory biases. While this model has not
been directly tested it accounts for the clinical characteristics of PTSD, the attention and memory biases found (Dalgleish, 1994) and the counter-intuitive finding that the presence of intrusive memories after trauma is a normal reaction that does not predict later adjustment (Creamer, Burgess, & Patterson, 1992).

Ehlers and Clark’s (2000) theory emphasises the interplay of the trauma memory with cognitions, metacognitions and thought control strategies that maintain a sense of “current threat” (for example: the belief that the world is a dangerous place or that the victim is too weak to cope) or discourage emotional processing of traumatic memories (believing flashbacks mean ‘gone mad’). Such cognitions are accompanied by the use of maladaptive coping strategies such as avoidance, rumination and distraction that maintain PTSD symptoms and further reinforce problematic cognitions. The continuing sense of “current threat” has been found in motor vehicle accident survivors (Steil & Ehlers, 2000), victims of assault (Dunmore, Clarke, & Ehlers, 1999) and political prisoners (Ehlers, Maercker, & Boos, 2000). Both models provide a rationale for cognitive behavioural intervention to promote processing and address maladaptive cognitions / strategies and there is evidence from prospective, randomised studies that such therapies are effective (Zoellner, Feeny, Cochran, & Pruitt, 2003).

**PTSD in children:**

Although for a long time research suggested that children’s reactions to trauma were not as serious as those developed by adults (Garmezy & Rutter, 1985), it has “become increasingly clear that exposure to traumatic events in childhood can have dire and long-lasting consequences, not only for traumatized children but for society
as well" (Fletcher, 1996, p. 242). As a result the increase of research into PTSD in adults has subsequently been mirrored for children. Terr’s (1983) descriptions of children’s responses to a kidnapping in Chowchilla, California were the first to demonstrate that even four years later children were strikingly similar to traumatised adults in their recall of events with ‘vivid immediacy’ and re-enactment through post-traumatic play. Yule and Williams’ (1990) use of a child self-report measure following a ferry disaster opened the way for child-centred assessments that provided increasing evidence for symptom clusters as described by DSM-IV in children of all ages. That children and adolescents experience unwanted thoughts, flashbacks, physiological arousal and display behavioural re-enactment on exposure to trauma related cues suggests the presence of Situationally Accessible Memories described within dual representation theories. Ehlers, Mayou and Bryant’s (2003) prospective longitudinal study of PTSD in 150 children following a road traffic accident reported that nearly all of the cognitive variables in Ehlers and Clark’s (2000) model showed significant correlations with PTSD severity in children. Using these variables (negative interpretation of intrusions, thought suppression, rumination, alienation from people, dissociation) to predict PTSD severity increased the accuracy of prediction from 14% (when using rating of stressor severity) to about 50%.

Ehlers et al.’s (2003) follow-up of these children also showed that, similar to adults, not all children experiencing the same type of event react in the same way. In fact injury severity was not significantly related to PTSD symptoms. The myriad of individual experiences and responses to trauma inevitably makes generalisations difficult but research in children has drawn on research among adults to provide testable hypotheses about what may affect children’s responses to trauma. These
findings in conjunction with concepts from developmental psychopathology have enabled a picture of vulnerability, resilience and risk factors to evolve (Meiser-Stedman, 2002). Fletcher's (1996) working model of the development of childhood PTSD coherently expresses the interplay of factors now known to affect PTSD in children and that should be considered if intervention is to be effective.

Figure 1. Fletcher's (1996) model of the context for the development of childhood PTSD.
Factors affecting prevalence and recovery:

The event:

PTSD differs from other psychiatric conditions in that it is the result of a specific etiological event. Yule et al. (2000) report the incidence of childhood PTSD in a community sample was 1 – 7.8%, whereas 51.5% of survivors of a cruise ship sinking from the same catchment area developed PTSD during the ensuing twelve years. Such high rates are not untypical; Goenjian et al. (1997) found 32% of adolescents met criteria for PTSD 4 years after the Armenian earthquake and Paunovic and Ost (2001) that PTSD in refugees varies between 10.7 and 86% depending upon the sample and traumatic event. Common sense dictates that some events are more likely to have a profound effect on children than others, for example: minor car accident in contrast with war bereavement. However judgements about the 'stressfulness' of events can be unhelpful as distress is a subjective experience influenced by perceptions of the personal impact of the event, controllability and its future threat (Fig. 1). Terr's (1991) conceptualisation of stressors identified two categories: type I- acute, non abusive stressors which are events that occur only once (floods, fires, road traffic accident) and type II- chronic or abusive stressors (chronic illness, war) and / or incidents of physical or sexual abuse, whether single or repeated occurrence. Terr argued that some of the same symptoms are displayed but that children who have experienced type II stressors tend to use more avoidance and numbing symptoms (criterion C) because their on-going nature forces children to come to some kind of accommodation to experiencing trauma. Yule et al.'s (2000) follow-up shows significant numbers of children (51.5%) develop PTSD even after one isolated type I event.
Individual Characteristics:

(i) Gender: Fletcher’s (1996) meta-analysis concludes that the few studies that have looked at gender differences in children’s responses have produced evidence that is “contradictory and inconclusive” (p.263). Hodes (2000) highlighted that males and females may have significantly different exposure to war and other violence including rape which may affect their response and subsequent mental health, but concluded that when exposure is similar findings have indicated no difference in resilience. While girls do generally tend to score higher than boys on self-report measures of internal distress, it is unclear whether this reflects different emotional experiences or reporting biases or both (Smith, Perrin, Yule, Hacam, & Stuvland, 2002). Rossman’s (1992) review of children’s coping suggested that girls were more likely than boys to use peers and parents to help them cope.

(ii) Age: Kilpatrick and Williams (1998) highlight conflicting evidence as to whether older or younger children display the greatest vulnerability to trauma. They cite some studies suggesting the older the child the greater the impact (eg: Gleser, Green, & Winget, 1981; Wolfe, Jaffe, Wilson, & Zak, 1985), and others suggesting the reverse (eg: Eth & Pynoos, 1985a; Hughes & Barad, 1983). Much of the discussion centres on the interaction between symptoms of distress and developmental level. Salmon and Bryant (2002) reviewed the impact of developmental levels of language, memory encoding, emotional regulation and social understanding on the way that the child encodes and resolves a traumatic experience. Their paper highlights the complexity involved in hypothesising about the impact of trauma as the child’s subjective experience is so hard to ‘measure’. They suggest that the impact will be different at different ages. Very young children are dependent on their carers to
appraise danger and so in the short term PTSD symptoms are often related to carer’s level of distress (Scheeringa & Zeanah, 2001). Salmon and Bryant (2002) speculate that at this stage verbal abilities and emotional regulation capacities may limit processing of SAMs, prolonging symptoms. We know that by lower primary school children can form coherent memories of trauma (Wilson & Kipp, 1998) that may lead to re-experiencing and hyperarousal but it is unlikely that processing will be impaired by abstract metacognitive coping strategies (cognitive avoidance, rumination or worry). Older children and adolescents are able to form coherent VAMs and process the trauma, however, they are also able to engage in maladaptive ways of coping (Ehlers et al., 2003).

(iii) Expressing Distress: It is apparent that children show distress in different ways (Fletcher, 1996) and sensitivity to this is necessary even when assessing same age children whose emotional repertoire will be different. According to Yule (2000) the idea that children do not easily talk about trauma has been replaced by evidence that children will give graphic accounts of their experiences if pitched at their developmental level. Kilpatrick and Williams (1998) report that emotional numbing symptoms could be measured as a loss of interest in activities or hobbies that previously gave pleasure and that both regressive or aggressive / destructive behaviour are accepted indicators of distress. Daydreaming, difficulty concentrating or nightmares as well as re-enactment through post-traumatic play may signify intrusive thoughts and children are particularly prone to these when falling asleep or if triggered by internal or external reminders (Perrin, Smith, & Yule, 2000). Distress is also expressed through anxious attachment behaviours or physical symptoms such as stomach and headaches (Scheeringa, Zeanah, Myers, & Putnam, 2003).
(iv) Response to distress: Pynoos, Steinberg and Piacentini (1999) highlight that factors intrinsic to the child (temperament and anxiety sensitivity, mastery experiences, relations with adults) affect their response to trauma. They suggest that adjustment involves not just understanding the experience and subsequent reactions but resuming age-related skill acquisition and developmental progression. This will be mediated by the individual’s psychological strengths and vulnerabilities, for example: self-esteem, coping style and locus of control. Fletcher (1996) argues that personal control and coping are particularly important because traumatic experiences are often experienced as unpredictable and uncontrollable.

Biological response:

The adult literature documents a range of physiological alarm reactions to trauma from terror about external danger to extreme helplessness / shame. These reactions are reported both during traumatic events themselves and subsequently form the characteristic over-arousal symptoms (criterion D). Perry, Pollard, Blakley, Baker and Vigilante (1995) argue this acute stress response has a lasting neurobiological impact on the developing brain as repeated activation of neural networks by trauma related cues cause functional changes in brain-related functions. Glaser (2000) reviews animal studies that indicate the long-term impact of stress on the developing brain, especially when it is unpredictable or uncontrollable. Pynoos et al. (1999) describe how frightening the rapid physiological reaction to trauma can be, reporting a 7 year olds’ account that ‘my heart was beating so fast I thought that it was going to break’. They suggest that experiencing a fast heart beat, sweating or having aches can intensify children’s distress and be overwhelming, particularly as the ability to regulate stress is developing. It may also support unhelpful thoughts that ‘something
is really wrong’ or ‘out of control’ resulting in selective attention to external threat and internal distress that in adults reinforce the occurrence and significance of the stress response (Wells, 1997).

**Conditioned Response:**

Fletcher’s (1996) review discusses the way that conditioning, heightened following a traumatic event, can become generalised through higher-order conditioning so that the number and variety of triggers that produce a stress response increase. He cites Jones and Barlow’s (1990) description of ‘learned alarms’ whose strong arousal components create a succession of associations to internal or external cues resulting in generalisation of triggers and increasing distress. Pynoos et al. (1999) illustrate how this process combines with the complexity of the trauma experience to result in a large number of cues so that reminders are often unexpected and reinforce feelings of lack of control.

**Making meaning:**

Early conceptualisations (Breuer & Freud, 1957; Horowitz, 1986) stated that traumatic events represent information that is unacceptable to the conceptual system. This aspect of Fletcher’s model (Fig. 1) has received much attention following Ehlers and Clark’s (2000) account of the way negative interpretations of intrusive symptoms maintain a sense of ‘current threat’ and promote maladaptive thought control strategies. Terr’s (1983) description of a child’s fear of being afraid is consistent with current conceptions of the impact of metacognitions and over-interpretation of signals of anxiety in the maintenance of more general anxiety disorders (Wells, 1997). Vasey (1993) has shown that children who believed that worrying might
prevent a feared event tended to worry much more. He also found that children exposed to trauma were more likely to have worries about a number of phenomena and speculates that as ‘worry’ requires the ability to imagine possible future events, it will be easier for those who have already experienced frightening events. We know that following trauma children’s attention is biased towards trauma-related information (Dalgleish, Modadi, Taghavi, Neshat-Doost, & Yule, 2001) although it remains unclear whether this maintains PTSD or is a symptom of it.

Characteristics of the social environment:

Fletcher’s model (Fig. 1) highlights a range of factors extrinsic to the child (parent behaviour, school and social ecology) that affect the child’s emotional response to and understanding of traumatic events. The impact of the trauma on the social environment will vary greatly. In some cases (parental death, earthquake) the trauma directly negatively impacts the social context of the child (reduced social support, loss of caretakers) compounding the trauma with a series of adverse life events which not only complicate efforts to adjust but also interfere with development (Pynoos et al., 1999). Existing difficulties (parental conflict, mental health problems, economic worries) will impact the child’s existing distress and caregivers’ availability to support them (Scheeringa & Zeanah, 2001).

Pynoos et al. (1999) also highlight the impact of trauma on a range of proximal developmental tasks for example sleep disturbances may affect concentration in class resulting in school failure, avoidance may result in lost developmental opportunities, and symptoms may affect parent-child interactions or peer relationships. They suggest that traumatic experiences often skew children’s expectancies about the self,
world and others. We know that such expectancies tend to be resistant to change (Cicchetti & Cohen, 1995) so that traumatic experiences that induce belief shifts may affect personality. Treatment must consider the social impact of traumatic events on children as lost developmental opportunities and impaired skills acquisition carry significant independent risks for a range of future difficulties (Glaser, 2000).

The literature repeatedly emphasises the critical role played by caregivers in allowing children to review past traumatic experiences. Salmon and Bryant (2002) stress the caregivers’ role in children’s encoding of the level of perceived threat and, as memory and language are developing, the story that is remembered. As children are reliant on others to support them to communicate their experiences, their caregivers’ response can either facilitate processing or prevent it by encouraging avoidant coping or maladaptive strategies. Pynoos et al. (1999) highlight that skills are learnt through social referencing to attachment figures so that parental responses to danger and distress actually become part of the child’s own repertoire. Stubenport, Donnelly and Cohen (2001) identify potential difficulties in this support system by highlighting (i) the common misconception that children will forget a traumatic experience if left alone (ii) that children often have difficulty expressing their emotions and (iii) that often caregivers are also upset by events (even if they were not directly involved) which may make them less emotionally available to the child. Kilpatrick and Williams (1998) found following witnessing domestic violence children’s level of symptoms corresponded to parental levels of fearfulness and anxiety.

Fletcher (1996) highlights that resilient children (those with a capacity to respond to distress with effective efforts at recovery) have been found to have close, positive
relationships with their care-givers and to receive support from within and without the family. LaGreca, Silverman, Vernberg and Prinstein’s (1996) study of 442 children at three points during the year after a hurricane concluded that children with higher levels of social support developed fewer PTSD symptoms. Sack, Clarke and Seeley (1995) found that PTSD in two generations of Cambodian refugees was significantly related, where a number of environmental variables (reported war trauma, loss, living arrangements, treatment received, socioeconomic status) and depression were not.

In applying PTSD models to children, the complex interaction between factors affecting prevalence and recovery provides numerous targets for research and intervention. What is striking is the need for both. There are many gaps in understanding and much evidence of the impact of trauma on long term functioning. Yule et al. (2000) found 26% of adolescent survivors of a cruise ship sinking suffered from the disorder for over 5 years and a third of these were still suffering between 5 and 8 years later. They stress that the risk of PTSD is lower for an accident or natural disaster than for other kinds of traumatic experience. Indeed, Sack, Him and Dickason (1999) found 67% Khmer youths interviewed following war trauma in 1983 and then 3, 6 and 12 years later met PTSD criteria during this time. This impact warrants further investigation as does the specific therapeutic needs of children exposed to trauma like this.

Refugee children

While the previous discussion has considered PTSD in children, it is important to acknowledge that refugee children have typically experienced an unusual number or
degree of stressful experiences (Yule, 2000). As a result there has been debate about the legitimacy of applying these models to the distress of refugees. In particular the process of diagnosing PTSD has been criticised for meaning that an understandable response to an abnormal situation is misconstrued as an abnormal state (Kleinman & Kleinman, 1991). Helman (2000) suggests this process pathologises expressions of distress and suffering by labelling them as anxiety, depression or PTSD. She argues this perpetuates a process begun in the country of origin where individuals are targeted because of 'bad' political or religious views and in exile are defined as 'illegal immigrants' and diagnosed with 'mental health problems'. Helman (2000) also argues the focus on relieving symptoms reflects a Western disease model of experiences that is at odds with refugees' understanding of illness and the social, environmental and cultural context in which losses have occurred. The risk is that diagnostic categories make assumptions about the expression of distress that break down when applied cross-culturally. For example, Kleinman (1995) suggests a classification historically based on what 'lies outside usual human experience' is ethnocentric considering much of the world regularly witnesses violence.

Concern about whether such classifications distort people's experiences by forcing people into Western categories has prompted a series of investigations into the way that catastrophic events are recounted in different cultural groups. Hodes’ (2002) review of this debate argues that the best available recent evidence supports the cross-culturally validity of PTSD. He suggests the huge range of individual responses to the same exposure means that descriptions of distress are needed because individuals need to be treated differently. He suggests that rather than diminishing moral and political aspects of suffering, diagnosing symptoms can be the
means of mobilising resources and highlighting the significance and long term impact of events, in the same way that a diagnosis of cholera does not lessen the necessity for social action when people are living in unsanitary conditions.

Sack, Seeley and Clarke's (1997) study explicitly aimed to see whether PTSD in Cambodian refugee youth resembled that reported by factor analytic studies with Caucasian samples. Data collected from 194 youth across different developmental levels indicated a four factor solution that resembled earlier studies on Caucasian and African-American adults, leading them to conclude that "PTSD as a result of prior war trauma appears to surmount the barriers of culture and language in this sample" (p.49). They found a distinction between experiences of PTSD following war trauma and depression following resettlement stresses and suggested a construct that merged these issues would not do justice to respective experiences and resulting difficulties. Instead, they conclude that the enduring tragedy of war and resettlement is highlighted by systematically assessing its impact on individuals' lives. If we assume that these experiences are measurable in some way and that we can draw on PTSD models to understand refugee children's experiences there will still be distinct features in the experience of refugee children that should be considered, for example: chronic and multiple traumas, the effect of resettlement and social/cultural losses.

**Nature of the stressor:**

There is little doubt that the experiences of many refugee children are contrary to what is considered to be the basic needs of every child (continuity of care by loved one, shelter and food, safety and security, need for good schooling; Yule, 2000). Models of PTSD would lead us to expect a significant relationship between the
amount of exposure and subsequent reactions and a review of studies from war zones confirms a high incidence of PTSD symptoms (e.g., Dyregrov, Gupta, Gjestad, & Mukanoheli (2000) 79% of sample of Rwandese children; Kuterovac, Dyregrov, & Studland (1994) 74% of sample of Croatian children; Thabet, Abed, & Vostanis (2004) 41% of sample of Palestinian children). Layne et al. (2001) report studies of children living in war zones have also found high rates of depression, complicated grief reactions, academic difficulties, somatic complaints and disturbances in family / peer relationships. Increased planful and prosocial behaviour (Macksound & Aber, 1996) has also been found and it is important to note that refugee children often display considerable strength and resilience (Summerfield, 2000; Timimi, 1998).

There will be individual differences in the impact of particular events but there is evidence that some types of experiences are more often associated with PTSD than others, for example, Dyregrov and Raundalen (1992, cited in Smith et al., 2002) found that exposure to dead bodies or body parts was the best predictor of intrusions and suggested that this may be related to the associated strong sensory impressions. Smith et al. (2002) suggest that PTSD is more likely following traumatic death, particularly where mourning rituals or ceremonies are disrupted by ongoing fighting, where bodies are hurriedly buried or are dug up in exchange for prisoners of war. They also suggest that the daily presence of reminders, for example seeing damaged buildings, may maintain a sense of current threat. During war situations continuous exposure with no foreseeable end to the violence combines with continuous extreme adversities to intensify trauma reaction and delay recovery (Barenbaum, Ruchkin, & Schwab-Stone, 2004). These not only create direct traumatic experiences but also indirectly cause economical damage and affect parents’ capacity to care for their
children (Paardekooper, deJong, & Hermanns, 1999). The extreme events and disruption during and after war or persecution is the antithesis of developing in a safe, secure, predictable environment highlighting the need for effective and culturally sensitive interventions (Yule, 2000).

**Immigration**

Barenbaum et al. (2004) argue that children form attachments to environments as well as to people so that displacement is inherently distressing and has been shown to be predictive of symptom severity, particularly in younger children. They highlight the importance of safety and security within any new setting, and that some settings may expose children to further levels of violence, alcohol abuse, quarrels, sexual assault and beatings. Refugees in the UK often have uncertain legal status, an additional stressor that Yule (2000) suggests may mean that families are unable to reveal the whole truth about their experiences. He highlights that families may have had to go to great lengths to escape threats in their home country and during the journey to safety and children may have been told not to reveal details of these events or of individuals who helped them. Their experiences with officials both prior to and in their country of refuge may make them suspicious of adults, particularly people in authority, making it harder for children to reveal what has happened. This can be additionally complicated when there is uncertainty about the safety of relatives left behind or adults’ attempts to protect children by not telling them about risks or the death of relatives has compromised children’s trust in adults (Yule, 2000). Cognitive models make clear predictions about the impact of feeling unable to express what has happened on children’s ability to process events and of a continuing sense of current threat. Contact with services may remind refugees of interrogation
experiences in home country or during the immigration process (Hodes, 2000). Administrative procedures surrounding immigration often last many years preventing rituals that allow separation from the old life and the start of a new one (Helman, 2000). The long period of uncertainty in the UK often means settlement is not in a ‘safe’ context and future plans are at best vague.

**Language and cultural bereavement**

Kleinman (1995) highlights that the language of distress may be different for refugee children and assessments need to utilise the illness narratives used by children to express suffering. Distress is often communicated through the body particularly as extreme experiences are likely to have had a physical impact on the body. Mesquita and Walker (2003) suggest that a culturally sensitive approach to difficulties involves recognising ways the meaning of events make subsequent feelings comprehensible, for example, in cultures where the perception of honour is prevalent, shame and anger are more likely to be elicited. Arrindel (2003) argues that accurate assessment of emotion, personality and cognitions is often compromised in clients from ethnic minorities and that more needs to be done to address this. Culturally sensitive assessments may use interpreters to explain linguistic nuances during conversation and aim to incorporate the prevailing cultural norms, spiritual or religious involvement and culture-specific ways of understanding, expressing and healing trauma (Barenbaum et al., 2004). Interpreters play a key role in facilitating this understanding but their presence may also increase clients’ fear of being traced by their own community or inhibit emotional expression (Hodes, 2000). Derges and Henderson (2003) stress the importance of acknowledging different cultural attitudes towards ‘health’ and ‘illness’ in communication between medical professionals and
refugees. The loss of an accepted way of speaking about distress highlights the importance of considering the impact of cultural bereavement on children. Kleinman (1995) suggests that these losses are often overshadowed by the dramatic nature of the trauma and given little attention. This is particularly important in light of Van Willigen's (2000) finding that suffering post migration was rated by some refugees as equal to the experience of torture. Eisenbruch (1991, cited by Barenbaum et al., 2004) introduced the term 'cultural bereavement' to describe experiences of loss, painful memories and guilt associated with the loss of social structure, cultural values and self-identity during resettlement.

Co-morbidity

Fletcher (1996) reports that rates of co-morbidity vary in different studies but are consistently higher for refugee children than for the general population, frequently reaching 40% for anxiety and depression. Sack et al. (1997) found that refugee adolescents had rates of depression that were four times higher than the population prevalence and the only significant predictors of this were current life stress and poorer spoken English. Thabet et al. (2004) tried to tease apart resettlement issues from the effect of war trauma using a sample of Palestinian children enduring ongoing trauma and found a high degree of co-morbidity and symptom overlap between PTSD and behavioural and emotional difficulties.

Family context

Rutter (1999) highlights that families can function as a protective factor and may be able to buffer the impact of trauma on children. Farwell (2001) described parents' attempts to buffer the effects of the Eritrean war by encouraging their children to
continue their education while in refugee camps in Sudan. Smith et al.’s (2002) review of children currently living in war zones found lower than expected rates of depression and anxiety, and while there may be many explanations for this they argue it suggests that adaptive coping is facilitated when the whole community are affected and able to pull together to survive.

The benefit of shared experience of war or political oppression is limited by displacement and in the UK refugees are often isolated from community networks and social support. Howard and Hodes’ (2000) retrospective case-control study found that refugee families referred to their service were more isolated and socially disadvantaged than a matched sample of non-refugee immigrant families and white British families. Farwell (2001) argues that war-related events compromise parents’ abilities to provide for and protect their children, constituting further stress for the child at precisely the time that children need reliable social structures to reassure them. Adapting to a new society will also have a cross-generational impact. Montgomery (1998) highlights that children’s attendance at school may enable them to learn English and form a peer group while parents remain isolated. Children acting as translator and adjusting to both parental and host culture may reduce parental influence over children. Hodes (2000) suggest this loss of status can be particularly difficult for men tortured because they held positions of influence, whose legal status means they are unable to work or support their family. Farwell (2001) highlights that intra-familial conflicts about whether to flee or stay may have a long term effect on family dynamics. These adjustment difficulties can compound the impact of the trauma.
Dyregrov, Gjestad and Raundalen’s (2002) study of longitudinal effects of war on 94 Iraq children revealed “a highly distressed population of children who continue to experience sadness over time, remain afraid of losing their family, and feel that friends and family do not really understand what they are going through. A majority did not talk with their parents about their feelings” (p.65). According to the children discussion and open expression about the war was rare with parents commonly telling children to forget what had happened and to try to put it behind them. In many cases children reported that they could not talk to their parents because it made their parents upset. The authors felt that parental preoccupation with their own problems acted to compound cultural norms for not talking. Barenbaum et al. (2004) suggest that cultural expectations for children to be well behaved and emotionally restrained can also make it harder to identify children who are struggling. They suggest that war often results in splitting people into ‘good’ or ‘bad’, simplifying complex moral dilemmas and modelling attitudes and behaviour that may contradict principles previously taught, adding to children’s confusion about how to behave. Sack et al.’s (1999) follow-up of Cambodian refugees found that traditional values shaped a coping style characterised by avoidance and a tendency to suppress feelings. This resulted in a high incidence of depressive disorders but few incidents of social or acting-out behaviours. These examples suggest that children from different cultural backgrounds may be socialised to respond to trauma differently and the impact of this on recovery and treatment warrants further investigation.

