A Systematic Review of School-Based Social-Emotional Interventions for Refugee and War-Traumatized Youth

Amanda L. Sullivan and Gregory R. Simonson
University of Minnesota

Refugees often experience significant psychological distress, but many do not receive necessary services. Among children and youth, most mental health services are provided by schools, so schools are an important service provider for young refugees. We conducted a systemic literature review to synthesize and evaluate the existing research on school-based interventions to improve mental health or social-emotional functioning of students who are refugees, asylum seekers, or immigrants with war trauma. Three types of school-based interventions were identified: cognitive behavioral therapy, creative expression, and multitiered or multimodal models. The review identified several interventions with positive effects, as well as multiple interventions that had null or negative effects. We address the implications of this body of intervention research for practice and research.

Keywords: school, intervention, refugee, cognitive behavioral therapy, creative expression therapy

The question of how to foster the resilience and well-being of refugees and war-exposed youth is a public health concern (Asarnow, 2011). The continued influx of refugees and others from trauma-ridden locales, many of whom are children, means that schools are often challenged to address the significant mental health needs of these unique populations. Although many refugees demonstrate considerable resiliency and adaptability, their premigration experiences, coupled with the difficult circumstances associated with resettlement, can cause substantial psychological distress for many refugee youth (Bronstein & Montgomery, 2011). Given the relations between mental health, academic performance, and general well-being, educators should be concerned with ensuring these students receive needed supports.

Furthermore, given disparities in access to pediatric mental health services (Alegria, Vallas, & Pumariega, 2010) and schools’ position as a primary provider...
of children’s mental health services, schools may be the first or only provider of mental health services for many of these children and youth. Thus, there is value in knowing what school-based interventions are available for this population. In this systematic review, we synthesize and evaluate the research on school-based social-emotional intervention for refugees and war-traumatized youth, emphasizing a psychoeducational perspective of understanding and intervening to improve youths’ functioning and well-being.

Who Are the World’s Refugees?

The world’s refugee population is composed of a diverse assortment of individuals and groups who fled their home countries due to actual or feared persecution. The United Nations High Commissioner for Refugees (UNHCR; 1951) formally defined a refugee as any person who,

Owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. (p. 14)

It is this persecution that generally distinguishes refugees from other immigrant and migrant groups. More broadly, the term person of concern describes an individual seeking asylum, lacking citizenship in any nation or state, or displaced within their native country by violence or conflict, as well as returning refugees.

As of 2012, there were an estimated 34 million known persons of concern worldwide, one third of whom were refugees (UNHCR, 2012b). The number of such individuals has been rising since 2005 due to new and continuing conflicts in the Middle East and Northeastern Africa (UNHCR, 2012a). Most refugees hail from a few countries: Palestine, Afghanistan, Iraq, Columbia, Sudan, Somalia, Burundi, Congo, Vietnam, Turkey, and Eritrea (UNHCR, 2009). In recent years, however, the number of asylum seekers from Eastern Europe has increased sharply (UNHCR, 2013b). Asia is temporarily host to nearly half of all refugees, but of industrialized nations, the United States receives the most applications for asylum (UNHCR 2013b) and has the largest number of permanently resettled refugees (UNHCR, 2009).

Nearly half a million refugees reside in North America, and as of 2012, there were an estimated 265,000 refugees and an additional 276,000 persons of concern residing in the United States (UNHCR, 2013a). Most U.S. asylum seekers are from China, Mexico, El Salvador, and Guatemala (UNHCR, 2013b). We limited this review to refugees and immigrant persons of concern because of the common persecution, flight, and resettlement experiences generally shared by these children and youth, which are increasingly recognized as warranting targeted intervention (Tyler & Fazel, 2014). Although there are certainly other groups that experience involuntary migration (e.g., victims of natural disasters, endemic
disease, famine; Brody, 1994), the persecution and violence or threat thereof is unique to these groups.

**Refugee Children**

Refugee services are an international issue for schools because 47% of persons of interest and 44% of refugees are younger than 18 years of age (UNHCR, 2010). In the United States, approximately 39% of new refugees are children and youth (Martin & Yankay, 2012). However, current statistics may underestimate the true number of child refugees worldwide, because children often lack official identification and, as such, are difficult to monitor. Refugee children are a particularly vulnerable and victimized group. They are at heightened risk due to war-induced trauma compared with adults (McCloskey & Southwick, 1996) and many are separated from their families, which further elevates the risk of severe psychological difficulty (Bronstein & Montgomery, 2011) and frequently exposes them to exploitation, trafficking, and abuse (United Nations Children’s Fund, 2012). This is not to say that refugee children and youth will necessarily experience impairment, as various cultural, familial, and experiential factors may bolster resilience and contribute to improved psychological functioning following trauma (Montgomery, 2010).

In the remainder of this article, we focus on mental health and related services of these youth because of the long-term implications of psychological impairments for individuals’ outcomes in education, work, and other societal contexts. These negative outcomes are especially true in children and youth, who may experience social, academic, and functional difficulties into adulthood as a consequence of childhood mental health problems (Currie & Stabile, 2007). For refugee children, numerous experiential factors increase their likelihood of experiencing symptoms and disorders that negatively affect their functioning and outcomes in a variety of contexts.

**Refugees’ Preflight Trauma**

Many factors may lead individuals to flee their home countries, but most refugees experienced some level of trauma prior to flight. Refugees often experience significant psychological distress due to exposure to direct or indirect trauma, as well as intergenerational trauma transferred between family members (A. Baker & Shalhoub-Kevorkian, 1999). Trauma can have a cumulative effect, such that effects increase with repeated trauma (Bronstein & Montgomery, 2011), or a dose-effect relationship between trauma and symptoms after resettlement (Kia-Keating & Ellis, 2007). Such symptoms increase by the number or severity of traumas.