PTSD in refugee children may be compounded by multiple trauma, continued uncertain legal status, language and cultural bereavement and social disadvantage,
precisely why finding effective and culturally sensitive treatments is challenging but greatly needed.

**PTSD treatment for refugee children**

Ruggiero, Morris and Scotti's (2001) review of treatments for children with PTSD emphasises the need for scientific evaluation of the interventions it reviews. They suggest that as a result of the lack of efficacy data treatment tends to be based more on clinical preferences and training background than on empirical evidence. This is further heightened if we narrow the search to studies concerning treatment for refugee children, perhaps surprising considering the detrimental effects of war on the development and mental health of children have been documented since World War II (Barenbaum et al., 2004). Cohen, Berliner and March's (2000) review of available research forms part of the practice guidelines for the International Society of Traumatic Stress Studies. They did not identify a single published treatment efficacy study targeting war traumatized children and adolescents. Their review called for effectiveness studies that use reliable and valid measures to assess defined target symptoms and the development of manualised and target-specific treatment protocols to facilitate these studies. This has begun to produce fruit but research is still in its initial stages. This section will review current research on individual and group treatments and refugees’ access to such interventions.

**Individual work:**

Yule (2000) highlights that the level of support required by refugee families varies greatly, in many cases children only require a sense of safety and support via their family and school but in other cases children may require psychosocial interventions.
It is important to emphasise that the major source of expertise in modelling cultural expressions of emotions and being sensitive and responsive to the child's expression of anger, frustration and distress is the child's family (Barenbaum et al., 2004). Scheeringa and Zeanah (2001) describe ways that families can help the child to manage stress and develop a sense of mastery and suggest this is the ideal context for children to process difficult memories. However, we know that parents in distress are often less responsive (see above) and therefore an important intervention goal is to reduce family distress and promote parental efficacy in helping their children to process trauma. Hodes (2000) suggests that working with refugee children and their families often demands a practical stance, including willingness to support requests for improved accommodation, help with official forms and asylum applications and as a result multi-agency support is often required.

As with all clinical difficulties Ruggiero et al. (2001) highlight that there are a range of approaches to helping children process past events. Psychodynamic therapists may help to uncover the experience of trauma and meaning attached to it, for example, associated feelings of weakness or strength, CBT therapists may utilise systematic prolonged exposure and cognitive restructuring to process the trauma memory, systemic approaches may consider the impact of the trauma on the child and their support systems and psycho-education regarding relapse and prevention skills may be used to bolster resources to cope with current and future PTSD symptoms. The evidence base for treating children tends not to specifically address refugee children and relies largely on evidence of effectiveness drawn from adapted adult interventions based on cognitive models of PTSD and so, as with many other disorders, it is largely CBT based (Perrin, Smith, & Yule, 2000). Reports on the
effectiveness of psychodynamic interventions are limited to case illustrations (Ruggiero et al., 2001) and there is no evidence for efficacy of pharmacotherapy (NICE, 2005). Saigh’s (1987a, b, c 1989) series of single incident case studies showed that CBT is an effective intervention, and Cohen and Mannarion (1996, 1997) conducted two randomised trials that found highly significant symptomatic improvement following trauma-focused CBT for sexual abuse and no change following nondirective therapy in 86 preschoolers and 49 children aged 7 to 14.

Yule (2000) argues the use of exposure to alter behaviour, physiology and cognitions through habituation and cognitive restructuring fits with models and results from adult research. However, he argues that in the absence of firm empirical guidance, practice with children usually involves a mixture of cognitive behavioural and family methods, which makes it hard to replicate. Ruggiero et al. (2001) suggest the greatest evidence base exists for a combination of anxiety management training packages and exposure based techniques. Smith, Dyregrov and Yule (1998) consider that the treatment of choice is multi-modal family based cognitive behavioural treatment as this tackles both the conditioned fear response to traumatic reminders that maintain avoidance and individual differences in threat perception and appraisal. Their review of treatment suggests that exposure should be preceded by coping skill enhancement so that the child feels in control of their symptoms before and during this work. This discussion highlights some of the difficulties of exploring treatment protocols in clinical settings. Clarke (1995) argues that controlled trials of protocol driven treatments are necessary before moving onto effectiveness studies in clinical populations, therefore while a variety of factors may contribute to lack of availability
of CBT, absence of a proven treatment ‘package’ is an important limiting factor in transporting benefits of CBT from research clinic to practice.

Survivors often agree that sooner or later they must ‘face up to the traumatic event’, Yule (2000) suggests that the problem for the therapist is how to help the survivor re-experience the event and associated emotions in a way that allows their distress to be mastered and not magnified as therapeutic exposure sessions that are too brief may sensitise rather than desensitise. There is some evidence that merely drawing or talking through events is not sufficient and may actually be re-traumatising (Machel, 2001) and experience with debriefing has suggested that early exposure to memories of traumatic events may interfere with processing and lead to an exacerbation of symptoms (Mayou, Ehlers, & Hobbs, 2000). In spite of this there is an accumulating evidence base to suggest that exposure under supportive circumstances can help intrusive thoughts and behavioural avoidance in children (Perrin et al., 2000). In this sense although little has been formulated about therapy techniques for displaced / war affected children (Barenbaum et al., 2004) it is possible to use techniques shown to be effective in working with children with PTSD in other settings.

Groups

More research, although still relatively few studies, have utilised a group format in treating refugee children. Farwell (2001) suggests that this is because in refugee situations the scale of need, lack of resources and the cultural incompatibility of individual talk-therapy demands that psychosocial support is offered within community contexts. Once again, however, much is gleaned from efficacy studies targeting children exposed to natural disasters or abuse, for example, Galante and
Foa (1986) evaluated monthly classroom sessions in the year following an earthquake in Italy and Yule (1992) reported that girls who received a cognitive behavioural treatment after a cruise ship sinking had lower scores on the Impact of Events Scale and a fear survey. Deblinger, McLeer and Henry (1990) used a group exposure-based intervention in conjunction with coping skills training and education for 19 sexually abused girls and found a statistically significant reduction in the number of PTSD, depression and general anxiety symptoms on measures taken before and after treatment.

Goenijian et al. (1997) evaluated the effectiveness of a school based intervention using classroom group and individual psychotherapy offered 1½ years after the Armenian earthquake. The intervention involved four half hour group sessions and an average of two 1 hour individual sessions that were offered over a three week period. Sessions were based on a developmental psychopathology model of trauma (fully outlined in Pynoos et al., 1999) and addressed post disaster stress and adversities, grief and the developmental impact of trauma as well as reconstruction and reprocessing of the trauma and dealing with reminders. The scale of destruction and limited number of mental health personnel meant the intervention could only be offered in some schools and it was therefore possible to compare schools that had or had not received it. The authors found the intervention alleviated PTSD symptoms (p<0.05) and prevented worsening depression found in those not treated (p=0.01). This was sustained at follow-up 1½ years later. The authors argued that the benefits extended beyond symptom reduction to affect a variety of aspects of development, for example, reducing distress among parents, helping concentration in classroom
and enhancing ability to cope with future stressors which maintained the effectiveness of the intervention.

March, Amaya-Jackson, Murray and Schulte (1998) evaluated a group cognitive behavioural protocol using a single case across time experimental design. 17 participants who met criteria for PTSD according to a structured interview entered into an 18 week programme. Participants had been exposed to a variety of single incident stressors including car accidents, fires, severe illness, gunshot injury and cranial assault. Fourteen participants completed treatment and of these 8 (57%) no longer met PTSD criteria immediately after treatment and 12 (86%) at follow-up (6 months). The authors found that clinically and statistically significant group mean differences occurred early in the treatment process and suggested shortening the protocol and using exposure-based interventions earlier. Saltzman, Pynoos, Layne, Steinberg and Aisenberg (2001) evaluated the effectiveness of the school-based trauma and grief protocol used by Goenijian et al. (1997) in treating 26 students exposed to community violence identified through a school screening programme. The authors reported improvements in PTSD, grief symptoms and academic performance post treatment.

Chemtob, Nakashima and Hamada (2002) were the first to describe a randomised controlled trial of psychosocial treatment. The project involved two stages, a community wide screening for high levels of disaster related trauma symptoms 2 years after a major hurricane and a treatment protocol, whereby children with persistent high levels of symptoms were randomly assigned to individual (n= 73) or group treatment (n= 176). The interventions took place in two waves so those
initially awaiting treatment served as wait-list controls. Both interventions were manual guided and involved 4 weekly sessions. The manuals were devised by the researchers to help children master disaster related psychological challenges, including restoring a sense of safety, expressing disaster-related anger and thinking about moving forward. The protocol outlined each session’s content and provided a specific repertoire of activities. Those treated had fewer self-reported symptoms than controls (p<0.001); group and individual treatments did not differ in their effectiveness, although fewer children withdrew from groups. This was maintained at 1 year follow-up. The authors noted that while such research has been difficult to perform because people often want to avoid reminders of the disaster, such large effect sizes suggest psychosocial interventions warrant further use and evaluation.

All of the above studies rely on self-report and studies finding no improvement are perhaps unlikely to make it into the literature, however, the cumulative findings are striking. Still, these findings concern non-refugee populations and it is possible that multiple trauma experiences, often resulting from interpersonal victimisation, may affect children’s perception of others and experience of group processes. We know that groups are not suitable for all children (Yule, 2000) and Gillis (1993) suggests that children whose lives were directly threatened, who directly witnessed death, had pre-existing problems, or who lack family support should be offered individual help. There have been two studies (Layne et al., 2001 and Ehntholt, Smith and Yule, 2005) investigating group treatment for traumatised refugee children.

Layne et al. (2001) utilised the protocol used by Goenijian et al. (1997) after the Armenian earthquake to generate a manualised intervention for war traumatised
adolescents addressing: (1) normalising stress reactions and enhancing coping skills; (2) identifying reminders of the trauma, exploring their personal meaning and enhancing coping; (3) recognising posttraumatic adversities and promoting problem-solving abilities; (4) addressing the interplay between trauma and grief by validating grief reactions to enhance coping; (5) resuming developmental progression by identifying missed opportunities and promoting goal-directed efforts. 55 students from 10 Bosnian secondary schools took part in evaluating the protocol. Students completed measures of PTSD, depression, grief and group satisfaction before and after the group. These yielded promising results with reduced psychological distress (approximately 50% of students showed reliable improvement in PTSD & grief and 35% in depression) and a positive association between psychosocial adaptation and group satisfaction.

Ehntholt et al. (2005) evaluated the effectiveness of a manualised group protocol ('Children and War: Teaching recovery techniques', Smith et al., 2000) used as a school based treatment for children who had experienced war trauma in their country of origin. The treatment group (n= 15) received six sessions of group CBT over a six-week period, while the control group (n= 11) were placed on a waiting list for six weeks. Children in the treatment group showed statistically significant decreases in the overall level of PTSD symptom severity (p=.003) while those on the waiting list did not show any improvement during the same time period. However, these improvements were not sustained at 2 month follow-up.

Barenbaum et al. (2004) suggest that group work is usually the treatment of choice for war traumatised children since it recognises that participants are not alone with
their experiences and emotions and allows them to learn problem-solving and coping skills from one another. This process normalises cognitive and affective reactions at the same time as allowing individuals to both receive and offer support to others (Stubenbort, Donnelly, & Cohen, 2001). The supportive peer environment is also perhaps particularly relevant for those whose experiences prior to and since arrival in the UK are typified by interpersonal victimization. Foy, Eriksson and Trice (2001) highlight “the clear relevance of joining with others in therapeutic work when coping with victimization...Bonding with similar others in a supportive environment can be a critical step towards regaining trust” (p.246). A group environment also runs counter to the avoidance and feeling of profound detachment that is typically observed in trauma survivors and experiences from a larger society that may judge or blame them for their predicament. This forum may also be particularly advantageous for children and adolescents whose sensitivity to peer approval and concern about their own and others normality means that the peer group has increased value (Layne et al, 2001). We know that traumatised young people often do not seek professional help and those that do frequently do not complete treatment (Saltzman et al., 2001). Using the peer group may make treatment more palatable and facilitate age-appropriate ways to appraise and respond to danger, regulate emotions, problem-solve and promote recovery.

Foy et al. (2001) highlight that CBT groups also capitalise on intrinsic therapeutic qualities of groups (Yalom, 1931) if they aim to build a therapeutic, safe and respectful environment. Following trauma these elements specifically include a group membership united by their experience of trauma, using disclosure and validation of traumatic experience, normalisation of trauma-related responses and the
validation of behaviours required for survival during the trauma. Yule (2000) proposes that work with children who have experienced war or persecution should not only address symptoms but be designed to mobilise coping resources within individuals and communities by facilitating externalisation of the source of distress and encouraging a determination to recover. It seems the best available evidence supports the use of psychoeducation, therapeutic exposure, cognitive restructuring, relaxation skills and practical problem solving as a first line treatment for traumatised children (Cohen et al., 2000) but further research is needed. Barenbaum et al. (2004) encourage clinicians to utilise more structured approaches in order to allow replication of work for both clinical and research purposes. It is apparent that both manuals reviewed above do this and include elements known to be effective.

Access to treatment:
Refugee children are often under-represented in clinic populations (Raval, 2005). Fazel and Stein (2003) collected teacher Strength and Difficulties Questionnaire (SDQ) ratings of 303 refugee children in Oxford schools and expressed “considerable concern that refugee children have large unmet mental health needs that need to be tackled” (p.134). Hodes (2000) identified some of the barriers to accessing services suggesting that it may be hard for carers to recognise children’s distress because of their own experiences / distress and that carers may have fears regarding confidentiality. He highlighted that the organisation of social, education and health services is bewildering and the practicalities of getting to services (new routes, travel expenses, childcare, language) may hinder attendance at appointments. Yule (2000) argues that therapeutic support should be directed through natural groupings that exist in communities. In the case of children, Hodes (2000) argues
that schools are an ideal route to access children whose families would not accept a referral to mental health services or do not want their children to miss school. He suggests that schools are accessible, minimise the stigma associated with receiving care and school personnel are usually knowledgeable about children's development and emotions. O'Shea, Hodes, Down and Bramley (2000) evaluated a school-based mental health service for refugees and found that children identified by teachers as having psychological difficulties were helped by a range of interventions offered within schools. This resulted in an overall reduction in mean SDQ scores from 21.3 to 15.7, a downward trend approaching significance. Rousseau, Drapeau, Lacroix, Bagilishya, and Heusch (2005) also found that teachers' identification of behavioural symptoms correlated with poorer social adjustment and that these children benefited from classroom based creative expression workshops designed to build self-esteem.

Yule's (2000) lecture on meeting the needs of war affected children proposed a system "whereby psychosocial help is delivered primarily through schools with only a small proportion of more complex needs being met by specially trained mental health professionals" (p.695). This may involve monitoring procedures to provide support when required or consultations with families, but Yule (2000) suggests that teaching self-help techniques within the school setting means that large numbers of children (20-30 at a time) can be helped to understand and manage their symptoms. This is particularly useful as Barenbaum et al. (2004) argue that following disruption either through war or migration school attendance helps restore normality, stability and allows children to take their role as students again. They maintain that classroom routines provide clear expectations, opportunities for social interaction and self-expression and for being given tasks and responsibilities. The school can also
provide psychosocial support and in some settings may involve children in extra activities, fostering commitment to recovery. This is important as relationships, social values and practices may have been destroyed and the resettlement process involves connecting with things that gave life meaning prior to the trauma (Barenbaum et al., 2004). La Greca, Silverman, Vernberg and Prinstein (1996) proposed that school based interventions would be especially useful in providing ongoing support and modelling of effective coping and problem-solving through building ties with teachers and classmates.

Involvement in a school setting is also important as PTSD symptoms, including concentration and sleep difficulties may impact school performance. Saigh, Mroueh and Bremner (1997) found that Lebanese students with PTSD had significantly lower scholastic achievement than an exposed but not symptomatic comparison group. As PTSD is largely an internalising disorder, teachers' may not be aware of the intrusive thoughts or concentration difficulties that children experience and so highlighting the potential impact of trauma within the school system may also function to increase teachers understanding and support. Saigh et al. (1997) argue that because learning is a cumulative process undetected difficulties may become compounded over time affecting future grades and college entry. Saltzman et al. (2001) actually found their group intervention resulted in improved academic performance as well as PTSD symptoms. In their setting, participation in some school activities, including field trips, was only available to those passing at school and so improved grades meant that group members were able to engage with extra-curriculum activities that had important social implications and promoted long term development and adaptation.
The developing evidence for PTSD treatment in refugee children suggests that treatments can be effective. Further use and evaluation of replicable, culturally sensitive and accessible interventions is warranted in order to understand what makes intervention effective.

Factors affecting the effectiveness of treatment

Tarrier, Sommerfield, Pilgrim and Faragher (2000) stress that despite good evidence CBT is effective some individuals consistently do not improve or continue to suffer residual symptoms. Fletcher’s (1996) model of childhood PTSD reviewed above (Fig.1) highlighted a host of variables that affect the prevalence of and recovery from PTSD. The interplay of these variables within an individual’s presentation will influence their response to treatment. Some of these trends have been alluded to above (eg: belief worrying effective maintains worries (Vasey, 1993); hypervigilance to threat means continued selective attention (Dalgleish et al., 2001); carer’s response can facilitate / prevent processing (Pynoos et al., 1999) and for a fuller account of the impact of these and other variables see Cohen et al. (2000) or Perrin et al.(2000)). However, in reviewing the literature the interplay between the necessity of emotional engagement with the traumatic memory for treatment to be effective (Jaycox, Foa, & Morral, 1998) and avoidance that Foa, Riggs and Gershuny (1995) argue is the most discriminating factor within the diagnostic triad is repeatedly singled out as warranting further attention (Fletcher, 1996; Meiser-Stedman, 2002).

Avoidance as a coping style

Steil and Ehlers’ (2000) study of survivors of motor vehicle accidents found that avoidant strategies (thought suppression, distraction, rumination and avoidance of reminders) accounted for a proportion of the variance in PTSD severity that was not
explained by intrusion frequency, accident severity or by general catastrophic thoughts when anxious. Aaron, Zaglul and Emery (1999) also found that greater thought suppression, not subjects' characteristics or extent of the trauma, was associated with greater PTSD symptomatology in children assessed after a physical injury. They conclude "its lack of correlation with peritraumatic fear, however, suggests that it assesses a trait distinct from the PTSD response itself" (p.341).

Overcoming avoidance is difficult for all clients, particularly perhaps for those where 'facing your fears' has the added edge of the reality of events and losses. However, Bryant and Harvey (1995) argue the selection of an avoidant cognitive strategy when faced with trauma may reflect an underlying avoidant coping style that in their sample of road traffic accident survivors impeded recovery and help seeking.

Aaron et al. (1999) highlight the paradox of this strategy in that some children avoided pain by keeping unpleasant thoughts away for some of the time, but high suppressors actually had more intrusive thoughts and images than those who allowed themselves to remember so that suppression directly predicted PTSD symptoms. Wenzlaff, Wegner and Roper (1988) investigated this paradox by analysing depressed adults' stream of consciousness during thought suppression tasks. They found a resurgence of negative thoughts because the thoughts generated to distract tended to be negative. It seems likely that similar processes occur in PTSD whereby the process of avoiding thinking about events actually activates associated networks. The findings are significant because while there are many things about the nature of the trauma and current situation for children that cannot be changed, coping strategies do provide a means of modifying outcome and the clear finding that thought suppression is unhelpful (Aaron et al., 1999) suggests that promoting open
discussion of events may help to prevent future symptoms. La Greca et al. (1996) prospectively examined the impact of coping styles on 442 children’s post disaster response to Hurricane Andrew. They found that PTSD symptoms were related to the types of coping used. Initially, more coping strategies were used by children with higher distress, perhaps because those with a greater need for coping had experienced more disturbing events, but it was the use of negative strategies (blaming self/others, getting mad) that predicted symptoms over time. They identified a bi-directional relationship between distress and avoidant strategies with distress contributing to the use of avoidant strategies as well as being maintained by their use. Rossman (1992) investigated the efficacy of coping methods by organising descriptions of what children do to feel better in stressful situations. He concluded that coping behaviours were a crucial link between the experience of distressing events and subsequent adjustment in children and that despite age-appropriate changes (eg: the shift from reliance on parents to peers for support) they remained relatively stable over time. Anthony, Lonigan and Hecht’s (1999) factor analysis of symptom clusters in children’s coping styles also revealed stable dimensions across late childhood and adolescence regardless of age at exposure, type of trauma and time elapsed since trauma suggesting that addressing these may have a lasting impact on recovery.

Farwell’s (2001) review of coping among youth returning to Eritrea from Sudan highlighted the variety of types and levels of coping strategies in children’s response to war-related events, including vigilance, planning for flight, powerlessness, mutual cooperation, immobilization, search for food / shelter. She highlights the differing impact of these coping styles and suggests effective interventions should build on existing adaptive strategies. Paardekooper et al. (1999) also highlight the varied
utility of coping strategies in war situations, for example, a belief of having some control over the situation can reduce stress, however taking a more active role in conflict may cause greater emotional problems later. They highlight that the range of coping mechanisms used by their sample of 316 Southern Sudanese children in refugee camps was greatly restricted by their environment. The camps provided few opportunities for problem focused coping as there was no means to earn a living or change circumstances and as a result, looking for distraction, wishful thinking and praying were the most commonly reported coping strategies. It is apparent that strategies that may have become entrenched when events were beyond children’s control may no longer be adaptive when working with children in the relative safety of the UK. Smith et al.’s (2002) finding that high avoidance scores on the Impact of Events Scale was not associated with children’s distress in a sample of 2,976 children from Bosnia-Hercegovina, perhaps indicates that avoidance may be one such factor, indicating good short-term coping in a war-torn context but shown to prolong unhelpful thoughts if the danger has passed (Aaron et al., 1999). Both avoidance and numbing were the best predictors of PTSD symptoms in Khmer adolescents living in the States (Sack et al., 1997). Avoidant coping may also be more salient when working with children from different cultures with value systems that as noted above (p. 27) may encourage different coping styles (Dyregrov et al., 2002; Sack et al., 1999).

Bryant and Harvey (1995) suggest that an avoidant coping style is associated with poor help-seeking behaviour and may cloak symptoms making them harder to identify, both of which have clear implications for the treatment process. Tarrier et al.’s (2000) investigation of variables that predicted treatment outcome found that
five out of eleven were related to attendance at therapy, including sessions missed, greater time between sessions and overall duration. They suggested that irregular attendance was a proxy measure of avoidance and that while avoidance is intrinsic to PTSD some clients demonstrate more avoidance of attending which was related to treatment outcome. It was unclear whether inconsistent attendance 'diluted' therapy or treatment resistant symptoms reduced client’s motivation to attend. Addressing children’s tendency to rely on an avoidant coping style, by discussing the paradox of thought suppression and treatment rationale, seems necessary if it is to be effective.

Summary and Conclusions:
Increasing understanding of PTSD demonstrated through development of DSM criteria and cognitive models (Brewin et al., 1996; Ehlers & Clark, 2000) has resulted in a rationale and targets for treatment culminating in prospective randomised controlled trials demonstrating CBT is effective in treating symptomatic adults (Zoellner et al., 2003). This process is now also occurring in work with children and adolescents so that the literature contains meta-analysis (Fletcher, 1996), models (Fletcher, 1996; Meiser-Stedman, 2002; Pynoos et al., 1999) and a randomised controlled treatment trial (Chemtob et al., 2002). However, there is a consistent consensus that there is need for much greater understanding. This is particularly so when looking at the literature on refugee children. Research (Al-Eissa, 1995; Dyregrov et al., 2002; Smith et al., 2002) has highlighted the impact of displacement, war and discrimination on children’s development, however limited treatment efficacy studies have been done (Cohen et al., 2000; Ruggiero et al., 2001). This presents a challenge to children’s mental health services, aware that these children have experienced extreme stresses with a limited evidence base to know
how best to meet their needs. Drawing on responses to natural disasters and abuse has provided some clues (Goenijian et al., 1997; March et al., 1998) and there are currently two protocols shown to be effective in helping refugee children in group contexts (Layne et al., 2001; Ehntholt et al., 2005) but more studies are needed.

An additional challenge is the difficulty refugee families have accessing existing mental health services (Hodes, 2000) so that it is probable that there are large unmet needs in UK communities (Fazel & Stein, 2003). In terms of children’s needs, both Hodes (2000) and Yule (2000) argue that schools are in a vital position to facilitate non-stigmatising, accessible interventions that ideally may also foster ongoing supportive relationships. O’Shea et al. (2000), Rousseau et al. (2005) and Ehntholt et al. (2005) have shown that this type of intervention can be effective but the viability of such interventions is a research priority.

Group and individual treatment protocols for refugee children with PTSD are based on the premise that some open discussion of events and exposure may help individuals to recover, however, one of the core symptoms of PTSD is an attempt to avoid thinking or talking about the past (Foa et al., 1995). There is some evidence that open discussion is harder for some children than others due to their preferred coping style (Bryant & Harvey, 1995) and although this has repeatedly been shown to affect level of PTSD symptoms (Aaron et al., 1999; La Greca et al., 1996) little is known about what effect this may have on the treatment process beyond perhaps meaning that individuals are less likely to attend (Tarrier et al., 2000). An important target for further interventions is to investigate the role that this may have on treatment acceptability and efficacy, particularly among refugee children.
References:


52


Empirical Paper

Can groups help refugee children with PTSD symptoms?
Investigating the pragmatics, effectiveness and participant engagement
in psycho-social-educational groups.
Abstract:
The large numbers of refugee children in the UK, their under utilisation of services and the limited number of studies evaluating treatment outcome means that evaluating different ways of delivering interventions is a research priority. This paper describes the pragmatics, effectiveness and participant engagement in a 5 session group psycho-social-education package offered to 33 war affected refugee children (aged 8 –18) attending psychology services and Secondary schools in London. There was a significant reduction in self-reported post traumatic stress symptoms and an increase in the self-rated efficacy of coping strategies after the group. Those with high avoidant coping styles showed a significantly greater shift in symptom levels. Further use of this group intervention in increasingly effective and culturally sensitive ways is warranted.
**Introduction:**

The plight of refugees and their treatment in the UK has been the focus of much debate and media coverage. In 2000 there were an estimated 169,370 refugees in the UK (UNHCR, 2002b) yet accurate estimates of numbers needing psychological treatment are rare. According to the United Nations a refugee is someone who “owing to a well-founded fear of being persecuted” is “outside that country of his (sic) former habitual residence” and “is unable or, owing to such fear, is unwilling to return to it” (UNHCR, 2005, p.13). These families have, by definition, been exposed to loss, disruption of lifestyle, high levels of violence and persecution. As all of these independently increase the risk of psychiatric disorders it is not surprising that up to 40% of refugee children meet diagnostic criteria, predominately for depression, posttraumatic stress disorder (PTSD) and other anxiety disorders (Hodes, 2000). Thus the number of people who would benefit from effective and culturally sensitive treatment presents a substantial challenge to services. Hodes’ (2000) estimate that 40% of the refugee community are under 18 years highlights the particular challenge for child and adolescent services that provides the background for this project.

**PTSD in refugee children**

As research into PTSD in children develops there is an increasing consensus about the potential long term impact of trauma on children (Yule et al., 2000) and the need for more research into effective treatments (Ruggiero, Morris, & Scotti, 2001). Both the potential long term impact (Sack, Him, & Dickason, 1999) and need for further research (Cohen, Berliner, & March, 2000) are even more marked when considering the needs of refugee children.
Assuming that we can draw on PTSD models to understand refugee children's experiences (Hodes, 2002), it is important to acknowledge that they have typically experienced an unusual number or degree of stressful experiences relative to other children with the same diagnosis (Yule, 2000). Layne et al.'s (2001) review of children and adolescents living in war zones confirmed high prevalence rates of PTSD (ranging from 8.3 - 75%) and a variety of adverse outcomes including depression, complicated grief reactions, academic difficulties, somatic complaints and disturbances in family / peer relationships. Paardekooper, deJong and Hermanns (1999) suggest that war and displacement not only create direct traumatic experiences but also indirectly affect parents' capacity to care for their children. The immigration process is an additional ongoing stressor for many refugee families in the UK (Yule, 2000), reinforcing a continuing sense of current threat and compromising the ability to process the past and look to the future. Refugee children will have experienced multiple losses including their home, school, community, social structure and cultural values during resettlement that are hard to tease apart from the effect of war trauma (Sack, Seeley, & Clarke, 1997). This can result in high levels of co-morbidity (Fletcher, 1996). The additional stressors associated with resettlement and the fact that refugee families tend to be more socially isolated (Howard & Hodes, 2000) may also compromise the support available. Dyregrov, Gjestad and Raundalen (2002) suggest children's struggles may be obscured by parental preoccupation with their own problems. It may be that children from different cultural backgrounds are socialised to respond to trauma differently and this needs to be considered during both assessment and treatment as language difficulties and culturally specific ways of expressing distress may be misunderstood by
clinicians (Arrindel, 2003). Therefore, finding effective and culturally sensitive treatment is challenging but greatly needed.

**Treatment for PTSD in refugee children**

Ruggiero et al.’s (2001) review of treatments for children with PTSD highlights the lack of treatment efficacy data. This is further heightened if we narrow the search to studies concerning treatment for refugee children. Cohen et al.’s (2000) review of available research forms part of the practice guidelines for the International Society of Traumatic Stress Studies. They did not identify a single published treatment efficacy study targeting war traumatized children and adolescents. Their review called for effectiveness studies that use reliable and valid measures to assess defined target symptoms and the development of manualised and target-specific treatment protocols to facilitate these studies. This has begun to produce fruit but research is still in its initial stages and much of the evidence relies on interventions following disasters with non-refugee populations. In this context group treatment is often favoured because of its ability to promptly serve a greater number of families with shared experience (Stubenbort, Donnelly, & Cohen, 2001). This also renders it particularly suitable for evaluating treatments for refugee children as it meets service demand at the same time as recognising the social element to children’s experience of war and displacement.

A group protocol has advantages in that it runs counter to the avoidance and feeling of profound detachment that is typically observed in trauma survivors and experiences from a larger society that may judge or blame them for their predicament. This forum may also be particularly advantageous for children and
adolescents whose sensitivity to peer approval means that the peer group has increased value (Layne et al., 2001). We know that traumatised young people often do not seek professional assistance and those that do present often do not complete treatment (Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001) so that using the peer group may help to make treatment more palatable and facilitate age-appropriate ways to appraise danger, regulate emotions, problem-solve and promote recovery.

**Group treatment studies for PTSD in children**

A number of studies using group interventions in different settings have reported a reduction in PTSD symptomatology. Yule (1992) reported that girls who received CBT after a cruise ship sinking had lower scores on the Revised Impact of Events Scale and a fear survey. Deblinger, McLeer and Henry (1990) found statistically significant reductions in measures of PTSD, depression and general anxiety taken before and after a group based exposure intervention for 19 sexually abused girls. Goenijian et al. (1997) evaluated school-based groups following the Armenian earthquake and found an alleviation of PTSD symptoms ($p<0.05$) after treatment, while there was worsening depression ($p=0.01$) in schools that did not have the intervention. The effects were sustained at 1 ½ year follow-up.

March, Amaya-Jackson, Murray and Schulte (1998) evaluated a group administered CBT protocol for 17 participants exposed to single incident stressors. Fourteen participants completed treatment and of these 8 (57%) no longer met PTSD criteria after treatment and 12 (86%) at 6 month follow-up. Saltzman et al. (2001) evaluated the protocol used by Goenijian et al. (1997) to treat 26 students exposed to community violence identified through a school screening programme. They
reported improvements in PTSD, grief symptoms and academic performance post treatment. Chemtob, Nakashima and Hamada (2002) used a community wide screening for high levels of disaster related trauma symptoms two years after a major hurricane and randomly assigned children with persistent high levels of symptoms to individual (n= 73) or group treatment (n= 176). Those treated had fewer self-reported symptoms than controls (p<0.001), maintained one year later. Group and individual treatments did not differ in their effectiveness, although fewer children withdrew from group treatment. The authors noted that while such research has been difficult to perform because people often want to avoid reminders of the disaster, such large effect sizes suggest psychosocial interventions warrant further use and evaluation.

**Group treatment studies for PTSD in refugee children**

It is possible that multiple trauma experiences, often resulting from interpersonal victimisation, may affect refugee children’s perception of others and experience of group processes. There have been two studies (Layne et al., 2001 and Ehntholt, Smith, & Yule, 2005) investigating group treatment for war traumatised children. Layne et al. (2001) adapted the protocol used effectively after the Armenian earthquake (Goenijian et al., 1997) to address the needs of war traumatised adolescents. 55 students from 10 Bosnian secondary schools took part in evaluating the protocol. Students completed measures of PTSD, depression, grief and group satisfaction before and after the group. These yielded promising results with significantly reduced psychological distress (approximately 50% of students showed reliable improvement in PTSD & grief and 35% in depression). However, such shifts are based on a small battery of self-report instruments and the lack of a control group also means that shifts in symptom levels may be the result of maturation, regression
to the mean or self-selection. The authors themselves note that the 'real-world setting' meant that some of the schools within the project did not complete the protocol and there were complications with supervision, training and monitoring implementation of the protocol. None the less the differences between mean scores on measures of PTSD, grief and depression before and after the group reveal large effect sizes. Layne et al (2001) demonstrated that the reduction in symptoms correlated positively with psychosocial adaptation (peer relationships, school interest & compliance) and negatively with school anxiety and withdrawal, arguing this indicates that the change was clinically as well as statistically significant.

Ehntholt et al. (2005) evaluated the effectiveness of a manualised group protocol ('Children and War: Teaching recovery techniques', Smith et al., 2000) used as a school based treatment for children in the UK who had experienced war trauma in their country of origin. The treatment group (n= 15) received six sessions of group CBT over a six-week period, while the control group (n= 11) were placed on a waiting list for six weeks. Children in the treatment group showed statistically significant decreases in the overall level of PTSD symptom severity (p=.003), while those on the waiting list did not show any improvement during the same time period. Reviewing the difference in total score on the Revised Impact of Events Scale (Smith, Perrin, Dyregrov, & Yule, 2003) between those who had and had not attended suggests that the group had a large effect size (d=.9). The authors describe such shifts as statistically significant but clinically modest because the majority of children continued to experience PTSD symptoms and many were still likely to meet diagnostic criteria for PTSD. However, Ehntholt et al. (2005) also note that children did display interest and enthusiasm for the group and even small decreases in
reported symptoms may result in a better quality of life. The small numbers in this study, large effect size and fact that these improvements were not sustained at 2 month follow-up suggests that further investigation of this protocol is warranted.

**Access to treatments**

Refugee children are often under-represented in UK clinic populations (Raval, 2005). Fazel and Stein (2003) collected teacher Strength and Difficulties Questionnaire (SDQ) ratings of 303 refugee children in Oxford schools and expressed "considerable concern that refugee children have large unmet mental health needs that need to be tackled" (p.134). Yule (2000) argues that therapeutic support should be directed through natural groupings that exist in refugee communities. Hodes (2000) suggests that in the case of children schools are an ideal route to access children whose families would not accept a referral to mental health services or do not want their children to miss any school. He argues that schools are accessible, minimise the stigma associated with receiving care and school personnel are usually knowledgeable about children’s development and emotions. O’Shea, Hodes, Down and Bramley (2000) evaluated a school-based mental health service for refugees and found that children identified by teachers as having psychological difficulties were helped by a range of interventions offered within schools. This resulted in an overall reduction in mean SDQ scores from 21.3 to 15.7, a downward trend approaching significance.

**This project**

There is evidence that group treatments for refugee children can be effective (Ehntholt et al., 2005; Layne et al., 2001) and that further use and evaluation of
culturally sensitive and accessible interventions is warranted. An evaluation of group
treatment was useful in order to expand the evidence base (Cohen et al., 2000) and
within the context of developing the service offered by the Child and Family team at
the Traumatic Stress Clinic. Therefore an evaluation of a structured protocol
enabling replication (Barenbaum, Ruchkin, & Schwab-Stone, 2004) and using
reliable and valid measures to assess defined target symptoms (Cohen et al., 2000)
within a school (Hodes, 2000) as well as clinic setting was proposed.

**Pragmatics:**

Ehntholt et al.’s (2005) study demonstrated that refugee children attending inner
London secondary schools experienced high levels of psychological distress, and that
a manualised group intervention ('Children and War: Teaching recovery techniques',
Smith et al., 2000) resulted in significant reductions in PTSD symptomatology. As
this has been the only study of its kind in the UK replication of the findings was
considered important, particularly by clinicians independent of the group that
designed the protocol. This is particularly so as the number of participants
completing treatment is relatively small (n=15) limiting generalisation of the
findings. Clarke’s (1995) review of effectiveness studies suggests that research
should address pragmatic research issues alongside theoretical models and a key
question in this instance was the feasibility of groups from the clinic and schools’
point of view and whether participants enjoyed and kept attending them.

**Effectiveness:**

Barenbaum et al. (2004) stress the importance of empirically evaluating treatments
for children exposed to war but argue that clinical screening tools should involve
direct interactions with the child and be simple and quick to administer. Child reports have increasingly been used as Yule (2000) suggests that parents and teachers may underestimate the level of distress. The primary index of change used by Ehntholt et al. (2005) was the Revised Impact of Events Scale (R-IES, Smith, Perrin, Dyregrov, & Yule, 2003). They found a significant change between scores before and after treatment with a sample of 15 on the R-IES total and intrusions sub-scale. It is important to note that while Ehntholt et al. (2005) found that participants reported a significant decrease in overall symptom severity and intrusive PTSD symptoms, this psycho-educational package was not intended to replace longer term specialist treatment but to reduce the numbers requiring it and to facilitate their identification. Its main purpose is to educate children about the symptoms of PTSD and teach them appropriate coping strategies and Smith et al. (2000) are clear to state that it is not expected to ‘treat’ childhood PTSD. This project also assessed the impact of the group on measures of self-reported coping strategies.

**Moderators:**

Developing the evidence base also involves investigating what makes intervention effective. While models of PTSD in childhood (Fletcher, 1996; Pynoos, Steinberg, & Piacentini, 1999) reveal numerous factors that may influence recovery from PTSD, knowledge can only progress by selecting one factor and investigating its role. In this instance an avoidant coping style was selected because in reviewing the literature the interplay between avoidant symptoms and the necessity for emotional engagement with the traumatic memory for treatment to be effective (Jaycox, Foa, & Morral, 1998) is repeatedly singled out as warranting further attention (Fletcher, 1996; Meiser-Stedman, 2002).
Bryant and Harvey (1995) argue the selection of an avoidant cognitive strategy when faced with trauma may reflect an underlying avoidant coping style that in their sample of road traffic accident survivors impeded recovery and help seeking. Aaron, Zaglul and Emery (1999) found that greater thought suppression, not subjects’ characteristics or extent of the trauma, was associated with greater PTSD symptomatology in children after a physical injury. Such findings are significant because while there are many things about the nature of the trauma and current situation for children that cannot be changed, coping strategies do provide a means of modifying outcome. Children respond to war-related events with a variety of coping responses (Farwell, 2001) and coping behaviours are a crucial link between the experience of distressing events and children’s adjustment (Anthony, Lonigan, & Hecht, 1999; Rossman, 1992). An avoidant coping style is likely to impact upon participants’ engagement in treatment (Tarrier, Sommerfield, Pilgrim, & Faragher, 2000). It is also perhaps particularly important to consider coping when working with children from different cultures with value systems that may encourage different coping styles. Dyregrov et al.’s (2002) longitudinal study of 94 Iraqi children found parents commonly told children to put the past behind them. Barenbaum et al. (2004) suggest that cultural expectations for children to be well behaved and emotionally restrained can make it harder to identify children who are struggling. Sack et al. (1999) found traditional values among Khmer youths shaped a coping style characterised by avoidance and a tendency to suppress feelings. Given that group treatment protocols for refugee children with PTSD are based on the premise that “some open discussion of the events...may help to prevent the subsequent development of PTSD symptoms” (Aaron et al., 1999, p.342) this project aims to
investigate whether such open discussion is harder for some children and the impact that this may have on the treatment process.

Summary of aims and hypothesis

The large numbers of refugee children in the UK, their under utilisation of services and the complexity of their needs (Hodes, 2000) has resulted in the call for "psychosocial help delivered primarily through schools...There is a strong need to evaluate different methods of delivering help and to develop new ways of reaching needy children in a non-stigmatising way" (Yule, 2000, p.695). This study aims to investigate ways of meeting this need by looking in a descriptive manner at the pragmatics, effectiveness and moderators of a psycho-social-education package:

(1) Pragmatics- the viability of using Smith et al.'s (2000) 'Children and War: Teaching recovery techniques' protocol in clinic and school settings in the UK ie: Do children attend? Do they enjoy coming? Do they find it helpful? We also wanted to see whether offering groups in schools accessed children unable to get to clinic groups.

(2) Effectiveness- whether there is an impact on children’s self-reported symptoms as a result of attending a psycho-educational group by looking at self-report measures and by asking participants whether they found it helpful. This replicates research by Ehntholt et al. (2005) although additional coping measures were also used.

(3) Moderators- whether children’s engagement in the group was related to their reported coping style ie: do children with more avoidant symptoms engage less in a group that involves thinking about the past? Does children’s engagement reflect how helpful they rate the group? Does it affect the impact of the group? This has implications how for groups will be run in future.
Method:

The project was approved by Camden and Islington Community Local Research Ethics Committee and North Central London Research Consortium (Appendix 1).

Design:

An experimental within-subjects pre-post design was used to investigate the relationship between self-report measures taken before and after treatment. As we wanted to both incorporate the groups into ordinary clinical practice and engage schools in the treatment process an uncontrolled cohort design was used. Such a design has been used in other preliminary treatment studies (O'Shea et al. (2000), Rosseau, Drapeau, Lacroix, Bagilishya and Heusch (2005), Saltzman et al. (2001).

Participants:

Participants in the study were refugee children referred by their GP, Psychiatrist or refugee/ youth workers within schools because of concern that they were troubled by difficult memories from their past. 33 participants for 5 groups were recruited from two sites: the Child and Family Team at the Traumatic Stress Clinic and a large inner city Secondary School. Ehntholt et al. (2005) recommend that groups be mixed gender as they found girls’ willingness to discuss their emotions encouraged the boys to do so as well. Participants were initially selected on the basis of cultural groupings to facilitate translation, sharing of experience, a sense of shared history and to decrease feelings of isolation as recommended by Ehnholt et al. (2005). Therefore groups were determined by the relative number of referrals. The two clinic-based groups involved 9 Albanian speakers: An adolescent group and a children's group. The greatest need in school was for children recently arrived from Iraq/ Kuwait and
two groups were run for these children. Demand from the school meant that the third school group was offered to children from different ethnic backgrounds (3 Arabic speakers and one Albanian, Farsi and Somali speaker). The clinic groups and one school group had an interpreter. Participants' English was such that an interpreter was not necessary in two of the school groups. As more than one language (Arabic and Kurdish) was spoken by group members within the school group different interpreters were used at different sessions to allow all a chance to express themselves fully.

**Figure 1. Overview of participants**

![Diagram showing participants distribution](image)

**Procedures:**

(i) **Recruitment:** The children's suitability for such a psycho-educational group was discussed with the referrer prior to recruitment and, when they were not the referring agent, participants' GPs were contacted by letter (Appendix 2) to facilitate monitoring and ensure communication between services. There were two routes (clinic and school) through which participants were recruited.
(a) Participants referred to the clinic-based groups were offered a group as one of the treatment options available at the clinic and those that expressed an interest were invited with their parents to a meeting to discuss the group and to explain what involvement in the research project would involve. In this instance all those referred were from Kosovo /Albania. Consent forms and information sheets (Appendices 3 & 4) were translated in these meetings and participants given the option of opting in, thinking some more or opting for individual treatment. Participants were invited to attend the group if they expressed an interest and once written consent was obtained from them and their primary caregiver.

(b) Participants for the school-based groups were identified by youth workers and refugee workers within a large inner city Secondary School. Refugee children who had arrived in the UK since 1998 from Iraq/ Kuwait were invited to a meeting to hear about the group and were given information sheets in English and Arabic for themselves and their carers (Appendices 3 & 4). This meeting and the information sheets explicitly stated that the groups were for children who had experienced distressing events and were currently distressed by their memories. This allowed children to opt into the group if they felt that it was relevant for them. Those who expressed an interest or returned consent forms were contacted again by the refugee worker or researcher. Once the student and their carer’s written consent was obtained participants were interviewed by the researcher. As with the clinic-based groups, the initial interview involved a description of the group, allowed participants to ask any questions but in this instance, as participants had not been formally referred, the SDQ and R-IES were used to assess the current level of distress and hence suitability for the group. By the third group, the school was keen that the group was offered to
children from a range of cultural backgrounds and workers referred students they thought would benefit. In this instance the researchers met students in pairs to explain the study and give consent forms. As before, those who expressed an interest or returned consent forms were contacted by the researcher.

Investigators were aware that approaching participants about the group might trigger unpleasant memories and distress so they allotted time around these meetings and ensured that all participants and their parents knew how to contact the clinic if necessary. An effort was made to ensure that participants and carers were fully informed about the use of exposure-based techniques as recommended by Ruggiero et al. (2001). Both parent and child information sheets (Appendices 3 & 4) explicitly stated that children may find talking about the past upsetting but that clinicians are trained to talk about these things in a way that helps children to feel safe. Assessment interviews (Appendix 5) prior to the group also highlighted this and assessed whether participants were supported enough to tolerate the work. In both instances it was assumed that children who were significantly distressed or isolated would not be suitable for a short term psycho-social-educational program. Therefore, participants had to have some form of on-going support structure at home, be able to attend school / college regularly and have relationships with some of their peers. Those that did not meet any of these criteria would have been taken on by either the team at Traumatic Stress Clinic or the local Child and Adolescent Mental Health Service for a longer term individual intervention, however, in this instance all of the children referred met these criteria. It is important to note that participants were informed that they could opt out of the group at any time and that if the clinicians running the groups or the referrers became concerned about the safety of individuals they would
be offered an alternative intervention and their GP informed. The facilitators' weekly monitoring and ratings of every child's engagement in the group formed part of the research protocol. The Child and Family Team had a Consultant Child and Adolescent Psychiatrist who was supportive of the project.

(ii) Facilitators:
Each group was run by two clinicians (a Clinical Psychologist and Trainee Clinical Psychologist) and an interpreter or member of teaching staff. Three clinicians were involved in different groups, although the Trainee Clinical Psychologist was involved in all groups. All clinicians were trained in the use of the manual and received fortnightly group supervision throughout the intervention. The school-based groups also utilised a member of staff with experience of running groups and an interest in continuing to run them on a longer term basis, if they proved effective. This ensured that the school was fully involved in the project, that it could continue longer term, facilitated channels of communication with the school system and allowed more children to participate. The interpreter working with the clinic groups also used their prior experience of working with children's groups and took an active role in reading through the manual and planning for sessions. One of the stated aims of the manual is to provide opportunities for liaison and discussion with 'front-line' workers. The manual was "designed to be delivered by people with a minimum of experience, but with supervision from someone with more mental health experience" (Smith et al., 2000) and it was hoped that the psycho-social-education package would enhance workers and children's understanding of the effects of traumatic experiences and techniques that may help them to recover.
(iii) Intervention:

The “Recovery Techniques” manual comprises five 2 hour sessions with homework exercises. Session one introduces the group, normalises reactions to the stresses of war, elicits reactions, reminders and traumatic events from participants and teaches them how to establish a ‘safe place’. The second session focuses on intrusive memories by teaching a series of imagery techniques to help participants change images that pop into their head, it also teaches techniques for auditory and olfactory intrusions, utilises dual attention techniques and then looks at bad dreams by drawing and practicing changing the ending. The third session is concerned with arousal symptoms and after highlighting bodily responses to stress, participants are taught breathing and muscle relaxation exercises. Coping self statements are introduced as a way to help feel relaxed and this session also covers sleep hygiene and activity scheduling for positive activities. The fourth session addresses avoidance through introducing graded exposure, grading traumatic reminders and encouraging participants to draw their own exposure ladders and carry out exposure in the week. The final session encourages participants to draw, write about and then talk to the rest of the group about their traumatic memories. While formal exposure is only introduced at this stage the whole protocol involves considerable implicit exposure to traumatic cues. Future plans are discussed and participants given the opportunity to feedback about their experiences of being part of the group.

While the clinic groups followed this format, the demands of the school timetable and school system meant that the maximum time available for sessions was 1 hour 15 mins. Therefore, the protocol was spread over seven weeks with shorter sessions, the first session was predominately taken getting all participants’ to the group and
writing future sessions in diaries and the last with discussing future plans and evaluating the group. Handouts were made to remind children of work that was done during the session and provided a space to fill in comments about the homework exercises. Each session opened with games and then reviewed the homework from the previous weeks. The manual recommends a concurrent carers’ group and letters were sent asking them to indicate if they were interested by ticking a box on form. This was scheduled for after the end of the group.

(iv) Measures:
Participants were asked to complete self-report measures prior to and after treatment (Appendices 6 & 7). These were administered as part of the first group and during the final session to ensure that the impact of treatment was uniformly assessed. Interpreters read items aloud to any participants with limited English and clinicians also monitored participants understanding and read items aloud where there were difficulties in order to minimise the effect of differences in reading skills. Participants were reminded that handwriting or spelling did not matter and that there were no right answers.