The preflight traumas experienced by refugee youth are diverse and severe. Youth who experienced or witnessed violence or the loss of a parent or family member are at the highest risk for developing psychopathology (Bronstein & Montgomery, 2011; Hodes, 1998; Kia-Keating & Ellis, 2007; Rousseau, 1995). In one small study of the preflight experiences of 100 refugee youth between the ages of 12 and 18 in the United Kingdom, 86% of the youth had witnessed or experienced violence, with an average of 4.8 violent incidents reported per child (Thomas, Thomas, Nafees, & Bhugra, 2004). In addition, 32% of the sample had
been raped, 13% had been imprisoned or detained, and 16% had lived in hiding. These refugees fled their home countries for various reasons: 37% fled due to the death or persecution of family members, 21% had been persecuted themselves, and 15% had been forced into war or sex slavery. Although the sample was small, their experiences mirror those reported by the children and adolescents who participated in many of the intervention studies reviewed in this article.

Scholars have suggested that refugees’ trauma extends beyond the experiences that spur their exit from their native country. Fazel and Stein (2002) categorized the typical traumas experienced by refugee children into three stages. First, children are often forced to flee their homes due to war or combat in their home country, meaning they experience firsthand or bear witness to the atrocities of war. Next, they journey to a host country, which is often a long and dangerous trek, and many children are separated from their families. Finally, they find respite in a host country but often have difficulty integrating and acculturating (Bronstein & Montgomery, 2011; Fazel & Stein, 2002). Refugees must adjust to a new culture and language, and their caregivers must find a way to establish themselves financially and socially (Kia-Keating & Ellis, 2007). Given these experiences, psychological distress is widespread in this population.

Psychological Sequelae of Refugees’ Trauma

Children and adolescents respond to trauma with a variety of symptoms: fear, sadness, apathy, inattention, anger, irritability, separation anxiety, sleep disturbances, somatic complaints (e.g., headaches and stomachaches), and school problems (American Psychological Association, 2008). Many children exposed to trauma display severe psychological distress. Several studies have documented high rates of anxiety, depression, posttraumatic stress disorder (PTSD), and attention-deficit/hyperactivity disorder among refugee youth (A. Baker & Shalhoub-Kevorkian, 1999; Bronstein & Montgomery, 2011; Ehntholt, Smith, & Yule, 2005; Hodes, 1998; McCloskey & Southwick, 1996; Rousseau, 1995). Hodes (1998) estimated that 40% to 50% of refugee youth experienced one or more mental disorders, a rate twice that of U.S. adolescents (Kessler et al., 2012).

Researchers have focused largely on PTSD, which is a psychiatric disorder in which the cause is a known traumatic event. Symptoms include reexperiencing of the trauma, avoidance of trauma-related stimuli or emotional numbing, and hyperarousal (American Academy of Child and Adolescent Psychiatry [AACAP], 2010). These general symptoms may present as sleep difficulties, irritability, anxiety, difficulty concentrating, oppositional behavior, separation anxiety, fears, apathy, and other impairments, including reduced academic achievement. Prevalence estimates of PTSD range from 5% up to 54% across studies (A. Baker & Shalhoub-Kevorkian, 1999; Bronstein & Montgomery, 2011; Ehntholt & Yule, 2006). Among refugees in the United Kingdom, for example, rates of PTSD are at least three times that of the general population (Fazel & Stein, 2003). A more recent meta-analysis of nearly 7,000 adult and 260 child refugees in Western countries showed the prevalence of PTSD among refugees to be 11% among children, 10 times that of age-matched Americans (Fazel, Wheeler, & Danesh, 2005).
It is worth noting that within psychiatry and psychology, some clinicians and scholars question the validity of psychiatric diagnoses for diverse populations such as refugees. Some researchers argued these children should not be considered ill as their behaviors reflect inevitable responses to extreme circumstances, whereas others argue that symptom manifestation is culturally bound (Rousseau, 1995). For example, Rousseau (1995) argued that following certain trauma, American children tended to have more externalizing symptoms, presumably due to a loss of control, whereas Thai and Cambodian children internalized symptoms, indicating that these children controlled their emotions in accordance with their cultural and religious beliefs. Conversely, Ehntholt and Yule (2006) contended that mental health diagnoses reflect an internationally agreed on system of classification, the International Classification of Diseases (ICD-10). Irrespective of these rival perspectives, the symptoms experienced by refugee youth may warrant medical or mental health services and supports to promote adaptive functioning and overall well-being.

**Mental Health Treatment and Utilization Among Refugees**

Mental health services include a variety of counseling, individual or family therapy, psychoeducation or skills training, family or peer support, and psychopharmacological interventions delivered by clinical, counseling, or school psychologists; psychiatrists; therapists; social workers; nurses; and physicians to address individuals’ psychiatric, social-emotional, or behavioral difficulties. Despite a frequent need for services, refugees often underutilize mental health services (Rousseau & Guzder, 2008). This unfortunate trend may be attributable to three factors: the mean age of refugees, the high frequency of internalizing symptoms, and the racial/ethnic minority status of most refugees. Refugees are disproportionately young, which may partially account for their low rates of service usage since children and adolescents generally utilize mental health services at lower rates than adults do (Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006), and because treatment is generally contingent on referral by parents or other adults.

Refugees often experience internalizing symptoms, which, relative to externalizing symptoms, are associated with lower rates of treatment, presumably because their symptoms are less noticeable or intrusive to others, thus reducing likelihood of referral. Finally, in most Western countries, racial-ethnic minorities have significantly lower rates of mental health treatment than their White peers (Bean, Eurelings-Bontekoe, et al., 2006) often because of linguistic and cultural barriers to appropriate services, but disparities in participation remain even when access is equalized (Alegria et al., 2010). As many refugee youth simultaneously demonstrate all of these factors, there may be a cumulative effect on service utilization.