- Expectations/ Feedback: Prior to treatment all participants were asked what they hoped that the group would help with, whether they thought talking was helpful, what they did when upset and to indicate how much they thought that the group would help them. After the group participants were asked whether they felt like they wanted to join in with activities, if they wanted to think about the topics discussed, whether they thought about the group in the week, what they did when they felt upset and to rate how much they joined in and found the group process helpful.
• **The War Trauma Questionnaire (WTQ):** Participants were asked to complete a short questionnaire designed to elicit demographic information and to give an indication of the child’s level of traumatic exposure. The WTQ was developed by Macksound (1992) through listing the different types of trauma and assessing the experiences of 2220 Lebanese children. The series of yes/no responses have been adapted slightly to fit different contexts, for example, by UNICEF to use in Bosnia-Herzegovina but the overall score provides an indicator of the amount of trauma children have experienced. In this study 6 questions were used to gather basic demographic information and 30 questions asked specifically about exposure to various war events.

• **Revised Impact of Events Scale:** (R-IES; Smith, Perrin, Dyregrov, & Yule, 2003) is a widely used cross-culturally valid measure of the prevalence of the triad of PTSD symptoms. It is a 13 item self-report scale: 4 concerned with intrusion, 4 with avoidance and 5 with arousal. The revised version used in this study was devised as part of a psychosocial programme for children in Bosnia following the war. It is shown to be reliable and valid for children aged eight years and above. A combined intrusion and arousal score of 17 was found to reliably distinguish between children who did and did not reach diagnostic criteria for PTSD (Sclare, 1997).

• **The Kidcope:** (published within the Child Psychology Portfolio by Sclare, 1997) is an anglicised version of the coping scale devised by Spirito, Stark, & Williams (1988). It was selected as it is short, designed for children, has been shown to be reliable and was validated against existing coping measures (Spirito et al., 1988). It is perhaps the most widely used checklist for assessing children’s coping and has been used for both clinical and research
purposes. It was included here to extend understanding of the impact of the group on coping styles and to investigate the role of avoidant coping.

- **The Strength and Difficulties Questionnaire:** (SDQ, Goodman, 1997) is a widely used measure of general behavioural problems that has been validated cross-culturally and translated into a number of languages. It was used to indicate general functioning.

- **The Revised Children's Manifest Anxiety Scale:** (RCMAS, Reynolds & Richmond, 1997) is a 37 item questionnaire requiring a yes/no answer. It has an implicit lie scale and the reading level is aimed at an average 8 year old. It has been shown to be reliable and have cross-cultural validity. Mertin, Dibnah, Cosbie, & Bulkeley (2001) developed UK norms.

- **Birleson Depression Self Rating Scale for Children:** (DSRSC- Birleson, 1981) is a short scale designed to detect depression in children over 8 years. It consists of 18 statements and the option of saying it is never true, sometimes true or true most of the time. It was initially shown to be reliable and has been clinically validated (Birleson, Hudson, Buchanan, & Wolff, 1987) and used in research looking at the long term impact of trauma (Yule et al., 2000).

- **Engagement during the group:** was measured by a subjective clinician rated measure of group participation. This asks clinicians to rate on a scale from 0-5 participants' involvement in group exercises, discussions, response to others and therapy disruptive behaviours (Appendix 8). Both clinicians independently rated each participant every session before the group was discussed and the inter-rater reliability was calculated at the end of the groups by correlating clinician ratings on each item across the five sessions (Appendix 9). The correlation across items was 0.63 (p<.001). A combined
impression of participants’ engagement across all items was used to generate a mean engagement rating for each participant.

(v) Post intervention:
At the end of the group, clinicians considered whether each participant required further treatment and the available options and ways to access these services were discussed. Referrals were made either directly or via the GP where necessary. Those identified as requiring further treatment after the group were able to access the team at the Traumatic Stress Clinic and local services through the refugee outreach worker.

Results:
This section will be divided into five parts, the first will highlight the clinical characteristics of the sample, including level of traumatic exposure and baseline self-rating measures and the next three will address the research aims in turn. It will assess whether the school groups accessed those unable to get to clinic groups, whether children attended regularly and whether they report that they enjoyed and/or found the group helpful. The group’s effectiveness will then be investigated by assessing the group’s impact on self-report measures of symptoms. The next section will analyse whether children’s engagement or coping style moderated how helpful they rated the group and any change in self-reported symptoms. The final section will review the situation post-intervention.
Sample characteristics:

The mean age and age range of each group is shown in Figure 2. All of the participants lived with family members. The clinic groups contained all Albanian speakers but the school groups were divided between those who spoke Arabic (50%), Kurdish (39%) and a small number (11%) who spoke both. The third more ethnically diverse school group contained three Arabic speakers and one Farsi, one Albanian and one Somali speaker. Most of the participants were Muslim (94%) with one participant reporting they were Christian and one choosing not to answer. Only one participant in the school sample reported prior contact with services.

Figure 2. Participants’ ages and drop out rates

The 3 participants (1 male and 2 females) who choose not to complete treatment reported a similar level of traumatic events on the war trauma questionnaire (mean = 14.3) compared with the rest of the sample (mean = 14.1) and had a similar mean age (13.7 years compared to 12.4 years) to the rest of the sample. One of the Albanian
children's group missed the initial session and so no preliminary data were available on his functioning prior to the group. Therefore, before and after self-ratings are available for 29 participants, 88% of the original sample.

**Traumatic Exposure:**

Most of the participants had experienced traumatic events a number of years ago (mean 6.25 years, SD= 2.20) with two participants reporting they occurred one year ago and one participant that they occurred 10 years ago. A proportion of children (21%) were not able to estimate how long ago events had occurred. Participants had experienced a range of traumatic experiences. Table 1 and 2 indicate the percentage of children that answered affirmatively to items on the War Trauma Questionnaire (WTQ). An indication of the number of children who answered each item (n) has been included. 5.5% of WTQ items were not answered by the clinic sample and 6.4% by the school sample. It is unfortunately not possible to distinguish between those who did not answer because they did not know and those who chose not to answer because it was too difficult.
Table 1: Table to show participants’ exposure to trauma as measured by the War Trauma Questionnaire (WTQ)

<table>
<thead>
<tr>
<th>Question and Response</th>
<th>Clinic- Kosovan (n = 9)</th>
<th>School- Iraqi/Kuwaiti (n = 24)</th>
<th>Total (n = 33)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Proportion (%)</td>
<td>Proportion (%)</td>
<td>Proportion (%)</td>
</tr>
<tr>
<td><strong>SEPARATIONS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1- separated from both parents for long time</td>
<td>(9) 33%</td>
<td>(24) 4%</td>
<td>(33) 12%</td>
</tr>
<tr>
<td>2- separated from one parent for long time</td>
<td>(9) 56%</td>
<td>(24) 42%</td>
<td>(33) 46%</td>
</tr>
<tr>
<td>3- separated from brother/sister for long time</td>
<td>(9) 22%</td>
<td>(24) 13%</td>
<td>(33) 15%</td>
</tr>
<tr>
<td><strong>HOME and POSSESSIONS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4- home seriously damaged</td>
<td>(8) 63%</td>
<td>(23) 52%</td>
<td>(31) 55%</td>
</tr>
<tr>
<td>5- forced to leave their home</td>
<td>(9) 100%</td>
<td>(22) 46%</td>
<td>(31) 61%</td>
</tr>
<tr>
<td>6- things stolen from their home</td>
<td>(6) 50%</td>
<td>(23) 57%</td>
<td>(29) 55%</td>
</tr>
<tr>
<td>7- had things stolen while trying to leave</td>
<td>(5) 40%</td>
<td>(20) 45%</td>
<td>(25) 44%</td>
</tr>
<tr>
<td><strong>THREAT or HARM TO LOVED ONES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8- friend/family member missing during travel</td>
<td>(7) 100%</td>
<td>(24) 29%</td>
<td>(31) 45%</td>
</tr>
<tr>
<td>9- threats to hurt/ kill family/ close friend</td>
<td>(9) 78%</td>
<td>(23) 44%</td>
<td>(32) 53%</td>
</tr>
<tr>
<td>10- family/close friends hurt</td>
<td>(9) 89%</td>
<td>(22) 55%</td>
<td>(31) 65%</td>
</tr>
<tr>
<td>11- family member fought in the war</td>
<td>(9) 44%</td>
<td>(24) 33%</td>
<td>(33) 36%</td>
</tr>
<tr>
<td>12- family member taken to camp/prison</td>
<td>(7) 43%</td>
<td>(22) 23%</td>
<td>(29) 28%</td>
</tr>
<tr>
<td>13- a loved one was tortured</td>
<td>(8) 89%</td>
<td>(20) 40%</td>
<td>(28) 54%</td>
</tr>
<tr>
<td><strong>DIRECT CONTACT WITH DANGER</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14- so hungry thought would die</td>
<td>(8) 89%</td>
<td>(20) 35%</td>
<td>(28) 50%</td>
</tr>
<tr>
<td>15- so cold thought would die</td>
<td>(8) 89%</td>
<td>(18) 39%</td>
<td>(26) 50%</td>
</tr>
<tr>
<td>16- hit/ kicked</td>
<td>(9) 67%</td>
<td>(21) 43%</td>
<td>(30) 50%</td>
</tr>
<tr>
<td>17- arrested or taken prisoner</td>
<td>(8) 11%</td>
<td>(21) 5%</td>
<td>(29) 7%</td>
</tr>
</tbody>
</table>
Table 2: Table to show participants' exposure to trauma measured by the War Trauma Questionnaire (WTQ)

<table>
<thead>
<tr>
<th>Question and Response</th>
<th>Clinic- Kosovan (n = 9)</th>
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<th>Total (n = 33)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WITNESSING VIOLENCE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18- saw destruction of property: bridges/buildings</td>
<td>(9) 78%</td>
<td>(22) 73%</td>
<td>(31) 77%</td>
</tr>
<tr>
<td>19- saw shelling or bombing at close distance</td>
<td>(9) 100%</td>
<td>(22) 68%</td>
<td>(31) 77%</td>
</tr>
<tr>
<td>20- saw shooting</td>
<td>(9) 78%</td>
<td>(22) 59%</td>
<td>(31) 65%</td>
</tr>
<tr>
<td>21- saw looting/ vandalism</td>
<td>(9) 89%</td>
<td>(24) 58%</td>
<td>(33) 67%</td>
</tr>
<tr>
<td>22- saw someone severely injured</td>
<td>(9) 89%</td>
<td>(24) 67%</td>
<td>(33) 73%</td>
</tr>
<tr>
<td>23- saw dead bodies</td>
<td>(9) 78%</td>
<td>(23) 57%</td>
<td>(32) 63%</td>
</tr>
<tr>
<td>24- saw anyone killed</td>
<td>(9) 33%</td>
<td>(22) 46%</td>
<td>(31) 42%</td>
</tr>
<tr>
<td>25- touch/ carry someone wounded/ killed</td>
<td>(9) 33%</td>
<td>(22) 18%</td>
<td>(31) 23%</td>
</tr>
<tr>
<td>26- witnessed someone being taken prisoner</td>
<td>(8) 50%</td>
<td>(22) 32%</td>
<td>(30) 37%</td>
</tr>
<tr>
<td><strong>PHYSICAL THREAT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27- shot at or seriously hurt</td>
<td>(9) 22%</td>
<td>(22) 14%</td>
<td>(31) 16%</td>
</tr>
<tr>
<td>28- soldiers/men with guns came to their house</td>
<td>(9) 89%</td>
<td>(23) 44%</td>
<td>(32) 56%</td>
</tr>
<tr>
<td>29- time strongly believed would be hurt/killed</td>
<td>(9) 89%</td>
<td>(23) 61%</td>
<td>(32) 69%</td>
</tr>
<tr>
<td><strong>LOSSES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30- father killed</td>
<td>(7*) 11%</td>
<td>(24) 13%</td>
<td>(31*) 13%</td>
</tr>
<tr>
<td>31- mother killed</td>
<td>(9) 0%</td>
<td>(24) 4%</td>
<td>(33) 3%</td>
</tr>
<tr>
<td>32- brother/sister killed</td>
<td>(9) 0%</td>
<td>(24) 0%</td>
<td>(33) 0%</td>
</tr>
<tr>
<td>33- a close member family killed</td>
<td>(7*) 44%</td>
<td>(24) 50%</td>
<td>(31*) 52%</td>
</tr>
<tr>
<td>34- close friend killed</td>
<td>(7*) 44%</td>
<td>(23) 57%</td>
<td>(30*) 57%</td>
</tr>
<tr>
<td>35- mean time since experiences happened</td>
<td>(9) 5.7 yrs</td>
<td>(17) 6.7 yrs</td>
<td>(26) 6.4 yrs</td>
</tr>
<tr>
<td>(yrs) standard deviation (SD)</td>
<td>(SD=0.7)</td>
<td>(SD=2.6)</td>
<td>(SD=2.2)</td>
</tr>
<tr>
<td><strong>range:</strong></td>
<td>(4-6)</td>
<td>(1-10)</td>
<td>(1-10)</td>
</tr>
<tr>
<td><strong>Total number of yes responses- mean</strong></td>
<td>(9) 19</td>
<td>(24) 12</td>
<td>(33) 14</td>
</tr>
<tr>
<td>standard deviation (SD)</td>
<td>(SD=4.9)</td>
<td>(SD=5.7)</td>
<td>(SD=6.25)</td>
</tr>
<tr>
<td><strong>range:</strong></td>
<td>(11-25)</td>
<td>(2-21)</td>
<td>(2-25)</td>
</tr>
</tbody>
</table>

* 2 participants' reported father & 2 friend 'missing' following war and don't know if killed
The high level of traumatic exposure in both samples was striking. Item 29 reveals that overall 69% of children remembered a time when they strongly believed that they would be hurt or killed. The clinic group reported a greater number of traumatic experiences (mean of 19 verses 12.5). This was particularly the case for direct contact with danger and threat / harm to loved ones. All of the clinic sample (100%) reported being forced to leave their home (item 5), missing a friend or family member as they left (item 8), and seeing shelling or bombing at close distance (item 19) and a further seven items were endorsed by 8 out of 9 participants (89%). The level of trauma exposure was very high among the school sample too, in particular on items relating to witnessing violence; 73% reported seeing property (buildings/bridges) destroyed (item 18), 68% reporting seeing bombing or shelling from close distance (item 19), and 68% seeing someone severely injured (item 22). There was a wider range of total trauma exposure in the school group (2- 21). Six participants were primarily upset by their parents’ accounts of what had happened to them or to relatives, fears about missing relatives and the safety of family members in Iraq. They had intrusive images of things they had seen on television, the internet or of telephone conversations with frightened family members in Iraq who had no water or electricity supply during the bombing. However a proportion had experienced multiple trauma and loss, including one participant who had lost both parents. This was not someone who had had any prior contact with services.

**Baseline self-report measures:**

The level of distress among children in both samples was also striking. Table 3 shows both school and clinic groups’ scores on the sub-scales of the Revised Impact of Events Scale (R-IES). Data from time 1 for Ehntholt et al.’s (2005) UK school
refugee sample and a sample without PTSD* are included for comparison. While this measure is not intended to be diagnostic, using a combined intrusion and arousal score of 17 as a threshold for identifying children who may reach DSM criteria (as suggested by Sclare, 1997) suggests that 29 (91%) participants (100% clinic and 88% school) were symptomatic.

Table 3: Table to show baseline scores on the Revised Impact of Events Scale:

<table>
<thead>
<tr>
<th>Sub-scale</th>
<th>Clinic (n= 8)</th>
<th>School (n = 24)</th>
<th>Total (n= 32)</th>
<th>Ehntholt (n=15)</th>
<th>No PTSD* (n=131)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean IES-15 (SD)</td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrusion subscale</td>
<td>15.1 (2.7)</td>
<td>9.6 (4.2)</td>
<td>11.0 (4.5)</td>
<td>13.5 (3.3)</td>
<td>5.7 (6.5)</td>
</tr>
<tr>
<td></td>
<td>10 - 18</td>
<td>2-18</td>
<td>2-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance subscale</td>
<td>16.3 (5.5)</td>
<td>15.2 (4.5)</td>
<td>15.4 (4.7)</td>
<td>14.6 (3.4)</td>
<td>8.3 (8.0)</td>
</tr>
<tr>
<td></td>
<td>5-20</td>
<td>4-20</td>
<td>4-20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arousal subscale</td>
<td>16.4 (6.1)</td>
<td>10.7 (5.8)</td>
<td>12.1 (6.3)</td>
<td>11.8 (5.7)</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>3 - 21</td>
<td>0-21</td>
<td>0-21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrusions +</td>
<td>31.4 (5.8)</td>
<td>24.8 (7.1)</td>
<td>26.4 (7.3)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>avoidance</td>
<td>21 - 38</td>
<td>6-34</td>
<td>6-38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total- all scales</td>
<td>47.8 (10.0)</td>
<td>35.5 (10.7)</td>
<td>38.5 (11.7)</td>
<td>39.8 (8.4)</td>
<td>14.0 (12.9)</td>
</tr>
<tr>
<td></td>
<td>30 -59</td>
<td>14-53</td>
<td>14-59</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*IES-15 scores from 131 children presenting to UK A&E Dept who did not have diagnosis of PTSD according to diagnostic interviews (Stallard, Velleman, & Baldwin, 1999).

There was a correlation between overall level of trauma exposure and the arousal sub-scale of the R-IES (r=0.48, p=0.006) but not with the level of intrusions (r=0.15, p= 0.400) or avoidance (r= -0.25, p=0.175). Participants’ scores on the other
screening measures also revealed elevated levels of distress relative to the norms for these measures (Table 4).

Table 4: Table to show baseline self-reported SDQ, anxiety and depression:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Clinic (n=8)</th>
<th>School (n=24)</th>
<th>Total (n = 32)</th>
<th>Norms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>Range</td>
<td>Range</td>
<td></td>
</tr>
<tr>
<td><strong>SDQ</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>4.9 (1.9)</td>
<td>3.6 (2.0)</td>
<td>3.9 (2.0)</td>
<td>3.8 (2.2)</td>
</tr>
<tr>
<td></td>
<td>2-7</td>
<td>0-7</td>
<td>0-7</td>
<td></td>
</tr>
<tr>
<td>Emotional problems</td>
<td>5.6 (3.0)</td>
<td>4.4 (2.1)</td>
<td>4.7 (2.3)</td>
<td>2.8 (2.1)</td>
</tr>
<tr>
<td></td>
<td>2-10</td>
<td>0-7</td>
<td>0-10</td>
<td></td>
</tr>
<tr>
<td>Peer Problems</td>
<td>3.0 (1.5)</td>
<td>2.7 (1.6)</td>
<td>2.8 (1.6)</td>
<td>1.5 (1.4)</td>
</tr>
<tr>
<td></td>
<td>1-5</td>
<td>0-7</td>
<td>0-6</td>
<td></td>
</tr>
<tr>
<td>Conduct difficulties</td>
<td>3.5 (1.9)</td>
<td>2.6 (2.0)</td>
<td>2.8 (2.0)</td>
<td>2.2 (1.7)</td>
</tr>
<tr>
<td></td>
<td>1-7</td>
<td>0-7</td>
<td>0-7</td>
<td></td>
</tr>
<tr>
<td>Total Problem score</td>
<td>17.0 (5.6)</td>
<td>13.5 (5.7)</td>
<td>14.4 (5.8)</td>
<td>10.3 (5.2)</td>
</tr>
<tr>
<td></td>
<td>8-24</td>
<td>2-20</td>
<td>2-24</td>
<td></td>
</tr>
<tr>
<td>Pro-social Scale*</td>
<td>7.1* (21.1)</td>
<td>8.0* (1.5)</td>
<td>7.8* (1.7)</td>
<td>8.0* (1.7)</td>
</tr>
<tr>
<td></td>
<td>4-10</td>
<td>5-10</td>
<td>4-10</td>
<td></td>
</tr>
<tr>
<td>RCMAS (n=30)</td>
<td>14.9 (6.7)</td>
<td>17.8 (6.8)</td>
<td>17 (7.0)</td>
<td>10.4 (5.27)</td>
</tr>
<tr>
<td></td>
<td>6-25</td>
<td>(n=22) 4-28</td>
<td>(n=30) 4-28</td>
<td></td>
</tr>
<tr>
<td>Birleson DSRSC</td>
<td>14.3 (5.9)</td>
<td>10.9 (5.3)</td>
<td>11 (5.0)</td>
<td>8.5 (4.4)</td>
</tr>
<tr>
<td></td>
<td>8-23</td>
<td>1-26</td>
<td>1-23</td>
<td></td>
</tr>
</tbody>
</table>

*A high score represents good functioning

a Based on norms for 4,228 11-15 yr British children from Meltzer, Gatward Goodman & Ford (2000).

b Based on norms for 12 year old British children in Mertin, Dibnah, Cosbie, & Bulkeley (2001).

c Based on norms for 250 children (Yule, Ollendick, & Blagg, 1992, cited in Sclare, 1997).

83
Participants reported more emotional, peer and overall difficulties on subtests of the SDQ, although mean self-rated hyperactivity, conduct difficulties and pro-social behaviour were similar to a normal sample. Mean self-reported depression on the Birleson DSRSC was higher than norms and 3 participants (9%) were above the threshold of 17 used to indicate depression. Although two participants’ RCMAS could not be reliably scored, rates of self-reported anxiety are markedly higher than reported by a normal sample and were actually higher within the school than clinic sample. Using a cut-off of 19 to indicate children with clinically significant distress identifies almost half of the sample (47%), 29% of clinic and 55% of school participants.

Pragmatics:

One aim was to see if the school groups accessed those not able to attend clinic groups and to assess whether children attended and if they found the groups helpful.

(a) Access- Only one of the children who attended the school groups reported any prior contact with mental health services. It was necessary for the Arabic speaking refugee worker to telephone a number of carers whose children expressed an interest in attending the groups but whose carers did not want them to see a Psychologist as they were ‘not crazy’. Discussion about the purpose of the groups and the fact they were being offered in school did allow these children to participate.

(b) Attendance- Only three participants decided to stop attending the group. One left due to a falling out with another group member, one reported that her father wanted her to stop attending and the eldest adolescent in the clinic group had repeatedly struggled to engage with help in the past. All three reported that they tried not to
think or talk about past events ‘often’ and their mean score on the avoidance scale of the IES was 18.3 (SD= 2.89), with two scoring at ceiling (20), compared to the overall sample mean of 15.4 (SD= 4.7). Of those who wanted to keep attending, the adolescent clinic group had the most fluctuating attendance with an overall attendance rate of 73%, perhaps not surprisingly as they had to travel to the clinic at the end of college. The children’s clinic group had 88% attendance, excluding the participant who missed the initial sessions gives a figure of 95% attendance. The school groups had similarly high attendance rates (92.5%). No carers responded to the letter about the carers’ group and so unfortunately no group was run.

(c) Reported helpfulness- 77% of participants reported that the group had helped them ‘a lot’ or ‘very much’ with only one participant saying that it had not helped. 73% reported that they felt like they wanted to join in with the group ‘a lot’ or ‘very much’, with a further 20% saying they wanted to ‘sometimes’ and only 2 participants (8%) reporting that they did ‘mainly not’ want to. Half (50%) reported thinking about the group ‘a lot’ during the week between sessions and a further 37% said they thought about it ‘sometimes’. There was a shift in participants’ response to a forced choice question about what they did when they remembered their frightening experiences. Fewer reported crying (6% before and none after) or telling no one (27% to 12%) after the group. Instead more participants’ (67% compared to 24%) indicated that they were managing their thoughts themselves. This question was followed by asking whether what they do when they remember helps them to feel better (Figure 3). This revealed a highly significant (t(26)= -4.60, p<.001) difference in participants’ sense of their ability to make themselves feel better with no participants after the group reporting ‘not at all’ and 70% reporting ‘a lot’ or ‘very
much’. The degrees of freedom are lower than the sample size as while all participants completed the questionnaires not all responded to every item, some wrote nothing or a comment instead.

Figure 3: Graph to show participants response to “Does what you do when you remember make you feel better?”

BEFORE:  

![Graph BEFORE:]

AFTER:

![Graph AFTER:]

There was also significant shift (t(27)= -2.22, p=0.035) in participants’ perception of whether talking will make them feel better or worse. 37% before the group reported that talking would make them feel worse compared with 17% afterwards and more participants (63% compared to 54%) reported afterwards that talking would make them feel ‘better’ or ‘much better’.