Even when refugees need and want services, however, they may not receive them. In a large study of nearly 1,000 randomly selected refugees and a similarly sized Dutch control sample, Bean, Eurelings-Bontekoe et al. (2006) found that nearly 60% of refugees reported the need for mental health services due to emotional distress, compared with about 8% in the control sample. Although 72% of refugees expressed willingness to utilize mental health services and only 12% of participants in the control group did, only 13% of refugee youth received services, compared to 16% of controls. Thus, refugees had significant unmet needs for treatment.
It is likely that several barriers reduce refugee youths’ access to services (Ehntholt et al., 2005). Immigrant families in Western countries often have difficulty navigating public services for children, and the difficulty understanding these systems of care may be exacerbated by economic disadvantage, limited transportation, and fear of disclosure or stigma (Hodes, 1998). Cultural differences in conceptualizations of psychological functioning and treatment may also hinder treatment-seeking behaviors among immigrants, but language differences, lack of information, and cost are considered primary barriers (Saechao et al., 2012).

Schools as a Key Site for Services to Refugees

School participation is associated with resilience in refugee youth (Montgomery, 2010). A study of Somali adolescent refugees showed that a greater sense of school belonging was associated with lower depression and higher self-efficacy (Kia-Keating & Ellis, 2007). Wilkinson (2002) asserted that positive performance in school in part reflects adjustment and acculturation. Developing positive relationships with students is also conducive to students’ social-emotional functioning and competence.

As a primary care institution, schools are an important facet of most students’ and families’ lives and are positioned well to help address these gaps in the treatment of refugee children and youth (Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005). Schools are often the first, and primary, institution of socialization with which refugee students interact (Wilkinson, 2002) and can provide a stable source of social support for refugee youth as they acclimate to Western society. Given the historically poor academic performance of refugee youth overall (McCloskey & Southwick, 1996; Rousseau, 1995; for discussion of exceptions, see Wilkinson, 2002), there may be an interaction between a child’s refugee experience and educational outcomes following resettlement (Rousseau, 1995). Refugee students’ academic performance is especially depressed if they previously lived in refugee camps (Wilkinson, 2002) or their parents reported significant emotional problems (Rousseau, Drapeau, & Corin, 1996). Such findings suggest the need to address refugee students’ unique experiences and mental health in order to foster academic success. With this in mind, it is in the best interest of the schools to work toward positive mental health outcomes for refugee students in order to bolster educational outcomes.

Schools already work in a variety of ways to enhance students’ resilience, foster academic progress, and bolster behavioral and social adaptation (Fazel & Stein, 2002). Schools also have opportunities to screen and monitor all vulnerable children (Fazel, Doll, & Stein, 2009). For many refugees, schools act as an essential and sometimes sole link to the broader community (Birman et al., 2005; Fazel & Stein, 2002). Thus, Fazel and Stein (2002) asserted that schools are vital to primary prevention in mental health care for refugee children. Schools are also well positioned to provide services to refugee students in groups since refugees tend to resettle in clusters, making group treatment practical and affordable (Ehntholt et al., 2005). In addition, school-based services allow for ease of access and can reduce stigma associated with treatment (Berger, Pat-Horenczyk, &
School-based programs also have the benefit of being locally developed and small in scale, permitting practitioners to account for the specific cultural and contextual factors when designing programs (Rousseau, 1995) and to foster the development of local support networks around refugee children and families. Although some sites may struggle to provide specialized therapy to children with severe mental health needs (Rousseau, Armand, 2012), several small studies have shown positive effects in utilizing school-based mental health services to reduce clinically significant psychological symptoms and learning difficulties in both immigrant and refugee populations (Rousseau & Guzder, 2008). Although schools should not be the only source of care for refugee youth with significant psychological needs, they can support a large number of students.

Thus, it is clear that many refugee youth have significant unmet psychological needs and schools are poised to fill this crucial gap in service delivery to enhance the mental health and academic performance of refugee youth. With this in mind, we systematically reviewed the literature on school-based interventions to improve mental health or social-emotional functioning of refugee, asylum-seeking, and war-traumatized immigrant youth, describing methodological and practical limitations, as well as recommendations for educators.

**Method**

**Search Strategy**

We conducted a comprehensive search of the literature using a variety of search databases available through a university-based blended search interface that included MEDLINE/PubMed, ERIC, JSTOR, ScienceDirect, PLoS, OneFile, Health Reference Center Academic, PMC, SwePub, Ovid, Directory of Open Access Journals, and several other academic publisher databases (e.g., PsycArticles, Wiley Online, SpringerLink, Sage Journals, Oxford Journal, Cambridge Journals). Three broad searches were conducted in May 2015: The first using the search terms school, intervention or treatment, and refugee, the second and third replacing refugee with asylum and then *migrants and (war or conflict). The searches were set to identify studies in which these terms were used anywhere in the records. The three searches yielded 121, 21, and 6 results, respectively.

**Inclusion Criteria**

We selected studies for inclusion in this review based on the following criteria: (a) the study was an intervention to improve one or more dimensions of mental health or social-emotional functioning; (b) the intervention was delivered in a P-12 school setting; (c) the sample included children or youth identified as refugees, asylum seekers, or immigrants from war-affected countries; (d) the study reported on one or more child outcomes; (e) the study was published in a peer-reviewed journal; and (f) the article was published in English. We did not include criteria regarding the research design so as not to privilege any given methodology (e.g., quantitative research or experimental/quasi-experimental designs). Although the authors approach this topic from a psychological framework, we did
not limit this review to any particular fields or specialty areas (e.g., psychology, social work, special education), so as not to exclude relevant interventions delivered in schools because of the disciplinary identification of the researchers. Because our review differed from previous reviews in these two respects (e.g., Tyler & Fazel, 2014), we did not place any date restrictions on the search, and included studies published at any time. Due to the commonalities in the experiences of refugee youth in receiving countries, we did not limit the search by geographic location, resulting in an international sampling of literature.

From the initial results, we eliminated those sources identified as not from peer-reviewed journals \((n=70)\), not reporting studies \((n=4)\), not published in English \((n=10)\), and duplicate entries \((n=24)\). The titles, abstracts, and, where necessary, method sections of 40 articles were reviewed to determine inclusion based on descriptions of setting, intervention, and sampling. Of these, several were eliminated because they did not report intervention studies \((n=13)\); did not sample children or adolescent refugees, asylum seekers, or war-affected immigrants \((n=10)\); were not implemented in a P-12 setting \((n=3)\); or reported an academic intervention \((n=1)\). Because of the low yield (<10 studies), we expanded our search to hand searches of the reference lists of included studies and relevant review articles, and of the *Journal of Refugee Studies* and *Journal of Migration and Refugee Issues* to ensure all potentially applicable studies were identified.

**Coding and Synthesis**

Data extraction included the sample size, youth status (i.e., refugee, asylum-seeker, war-traumatized immigrant, other), national origin, geographic location of study, design, intervention component, and reported outcomes if available. We evaluated the identified studies to catalogue key elements of the designs. Because of the variability in methodologies included in the final sample of studies, we did not apply any formal analysis of the method, and instead provide qualitative discussion of the interventions and study methods. Studies were categorized by the types of interventions reported: cognitive behavioral interventions, creative expression interventions, and multitiered or multimodal strategies. These categories are described in more detail below.

**Results**

The review yielded 13 studies of school-based interventions with refugee, asylum-seeking, or war-traumatized immigrant children and youth. All studies were published since 2000. The studies varied in treatment approaches, dosage, dependent variables, and timeframes of assessment, precluding systematic aggregation (i.e., meta-analysis). As such, we provide narrative description and interpretation of these studies. The characteristics of the participants and settings are described in Table 1, followed by a description of the interventions and outcomes in Table 2.

**Participant and Setting Characteristics**

The studies reviewed included students of a variety of national and experiential backgrounds and were conducted in diverse educational settings, from refugee schools in the Middle East and Asia to U.S. urban public schools. Altogether, the
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<tr>
<th>Authors</th>
<th>n</th>
<th>Age range</th>
<th>Sample type</th>
<th>National/regional origins</th>
<th>Location</th>
<th>School type</th>
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<tbody>
<tr>
<td>F. Baker and Jones (2007)</td>
<td>43</td>
<td>11–16</td>
<td>Refugees</td>
<td>Sudan, Iran, Liberia, Rwanda, Ethiopia, Congo</td>
<td>Australia</td>
<td>English-language reception center high school in Queensland</td>
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<tr>
<td>Durà-Vilà, Klasen, Makatini, Rahini, and Hodes (2012)</td>
<td>120</td>
<td>3–17</td>
<td>Refugees</td>
<td>Middle East, Africa, European</td>
<td>U.K.</td>
<td>Primary school, secondary school, and homeless family service near London</td>
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<td>Ehntholt et al. (2005)</td>
<td>26</td>
<td>11–15</td>
<td>Refugees, asylum seekers</td>
<td>Kosovo, Sierra Leone, Turkey, Afghanistan, Somalia</td>
<td>U.K.</td>
<td>Two London secondary schools</td>
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<tr>
<td>Ellis et al. (2013)</td>
<td>30</td>
<td>11–15</td>
<td>Refugees</td>
<td>Somalia</td>
<td>U.S.</td>
<td>Middle school in New England to classes for English language learners</td>
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<td>Fazel et al. (2009)</td>
<td>141</td>
<td>4–19</td>
<td>Refugees</td>
<td>Balkans, Asia, India, Africa</td>
<td>U.K.</td>
<td>Primary, middle, and high school in Oxford with highest number of refugees</td>
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<tr>
<td>Kalantari, Yule, Dyregrov, Neshatdoost, and Ahmadi (2012)</td>
<td>64</td>
<td>12–18</td>
<td>Refugees</td>
<td>Afghanistan</td>
<td>Iran</td>
<td>Afghani refugee school</td>
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<td>O'Shea, Hodes, Down, and Bramley (2000)</td>
<td>14</td>
<td>7–11</td>
<td>Refugees</td>
<td>Middle East, Africa, Europe</td>
<td>U.K.</td>
<td>Junior school in inner-city west London</td>
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<th>Authors</th>
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<tr>
<td>Rousseau et al. (2005)</td>
<td>138</td>
<td>8–10</td>
<td>Refugees, immigrants</td>
<td>South America, Asia</td>
<td>Canada</td>
<td>Two Quebec elementary schools in integration classrooms for immigrants learning French and regular classes</td>
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<td>Rousseau et al. (2007)</td>
<td>123</td>
<td>12–18</td>
<td>Refugees, immigrants</td>
<td>South America, Asia, Eastern Europe, Africa</td>
<td>Canada</td>
<td>Montreal high school in integration classrooms for immigrants learning French</td>
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<td>Rousseau, Armand, et al. (2012)</td>
<td>55</td>
<td>12–18</td>
<td>Refugees, immigrants</td>
<td>South America, Asia</td>
<td>Canada</td>
<td>Montreal high school for underprivileged immigrants</td>
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<td>Yankey and Biswas (2012)</td>
<td>300</td>
<td>13–19</td>
<td>Refugees</td>
<td>Tibet, Nepal, Bhutan</td>
<td>India</td>
<td>Tibetan Children’s Village (school for refugees)</td>
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<tr>
<td>Authors</td>
<td>Design</td>
<td>Intervention</td>
<td>Interventionists</td>
<td>Targeted domains</td>
<td>Measures</td>
<td>Outcomes</td>
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<tr>
<td>Creative expression interventions</td>
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<tr>
<td>F. Baker and Jones (2007)</td>
<td>Two-group crossover experimental</td>
<td>2–5-week blocks music therapy, two times per week, for 30–40 minutes addressing sharing culture, self-identity, social skills, agency, impulse control, adjustment, acculturation, antiracism</td>
<td>Music therapist</td>
<td>Internalizing behavior, externalizing behavior, school and adaptive problems</td>
<td>Behavior Assessment Scale for Children–Teacher Report</td>
<td>Reduced externalizing behavior</td>
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<td>Kalantari et al. (2012)</td>
<td>Randomized controlled trial</td>
<td>3 days of two 15-minute group sessions over 3 days of Writing for Recovery activities about feelings and trauma</td>
<td>NR</td>
<td>Traumatic grief</td>
<td>Traumatic Grief Inventory for Children</td>
<td>Reduced traumatic grief</td>
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<td>Rousseau et al. (2005)</td>
<td>Quasi-experimental, nonequivalent groups</td>
<td>12-weekly 2-hour sessions of creative arts workshop featuring verbal and nonverbal expression</td>
<td>Art therapist, psychologist, and teacher</td>
<td>Self-esteem, emotional and behavioral problems</td>
<td>Piers-Harris Children’s Self-Concept Scale; Dominic Interactive Self-report; Child Behavior Checklist–Teacher Report</td>
<td>Increased self-esteem, decreased mental health symptoms</td>
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<tr>
<td>Rousseau et al. (2007)</td>
<td>Experimental</td>
<td>9-weekly 75-minute sessions of drama therapy program to share group stories to construct meaning and identity</td>
<td>Drama team trained in psychology, fine arts, and art therapy</td>
<td>Emotional and behavioral problems, academic performance</td>
<td>Strengths and Difficulties Questionnaire—Teaching rating and Self-report</td>
<td>No change in symptoms, less self-reported impairment, improved math relative to control</td>
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<tr>
<td>Rousseau, Armand, et al. (2012)</td>
<td>Quasi-experimental, nonequivalent groups</td>
<td>12-weekly 90-minute sessions of drama workshops and language awareness activities on varying themes</td>
<td>Drama therapist and teacher</td>
<td>Mental health symptoms, impairment, empowerment</td>
<td>Strength and Difficulty Questionnaire—Teacher rating, observations, unstructured interviews</td>
<td>Decreased impairment</td>
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TABLE 2 (continued)