Effectiveness:

The group’s effectiveness was measured by comparing measures of children’s self-report symptoms during the first and last sessions (Table 5). All variables were screened for skewedness or kurtosis prior to this analysis.
Table 5: Mean scores for all participants (n= 29) on measures at Time 1 and Time 2:

<table>
<thead>
<tr>
<th>Scale</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Significance</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD) (range)</td>
<td>Mean (SD) (range)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>R- IES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrusion subscale</td>
<td>11.21 (4.59) 2-18</td>
<td>9.14 (4.16) 0-18</td>
<td>t(28)= 2.23, p=.034*</td>
<td>d=.41</td>
</tr>
<tr>
<td>Avoidance subscale</td>
<td>15.14 (4.80) 4-20</td>
<td>13.03 (5.75) 0-20</td>
<td>t(28)= 1.84, p=.077</td>
<td>d=.34</td>
</tr>
<tr>
<td>Arousal subscale</td>
<td>12.41 (6.34) 0-21</td>
<td>11.72 (4.83) 3-21</td>
<td>t(28)= 0.62, p=.541</td>
<td>d=.12</td>
</tr>
<tr>
<td>Intrusion+avoidance</td>
<td>26.34 (7.51) 6-38</td>
<td>22.17 (8.55) 0-34</td>
<td>t(28)= 2.65, p=.013*</td>
<td>d=.49</td>
</tr>
<tr>
<td>Total- all scales</td>
<td>38.76 (11.83) 14-59</td>
<td>33.55 (11.20) 6-55</td>
<td>t(28)= 2.20, p=.036*</td>
<td>d=.41</td>
</tr>
<tr>
<td><strong>SDQ</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>3.97 (2.05) 0-7</td>
<td>4.24 (2.10) 0-8</td>
<td>t (28)=0.71, p=.486</td>
<td>d=.13</td>
</tr>
<tr>
<td>Emotional problems</td>
<td>4.69 (2.38) 0-10</td>
<td>4.59 (2.47) 1-9</td>
<td>t (28)=0.21, p=.837</td>
<td>d=.04</td>
</tr>
<tr>
<td>Peer Problems</td>
<td>2.72 (1.58) 0-6</td>
<td>3.24 (1.77) 0-6</td>
<td>t (28)=1.40, p=.188</td>
<td>d=.25</td>
</tr>
<tr>
<td>Conduct difficulties</td>
<td>2.72 (2.02) 0-7</td>
<td>3.31 (1.80) 0-7</td>
<td>t (28)=-1.36, p=.185</td>
<td>d=.25</td>
</tr>
<tr>
<td>Total Problem score</td>
<td>14.28 (6.00) 2-24</td>
<td>15.45 (5.27) 7-24</td>
<td>t (28)=-1.11, p=.278</td>
<td>d=.21</td>
</tr>
<tr>
<td>Pro-social scale*</td>
<td>7.97* (1.59) 4-10</td>
<td>7.28* (1.96) 3-10</td>
<td>t (28)=1.42, p=.167</td>
<td>d=.26</td>
</tr>
<tr>
<td><strong>RCMAS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16.85 (6.44) 4-28</td>
<td>15.81 (7.26) 1-27</td>
<td>t(26)= 0.95, p=.352</td>
<td>d=.18</td>
</tr>
<tr>
<td><strong>Birleson DSRSC</strong></td>
<td>11.90 (5.63) 1-26</td>
<td>12.93 (5.74) 1-27</td>
<td>t(28)= -0.90, p=.381</td>
<td>d=.16</td>
</tr>
</tbody>
</table>

* A high score represents good functioning

Table 5 shows a trend for mean R-IES scores to be slightly lower at time 2, with a significant difference between the level of self-reported intrusions, the combined intrusions and avoidance subscales (which together make up the measure of 'caseness'), and total across all scales before and after the group. 80% (compared to 91%) of the sample (100% clinic & 73% school) was above the threshold commonly seen as indicating PTSD. Table 5 shows that there was no significant difference between participants' self-report on the SDQ, RCMAS anxiety or Birleson DSRSC.
Children’s self-reported methods of coping (as measured by the Kidcope) before and after the group are shown in Table 6. Some coping strategies were more widely used and most were rated by participants as more efficacious after the group.

Table 6: Table to show self-reported coping before and after the group on the Kidcope

<table>
<thead>
<tr>
<th>Coping Strategy</th>
<th>Frequency- mean (std dev)</th>
<th>Efficacy- mean (std dev)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before</td>
<td>After</td>
</tr>
<tr>
<td>Distraction</td>
<td>1.82 (0.86)</td>
<td>1.86 (0.97)</td>
</tr>
<tr>
<td>Social withdrawal</td>
<td>1.52 (1.19)</td>
<td>1.37 (1.08)</td>
</tr>
<tr>
<td>Cognitive restructuring</td>
<td>1.57 (0.84)</td>
<td>2.18 (0.86)**</td>
</tr>
<tr>
<td>Self-criticism</td>
<td>0.96 (0.99)</td>
<td>1.04 (0.96)</td>
</tr>
<tr>
<td>Blaming others</td>
<td>1.19 (1.30)</td>
<td>1.44 (1.12)</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>1.04 (0.96)</td>
<td>1.46 (0.92)</td>
</tr>
<tr>
<td>Emotional regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shout/ scream/ hit</td>
<td>0.86 (0.93)</td>
<td>1.18 (1.12)</td>
</tr>
<tr>
<td>something</td>
<td>1.70 (1.03)</td>
<td>1.67 (1.11)</td>
</tr>
<tr>
<td>Go for walk/ relax/ calm down</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wishful thinking</td>
<td>2.27 (1.00)</td>
<td>2.00 (1.02)</td>
</tr>
<tr>
<td>Social support</td>
<td>1.22 (1.05)</td>
<td>1.63 (1.18)</td>
</tr>
<tr>
<td>Resignation</td>
<td>1.63 (1.08)</td>
<td>1.78 (0.93)</td>
</tr>
</tbody>
</table>

♦significant difference (p<.05) **significant (p<.01) *** significant (p<.001)

Participants used cognitive restructuring more frequently (t(27)=-3.23, p=.003) and effectively (t(25)=-4.3, p<.001) after the group and problem solving more effectively (t(26)=-3.5, p=.001) after the group. The frequency with which participants used distraction (t(27)=-1.67, p=.869) and resignation (t(26)=-0.724, p=.476) did not change but both were rated as significantly more effective.
(distraction $t(25) = -2.83, p = .009$, & resignation $t(24) = -2.83, p = .009$) after the group. Wishful thinking was used slightly but not significantly less ($t(25) = .94, p = .355$) after the group but was rated as significantly ($t(24) = -3.17, p = .004$) more helpful. The increased rating of the efficacy of using social support was approaching significance ($t (26) = -1.86, p = .074$). As above while all participants completed the Kidcope some participants did not rate every item, one left his blank, writing that he had no difficult memories to have to cope with anymore.

**Moderators of treatment:**

The third aim was to investigate whether children’s engagement in the group moderated how helpful children rated the group and any change in self-reported symptoms or coping style. Mean engagement score (mean of two clinicians’ ratings on questionnaire- Appendices 8 & 9) was correlated ($r = 0.48, p = 0.007$) with children’s impression of their engagement (measured by asking them afterwards how much they thought they had joined in with the group). It was also correlated with their prior expectations about how much the group would help them ($r = 0.40, p = 0.030$) and retrospective rating of whether they wanted to talk about the things that the group talked about ($r = 0.49, p = 0.005$). It correlated highly with their own rating of how much the group had helped them ($r = 0.60, p < 0.001$). Clinicians’ ratings of children’s engagement was not, however, correlated with self-reported avoidance on the subscale of the R-IES ($r = -0.131, p = 0.48$) or measures from the Kidcope that may reflect an avoidant coping style (distraction, $r = 0.15, p = 0.41$; social withdrawal, $r = 0.03, p = 0.86$). These measures were also not correlated with each other.
In order to investigate whether level of engagement moderated the change in symptom levels, it was necessary to first investigate the distribution of the variable and whether any demographic factors themselves modified the effectiveness of the group. There were two outliers in terms of engagement, both individuals whose ongoing behavioural difficulties made it hard to assess whether disengagement was related to the content of the group or generalised difficulties (Appendix 10) and so these were excluded in order to ensure that analysis actually reflected engagement in the group process. Repeated measures ANOVA revealed that gender, age and whether participants attended groups at the school or clinic did not significantly affect the outcome of treatment on any of the self-report measures (Appendix 11). A repeated measures ANOVA with mean engagement as a covariate suggested that contrary to expectations there was no significant interaction between engagement rating and the change in self reported symptoms at time 1 and time 2 (Appendix 11).

The interaction between coping style and impact of the group was calculated by generating the mean of two Kidcope scales reflecting avoidant coping (distraction and social withdrawal) and investigating whether this was related to change in symptoms on R-IES. There was a significant interaction between avoidant coping style and the change in R-IES intrusion (Wilks’ Lambda = 0.595, F(1,26)= 17.695, p< 0.001), arousal (Wilks’ Lambda = 0.856, F(1,26)= 4.370, p= 0.046) and total problem score (Wilks’ Lambda = 0.838, F(1,26)= 5.034, p= 0.034). There was no interaction between avoidant coping style and the change in avoidant symptoms on the R-IES (Wilks’ Lambda = 0.999, F(1,26)= 4.370, p= 0.863).
The regression equation from these analyses was used to estimate the predicted change in intrusion and arousal symptoms during the group for participants with high and low avoidant coping styles (calculated by taking scores one standard deviation above and below the mean). The differing outcomes are demonstrated in Figure 4. Participants who reported a higher frequency of use of avoidant coping on the Kidcope showed a significantly greater reduction in symptoms during the group than those who tended to use a less avoidant coping style.

Figure 4: Graphs to show predicted change in mean scores on intrusion and arousal sub-scales of R-IES for participants with high and low avoidant coping strategies

Post intervention:

The group intervention within the clinic has formed part of ongoing work with a number of participants, some of whom have been referred to local services and others continue to be seen by the team. The school is keen for groups to keep running there and recruitment is under way for the next group, aimed at an older year group and in September refugee children from the new intake will be screened to see if any
would benefit from the group. Two individuals who clinicians felt continued to have significant difficulties at the end of the group continue to be monitored by one of the clinicians. A 3 month follow-up is intended for all participants.

Discussion:

Sample characteristics:

Using the War Trauma Questionnaire (WTQ) with this sample of 33 refugee children attending a clinic and Secondary school in London reveals experience of a multitude of stressors, each of which alone would be considered traumatic in a peaceful society. Perhaps unsurprisingly as they had presented to a specialist trauma service, the clinic sample had experienced a greater mean number of traumatic experiences. These children had experienced multiple trauma and loss with a mean of 19 endorsed WTQ items. Two members remained unsure of whether their father had been killed and others were unsure about whether a close friend had. Hodes (2002) suggests that children whose relatives disappear and who cannot grieve or participate in death rituals may be more distressed than those who know relatives have been killed. Looking in more detail at these 4 participants confirms high level of distress (R-IES mean total problem score = 52.75, SD= 8.1), the mean avoidance sub-scale score was 0.5 from the ceiling of the scale, and these participants also showed high levels of anxiety (RCMAS mean 17; SD=8.3) and depression (DSRSC mean 16; SD= 7.17.)

The range and extent of trauma exposure (mean WTQ total of 12, SD= 5.7) among participants in the school sample was consistent with Ehntholt et al.'s (2005) sample (mean WTQ total of 17.5, SD=6.6) but a surprise to school staff. Only one had had any prior contact with services (and this participant had a WTQ total of 12, the
sample mean). In both cases school workers had referred students that had experienced trauma to the group and so we would expect greater exposure than in a random sample, however, that students had experienced multiple traumatic experiences highlights the utility of providing interventions in this context. 88% of the school sample were displaced from Iraq or Kuwait and other samples of Kuwaiti (Al-Eissa, 1995) and Iraqi children (Dyregrov et al., 2002) revealed high levels of exposure to the same war experiences (fighting, destruction of property, physical assault and killing) that were remembered by a high proportion of this sample.

Participants' self-report on the R-IES revealed high levels of distress that was also comparable with Ehntholt et al.'s (2005) UK school sample, but markedly different from age matched norms. Given the level of exposure and referral route to the groups, it is not surprising that the clinic sample had a higher level of symptomatology than the school sample, but considering the comparison is between a specialist trauma service and a Secondary school population with no input from services the difference is smaller than might have been expected. Using the R-IES threshold recommended by Sclare (1997) suggests that 91% of the participants (100% clinic, 88% school) are likely to be suffering from PTSD. This supports the recruitment and referral systems used in both settings but also reveals high numbers of children experiencing considerable distress. This is comparable to other studies (Ehntholt et al. (2005) found 92.3% and Dyregrov et al. (2002) 80% of their sample scored above 17 on R-IES).

It was interesting that only the arousal subscale of the R-IES correlated with the mean level of trauma exposure, whereas Ehntholt et al. (2005) found all the other
subscales apart from arousal correlated with mean trauma exposure. The complex interplay of factors that influence the likelihood of individuals experiencing symptoms has been repeatedly highlighted (Fletcher, 1996; Meiser-Stedman, 2002) and this finding again highlights the complexity of the relationship between exposure to trauma and PTSD symptoms. Certainly anecdotally it was probably the high levels of distress and persistence among participants in this sample with lower levels of trauma exposure that meant they were recruited into the groups alongside those with greater trauma exposure. They reported intrusive images of stories of their past, fears about family members or television/internet scenes and a few of these repeatedly came to find clinicians to ask if they could come to the group. The correlation may also have been reduced if participants found it hard to endorse particularly distressing items. When completing the questionnaire some participants did report that they would rather not answer certain items, although the fact that very distressing events, including being arrested and having parents killed or missing, were reported suggests this is unlikely to have had a significant impact.

Al-Eissa’s (1995) study of displaced Kuwaiti children found that children’s dysfunctional social and emotional behaviour was a function of their experience of aggression, age and sex. Participants’ scores on the SDQ in this sample were slightly elevated for both emotional and peer problems but did not differ greatly from a normal sample in terms of self-rated hyperactivity, conduct problems or pro-social behaviour. There has been much discussion about the fact that the resilience of refugee children is often overlooked in research and clinical practice (Summerfield, 2000; Timimi, 1998) and this is perhaps one clear example of the resilience of participants in both clinic and school samples despite high levels of trauma exposure.
Sack et al. (1999) found no association between war trauma and social functioning despite persistent PTSD symptoms in their 12 year follow up study of Khmer youths and these SDQ scores, particularly among the school sample, may reflect a similar adaptation to social demands in spite of high levels of internal distress.

It would have been interesting to have teacher ratings on the SDQ to compare with self ratings, however, the fact that within the school setting some teachers expressed surprise that certain participants needed to attend a group about trauma suggests the extent of children’s distress was often unrecognised. Children with internalising difficulties are typically overlooked relative to those with conduct or externalising difficulties in school settings (Hodes, 2000) and one probable reason that participants’ distress was unrecognised was that in a large inner city Secondary school conduct difficulties and hyperactivity (closer to above norms) are more easily recognisable than emotional problems, intrusions, anxiety or low mood.

The higher rates of depression on Birleson DSRSC relative to a normal sample is consistent with observed co-morbidity between PTSD symptoms and depression (Fletcher, 1996; Sack et al., 1997; Thabet, Abed, & Vostanis, 2004). Fewer (9%) were above the normal range than the 61.5% within Ehntholt et al.’s (2005) sample. However, elevated scores are notable as Birleson et al. (1987) suggest that children have difficulty reporting depression and tend to under-report on scales like the DSRSC. The RCMAS however, identified nearly half of participants (47%) as being above the cut-off indicative of anxiety and proportionally more of the school sample. This may reflect the setting as, as alluded to above, the school setting was chaotic, noisy, socially demanding and sometimes violent.
Pragmatics:

Teachers' surprise that certain participants were attending the group and that only one participant within the school groups had prior contact with services suggests the groups did access children who would not traditionally attend services. The high levels of trauma exposure and distress among this group indicate both the need for input and that youth workers can identify children with internalising difficulties and refer appropriately in this context (O'Shea et al., 2000). The existing relationships and cultural insights of these professionals were crucial in breaking down some of the barriers to accessing services (Hodes, 2000). In particular having an Arabic speaking worker able to articulate parental concerns to clinicians and to challenge carers' assumptions that referral to a Psychologist meant their child was 'crazy' enabled children whose carers would probably have avoided services to attend. This dialogue often resulted in carers expressing concerns about their children's distress, nightmares or difficulties in school and actually requesting help. Many carers also expressed concern about children missing lessons or being stigmatised by peers or teachers and the fact that the groups were being offered in schools with the Head teacher's support helped this.

Studies have shown high attrition from psychological services, Startup (1994) estimates 33% of adults drop out and March et al. (1998) found 18% withdrew from their CBT for trauma group. We know that attendance can be harder for refugee families (Hodes, 2000) and so it seems that the retention of all but 3 participants (9%) is a good indicator that participants found something about the groups useful. Although 3 is too small a number to extrapolate from and 2 participants stopped attending for reasons apparently unrelated to the group, the higher than average
levels of avoidance among these 3 participants suggests that obstacles to attendance may have been less readily overcome. Certainly other participants involved in disagreements during the course of the groups kept attending and other participants also managed to persuade carers to let them stay after school.

Attendance rates across the groups were also fairly high. Although participants in school groups had the advantage of not having to travel to sessions and of missing lessons, they did have to contend with classmates knowing that they were going to a group and agree to stay for 15 minutes after school. Carers were largely responsible for bringing participants to the clinic children’s group but they did seem to enjoy coming, requesting more sessions and a reunion at the end. The attendance figure given does not reflect one session re-scheduled to meet carers’ needs. The fluctuating attendance in the adolescent group (73%) is not surprising given the known difficulties of engaging this age group (Saltzman et al., 2001) and the fact that participants had to make their own way to the clinic for a two hour group at the end of a day at college.

The lack of interest from carers in a group explaining what their children had been learning reflected Ehntholt et al.’s (2005) experience and is an area that needs addressing more fully in future studies. We know that the family context is vital to children’s recovery from traumatic experiences (eg: Farwell, 2001; Scheeringa & Zeanah, 2001) and encouraging participants to discuss their nightmares, memories and distress with their carers was an important part of the coping strategies taught in the manual (Smith et al., 2000). A carers’ group would have allowed participants to practice this and made the process more salient. It may also have meant that clinicians had more confidence in emphasising the utility of this coping strategy, as
knowing little about the home situation of group participants may have diluted the weight given to it. We were particularly keen to engage parents within the school groups as the Iraqi children in Dyregrov et al.'s (2002) study had found it particularly hard to talk to their carers about the past.

The majority of participants (77%) reported that the group had helped them a lot or very much, with only one saying it had not. While acknowledging responses have an element of social desirability, participants were encouraged to be honest because their answers would be used to plan the next group and were left alone to write down “what they really thought”. Other questions about the group process also suggested that the majority of participants’ wanted to join in a lot (73%) or sometimes (20%) and 87% reported that they thought about the group a lot or sometimes in the week between sessions. Participants’ were also able to react differently when they were reminded of the past and the highly significant difference between participants’ sense of their ability to make themselves feel better before and after the group suggests that from participants point of view the group had been helpful.

Effectiveness:
There was a trend for R-IES self-reported symptoms to be lower across sub-scales at time 2, with a significant difference between the total level of self-reported symptoms, and significant changes in level of intrusions and the combined intrusions and avoidance subscales (which together make up measure of ‘caseness’). The change in avoidant symptoms is also approaching significance. This replication of Ehntholt et al.’s (2005) findings is important as it shows that the manual can be effectively used in different service contexts and outside the team that designed it. In
both studies it was the arousal sub-scale that showed the least shift and it may be that additional techniques could be introduced to address this.

Despite the improvement on R-IES self-report, the majority of children in both samples continue to experience high levels of intrusions and distress that suggest they are likely to meet diagnostic criteria for PTSD. Ehntholt et al. (2005) reported mean R-IES Total of 33.8 and an intrusion sub-score of 10.5 at time 2 and the means were almost identical in this sample (total mean = 33.6; intrusion = 9.1). Such findings are replicated in other studies even where marked significant differences were found (eg: March et al. (1998) found 43% and Goenjian et al. (1997) that 28% were still symptomatic). We know that refugee children from war situations are likely to have greater baseline symptoms than following single incident stressors (Smith et al., 2002) and that in the UK context these children may also be facing additional stressors in terms of immigration (Yule, 2000), language difficulties and cultural bereavement (Barenbaum et al., 2004), social isolation and disadvantage (Howard & Hodes, 2000) and the impact of trauma and displacement on familial interactions (Farwell, 2001). The short term psycho-social-educational package is not designed to be a treatment for PTSD and would not be expected to have a substantial impact on children whose families and lives had been repeatedly disrupted by the level of war trauma reported in this sample. A longer treatment addressing social, family and individual needs will be necessary. Nonetheless, it was enough to bring symptoms to below threshold levels for 11% of this sample.

There were no significant differences between participants’ self-report on the SDQ, RCMAS anxiety or Birleson DSRSC. Interestingly there was a slight increased
reporting of conduct difficulties, hyperactivity, peer problems and depression and slightly lower pro-social scores after the group and although these differences were not significant it is worth considering the possibility that participants who had less exposure to trauma may have been negatively affected by hearing the stories and accounts of other group members (Barenbaum et al., 2004). However, as there were no significant differences or reports from teachers or carers that children had become more disruptive during the time they attended the group, it is more likely that this reflects natural fluctuation or indicates participants felt freer to answer more honestly at the end of the group. A number of participants within the school groups referred because of difficulties, initially had very low scores on the Birleson DSRSC that appeared at odds with referrer’s report, for example the participant who had lost both parents initially scored 6 on the Birleson DSRSC and a total problem score of 5 on the SDQ whereas his after group scores of 21 on the Birleson DSRSC and 19 on the total problems scale of the SDQ seemed a much more accurate picture. It is apparent that shifts in this direction have a marked impact on the mean scores. We could speculate that the significantly lowered R-IES scores after the group may under estimate the level of change if individuals are feeling freer to acknowledge their distress more openly having been in a group that normalises it as opposed to a school situation where toughness is highly esteemed, but this is speculation.

One of the stated aims of the manual is to enhance coping and an additional aim of this study was to assess the group’s impact on children’s perception of the efficacy of coping strategies. Participants reported using some of the skills that were explicitly taught (cognitive restructuring, distraction and problem solving) significantly more effectively after the group and the reported efficacy of social support also slightly
increased. Some strategies not taught in the group (resignation and wishful thinking) were not used more often but were rated as more useful. It may be that participants developed these skills indirectly, through other group members or they reflect participants' overall sense of coping better.

**Moderators:**

There were no age related differences in the effectiveness of treatment in keeping with other studies (Deblinger et al., 1990; March et al., 1998). The effectiveness of treatment was also not moderated by the gender of participants or whether the treatment was conducted in a clinic or school setting. The latter is important as while there were a number of different demands within each setting it seems that the protocol can be effectively adapted to both contexts without compromising its relative effectiveness.

Clinician and participants' own ratings of engagement in the group were significantly correlated and as expected participants who thought the group would help them and wanted to talk about the things that the group talked about were rated by clinicians as more engaged. Clinician rated engagement was significantly correlated with participants' rating of how much the group had helped them. However, clinician engagement rating did not correlate with any of the standardised measures of avoidance (distraction or social withdrawal on the Kidcope, avoidance on R-IES) and contrary to the hypothesis there was no overall interaction between clinician rated engagement and the impact of the group on self reported R-IES symptoms.
In some senses this is encouraging as it suggests that overall participants in this sample got something from the group whether or not clinicians rated them as engaged in the treatment. However, the small sample size and limitations of this measure caution against generalising this finding. The fact that the measure of engagement created for this study (Appendix 8) did not correlate with self-reported R-IES avoidance or avoidant coping on the Kidcope suggests it may not have been accessing participants’ willingness to engage with traumatic memories. The distribution of scores on this measure (Appendix 10) also indicated that the measure was poor at distinguishing between general behavioural problems and avoidance of traumatic material. Two cases were removed from the analysis because ongoing behavioural difficulties made it hard to assess whether disengagement was related to the content of the group or generalised conduct difficulties. It would perhaps have been useful to form a baseline rating from which to rate participants’ engagement by observing them in lessons or the waiting room and then comparing this to participation / engagement in the group. It was also difficult to distinguish participants who were emotionally engaged with tasks in the way Jaycox et al. (1998) argue is necessary from those who were complying with instructions but actually avoiding thinking about distressing material. There was a real risk of clinicians confounding compliance with engagement, particularly in groups where managing participants’ behaviour was challenging. In one group it only became apparent after two participants had described their pictures to the group that they had not actually drawn nightmares they were really scared of because they thought they were ‘too bad’ and talking would make them worse.
Cognitive models of PTSD propose that the frequency of intrusions is related to an avoidant coping reaction to traumatic memories (Bryant & Harvey, 1995; Guthrie & Bryant, 2000). Measures of self-reported avoidance (mean distraction and social withdrawal components of the Kidcope) did, as expected, correlate with self-reported level of intrusions ($r = 0.61$, $p < 0.001$) arousal ($r=0.372$, $p=0.039$) and total score ($r=0.573$, $p=0.001$) on R-IES. The group had a significantly greater impact on the level of self-reported intrusions and arousal of participants who used avoidant coping strategies more frequently than those who reported using avoidant coping less frequently. Therefore, in this sample a higher avoidant coping style rather than limiting the impact of the group through making open discussion difficult may have signalled an attitude to memories that was significantly helped by attending a group that involved talking about and learning to cope with traumatic memories.