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<th>Authors</th>
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<td>Ehntholt et al. (2005)</td>
<td>Quasi-experimental nonequivalent waitlist control</td>
<td>Six 1-hour sessions of manualized CBT, <em>Children and War: Teaching Recovery Techniques</em></td>
<td>Clinical psychology trainee</td>
<td>PTSD symptoms, depression and anxiety</td>
<td>Birleson’s (1981) Depression Self-Rating Scale and Teacher-Rating Scale; Revised Impact of Event Scale, Revised Children’s Manifest Anxiety Scale; Strengths and Difficulties Questionnaire</td>
<td>Reduction in PTSD</td>
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<td>Fox et al. (2005)</td>
<td>Pre-/posttest</td>
<td>8-weekly 1-hour group sessions of manualized cognitive behavior intervention for coping skill building with homework</td>
<td>Bilingual teachers and nurses</td>
<td>Depressive symptoms</td>
<td>Children’s Depression Inventory (Self-Report)</td>
<td>Reduction depression symptoms</td>
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<td>Schottelkorb et al. (2012)</td>
<td>Randomized controlled trial</td>
<td>12 weeks of twice weekly 30-minute sessions of manualized child-centered play therapy plus six 15-minute parent consults or nine 30-minute twice weekly manualized trauma-focused cognitive-behavioral therapy plus 2–4 parent meetings</td>
<td>Counseling graduate students supervised by licensed professional counselor</td>
<td>PTSD symptoms</td>
<td>UCLA PTSD Index for DSM-IV (American Psychiatric Association, 2000); Parent Report of Posttraumatic Symptoms</td>
<td>Decreased severity of PTSD symptoms for both groups according to parent and child report; no group differences</td>
</tr>
<tr>
<td>Yankey and Biswas (2012)</td>
<td>Quasi-experimental</td>
<td>30–45 sessions over 7 months of World Health Organization life skills training module contextualized for sample, for 10 core skills using brainstorming, role play, and group discussions</td>
<td>NR</td>
<td>Stress</td>
<td>Problem Questionnaire</td>
<td>Reduced stress</td>
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<th>Interventionists</th>
<th>Targeted domains</th>
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<td><strong>Multitiered or multimodal interventions</strong></td>
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<tr>
<td>Durà-Vilà et al. (2012)</td>
<td>Pre-/posttest</td>
<td>Varied community-based mental health services including family therapy, narrative therapy, cognitive therapy</td>
<td>Family therapists, psychiatric nurses, psychiatry trainee</td>
<td>Mental health symptoms, impairment</td>
<td>Strengths and Difficulties Questionnaire— Teacher and parent ratings, clinical interviews</td>
<td>Reduced symptoms and impairment</td>
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<td>Ellis et al. (2013)</td>
<td>Pre-/posttest</td>
<td>Project SHIFA: Tier 1: community education; Tier 2: 9 months of weekly resilience skill building group; Tier 3: skill-building trauma systems psychotherapy; Tier 4: home-based trauma systems therapy</td>
<td>Clinicians, social work interns in consultation and collaboration with Somali cultural brokers</td>
<td>Emotional and behavioral control</td>
<td>War Trauma Screening Scale, Adolescent Post-War Adversities Scale–Somali version, UCLA PTSD Reaction Index for DSM-IV, the Depression Self-Rating Scale</td>
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<td>Fazel et al. (2009)</td>
<td>Quasi-experimental nonequivalent control groups</td>
<td>Mental health consultation to teachers, family interventions, group interventions, individual psychotherapy, in-home treatment (range 2 sessions to weekly session for academic year)</td>
<td>Psychiatry trainee, creative arts psychotherapist</td>
<td>Mental health symptoms, impairment</td>
<td>Strengths and Difficulties Questionnaire— Teaching rating</td>
<td>Reduced problems, strongest effects for hyperactivity and peer problems</td>
</tr>
<tr>
<td>O'Shea et al. (2000)</td>
<td>Pre-/posttest</td>
<td>Family therapy, cognitive-behavioral therapy, exposure therapy, peer social skills groups, psychological debriefing via artwork</td>
<td>Outreach mental health worker</td>
<td>Mental health symptoms, impairment</td>
<td>Strengths and Difficulties Questionnaire— Teaching rating</td>
<td>Nonsignificant decrease in score</td>
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Note. DSM-IV = *Diagnostic and Statistical Manual of Mental Disorders*, text revision; NR = not reported; PTSD = posttraumatic stress disorder; CBT = cognitive-behavioral theory.
studies involved a total of 1,433 participants from 26 countries and 6 regions. All studies included students identified as refugees, one study also included asylum seekers, and five included other immigrants with war trauma. Participants ranged from age 3 to 19 years, but most included students aged 12 years or older. Description of the refugee-related experiences of students ranged from minimal (e.g., Rousseau et al., 2005) to detailed, with the specific types and frequencies of traumas experienced by students from detailed parent interviews or self-report measures (e.g., Durà-Vilà et al., 2012; Ehntholt et al., 2005).

Of the 13 studies, four were conducted in the United Kingdom, three each in the United States and Canada, and one each in Australia, Iran, and India. In half of the reviewed studies, researchers based participant recruitment or selection on referral by teachers or other service providers in the school setting due to known refugee status (F. Baker & Jones, 2007), trauma exposure (Ehntholt et al., 2005; Schottelkorb et al., 2012), or distress or impairment (Durà-Vilà et al., 2012; Fazel et al., 2009; O’Shea et al., 2000). This approach places the onus on teachers to maintain relationships with students that permit knowledge of students’ and families’ experiences or observation of both internalizing and externalizing problems. However, this strategy may be an efficient means of identifying students whose symptoms or impairment most affect their school functioning.

The remaining studies based selection on students’ school or classroom enrollment. In these cases, interventions were delivered in schools enrolling refugees (Kalantari et al., 2012; Yankey & Biswas, 2012) or immigrants only (Rousseau, Armand, Laurin-Lamothe, Guathier, & Saboundjian, 2012), or classrooms for English language learners (Ellis et al., 2013) or immigrants (Rousseau et al., 2005; Rousseau et al., 2007) in which all students participated in the study. Only one study (Fox et al., 2005) did not describe how participants were selected. With the exception of Kalantari et al. (2012), who described the destitute conditions of the Afghani refugee school in which their study took place (“overcrowded, noisy, with poor air-conditioning . . . no tables,” p. 143), authors provided minimal descriptions of the educational institutions in which interventions were delivered. In addition, with few exceptions (Fox et al., 2005), little can be inferred about school resources to support refugees’ mental health and social-emotional functioning because most interventions were delivered by mental health clinicians and trainees enlisted by the researchers, or by the researchers themselves, rather than by members of the school staff (see description of interventionists in Table 2).

**Targeted Domains of Functioning**

Regardless of intervention type, most studies sought to reduce students’ psychiatric symptoms, severity, or impairment. Six studies measured students’ mental health functioning relative to a variety of symptoms and impairments, four measured PTSD or trauma symptoms and severity, and three measured depression, consistent with the high rates of psychopathology, particularly PTSD, reported in refugee populations discussed above.

The most commonly used measure was the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). This brief screener assesses both psychopathology and strengths, with items tapping five factors: emotional symptoms, conduct problems, hyperactivity-inattention, peer problems, and personal
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strengths (Goodman, 2001). The SDQ comes in parent, teacher, and self-rating forms for use with children and youth ages 3 to 16, and has been translated into more than 70 languages and dialects, although norms are only available for 10 countries (“SDQ: Information,” 2012). It has been shown to be a reliable measure of difficulties, and use of the total score over use of the subscales is recommended due to lower reliability (e.g., Hoofs, Jansen, Mohren, Jansen, & Kant, 2015). The SDQ teacher and parent forms have been shown to be as effective as longer measures at detecting internalizing and externalizing difficulties (Goodman & Scott, 1999). As a brief screener that can be completed in just a few minutes (“SDQ: Information,” 2012), the SDQ was a convenient option for researchers and teachers. The teacher ratings were the most frequently used in these studies.

Nearly half of the studies relied on multiple measures of functioning, consistent with recommendations that a multimethod, multisource approach to assessment of psychopathology is warranted because of differences in informant ratings of behavior (Achenbach, 2011). Parent and teacher ratings show only modest correlations and may vary by meaningful contextual differences between school and home, as well as relevant differences in informants’ perspectives (Dirks, De Los Reyes, Brigg-Gowan, Cella, & Wakschlag, 2012). Correlations tend to be lowest for internalizing problems (Achenbach, 2011), which are common among refugee children and youth. Informant differences, though in the same direction, appear to vary significantly in magnitude across societies (Rescorla et al., 2013).

More problematic, however, is the lack of appropriate norms for use with immigrant populations, which may limit the validity and applicability of obtained scores (Achenbach, 2011). Most of the measures used in these studies were developed by U.S. researchers and normed with U.S. populations or other Western societies. As Achenbach (2011) noted, “The meaning of scores obtained from multi-informant ratings depends on comparisons with norms for the child’s age and gender, the type of informant, and the relevant societies” (p. 85). Norms for immigrant or refugee students’ home countries are generally lacking, so assessment is necessarily limited to measures for which validity evidence is available. As such, both researchers and educators should use them with caution and rely on multimethod, multisource assessment whenever possible.

Creative Expression Therapy

The most commonly used approach in the studies reviewed was creative expression intervention. Creative expression and play therapies generally incorporate creative elements designed to provide individuals with outlets to express feelings and process emotions. Five studies reported experimental and quasi-experimental tests of interventions using art, music, or drama to provide opportunities for students to process their trauma, develop social-emotional skills, and, by extension, reduce impairment and improve school behavior or academic performance. Each of these studies tested interventions shown to be effective with other populations of children with mental health difficulties, including exposure to trauma. The intensity of these interventions ranged from a few hours of intervention over the course of 3 days (Kalantari et al., 2012) to 90-minute weekly sessions over 3 months (Rousseau, Armand, et al., 2012). The magnitude and scope
of behaviors affected varied across studies, but all authors reported some degree of improvement in student outcomes.

Both Kalantari et al. (2012) and Rousseau et al. (2005) used classwide writing or drawing activities with refugee and immigrant students in fairly homogenous settings serving refugees and newly arrived immigrants and refugees, respectively. Kalantari et al. (2012) administered brief 15-minute sessions in gender segregated groups in which students wrote about their feelings and traumas, advice for others in similar situations, and what they learned from the experiences. There was no discussion of materials, but rather the researchers predicted that the act of writing would decrease negative feelings and thoughts related to the traumas described. Students in both the experimental and control groups completed a measure of traumatic grief before and after the intervention was implemented, and the experimental group showed decreased grief whereas the scores of the control group increased. Follow-up was not possible because of dropout and organizational issues that temporarily closed the school.