The role of avoidance in limiting processing and therefore maintaining symptoms is central to cognitive models of PTSD (Brewin, Dalgleish, & Joseph, 1996; Ehlers & Clark, 2000) and it may be that the group process was more successful than we expected it would be in implicitly and explicitly challenging this coping style resulting in less intrusions and arousal. Certainly the protocol was explicitly designed to introduce exposure and the fact that using this significantly helped participants who were initially avoidant seems to corroborate the finding that avoidant coping actually maintains participants' distress (Bryant & Harvey, 1995; La Greca, Silverman, Vernberg & Prinstein, 1996). However, this sample of participants were perhaps not the most avoidant to start with as they had both selected to attend the group and kept attending. The correlations with self-reported symptoms on R-IES also highlight that those with an avoidant coping style were more symptomatic
before the group and thus this effect may reflect a regression to the mean phenomenon, with greater change after treatment in those with higher initial levels of symptoms. In this instance it is not possible to determine whether symptom change was a result of the exposure elements of the group that specifically challenged participants’ avoidant coping style or whether those who were more symptomatic overall experienced greater relief from learning coping strategies. Future studies with greater numbers are needed to fully investigate these issues, but these findings reinforce the impact of an avoidant coping on symptom levels and suggest that treatments that target this can produce significant improvements in the level of participants’ intrusions and sense of efficacy coping with traumatic memories. This has implications for the recruitment of participants most likely to benefit from such interventions. It may be that measures of coping style could be used to guide or target treatment towards those with a more avoidant coping style who regardless of whether due to symptom severity or exposure elements in the group seem to benefit most from treatment.

Limitations:

This project involved referred children and adolescents in a service delivery context. This means that the findings can directly inform clinical practice (Clarke, 1995) but also that there are many factors within the process that could not be controlled for. Most obviously the number of participants is small making generalisation difficult, particularly as it is possible that the most avoidant or traumatised individuals are less likely to engage in a research protocol. There was no comparison control group as allocation to clinic groups was incorporated into ordinary clinical practice and engaging with the school required that referred participants went straight into
treatment groups. It is of relevance here that Ehntholt et al. (2005) found no improvement (and in fact a non-significant overall trend to increased symptoms) in their wait list control group with a similar cohort, however, it would have been useful to replicate this. Even if a waiting list control group was difficult to obtain a small number or a single pre-treatment assessment session may have enabled the stability of symptomatology to be assessed before the groups began. At the moment, apart from Ehntholt et al.'s (2005) findings, there is little to preclude symptom reduction as a result of other variables associated with passage of time. Therefore as a preliminary study of the utility of the protocol, a change in self-reported symptoms here is necessary but not sufficient to show that the protocol is effective.

The reliance on self-report questionnaires is also a limitation as individuals may differ in their level of insight, ability to comprehend items and have differing motivation to exaggerate / minimise exposure to war or symptoms. Smith, Dyregrov and Yule (1998) suggest that accurate assessment of children's PTSD symptoms requires multi-method, multi-informant measures. Cohen (1998) highlights the particular difficulties of ascertaining avoidant and numbing symptoms from child's self-reports. The measures used do not have cut-off scores designed for populations of refugee children (Ehntholt et al., 2005) and although as much as possible the measures selected had been used cross-culturally, questions remain about the validity of using such instruments with children whose first language is not English and who may conceptualise and express distress differently (Arrindel, 2003). Self-report measures may also fail to capture the range of psychosocial difficulties or shifts in patterns of interaction whereas interview methods or different informants are more likely to detect these. On the other hand, the distribution in acknowledging various
reactions does indicate that children were able to discriminate between responses. Participants repeatedly asked if they did not understand and in some cases interpreters translated all questionnaires. Responses on the war trauma questionnaire did reflect what was known of participants' experiences but it was not possible to verify self-reported symptom levels.

Clinicians running the groups were not blind to the purpose of the study or the protocol's aim to help children overcome their avoidant symptoms in order to process past events. Clinicians were kept blind to participants' scores on questionnaires until after the group in order to prevent contamination in the process of trying to engage children with different coping styles or levels of avoidance. Knowledge of the project's aims may have affected clinicians' behaviour towards participants, although the demands of running the groups and tendency of clinicians to try to involve all participants probably limited the impact of this. The practicalities of running the groups with different participants, clinicians and settings will also influence the process and outcome of the groups. One of the greatest challenges in the school groups was managing participants' behaviour whereas in the clinic based groups it was catering for a wider age range. These did impact pragmatics, effectiveness and participants' engagement.

Can groups help refugee children with PTSD?

These groups did make psychological help accessible to a number of refugee children, and running them in schools enabled a group that would not readily access services to receive help. Participants tended to keep attending regularly and report that the groups did help them (77% 'a lot' or 'very much'). Participants had a
significantly greater sense of efficacy in making themselves feel better when they thought about upsetting memories after the group and used certain coping strategies more frequently and effectively after the group. There was a significant reduction in the self-reported total symptoms, particularly frequency of intrusions and avoidance on the R-IES, so that 11% of the sample that may have met criteria before the group did not afterwards. Those rated by clinicians as more engaged in the group were those who expected to find the group helpful and reported that it had been most helpful, however, this did not impact the change in self-reported symptoms on the R-IES. There was, however, a significant interaction between avoidant coping style and the outcome of treatment with participants who used avoidant coping more frequently experiencing a significantly greater change in the level of self reported intrusion and arousal symptoms on the R-IES after the group.

The experience of setting up and running these groups within both settings proved challenging in different ways and was as Ehntholt et al. (2005) found “an extremely difficult and time consuming task” (p. 247). This is described in more detailed in the critical review, however, it is worth noting that future school groups would benefit from a dedicated teacher or member of school staff willing to become involved in planning and running the group, a maximum of eight members, a room that will not be interrupted and developing an explicit plan for the management of challenging behaviour within the group. Clinic groups would benefit from a concurrent carers group, as offering the group at the same time may have enabled carers who felt overwhelmed with demands on their time to attend. We found that carers were committed to bringing their children to the clinic and really enjoyed drinking tea and
meeting each other in the waiting room while their children attended the group, with some swapping phone numbers at the end of the group.

The stated aims of this project were to "evaluate different methods of delivering help and to develop new ways of reaching needy children in a non-stigmatising way" (Yule, 2000, p.695). This was achieved through using a protocol driven treatment trial in a service context (Clarke, 1995) and evaluating its effectiveness using reliable and valid measures (Cohen et al., 2000). While the context in many ways means that the findings are not clear cut, it does show that help can be delivered in the form of a psycho-social-educational group to refugee children in school and clinic contexts in a way that is acceptable, they enjoy and report is helpful. Such an intervention significantly increases the range and efficacy of participants' ability to cope with the past and significantly reduces levels of self-reported PTSD symptoms. Further work is necessary in order to find ways that the protocol can be used to facilitate greater symptom reduction, particularly with regard to arousal symptoms. The project suggests that avoidance and engagement processes are multi-faceted but reinforces the impact of an avoidant coping style on symptom levels and suggests attending a group that involves talking about and learning to cope with traumatic memories is particularly helpful for participants with a high avoidant coping style. Using this protocol in increasing effective and culturally sensitive ways will enable the clinic to meet some of the challenges of working with traumatised children and adolescents.
References:


Part 3: Critical Appraisal:

Can groups help refugee children with PTSD symptoms?
The starting point of this project was the challenge of developing effective and culturally sensitive treatments for refugee children with symptoms of PTSD. The lack of an evidence base for treatment (Ruggiero, Morris, & Scotti, 2001) and numbers of refugee children in the UK (Hodes, 2000) many of whom were not accessing services (Fazel & Stein, 2003) meant that evaluating different methods of delivering interventions was a service priority. The need to evaluate treatments for this population has been highlighted as a research priority (Cohen, Berliner, & March, 2000). This appraisal will review what has been learnt about delivering this intervention from the process of running the groups and the results of the evaluation.

A number of recommendations about effectiveness studies were considered in planning this project. A number of researchers called for evaluation within the service context (Clarke, 1995; Weisz, Weiss, Han, Granger, & Morton, 1995) so that the findings can directly inform clinic-based interventions. Saltzman, Pynoos, Layne, Steinberg and Aisenberg (2001) argue that group treatments have received somewhat more attention in the efficacy literature on childhood trauma because groups are able to provide for greater numbers, particularly useful after natural disasters where much of the research has been conducted. The existence of manualised protocols (Smith et al., 2000; Layne et al., 2001) enables reproducibility and a structured therapeutic approach (Clarke, 1995). Groups also confer additional advantages in that among children sensitivity to peer approval, concern for 'normality' and difficulty engaging with traditional services mean utilising others to offer and receive support can foster developmentally appropriate recovery (Pynoos, Steinberg, & Piacentini, 1999). In this instance the psycho-social-education group
protocol designed by Smith et al. (2000) was selected as it had recently been successfully used within schools in the UK (Ehntholt, Smith, & Yule, 2005).

**Practicalities and process of the groups:**

Evaluating within a clinical service provided useful insights into the process of setting up and running this group intervention but also introduced a number of complexities that make clear interpretation of the findings difficult. One of the stated aims of this project was to evaluate the pragmatics of running these groups. Some of the recruitment difficulties, challenging behaviour and demands of the school context have been alluded to in the empirical paper, as has Ehntholt et al.’s (2005) description of the process as “an extremely difficult and time consuming task” (p.247). These will be discussed in more detail here as the insights into the process of running the groups are necessary to help plan future projects.

While the protocol used was the same across clinic and school groups there were a number of differences in the way that the two groups were set up and run. Interestingly this did not moderate the overall effectiveness of either intervention but the smaller clinic group of individuals who did not know each other travelling to meet in a clinic room differed greatly from a group of schoolmates who did know each other meeting in a classroom amidst repeated interruptions in a sometimes violent school context where toughness was highly esteemed.

Participants who were referred for the clinic groups in many ways followed a tried and tested referral route, resources were in place to access interpreters, book a regular room, materials (flip charts, pens, music) were available as was information
about participants network. In the school context recruitment was a much more proactive task because of the practicalities of working within a stretched and demanding school system. When approached about the project the refugee worker reported feeling overwhelmed by the number of refugee children and the extent of their needs, describing continual ‘fire-fighting’ in dealing with one crisis after another. The list of refugee children who may have been traumatised was long and the process of identifying groups from the same ethnic background as recommended by Ehntholt et al. (2005) was met with concern about segregating ethnic groups when the school were trying to reduce conflict and promote shared experience. A number of meetings were necessary with staff at different levels of management within school system (tutors, year heads, EAL teachers, youth workers, Head of Campus) in order to negotiate these kinds of concerns as well as participants’ being released from lessons, access to information about participants’ difficulties, room availability and what staff members could be involved. In the context of a fully timetabled week with constant immediate demands on staff time, many of whom are feeling overwhelmed by the needs of students, much time needs to be allotted to setting up and holding these conversations. Workers within the school system knowledgeable about differing staff roles were essential and time spent in the staff room getting to know staff and concerns within the school, while initially time consuming, paid dividends once the groups began to run and made subsequent discussion and recruitment easier.

Some teachers expressed concerns about opening a can of worms that could not subsequently be contained (Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005) and others wondered if the group would provide difficult students with an excuse for poor behaviour. A number of staff expressed support and interest in the
group, however, being involved in running the groups longer term was additional to timetabled responsibilities and involved considerable commitment on the part of those involved. Those who did volunteer were sometimes called away due to staffing shortages or crises within the school that needed extra help and time commitments meant they could not be as involved in the planning as had been hoped. Ideally staff involved in these groups in the future could be released from some additional responsibilities, particularly if they are to be encouraged to increasingly take the lead with supervision as the protocol recommends (Smith et al., 2000). The protocol had to be adapted to shorter sessions in order to fit with the timetabling requirements of the school system and there were times, for example, the end of term disco and during SAT’s that flexibility was needed in terms of rescheduling at the last minute.

A dynamic that interplayed within the recruitment and group process was the interaction between arousal symptoms of PTSD and challenging behaviour of participants. Conduct or externalising difficulties are more easily detected in school settings (Hodes, 2000) and students initially referred to the group tended to be those whose behaviour teachers found difficult to manage in class. An important part of the consultation process with the school was considering those who were quiet or isolated in class alongside those who were getting into trouble. Although recruitment did become increasingly concerned with children’s possible exposure to war (by considering how long ago and where children had been displaced from) a proportion of participants in all 3 school groups had significant conduct difficulties. In some ways this is appropriate as concentration difficulties, irritability, hyper vigilance and strong reactions to perceived threat are symptoms of PTSD. Furthermore, we know that chronic activation of the stress response due to threat results in long term
neurobiological consequences (Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Glaser, 2000). However, a more comprehensive screening may have detected more individuals whose distress was hidden or manifested by withdrawal.

Participants' behaviour did impact the way that groups were run and in some senses this was the clearest distinction between clinic and school groups. While the rules for the children's group in the clinic could include items such as 'everyone must tell one joke each session', 'food, drink and music during the break', within the school groups the rules concerned sanctions for difficult behaviour (a yellow - red card system) and these were repeatedly acted on. Clinicians had to exclude participants for fighting, keep individuals after the group for difficult behaviour and threaten to telephone carers, none of which sat very comfortably with the concept of a therapeutic group. Using participants' choice of music to mark the beginning, breaks and end of the group, clearly writing and explaining the session plan and setting a timer to indicate how long activities would take were used effectively in later sessions.

The difficulty of creating a sense of safety within the school system was demonstrated physically as well as through discipline issues. Regardless of notices on the door, sessions were often interrupted by staff or by other pupils running into and out of the room. This made it hard to generate a safe environment and made a number of exercises difficult, for example, as Ehntholt et al. (2005) found, it was not possible for participants to genuinely relax during imagery or progressive muscle relaxation tasks. A lockable room was chosen for the last group and is recommended for future groups, although other students still occasionally banged on the door.
Relations between participants also did not always make it safe enough to talk freely. That participants already knew each other and would continue to see each other could have been an asset in terms of continuing support but it actually seemed to mean that existing rivalries and concern for self-image inhibited some self-expression. Name calling and teasing were much more prevalent in the school groups than in clinic groups where participants did not know each other. A concern had been that conflict between Kurdish and Iraqi participants may affect dynamics but actually there was more conflict between participants from the same community whose relatives knew each other. On a number of occasions clinicians detected participants teasing one another for things that had been shared in the group, contrary to group rules and marking this as unacceptable without further alienating the participant being teased was difficult. A clear statement at the beginning of the group about the sanctions for teasing would have made it easier to firmly deal with these situations with less disruption to the group process. In the first school group half of one session was taken up with discussing the dynamics and behaviour of participants following a fight and it may be that extra time should be scheduled to address these issues within a school context, where confidentiality and safety are harder to establish. The decision to allow a more ethnically diverse group was partly driven by demand from the school but was also partly to see whether reduced ties would reduce internal conflicts. There was less, although still some teasing in the third group, but this may also be because clinicians were firmer about the group’s rules by this stage.

Therefore while in many ways schools were an ideal way to contact children who may not traditionally access services and to alert children’s system (carers and school) to the impact of trauma on development, in other ways they were not an ideal
environment for the formation of a therapeutic group. We know therapeutic groups can be successfully run in school settings (Goenjian et al., 1997; Rousseau et al., 2005; Saltzman et al., 2001) and the significant shifts in PTSD symptoms and coping indicate this instance was no exception. However, a school context like this makes generating a safe place even more important to the success of the group. This may necessitate more time being spent on careful recruitment, establishing and thinking through group rules and perhaps allocating sessions to consider the impact of rule breaking and group processes. Clinicians must also firmly protect the group boundaries and find a protected space within the school system. The realities of the school setting will vary from school to school but in some instances there may be a trade off between actually getting a group running and having the desired set-up and process, particularly for the first group within a particular school context. This school was typical of the kind of Secondary schools that refugee children in inner London usually attend and it is likely that difficulties finding any available room space, staff facing urgent demands on their time, disruption from announcements / bells and tensions from outside the group will impact dynamics to some extent. The decision at this point is whether the context limits the effectiveness of the intervention to the point that it becomes fruitless or whether the process can still be helpful.

Impact of the groups:

The experience of this project suggests that, although over time much was learnt about how to make the process better, most participants experienced relief from their symptoms in terms of significantly reduced R-IES scores and increased reported efficacy of coping strategies. In spite of discipline problems, teasing and internal conflicts it was striking that participants did share very difficult memories of their
past, describe deeply personal nightmares and fears and some even brought in photographs of family members and stories that they had written. Many reported to clinicians that there had been a shift in their nightmares and sleep difficulties and that they were feeling much better.

Feedback forms that asked participants to indicate the worst and best thing about the group provided clear examples of things that participants had found helpful and relatively few things that they did not like (See Appendix 12 for full list of comments). While social desirability may have influenced responses to some extent, participants generated varied and concrete examples of things that they liked about the group with prompting to be honest about what they did not like. Difficult aspects of the group (name calling, having to “talk to the teacher or other students about yourself”) were expressed suggesting participants did feel that they could be honest. Some participants highlighted that talking about the past was difficult (“When you should talk or draw or write it makes me so more scared”); “I don’t really like to talk about what happened but it was ok”) but it is striking that the same participants reported that the best thing about the group was (“When they say to practice in the room or look at your fear or talk to your parents”); “I talked and drawed about what happend a long time ago which kind of helped me”). Many described that the group had helped them “forgetting my fears and memories”, to “handle”/ “vanish the bad memories” or that it made the “picture get out of my mind”. Others found the presence of others most helpful reporting that the best thing about the groups was “the way that there was other people there like me”, finding that “other people feel the same way I do” and hearing “everyone’s ideas of how to deal with things”. Some participants reported specific techniques that had been helpful, particularly those
relating to intrusive images “relaxing and the TV with the black and white colour” (a technique using imagery to change colours/ brightness/ size of intrusive image), “change the pictures and to small a picture to make me sleep” and “learning how to take the image away from us mind, how to sleep nice, smell stuff for sleep relax much more more much more”. It was encouraging that participants remembered the specifics of techniques, had found them useful and seemed to be continuing to use them effectively.

These comments clearly indicate participants felt that the group was helpful. The difficulties of self-report and participants’ responses on these scales have been highlighted within the empirical paper but participants’ feedback about the group lends more support to the idea that the group process allowed participants to acknowledge distress in a way that the culture at school / home did not. Certainly a number of participants who said that they had been sleeping much better / not seeing images over the past few weeks continued to score highly on these items on the R-IES at time 2 and it may have been that participants rated experiences they had had rather than focusing only on the previous week. This is not to undermine the continuing level of symptomatology among participants or the need to adapt the intervention in order to make it more effective, but it does suggest that despite the challenges of working in this setting, participants did experience relief as a result of participating in the group.

Within the clinic context these groups provided a good way of getting to know participants’ needs, normalising their experiences and introducing them to coping strategies to help them manage symptoms. Participants seemed to enjoy attending
and carers were committed to bringing them. Ensuring a concurrent carers group is a priority for future groups, however, this involves considerable resource allocation from the clinic team. One of the obstacles to running groups in this setting is the fact that participants miss school and running them after school is hard because children tend to be tired. We found that starting groups during half term and school holidays helped participants to attend. Participants also reported this was a good time as they found the lack of routine during holidays difficult. The summer holidays are perhaps ideal but attendance may be interrupted by holidays. The other issue is that recruitment relies on a number of individuals of similar ethnicity with roughly similar ages being referred. Keeping track of the waiting list would allow clinicians to monitor when sufficient participants had been referred and at times mixed ethnicity groups may be necessary.

The fact that the school are keen for groups to continue to run and that recruitment is under way for the next group suggests that from their point of view this protocol can be effectively used in this context. The hope is that staff within schools will increasingly be able to take over running the groups, although there is some concern that time and staffing pressures will mean that without outside support or timetable provision it will not be feasible. It is also true that investigating a number of ways to increase the effectiveness of the groups will require continued input from clinicians, particularly if introducing individual pull-out sessions (see below) or time away from the protocol to deal with the group process. It is important to note that not all refugee children, even those arriving from areas of conflict will be experiencing PTSD symptoms as a result of their experiences and a careful recruitment process is necessary. It will be important as staff become more involved to maintain the
emphasis on PTSD symptoms as it will be harder for those within the system, facing the demand to help more volatile individuals not to prioritise their needs relative to quieter participants. It is also the case that a number of non-refugee children within these schools have witnessed traumatic events including domestic violence, racist attacks, fights/ stabbings within their communities and it may be that some of the techniques used in this treatment protocol could be usefully applied to them. Saltzman et al. (2001) successfully adapted a trauma protocol for participants exposed to community violence.

**Future directions:**

While participants reported that the group was helpful and we can hope that decreased PTSD symptoms and increased sense of efficacy and coping strategies will impact their quality of life, it remains unclear whether this translates into a “real” difference in the everyday lives of participants. One of the reasons for opting for a group protocol was that it counters avoidance and detachment from others that characterises some trauma survivors (Foy, Eriksson, & Trice, 2001) and utilises the salience of the peer group within this age group (Layne et al., 2001). It would have been interesting to assess whether their participation in the group affected participants perception of their peers. Certainly a few participants in both clinic and school groups commented on the feedback form that the best thing about the group was “the way there were other people like me”. It was also hoped that the involvement of teachers and youth workers would create longer term contacts for participants and that even brief interactions with parents may have increased home and school’s awareness of the ongoing impact of war trauma but this was not evaluated. Resilience is increasingly understood not as an individual trait but rather a range of mechanisms that operate to help children respond to adversity (Rutter, 1999)
and as such the aim of the groups was to promote resilience by building resources for participants. Capturing this empirically is hard but warrants further attention if we are to meaningfully evaluate interventions for war traumatised children.

Cohen et al.’s (2000) practice guidelines recommend inclusion of carers in treatment and the difficulty of organising carers groups in this project probably limited the protocol’s effectiveness. Future work, particularly in schools, should place greater emphasis on engaging carers in the treatment process, perhaps by attending parents evenings at the school or utilising existing links with staff members. In setting up these groups clinicians became very aware of the stigma associated with mental health among participants and their families and while every effort was made to normalise experiences, the group inherently selected those with difficulties as a result of war trauma. In many ways there is no way around this as the group is not suitable for those with no trauma as they may be upset by others’ accounts (Barenbaum, Ruchkin, & Schwab-Stone, 2004) but it did highlight the importance of planning mental health interventions collaboratively within the communities concerned. The school is well placed to do this as many refugee families have high aspirations for their children’s future (Hodes, 2000) and expressed reluctance to talk about the past is often fused with the wish for a better future through education. Schools may therefore be highly valued by families as well as being representative of and accessible to communities. We found working in the school was helpful in promoting access to and knowledge of available services.

There are a number of additional ways that the group’s effectiveness may be enhanced and investigated in future studies including longer interventions,
individualised ‘pull-out’ sessions to focus exposure on individuals’ needs, booster sessions to ensure gains are maintained, tailoring sessions to individual concerns, for example thinking more explicitly about the conflict in Kosovo / Iraq and / or using culturally appropriate narratives. The manual also includes a module based around traumatic grief that was not utilised here (Smith et al., 2000). As the treatment protocol incorporates a range of treatment components and ‘recovery techniques’ it would be useful to assess what components participants found most helpful in order to work out what to spend more time on and to look at the relative effectiveness of different treatment components. It may be that comparing this psycho-social-educational protocol with a different treatment modality aimed at helping children recover from trauma (supportive psychotherapy, art therapy, narrative group) would further build up an evidence base about what is effective in helping refugee children. As a number of participants went from the group to individual work, a comparison between the effectiveness of group and individual treatment would also be helpful.

Rousseau et al. (2005) highlight the diversity of experiences of refugee children within the same school context and this project further emphasises the vastly divergent experiences of homeland and migration within a group selected to be similar in age, ethnicity and time in the UK as a result of the same conflict situation. Participants’ sense of cultural identity differed greatly with some individuals expressing a strong desire to be back in Iraq / Kuwait / Kosovo and others to be British citizens. Identity issues ran deep creating tension between participants and were powerfully reflected in safe place imagery and future hopes. A group devised by the school / health professionals that utilises a Western model of trauma (Summerfield, 2000) to talk about the past that some participants were trying to
forget was disparate with aspects of both these groups’ sense of identity. In many ways this process reflected the interface between host culture and homeland that participants faced in displacement and moving between home and school contexts. While creating a space to discuss the past and its impact on current life implicitly recognised some of the internal conflicts, the psycho-social-educational protocol was predominately concerned with learning techniques and it may have been useful to explicitly recognise and discuss the impact of living within differing cultures on symptoms, memories and future hopes.