Rousseau et al. (2005) utilized more intensive classwide creative expression workshops, which demonstrated moderate, but significant decreases in externalizing and internalizing symptoms and increases in students’ self-reported popularity. This program included both individual writing and drawing time, with presentations to the group. The prompts for individual sessions included attention to migration processes, premigration experiences, exploration of minority identity and nondominant culture, and home and community experiences. An art therapist and psychologist implemented the intervention with assistance from teacher volunteers at the school. In addition to students’ self-reported outcomes, teachers reported decreases in students’ internalizing symptoms and increased self-esteem (Rousseau et al., 2005).

Rousseau et al. (2007) and Rousseau, Armand, et al. (2012) examined the effects of classwide theatrical activities on students’ symptoms, impairment, and school performance. Both studies implemented drama workshops in which students completed warm-up activities focusing on language and dramatization, followed by acting out stories developed by participants addressing various themes related to family, friendship, migration, culture, identity, and belonging. In the 2007 study, the process was facilitated and modeled by a drama team consisting of actors and musicians trained in psychology and art therapy. In the 2012 study, the intervention was delivered by a drama therapist and teacher volunteer. Rousseau et al. (2007) did not find significant decreases in students’ symptoms, but noted that students, particularly the boys, showed improved school performance and some, particularly the girls, reported significant decreases in their perception of impairment as measured by interference with their friendships, leisure activities, and home life. The authors suggested that drama might be a useful strategy in helping adolescents cope with challenges even though emotional difficulties may remain, and that these may have differential gender effects (Rousseau et al., 2007). More recently, Rousseau, Armand, et al. (2012) also reported that students demonstrated significant decreases in their perceived impairment, but overall social-emotional problems did not change.

F. Baker and Jones (2007) implemented classwide music therapy to “to foster a sense of safety within the group and later to promote self-confidence and
creativity, improve impulse control and explore peer relationships” (p. 253). Researchers described the sessions as tailored to the group needs but as addressing themes of “sharing of musical cultures, exploration of self-identity, developing appropriate social skills, experiencing a sense of agency and developing impulse control” in the first phase of treatment and “adjustment and acculturation, anti-racism and feelings of failure in the classroom” in the second phase of treatment (F. Baker & Jones, 2007, p. 253). A variety of activities were utilized, including “instrumental improvisations, dancing, song learning and singing and students sharing pre-recorded music” (F. Baker & Jones, 2007, p. 253), along with group song writing and discussions structured and facilitated by a music therapist. The intervention was provided over 5 weeks in which classes alternated between weeks of intervention and nonintervention. Teachers provided ratings of students’ behavior before intervention and after each week. The researchers reported inconsistency in students’ behaviors, with an increase in behavior problems during the nonintervention blocks, with significant improvement demonstrated only in externalizing behaviors over the 5 weeks of the study. Internalizing behaviors and school problems increased.

In sum, researchers have tested a variety of structured and semistructured creative expression interventions in schools to improve refugees’ functioning. Interventions were generally delivered by trained arts therapists, with occasional assistance from classroom teachers. Only Kalantari et al.’s (2012) writing intervention was not dependent on trained therapists. Intervention dosage ranged from a 1.5 cumulative hours to 18 hours, and the authors reported a range of outcomes related to their purposes. Only one intervention, music therapy, appeared to have iatrogenic effects, though it is not possible to determine whether the modality, themes, or some other factor caused the deterioration in observed behavior. The drama intervention did not result in reduced symptoms as measured by participant responses on the SDQ although participants perceived less severe impairments. Conversely, the writing and drawing interventions resulted in positive outcomes on the measures used.

Cognitive Behavior Interventions

Four studies utilized cognitive behavioral interventions or therapy (CBT). CBT integrates attention to thoughts, behaviors, and feelings, with particular attention to maladaptive behaviors and thoughts, and is generally problem-focused and goal-oriented, and requires practice beyond the sessions. Trauma-focused CBT (TF-CBT) is commonplace in the treatment of children who have experienced a range of traumas (e.g., abuse, neglect, community violence) and has been shown to be effective in reducing symptoms of PTSD, as well as depression and problem behaviors to a lesser extent (Cary & McMillen, 2012). TF-CBT generally emphasizes development of stress management skills through several components: psychoeducation, parent training, relaxation training, affective modulation, cognitive processing, developing narratives of the trauma, mastering feared stimuli, and addressing safety concerns (AACAP, 2010).

The intensity of the CBT programs tested with refugees varied from 6 to 12 hours or more. Like the creative expression interventions, they targeted a range of symptoms and had a variety of research designs that preclude comparison across
programs. Three studies used preexisting trauma-focused manualized CBT programs (Schottelkorb et al., 2012), including two developed specifically for use with war-traumatized youth (Ehntholt et al., 2005) or refugees (Fox et al., 2005). Only Fox et al. (2005) used a program designed specifically for the study sample. In addition, Schottelkorb et al. (2012) sought to determine whether play therapy was effective compared to the evidence-based TF-CBT program. All studies reported significant reductions in the focal dependent measures.

Ehntholt et al. (2005) tested the effects of the manualized group program, *Children and War: Teaching Recovery Techniques*, to “educate children about the symptoms of PTSD and to teach them appropriate coping strategies” (p. 237) through dual-attention techniques, breathing exercises, progressive muscle relaxation, coping self-statements, graded exposure, processing of wartime experiences, and attention to sleep hygiene and pleasurable activities. The first session dealt with normalizing war experiences, identifying stress responses, and developing a safe place coping strategy. Although the intervention was implemented by a psychology trainee, the authors describe the manual as providing “adults who are not trained mental health professionals with the knowledge and skills necessary to conduct effective group interventions” (Ehntholt et al., 2005, p. 237). The authors measured students’ PTSD, depression, and anxiety symptoms in both an experimental and control group and reported significant decreases overtime for the experimental group in PTSD symptoms only. Depressive symptoms were unaffected in both groups and changes in anxiety were not significant.