We know that refugee families tend to be more socially disadvantaged (Howard & Hodes, 2000) and in both contexts clinicians became aware of pressing social needs that made current life, let alone symptom reduction, difficult. Many participants lived in overcrowded accommodation with many members of the extended family living together. A number of participants were in the process of being re-housed during the course of the group which was unsettling, for two of the participants this involved spending some nights with their parents and some with other family members. For another participant this meant moving with very little notice into bed and breakfast accommodation, a living situation that is notoriously noisy, overcrowded and with shared bathrooms and kitchens affords limited privacy. Another returned from school to find their flat and belongings had been destroyed in a fire. The level of disruption and uncertainty was striking especially considering these groups provided an insight within a short period of time into 33 participants’ experiences. Scheeringa’s (1999) observation that “if children and families do not feel safe and do not have basic needs met, no extra energy will be left over to engage in therapy” (p.23) perhaps has particular relevance to refugee families whose unsafe social situation is often
compounded by uncertainty about immigration status. While stories of people being taken to detention centres circulated in all groups, this was a particular concern for Albanian participants whose community was rife with discussion about government agendas for repatriation and rumours of cases of forced repatriation or returning unaccompanied minors at 18. The sense of current threat that we know maintains PTSD (Ehlers & Clark, 2000) was very evident. Al-Eissa (1995) highlighted the importance of mobilising social support in order to buffer the effect of war on displaced Kuwaiti families. The majority of participants in the school sample had no contact with social services and clinicians running groups in this context have to decide how involved they want to be in supporting participants and school staff as they try to address these social needs.

It is interesting that the demand in the clinic sample was for groups from Kosovo-Albania and in school it was for children from Iraq/Kuwait. Given the relative time scales of the conflicts, it is perhaps an indication of the time that it takes for families to be established enough to negotiate the tiered health system in the UK in order to access specialist services, whereas education is a more immediate and accessible priority as Hodes (2000) predicted. The relative time to access psychological help emphasises the role of the wider context in individuals’ experience of trauma symptoms. Increased access to services is important in promoting resilience among refugee children and psycho-social-educational interventions to normalise, enhance coping and to identify those needing specialist help may be one way of doing this.

The stated aims of this project were to “evaluate different methods of delivering help and to develop new ways of reaching needy children in a non-stigmatising way”
(Yule, 2000, p.695). While the context in many ways means that the findings are not clear cut, it does show that help can be delivered in the form of a psycho-social-educational group to refugee children in school and clinic contexts in a way that is acceptable, they enjoy and report is helpful. Such an intervention significantly increases the efficacy of participants’ ability to cope with the past and significantly reduces PTSD, particularly the frequency of intrusion and avoidance. The change in symptom levels was particularly marked for those with an avoidant coping style. While further work is necessary in order to find ways that the protocol can be used to facilitate greater symptom reduction this psycho-social-education group was able to help refugee children. Using this protocol in increasingly effective and culturally sensitive ways will enable clinicians to meet some of the challenges of working with traumatised refugee children and adolescents in different settings.
References:


Appendices

Contents:

Appendix 1- Pages 135-141

1) Approval letter from Camden and Islington Community Local Research Ethics Committee (and Approval for amendments.) (p.135-139).

2) Approval letter from North Central London Research Consortium (p.139-141).

Appendix 2- Pages 142-143

Information letters to GP’s about study and participants involvement

Appendix 3- Pages 144-148

Information letters about project for

1) Carers (p.144-145)

2) Participants (p.146)

3) Example of translated information sheet (p.147-148)

Appendix 4- Pages 149-151

Consent forms for

1) Carers (p.149)

2) Participants (p.150)

3) Example of translated information sheet (p.151)

Appendix 5- Page 152

Assessment interview- standardised screening whether suitable for the group ie: able to attend school regularly, were supported at home and not socially isolated.
Appendix 6- Pages 153- 161

Questionnaires used before the group to measure symptoms before the group and collect expectations.

Appendix 7- Pages 162- 170

Questionnaires used after the group to measure symptoms after the group and collect feedback.

Appendix 8- Page 171

Clinician rated measure of engagement

Appendix 9- Page 172

Table to show correlations between clinician rating of engagement across items and sessions

Appendix 10- Page 172

Graph to show distribution of mean clinician rated engagement across groups.

Appendix 11- Page 173

Table to show F and p values for repeated measures ANOVA using Wilks’ Lambda on R-IES measures

Appendix 12- Page 174- 176

Responses on feedback form about the group.
10 May 2004

Miss Beth Hill
Trainee Clinical Psychologist
Sub-department of Clinical Health Psychology
University College London
Gower Street
London
WC1E 6BT

Dear Miss Hill,

Full title of study: Investigating the relationship between an avoidant coping strategy, engagement in treatment and the efficacy of group treatments for post traumatic stress in refugee children

REC reference number: Protocol number: 1

Thank you for your letter of 21 April 2004, responding to the Committee's request for further information on the above research.

The further information has been considered on behalf of the Committee by the Chair and Professor Chris Brewin.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation.

The favourable opinion applies to the following research site:

Site: Child and Family Team at the Traumatic Stress Clinic
Principal Investigator: Miss Beth Hill

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type: Application
Management approval

The study may not commence until final management approval has been confirmed by the organisation hosting the research.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant host organisation before commencing any research procedures. Where a substantive contract is not held with the host organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Notification of other bodies

We shall notify the North Central London Research Consortium that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

| REC reference number: | Please quote this number on all correspondence |

Yours sincerely,

Stephanie Ellis
Chair

Enclosures: Standard approval conditions
01 December 2004

Miss Beth Hill

Trainee Clinical Psychologist
University College London
Sub-department of Clinical Health Psychology
Gower Street
London
WC1E 6BT

Dear Miss Hill,

**Study title:** Investigating the relationship between an avoidant coping strategy, engagement in treatment and the efficacy of group treatments for post traumatic stress in refugee children

**REC reference:**

**Protocol number:** 2

**Amendment number:** 1
**Amendment date:** 22/11/04

The above amendment was reviewed at the meeting of the Sub-Committee of the Research Ethics Committee.

**Ethical opinion**

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

**Approved documents**

The documents reviewed and approved at the meeting were:

Document: Notice of Substantial Amendment
Version: 1
Dated: 22/11/04
Date Received: 26/11/04

Document: Research Proposal (Protocol)
Version: 2
Dated: November 2004
Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed below.

Management approval

All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects local management approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC reference number: Please quote this number on all correspondence

Yours sincerely,

Kathryn Simpson
Administrator

E-mail:

List of members who reviewed the amendment

Stephanie Ellis (Chair)
Professor Chris Brewin
Miss B Hill  
Sub-Department of Clinical Health Psychology  
University College London  
London  
WC1E 6BT

Dear Miss Hill,

LREC Ref:  
Title: Investigating the relationship between an avoidant coping strategy, engagement in treatment and the efficacy of group treatments for post traumatic stress in refugee children

I am pleased to note that the Local Research Ethics Committee has recommended to the Trust that there are no ethical reasons why your study should not proceed.

Projects are registered with the North Central London Research Consortium if they utilise patients, staff, records, facilities or other resources of Camden Primary Care Trust, Islington Primary Care Trust, the Camden & Islington Mental Health and Social Care Trust, Barnet Primary Care Trust, Enfield Primary Care Trust or Haringey Teaching Primary Care Trust. On the basis of the documentation supplied to us, your study has the support of the clinical service manager/assistant locality director of the service in which it will be based.

The Camden and Islington Mental health and Social Care Trust therefore grants approval to begin research based on the proposal reviewed by the ethics committee and subject to any conditions set out in their letter of 10 May 2004. Should you fail to adhere to these conditions or deviate from the protocol reviewed by the ethics committee, then this approval would become void. The approval is also subject to your consent for information to be extracted from your project registration form for inclusion in NHS project registration/management databases and, where appropriate, the National Research Register and the UCL Clinical Research Network register.

Permission to conduct research is also conditional on the research being conducted in accordance with the Department of Health Research Governance Framework for Health and Social Care:
• Appendix A to this letter outlines responsibilities of principal investigators;
• Appendix B details the research governance responsibilities for other researchers. It also outlines the duties of all researchers under the Health and Safety at Work Act 1974. Principal investigators should disseminate the contents of Appendix B to all those in their research teams.

Further information on the research governance framework for health and social care can be found on the DH web pages at http://www.doh.gov.uk/research/
Staff working within trusts covered by the research consortium can also find the information on the Trust Intranet.

Researchers are also reminded that personally identifiable information on living persons must be collected, stored, processed and disclosed in accordance with the Data Protection Act 1998. Such data may be in the form of electronic files, paper files, voice recordings or photographs/scans/X-rays. Further information on the Data Protection Act is available from your organisations Data Protection Officer or from the Consortium R&D Unit. The Medical Research Council also publishes the guidance booklet ‘Personal Information in Medical Research’ which is available from http://www.mrc.ac.uk/pdf-pimr.pdf

Except in the case of commercially funded research projects, the following acknowledgement and disclaimer MUST appear on all publications arising from your work.
"This work was undertaken with the support of [***Insert Trust***] Trust, who received [***insert "funding" or a "proportion of funding" ***] from the NHS Executive; the views expressed in this publication are those of the authors and not necessarily those of the NHS Executive."

"a proportion of funding" where the research is also supported by an external funding body;
"funding" where no external funding has been obtained.

This is a requirement of the contract between the Trust and the NHS Executive in which the Trust receives funding to cover the infrastructure costs associated with performing non-commercial research.

Please make all members of the research team aware of the contents of this approval. I wish you every success with your research.

Yours sincerely,

Angela Williams
Acting Co-Director of Research Operations

November 2003.
Treatments for refugee children who have experienced traumatic events.

Thank you for your referral to the Child and Family Team at the Traumatic Stress Clinic. We are currently undertaking a research project evaluating group treatments for Post traumatic stress disorder (PTSD) in refugee children. We have sent the parents/carers and children information about the study and asked them to indicate if they would like to be involved.

We wanted to tell you why the research is being done and what the family you have referred would be asked to do, if they decide to be involved. Treatment will be offered to the family regardless of their decision. Please take a few minutes to read it, even if we have previously spoken on the telephone about the project.

What is the purpose of this study?
There is limited knowledge about the best treatments for refugee children with PTSD. The Child and Family team currently use a group treatment protocol developed by Smith, Dyregrov and Yule in 1999 designed to help children learn 'recovery techniques' to manage their symptoms. A recent study (Ehntholt and Yule, in press) has shown that this is effective but we would like to understand more about what helps children to learn these techniques and get the most out of the group, so that we can make the treatments as useful as possible for children.

Who is eligible?
We are interested in all refugee children between 8-16 years who have experienced traumatic events in their country of origin, have PTSD symptoms (including: repeated and unwanted re-experiencing of distressing events, difficulty sleeping and concentrating, emotional numbing and avoidance of anything that serves as a reminder of the events) and you think may benefit from learning 'recovery techniques'.

What will happen if they take part?
If carers and children agree to take part, the children will attend four 2 hour sessions which look at different troubling symptoms and how to manage them better. The only difference between the treatment study and ordinary treatment is that children in the study will be asked to fill in more questionnaires at the start and finish of the group. This will mean that the first and last sessions will be about 20 minutes longer. Children in these groups will also be observed and rated by clinicians running the group. Children can decide to withdraw at any time, without giving a reason. This will not affect the standard of care they receive.

Are there any risks?
We do not expect there to be any risks. Children in the study will receive the same treatment as those not in the study. Learning 'recovery techniques' will involve talking about the frightening things that they have experienced which children may find upsetting, but the clinicians leading the groups are used to talking to children about these things in a way that helps them to feel safe. We are happy to discuss any worries you have about this.
What are the benefits of taking part?
We hope that the treatment will help children to learn to manage symptoms better. We also hope that it will help us to understand more about what helps children to learn these techniques. This should help us to make the treatments as useful as possible for children and to make sure that all children can benefit from treatment.

What happens when the study stops?
Those referred will be being treated as a patient at the clinic and they will be monitored throughout treatment. If they are still having other problems when the group is finished, they will continue treatment in the normal way.

Ethical review
The ethics committee from Camden and Islington Community Health Services Local Research Ethics Committee has reviewed this study.

What we are asking you to do?
We have sent information sheets and consent forms to the families/carers and to the children themselves—please let us know if the families require this information translated. We know that this population may find it difficult to express concerns about the project and so to facilitate informed consent we have told parents/carers that they can approach their GP or the clinic directly. We hope that the option of approaching yourself will allow them to indicate their preference and raise concerns in a familiar environment, should they wish to do so. Feel free to contact us if you would like to discuss this further or have questions that you wish to channel onto the team.

You can contact Beth Hill (researcher) directly by e-mail: b.hill@ucl.ac.uk or by telephone through the child and family team on

Thank you in advance for your help.

Beth Hill is a Trainee Clinical Psychologist whose work on this study will be supervised by David Trickey (Chartered Clinical Psychologist) and Pasco Fearon (Lecturer in Clinical Psychology).
Groups for refugee children who have experienced frightening events.

The Child and Family team at the Traumatic Stress Clinic are running some groups at School as part of a research study looking at how refugee children are helped by group treatments. Your child or the child for whom you are responsible has been referred to one of these groups.

We wanted to tell you why the research is being done and what you would be asked to do, so that you can decide whether or not you would like your child to take part.

Please take a few minutes to read it.

What is the purpose of this study?
We have found that refugee children who have experienced frightening events can be upset by memories and that some children are helped by attending a group that teaches them 'recovery techniques'. These 'techniques' help them to cope with the difficulties caused by living with upsetting memories. The study hopes to look at what helps children to learn 'recovery techniques' so that we can make treatment better in the future.

Why has my child been chosen?
We are interested in all refugee children who may want help with troubling memories and we think would be helped by being taught about recovery techniques in a group.

Do I have to take part?
It is up to you to decide whether or not to take part. This information sheet is to help you decide.

What will happen if I take part?
If you and your child agree to take part, they will be taught 'recovery techniques' in a group. The group will meet several times for 1 ½ hours. Each week will look at different troubles caused by past experiences and how to manage these better. The only difference between the treatment study and ordinary treatment is that children in the study will be asked to fill in more questionnaires on the first and last week. This will mean that the first and last sessions will involve completing some forms. The clinicians running the groups will also answer written questions about the children's learning in these groups.

Are there any risks to us if we take part in the study?
We do not expect there to be any risks. Children in the study will receive the same treatment as those not in the study. Learning ‘recovery techniques’ does mean talking about frightening past events but the clinicians leading the groups are trained to talk to children about these in a way that helps them to feel safe. We are happy to discuss any worries you have about this.
What are the benefits of taking part?
We hope that the treatment will help your child to learn to manage better. We also hope it will help us to learn more about how to help children manage the troubles caused by difficult memories. This should help us make treatment better for all children in the future.

What happens when the study stops?
Your child will be monitored throughout treatment. If they are still having other problems when the group is finished, we will consider whether they require further treatment, and will discuss with them the options available to them and how to access them.

What happens to the information collected?
All the information collected for the research project will be kept confidentially. The results will be coded so that your child’s name is not on them. The list of names and codes will be kept carefully and stored away from the questionnaires.

What if something goes wrong?
We are obliged to inform all participants that whilst we do not think any additional problems will be caused by the research, if something goes wrong there are no special compensation arrangements. In the event of negligence you may have grounds for legal action but you will have to pay for it. If you wish to complain or have concerns about this study you can complain using the normal NHS complaints procedure.

Ethical review
The ethics committee from Camden and Islington Community Health Services Local Research Ethics Committee has reviewed this study.

If you do decide to take part.....
• you can keep this information sheet and sign the consent form enclosed with this sheet, returning it to Westminster Community School through the register.
• you can still withdraw at any time, without giving a reason. Your decision will not affect the standard of care your child receives.
• your child will be put on the waiting list for the next group

If you decide not to take part....
• your child is still entitled to treatment. You can contact your GP and tell them that you do not wish to take part in the study but that you wish your child to have treatment.

If you have any more questions....
• whether or not you want to take part, you can speak with your GP or the team at the clinic if you would like more information or have any questions.
• you can also contact Beth Hill (researcher) directly by e-mail: or by telephone through the child and family team on

Thank you in advance for your help.

Beth Hill is a Trainee Clinical Psychologist whose work on this study will be supervised by David Trickey (Chartered Clinical Psychologist) and Pasco Fearon (Lecturer in Clinical Psychology).
ما هي فوائد المشاركة؟

نحن نأمل أن يساعد العلاج طفلك على التغلب على الصعاب بطريقة أفضل. و نأمل أيضا أن هذا سوف يساعدنا على الحصول على معلومات إضافية عن الطريقة التي تبقي بها الأطفال على الاضطرابات الناجمة عن الذكريات المزعجة. و هذا سيساعدنا على جعل العلاج في المستقبل أكثر نجاحاً لكل الأطفال.

ماذا يحدث عندما تنتهي الدراسة؟

سوف يتم مراقبة طفلك طوال مدة العلاج. فإذا كان لا يزال يعاني من اضطرابات أخرى عندما ينتهي العلاج، سوف ندرس إمكانية تقديم المزيد من العلاج له وسنقوم بمناقشة الخيارات المتاحة له وكيف يحصل عليها.

ماذا يحدث للمعلومات التي تم جمعها؟

سوف يحافظ على سرية جميع المعلومات التي يتم جمعها خلال الدراسة. و سيتم تشفير النتائج بحيث لا يكون اسم طفلك من ضمنها. و سيتم حفظ قائمتي الأسماء و الشفرات في مكان آمن بعيدا عن الاستبيانات.

ماذا يحدث لو وقع خطأ؟

نحن ملزمون على إعلام كل المشاركين أنه بالرغم أننا لا نعتقد أن الأبحاث تسبب مشكلات إضافية، فإنه في حالة ما سارد الأعراض غير مرغوب فيها، لا يوجد نظام للتعويضات. في حالة الأموال، قد تكون لديك أسباب لرفع دعوى قضائية، لكن يجب عليك تحمل جميع مصاريف المقابلة. إذا أردت تقديم شكوى أو كنت تشعر بالقلق بخصوص هذه الدراسة، يمكنك تقديم شكوى باللجوء إلى نظام الشكاوى المعمول به في الخدمات الصحية الوطنية.

مراجعة أخلاقيات هذه الدراسة

قامت لجنة الأخلاقيات التابعة لخدمات صحة المجتمع في كامدن و إلنجتون بمراجعة هذه الدراسة.

إذا قررت المشاركة........

• بمثابة الاحترام لهذه الشبكة الإرشادية و توقيع إقرار اتفاقية الوفاء هذه النشرة و قدمها إلى إدارة مدرسة Westminster Community School وستمستر

• بمثابة الاحترام لهذه الشبكة الإرشادية و توقيع إقرار اتفاقية الوفاء هذه النشرة و قدمها إلى إدارة مدرسة Westminster Community School وستمستر.

• يمكنك الامتناع عن أي وقت بدون إعداد الأسئلة. و لن يؤثر قرارك على مستوى الرعاية التي يحصل عليها طفلك.

• يتم إدراج اسم طفلك على قائمة الانتقال الخاصة بالدورة المقبلة.

إذا قررت عدم المشاركة........

• فإن طفلك لا يزال يتمتع بالحق في العلاج. يمكنك الاتصال بالطبيب الخاص بك وخبره ذلك. لا تدفع المشاركة.

• في الدراسة لن ترغب في أن ينثني طفلك العلاج.

إذا كنت لديك استفسارات أخرى........

• يمكنك الاتصال بالResearchers (باحثين) في الدراسة أو إلى طبيب الطفل الدراسة إذا رغبت في الحصول على معلومات إضافية أو كنت لديك استفسارات.

• يمكنك أيضا الاتصال بـ "باحث هل" (باحث) مباشرة عن طريق البريد الإلكتروني: prof.beth.hill@candi.nhs.uk أو بواسطة هاتف فريق الطفل والعائلة على الرقم: 0207 530 3677

شكراً مسبقاً على مساعدتك.

السيدة "بات هيل" Prof. Beth Hill هي مديرية علم النفس السريري و سوف يشرف على عملها في هذه الأبحاث السيد داي فورن Prof. Pasco Fearon (باحث في علم النفس السريري) و داي فيركي Prof. David Trickey (عالم نفس السريري).
PARENT/ CARER CONSENT FORM

Name of Researcher: Beth Hill

Please initial box

1. I confirm that I have read and understand the information about this study and have had the opportunity to ask questions. □

2. I have had enough time to decide whether I want my child to be involved in this study. □

3. I understand that my child's participation is voluntary and that they are free to withdraw at any time without giving any reason, without my child's medical care or legal rights being affected. □

4. I understand that sections of my child's medical notes may be looked at by the researchers. I give permission for these individuals to have access to my child's records. □

Name of Patient ____________________________ Date ____________________________ Signature ____________________________

Name of Person taking consent (if different from researcher) ____________________________ Date ____________________________ Signature ____________________________

Researcher ____________________________ Date ____________________________ Signature ____________________________

1 for patient; 1 for researcher; 1 to be kept with patient's notes

Consultants & Honorary Consultants in the Traumatic Stress Clinic:
Child and Family Service: Guinevere Tufnell, Psychiatrist
Adult Traumatic Stress Service: Chris Brewin, Deborah Lee.
Refugee Service: Mary Robertson.
Honorary Consultants: Dora Black, Jean Harris-Hendricks, Tony Kaplan, James Thompson.
CHILD CONSENT FORM

Name of Researcher: Beth Hill

1. I have read and understand the information about this study and have asked any questions that I wanted to.

2. I have had enough time to decide if I want to take part in the study.

3. I understand that I only need to take part if I want to and that I'm free to stop at any time, without giving any reason, and that this will not affect how I am treated in this service.

4. I understand that the person doing the research project (Beth Hill) may look at my notes from the trauma clinic if she needs to. It is okay for my parents/carers to let her.

5. I agree to take part in the above study.

______________________________  _____________________  _______________________
Name of Patient                                Date                             Signature

______________________________  _____________________  _______________________
Name of Person taking consent (if different from researcher)  Date                             Signature

______________________________  _____________________  _______________________
Researcher                                Date                             Signature

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Child and Family Team
The Traumatic Stress Clinic
Established as a National Centre for PTSD

Beth Hill

أوافق على المشاركة في الدراسة أعلاه.

التوقيع
التاريخ
اسم الأب أو الأم

التوقيع
التاريخ
مستشار الموافقة (إذا كان شخصًا غير الباحث)

التوقيع
التاريخ
الباحث

نسخة للمريض، نسخة للباحث، نسخة لملف المريض

Consultants & Honorary Consultants in the Traumatic Stress Clinic:
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Honorary Consultants: Dora Black, Jean Harris-Hendricks, Tony Kaplan, James Thompson.
School Screening interview:

Name: Class:

1. Impact of Events Scale
2. Have scary memories stopped you from doing anything?
   What kinds of things?
   \[\ldots\]\n   Details:
   \[\ldots\]\n   Have they ever stopped you from coming to school?
   \[\ldots\]\n
3. Birleson Depression Scale
4. So if you're feeling sad or upset - who do you talk to about it?
   Who's in your family or lives with you at home?

<table>
<thead>
<tr>
<th>Mum</th>
<th>Dad</th>
<th>Brother(s)</th>
<th>Sister(s)</th>
<th>Grandad</th>
<th>Gramp</th>
<th>Aunt/Unc</th>
<th>Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other:

Do any of those people help if you are sick or unwell?
   \[\ldots\]\n   What do they do if they know you are feeling sad?
   \[\ldots\]\n   Have you even seen a Dr/Nurse/Socialworker to talk about any problems you have had? Who?

<table>
<thead>
<tr>
<th>Dr</th>
<th>Nurse</th>
<th>Social worker</th>
<th>Counsellor</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Strengths and Difficulties Questionnaire
6. PEERS: Who do you spend time with at break and lunch?

Have they been your friend for long?   \[YES/ NO\]   How long (roughly)?
Do you see them outside school?   \[YES/ NO /SOMETIMES\]
Have you got other friend(s) that you see?   \[YES/ NO\]   Details:

p. 152
This book contains some questions that we would like you to answer before we start the group!

There are no right or wrong answers- we just want you to tell the truth. Your answers will be kept safe and even the people running the group will not look at what you have said until afterwards.

- Sometimes you will be asked to say yes or no to something. Please mark the box that is true, for example:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>I like playing football</td>
<td></td>
<td>√</td>
</tr>
</tbody>
</table>

- Sometimes you will be asked to show how much you agree, for example:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>Sometimes</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>I like football</td>
<td></td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>

- Sometimes we will ask you to write something—
  I like football because... eg: I like scoring goals..............

If you find it hard to write, please tell us and remember we don’t mind if you spell things wrong!

Please ask if you do not understand a word and tell us if you feel upset. Some of the questions are about the troubles that we are here to learn how to recover from.
Let’s start!

Everyone in the group is here because they have had frightening experiences. The group is going to teach you ‘recovery techniques’. How much do you think that the group will help you?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>No change</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group will help me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What do you do now when you remember your frightening experiences?

<table>
<thead>
<tr>
<th></th>
<th>Tell someone</th>
<th>Tell no-one</th>
<th>Try to think about something else</th>
<th>Cry</th>
<th>Something different</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I’m frightened</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Write below</td>
</tr>
</tbody>
</table>

Write your own here: .................................................................

................................................................................................

Does what you do when you remember help you to feel better?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>No change</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Did you think talking about memories will make you feel better, worse, no different?

<table>
<thead>
<tr>
<th></th>
<th>Much worse</th>
<th>A little worse</th>
<th>No change</th>
<th>Better</th>
<th>Much better</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

p.154
Now we want to ask you about things that have happened in the past. Remember to tell us if you are feeling upset!

UNICEF PSYCHOSOCIAL ASSESSMENT
WAR TRAUMA QUESTIONNAIRE- adapted version

(1) Where do you live today?
☐ with your own family
☐ with another family
☐ on your own
☐ in a children's home or hostel

(3) If you are not living with your mother and father, do you know where they are? Yes/ No

(4) What language do you speak? ................................................

(5) What religion are you? ......................................................

ABOUT THINGS THAT MIGHT HAVE HAPPENED

<table>
<thead>
<tr>
<th>SEPARATIONS</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Were you separated from BOTH your parents (or primary caregivers) for a long time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Were you separated from ONE of your parents (or primary caregivers) for a long time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Were you separated from a brother or sister for a long time?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOME AND POSSESIONS</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4) Was your home seriously damaged in the war?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Were you forced by violence or threat of violence, to leave your home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) Were things stolen from your home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) Did someone steal money or things from you or your family while you were trying to leave your country?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THREAT AND HARM TO LOVED ONES</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>(8) During or after your travel out of your country, was a family member or close friend missing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9) Did anyone threaten to seriously hurt or kill a family member or close friend?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10) Was anyone in your family or close friends hurt?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(11) Did anyone in your family fight in the war?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>(12) Was anyone in your family taken to a camp or prison?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(13) Was a loved one tortured?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DIRECT PHYSICAL CONTACT WITH DANGER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(14) Were you ever so hungry that you thought you would die?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(15) Were you ever so cold that you thought you would die?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(16) Were you ever hit or kicked?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(17) Were you ever arrested or taken prisoner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WITNESSING VIOLENCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(18) Did you see lots of property destroyed eg: bridges or building burned or shelled?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(19) Did you see shelling or bombing from a close distance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(20) Did you see shooting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(22) Did you see looting or vandalism of property?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(23) Did you see someone severely injured?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(24) Did you see dead bodies?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(25) Did you see anyone being killed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(26) Did you touch or carry someone who had been wounded or killed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(27) Did you witness someone being taken prisoner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PHYSICAL THREAT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(28) Were you ever shot at or seriously hurt?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(29) Did soldiers or men with guns ever come to your home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(30) Was there ever a time when you strongly believed that you would be seriously hurt or killed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LOSSES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(31) Was your father killed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(32) Was your mother killed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(33) Was your brother or sister killed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(34) Was a close member of your extended family killed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(35) Was a close personal friend killed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(36) How long ago did these experiences happen? (years/ months/ don’t know)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
We are now going to ask you a few questions about how your experiences affect you right now.... Here is a list of comments made by people after frightening experiences. We would like you to think about the most frightening thing that happened to you....and please tick each item which shows how often this comment was true for you during the past seven days.

If they did not occur during that time please tick 'not at all' box.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do you think about it even when you don't mean to?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Do you try to remove it from your memory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Do you have difficulties paying attention or concentrating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Do you have waves of strong feelings about it</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
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</table>

© Institute of Psychiatry 1998
Name:

Instructions: Please read each item and choose a phrase that applies (if any). Next, answer both questions to the right of each selected item and circle the best answer.

I thought about something else; tried to forget it; and/or went and did something like watch the telly or play games to get it out of my mind.

I stayed away from people; kept my feelings to myself; and handled that time on my own.

I tried to see the good side of things and/or concentrated on something good that could come out of it.

I realized I brought the problem on myself and blamed myself for causing it.

I realized that someone else caused the problem and blamed them for making me go through this.

I thought of ways to solve the problem; asked others to get more facts and information about the problem and/or tried to solve the problem.

I talked about how I was feeling; cried, screamed or hit something.

I tried to calm down by talking to myself, going for a walk and/or I just sat down.

I thought of ways to solve the problem; led to solve the problem.

I accepted the problem because I couldn’t do anything about it.
For each item please mark the box for Not true, Somewhat true or Certainly True. Could you answer these as best you can even if you are not absolutely certain or the answer seems daft!

<table>
<thead>
<tr>
<th>I try to be nice to other people. I care about their feelings</th>
<th>Not true</th>
<th>Somewhat true</th>
<th>Certainly true</th>
</tr>
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<tr>
<td>I usually do as I am told</td>
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<tr>
<td>I am often unhappy, down-hearted or tearful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other people my age generally like me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am easily distracted, I find it difficult to concentrate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am nervous in new situations. I easily loose confidence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am kind to younger children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am often accused of lying or cheating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other children or young people pick on me or bully me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often volunteer to help others (parents, teachers, children)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I think before I do things</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take things that are not mine from home, school or elsewhere</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I get on better with adults than with people my own age</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I have many fears, I am easily scared</td>
<td></td>
<td></td>
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<tr>
<td>I finish the work I'm doing. My attention is good</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Revised Children's Manifest Anxiety Scale

Please read each sentence carefully and put a circle around the word YES if you think it is true about you, and put a circle around the word NO if you think it is not true about you.

| 1 | I have trouble making up my mind. | Yes | No |
| 2 | I get nervous when things do not go the right way for me. | Yes | No |
| 3 | Others seem to do things easier than I can. | Yes | No |
| 4 | I like everyone I know. | Yes | No |
| 5 | Often I have trouble getting my breath. | Yes | No |
| 6 | I worry a lot of the time. | Yes | No |
| 7 | I am afraid of a lot of things. | Yes | No |
| 8 | I am always kind. | Yes | No |
| 9 | I get mad easily. | Yes | No |
| 10 | I worry about what my parents will say to me. | Yes | No |
| 11 | I feel that others do not like the way I do things. | Yes | No |
| 12 | I always have good manners. | Yes | No |
| 13 | It is hard for me to get to sleep at night. | Yes | No |
| 14 | I worry about what other people think about me. | Yes | No |
| 15 | I feel alone even when there are people with me. | Yes | No |
| 16 | I am always good. | Yes | No |
| 17 | Often I feel sick in my stomach. | Yes | No |
| 18 | My feelings get hurt easily. | Yes | No |
| 19 | My hands feel sweaty. | Yes | No |
| 20 | I am always nice to everyone. | Yes | No |
| 21 | I am tired a lot. | Yes | No |
| 22 | I worry about what is going to happen. | Yes | No |
| 23 | Other children are happier than I am. | Yes | No |
| 24 | I tell the truth every single time. | Yes | No |
| 25 | I have bad dreams. | Yes | No |
| 26 | My feelings get hurt easily when I am told off. | Yes | No |
| 27 | I feel someone will tell me I do things the wrong way. | Yes | No |
| 28 | I never get angry. | Yes | No |
| 29 | I wake up scared some of the time. | Yes | No |
| 30 | I worry when I go to bed at night. | Yes | No |
| 31 | It is hard for me to keep my mind on my schoolwork. | Yes | No |
| 32 | I never say things I shouldn't. | Yes | No |
| 33 | I wiggle in my seat a lot. | Yes | No |
| 34 | I am nervous. | Yes | No |
| 35 | A lot of people are against me. | Yes | No |
| 36 | I never lie. | Yes | No |
| 37 | I often worry about something bad happening to me. | Yes | No |
The statements below refer to how you felt over the past week. There are no right answers but it is important to say how you have felt. Please answer as honestly as you can. Put a tick in the appropriate box. Thank you.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I look forward to things as much as I used to</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>2.</td>
<td>I sleep very well</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>3.</td>
<td>I feel like crying</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>4.</td>
<td>I like to go out to play</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>5.</td>
<td>I feel like running away</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>6.</td>
<td>I get tummy aches</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>7.</td>
<td>I have lots of energy</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>8.</td>
<td>I enjoy my food</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>9.</td>
<td>I can stick up for myself</td>
<td>[ ]</td>
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<td>10.</td>
<td>I think life isn't worth living</td>
<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>11.</td>
<td>I am good at things I do</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>12.</td>
<td>I enjoy things I do as much as I used to</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>13.</td>
<td>I like talking with my family</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>14.</td>
<td>I have horrible dreams</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>15.</td>
<td>I feel very lonely</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>16.</td>
<td>I am easily cheered up</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>17.</td>
<td>I feel so sad I can hardly stand it</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>18.</td>
<td>I feel very bored</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Well done! You've finished! Thank you for your help.
Do you remember that before the group started we gave you a book with some questions to answer? Now, as we finish we are going to ask you to answer some more questions.

We are doing this so that we can make the group better for other children in the future. Remember......

There are no right or wrong answers- we just want you to tell the truth. Your answers will be kept safe and even the people running the group will not look at what you have said until afterwards.

- Sometimes you will be asked to say yes or no to something. Please mark the box that is true, for example:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>I like playing football</td>
<td></td>
<td>√</td>
</tr>
</tbody>
</table>

- Sometimes you will be asked to show how much you agree, for example:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Mainly not</th>
<th>Sometimes</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>I like football</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Sometimes we will ask you to write something- I like football because...eg: I like scoring goals..............

If you find it hard to write, please tell us and remember we don’t mind if you spell things wrong!

Please ask if you do not understand a word and, as you have been asked throughout the group, please tell us if you feel upset!!
Let's start with some writing questions!

Did you feel like you wanted to join in with the group?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Mainly not</th>
<th>Sometimes</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
</table>

Did you want to talk about the things we talked about?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Mainly not</th>
<th>Sometimes</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
</table>

Did you think about the group in the week between the sessions?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Mainly not</th>
<th>Sometimes</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
</table>

How much do you think that you joined in with the group?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Mainly not</th>
<th>Sometimes</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
</table>

Do you think that the group helped you?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Mainly not</th>
<th>Sometimes</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
</table>

What do you think was helpful about the group?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
Since you’ve been involved in the group how have you been trying to deal with remembering your frightening experiences?

<table>
<thead>
<tr>
<th></th>
<th>Tell someone</th>
<th>Tell no-one</th>
<th>Try to think about something else</th>
<th>Cry</th>
<th>Something different</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I’m frightened 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Write below</td>
</tr>
</tbody>
</table>

Write your own here: .................................................................

........................................................................................................

........................................................................................................

Since you’ve been in the group, does what you do when you remember help you to feel better or not?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>No change</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
</table>

Do you think talking about memories will make you feel better, worse, no different?

<table>
<thead>
<tr>
<th></th>
<th>Much worse</th>
<th>A little worse</th>
<th>No change</th>
<th>Better</th>
<th>Much better</th>
</tr>
</thead>
</table>

The worst thing about the group was:

........................................................................................................

........................................................................................................

........................................................................................................

The best thing about the group was:

........................................................................................................

........................................................................................................
We are now going to ask you a few questions about how your experiences affect you right now... Here is a list of comments made by people after frightening experiences. We would like you to think about the most frightening thing that happened to you... and please tick each item that shows how often this comment was true for you during the past seven days. If they did not occur during that time please tick the ‘not at all’ box.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you think about it even when you don’t mean to?</td>
<td>[ ]</td>
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<td>2. Do you try to remove it from your memory</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>3. Do you have difficulties paying attention or concentrating</td>
<td>[ ]</td>
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<tr>
<td>4. Do you have waves of strong feelings about it</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
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<td>5. Do you startle more easily or feel more nervous than you did before it happened?</td>
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<td>6. Do you stay away from reminders of it (e.g. places or situations)</td>
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<td>7. Do you try not talk about it</td>
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<td>8. Do pictures about it pop into your mind?</td>
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<td>[ ]</td>
<td>[ ]</td>
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</tbody>
</table>
In the group we have been thinking about how to use 'recovery techniques' to cope with frightening experiences.

We would like you to think about times that your frightening experiences have bothered you since you have been coming to the group and tell us in the last week what you have tried and what you have found helpful or not........???
**Kidcope — Older Children**

Name:

**Instructions:** Please read each item and circle a phrase that applies (if any). Next, answer both questions to the right of each selected item and circle the best answer.

- How often did you do this?
- How much did it help?

1. I thought about something else; tried to forget it; and/or went and did something like watch the telly or play games to get it out of my mind
   - Not at all
   - Sometimes
   - A lot of the time
   - Almost all the time

2. I stayed away from people; kept my feelings to myself; and handled that time on my own
   - Not at all
   - Sometimes
   - A lot of the time
   - Almost all the time

3. I tried to see the good side of things and/or concentrated on something good that could come out of it
   - Not at all
   - Sometimes
   - A lot of the time
   - Almost all the time

4. I realized I brought the problem on myself and blamed myself for causing it
   - Not at all
   - Sometimes
   - A lot of the time
   - Almost all the time

5. I realized that someone else caused the problem and blamed them for making me go through this
   - Not at all
   - Sometimes
   - A lot of the time
   - Almost all the time

6. I thought of ways to solve the problem; talked to others to get more facts and information about the problem and/or tried to solve the problem
   - Not at all
   - Sometimes
   - A lot of the time
   - Almost all the time

7. I talked about how I was feeling; shouted, screamed or hit something
   - Not at all
   - Sometimes
   - A lot of the time
   - Almost all the time

8. I tried to calm down by talking to myself, going for a walk and/or I just relaxed
   - Not at all
   - Sometimes
   - A lot of the time
   - Almost all the time

9. I kept thinking and wishing that this had never happened; and/or that I could change what had happened
   - Not at all
   - Sometimes
   - A lot of the time
   - Almost all the time

10. I turned to my family, other adults or ends to help me feel better
    - Not at all
    - Sometimes
    - A lot of the time
    - Almost all the time

11. I accepted the problem because I couldn't do anything about it.
    - Not at all
    - Sometimes
    - A lot of the time
    - Almost all the time


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For each item please mark the box for Not true, Somewhat true or Certainly True. Could you answer these as best you can even if you are not absolutely certain or the answer seems daft!

<table>
<thead>
<tr>
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<th>Not true</th>
<th>Somewhat true</th>
<th>Certainly true</th>
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</thead>
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<td>I am helpful if someone is hurt, upset or feeling ill</td>
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<td>I am constantly fidgeting or squirming</td>
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<td>I have one good friend or more</td>
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<td>I am often unhappy, down-hearted or tearful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other people my age generally like me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am easily distracted, I find it difficult to concentrate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am nervous in new situations. I easily lose confidence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am kind to younger children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am often accused of lying or cheating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other children or young people pick on me or bully me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often volunteer to help others (parents, teachers, children)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I think before I do things</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take things that are not mine from home, school or elsewhere</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I get on better with adults than with people my own age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have many fears, I am easily scared</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I finish the work I'm doing. My attention is good</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Revised Children's Manifest Anxiety Scale

Name: ................................................................. Date of birth: ..................................... Today's date: ..................................

Please read each sentence carefully and put a circle around the word YES if you think it is true about you, and put a circle around the word NO if you think it is not true about you.

<table>
<thead>
<tr>
<th></th>
<th>1 I have trouble making up my mind.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 I get nervous when things do not go the right way for me.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>3 Others seem to do things easier than I can.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>4 I like everyone I know.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>5 Often I have trouble getting my breath.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>6 I worry a lot of the time.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>7 I am afraid of a lot of things.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>8 I am always kind.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>9 I get mad easily.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>10 I worry about what my parents will say to me.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>11 I feel that others do not like the way I do things.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>12 I always have good manners.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>13 It is hard for me to get to sleep at night.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>14 I worry about what other people think about me.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>15 I feel alone even when there are people with me.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>16 I am always good.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>17 Often I feel sick in my stomach.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>18 My feelings get hurt easily.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>19 My hands feel sweaty.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>20 I am always nice to everyone.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>21 I am tired a lot.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>22 I worry about what is going to happen.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>23 Other children are happier than I am.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>24 I tell the truth every single time.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>25 I have bad dreams.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>26 My feelings get hurt easily when I am told off.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>27 I feel someone will tell me I do things the wrong way.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>28 I never get angry.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>29 I wake up scared some of the time.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>30 I worry when I go to bed at night.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>31 It is hard for me to keep my mind on my schoolwork.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>32 I never say things I shouldn't.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>33 I wiggle in my seat a lot.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>34 I am nervous.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>35 A lot of people are against me.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>36 I never lie.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>37 I often worry about something bad happening to me.</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
The statements below refer to how you felt over the past week. There are no right answers but it is important to say how you have felt. Please answer as honestly as you can. Put a tick in the appropriate box. Thank you.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I look forward to things as much as I used to</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>2.</td>
<td>I sleep very well</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>3.</td>
<td>I feel like crying</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>4.</td>
<td>I like to go out to play</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>5.</td>
<td>I feel like running away</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>6.</td>
<td>I get tummy aches</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>7.</td>
<td>I have lots of energy</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>8.</td>
<td>I enjoy my food</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>9.</td>
<td>I can stick up for myself</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>10.</td>
<td>I think life isn't worth living</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>11.</td>
<td>I am good at things I do</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>12.</td>
<td>I enjoy things I do as much as I used to</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>13.</td>
<td>I like talking with my family</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>14.</td>
<td>I have horrible dreams</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>15.</td>
<td>I feel very lonely</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>16.</td>
<td>I am easily cheered up</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>17.</td>
<td>I feel so sad I can hardly stand it</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>18.</td>
<td>I feel very bored</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

WELL DONE! YOU'VE FINISHED!

Thank you for your help.
Engagement in group

Name: [ ] Date of session: [ ]

Child ID: [ ] Session No. [ ]

1. To what extent did she/he join in group discussions?

0 --- 1 --- 2 --- 3 --- 4

- Said nothing
- Spoke occasionally
- Shared at every opportunity

2. To what extent did she/he participate in exercises?

0 --- 1 --- 2 --- 3 --- 4

- Reluctant to do tasks
- Completed some tasks
- Completed all tasks

3. To what extent did she/he show a full range of feelings including difficult/uncomfortable ones?

0 --- 1 --- 2 --- 3 --- 4

- No feelings/emotions shown
- Some +ve and -ve feelings
- Range of +ve and -ve

4. To what extent did she/he disengage from emotional material by behaviour eg: interrupting others, talking about irrelevant material (e.g. TV) or acting out?

0 --- 1 --- 2 --- 3 --- 4

- Behaviour repeatedly disengaged
- Behaviour sometimes disengaged
- No disengagement from material

5. To what extent did she/he attend to (listen, watch) what was happening in the group?

0 --- 1 --- 2 --- 3 --- 4

- Not attending - daydreaming
- Attended at times
- Following events intently

6. Overall how would you rate his/her engagement in the group today?

0 --- 1 --- 2 --- 3 --- 4

- Not participating/engaged
- Sometimes engaged
- Fully participated
Appendix 9:

Table to show correlations between clinician rating of engagement across items and sessions

<table>
<thead>
<tr>
<th></th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Mean-all sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Join in discussions</td>
<td>0.693</td>
<td>0.619</td>
<td>0.832</td>
<td>0.588</td>
<td>0.538</td>
<td>0.65</td>
</tr>
<tr>
<td>(2) Participate in exercises</td>
<td>0.745</td>
<td>0.836</td>
<td>0.619</td>
<td>0.486</td>
<td>0.557</td>
<td>0.65</td>
</tr>
<tr>
<td>(3) Show range of feelings</td>
<td>0.584</td>
<td>0.576</td>
<td>0.348</td>
<td>0.380</td>
<td>0.522</td>
<td>0.48</td>
</tr>
<tr>
<td>(4) Disengage from tasks</td>
<td>0.826</td>
<td>0.683</td>
<td>0.624</td>
<td>0.589</td>
<td>0.833</td>
<td>0.71</td>
</tr>
<tr>
<td>(5) Attend (listen/ watch)</td>
<td>0.436</td>
<td>0.736</td>
<td>0.575</td>
<td>0.734</td>
<td>0.686</td>
<td>0.63</td>
</tr>
<tr>
<td>(6) Overall rating</td>
<td>0.741</td>
<td>0.572</td>
<td>0.583</td>
<td>0.621</td>
<td>0.783</td>
<td>0.66</td>
</tr>
<tr>
<td>Mean- All Questions</td>
<td>0.67</td>
<td>0.67</td>
<td>0.60</td>
<td>0.57</td>
<td>0.65</td>
<td>0.63</td>
</tr>
</tbody>
</table>

Appendix 10:

Graph to show distribution of mean clinician rated engagement across groups.
Appendix 11:

Table to show $F$ and $p$ values for repeated measures ANOVA using Wilks' Lambda on R-IES measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Age $F(1, 27)$</th>
<th>Gender $F(1, 27)$</th>
<th>School/Clinic $F(1, 27)$</th>
<th>Mean engagement $F(1, 25)$</th>
</tr>
</thead>
<tbody>
<tr>
<td>R-IES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrusion subscale</td>
<td>$F = 1.49$</td>
<td>$F = 0.055$</td>
<td>$F = 0.417$</td>
<td>$F = 0.372$</td>
</tr>
<tr>
<td></td>
<td>$p = 0.233$</td>
<td>$p = 0.816$</td>
<td>$p = 0.524$</td>
<td>$p = 0.547$</td>
</tr>
<tr>
<td>Avoidance subscale</td>
<td>$F = 1.308$</td>
<td>$F = 0.550$</td>
<td>$F = 2.979$</td>
<td>$F = 0.001$</td>
</tr>
<tr>
<td></td>
<td>$p = 0.263$</td>
<td>$p = 0.465$</td>
<td>$p = 0.096$</td>
<td>$p = 0.980$</td>
</tr>
<tr>
<td>Arousal subscale</td>
<td>$F = 1.066$</td>
<td>$F = 0.689$</td>
<td>$F = 0.007$</td>
<td>$F = 0.126$</td>
</tr>
<tr>
<td></td>
<td>$p = 0.311$</td>
<td>$p = 0.414$</td>
<td>$p = 0.934$</td>
<td>$p = 0.726$</td>
</tr>
<tr>
<td>Intrusions + avoidance</td>
<td>$F = 2.529$</td>
<td>$F = 0.157$</td>
<td>$F = 0.679$</td>
<td>$F = 0.001$</td>
</tr>
<tr>
<td></td>
<td>$p = 0.123$</td>
<td>$p = 0.695$</td>
<td>$p = 0.417$</td>
<td>$p = 0.975$</td>
</tr>
<tr>
<td>Total- all scales</td>
<td>$F = 0.149$</td>
<td>$F = 0.605$</td>
<td>$F = 0.062$</td>
<td>$F = 0.000$</td>
</tr>
<tr>
<td></td>
<td>$p = 0.702$</td>
<td>$p = 0.444$</td>
<td>$p = 0.805$</td>
<td>$p = 0.997$</td>
</tr>
</tbody>
</table>
Appendix 12:

Responses on feedback form about the group

Participants wording and spelling has been used as much as possible. A number of participants left the forms blank but all responses are reported here.

The worst thing about the group was…

Most participants left this blank. The responses of those who did respond were:

- Six responded “nothing”
- I didn’t know what to do and I was not a friend so I was by myself (participant dropped out)
- When the others couldn’t answer and the teacher just picked someone if it was me it would have been hard
- The worst thing is when we have to talk to the teacher or other students about yourself
- Too much paper work
- That lots of the children called me names like fat nose
- Talking
- When you should talk or draw or write it makes me so more scared
- It was a bit long
- That there were more boys than girls
- The wasn’t really anything worse but I don’t really like to talk about what happened but it was ok
- When the bean bag ripped
- Thinking about it to forget it
- That they don’t normally let us do whatever we want
The best thing about the group was........

Many more participants completed this section. Their responses were:

- Three said “everything”
- How to cooperate with your fear- how to face your fear
- The best thing was it was very helpful when you draw or write about your bad memories
- Other people feel the same way I do
- I think the helpfullest thing was that I forgot about my fears and I don’t think about them anymore.
- I learnt a lot about forgetting my fears and memories
- Learning how to change the pictures and to small a picture to make me sleep and we was thinking about how to smash the picture in your mind
- Learning how to take the image away from us mind, how to sleep nice, smell stuff for sleep relax much more much more much more
- Drawing all the stuff we did
- The children and the teacher
- They showed they cared a lot
- That they were helpful
- It was not by myself it was as a group and some good ideas
- The relaxing and the TV with the black and white colour and lesson to music
- We speak to each other and cheat the information
- The thing that you telly use and you don’t make us very scared
- It helped the picture get out of my mind
• When they say to practice in the room or look at your fear or talk to your parents\(^y\)
• To face your fears with practice when they gave you homework to practice
• I heard everyone's ideas of how to deal with things
• I learned how to deal with bad memories and images
• Expressing yourself and sharing your opinion with other members of the group
• The group was helpful to me because they taught me how to vanish the bad memories
• I liked everything in the group
• The way that there was other people there like me
• I talked and drewed about what happened a long time ago which kind of helped me\(^x\)
• Everything they learned us how we could handle the memories
• I learnt some new things
• Calming our stories down (Missing IT and Humanities)
• They helped me to forget and how to control my memories
• They made me forget things and maked me be brave
• The pictures and that if we never wanted to say anything you didn't have to

\(^x = \text{same participant}; \ ^y = \text{same participant}\)