Fox et al. (2005) developed a CBT program to foster coping skills in their sample of Southeast Asian refugees, incorporating discussion of ethnic traditions and resettlement experiences. Bilingual teachers, school nurses, and nurse researchers developed and implemented the intervention emphasizing skill building in eight objective-driven sessions. Participants were introduced to a coping strategy (e.g., verbalizing feelings to family members, using a decision-making process, role-playing, drawing) and assigned homework to facilitate interactions with parents. Participants showed significant decreases in depressive symptoms over the 8-week intervention and a further reduction at a 1-month follow-up.

Schottelkorb et al. (2012) compared the effectiveness of manualized child-centered play therapy (CCPT) and TF-CBT. TF-CBT was a manualized program based on a sequence of 10 components: “psychoeducation and parenting skills, relaxation skills, affective modulation, cognitive coping and processing, developing and processing a trauma narrative, in vivo mastery of trauma reminders, joint parent-child sessions, and safety planning” (Schottelkorb et al., 2012, pp. 58–59). Interpreters were utilized when parents preferred the service. Though not previously tested with refugee children, the authors noted that TF-CBT was a recommended treatment approach for children who have experienced trauma (Schottelkorb et al., 2012). CCPT was also a manualized program of sessions focused on the use of specific toys and therapists’ positive regard and empathy to allow students opportunities to communicate their thoughts, feelings, and desires. The typical materials were adapted for use with the refugee sample to include “multicultural dolls, musical instruments, play food, and other toys that were reflective of the cultural backgrounds of the children” (Schottelkorb et al., 2012, p. 63). Fidelity was monitored by licensed supervisors who reviewed videotaped
sessions using specialized checklists. The researchers concluded that the two approaches were equally effective in reducing students’ PTSD symptoms. This study added to the strong effectiveness evidence for TF-CBT and provided initial evidence for the effectiveness of CCPT for children who experienced this trauma.

In the final study in this category, Yankey and Biswas (2012) adapted life skills training materials to include Tibetan themes, background, characters, and places in activities. The module taught 10 core skills—“decision making, problem solving, effective communication, interpersonal relationship, empathy, coping with emotions and coping with stress . . . creative thinking, critical thinking and self-awareness” (Yankey & Biswas, 2012, p. 519)—and 28 subskills in 30 sessions, with 15 additional remedial sessions available for students who did not meet benchmarks on an initial posttest. Training techniques included “brainstorming, role playing and group discussion” (Yankey & Biswas, 2012, p. 520). The authors concluded that the training reduced stress and improved functioning among participants. In sum, researchers have applied multiple highly structured CBT programs with refugee students. Each featured tailoring to the students’ culture and one specifically incorporated war trauma. All demonstrated positive outcomes.

Multitiered or Multimodal Interventions

The studies described in previous sections provided participants with singular interventions, whereas the final identified category of intervention featured multimodal or multitiered interventions in which a student’s treatment depended on the severity of their needs. Accordingly, intensity was individualized. Researchers examined whether implementation of the general model or approach was associated with improved outcomes among recipients. In three studies (Durà-Vilà et al., 2012; Fazel et al., 2009; O’Shea et al., 2000), external mental health clinicians provided services on site to students referred by their teachers or other school professionals over the course of the school year. Services included consultation to teachers, group interventions, family therapy, individual therapy of a variety of approaches, and in-home services.

Fazel et al. (2009) tested a consultation framework in which teachers referred students to a mental health consultation team consisting of two psychiatrists, their trainee, and an arts psychotherapist who met weekly to discuss potential classroom interventions and, later, students’ responsiveness to intervention. Students showed significant overall improvement in SDQ scores and modest but significant improvement in hyperactivity and peer relations. In O’Shea et al.’s (2000) study, teachers also referred students to the mental health professional who was on site 1 day per week and contacted families to determine services needed. The school provided an interpreter who was familiar with the families to assist the process. Specific treatments were selected after assessment of the student and family. Children showed nonsignificant decreases in SDQ scores after participating in the intervention.

In the study by Durà-Vilà et al. (2012), a similar approach was taken in which teachers or social workers referred students with obvious problems or distress to staff from nearby community mental health providers. They provided services on site following consultation with staff, clinical interviews, and other assessments with the family. Researchers reported that three quarters of the students served
demonstrated improvement in their overall SDQ scores, with a significant difference for the treatment group pre–posttest.

In the final study, Ellis et al. (2013) evaluated a multitiered program based on trauma systems therapy with Somali refugees. Their four-tier model included the following activities. Tier 1 activities included psychoeducation, outreach, and engagement for the Somali community. Tier 2 activities consisted of weekly skill-building groups for all Somali English language learner students over the course of the academic year. Tier 3 included trauma systems therapy for students referred by teachers for emotional dysregulation. Finally, Tier 4 consisted of intensive therapy and home-based care for severely impaired students. Trauma systems therapy is a phased model targeting stressors in the social environment (e.g., inadequate access to food, neighborhood violence) and emotional dysregulation (e.g., aggression, self-injury). Services were facilitated by cultural brokers from the Somali community to ensure services were in keeping with understanding of the Somali culture. The authors noted that students served at all tiers showed improvements in measured outcomes, but they did not address the potential effects of receipt of multiple tiers of service.

Thus, effects across the three multimodal studies were mixed, suggesting that provision of community-based mental health services at a school site may be beneficial in reducing students’ symptoms and impairment. The multimodal treatment models did not tailor services to refugees, but ensured ease of access by delivering services through the students’ schools. Ellis et al.’s (2013) multitiered prevention and intervention program tailored to the Somali refugees showed that students benefited from all four tiers of services, from universal strategies to intensive therapies.

Discussion

In this review, we synthesized the research on social-emotional interventions for students who are refugees, asylum seekers, or otherwise traumatized by war. We uncovered a variety of interventions, most previously established with other populations who have experienced trauma or psychopathology. Effects varied, but in general, the findings suggest that school-based interventions may be effective in reducing students’ trauma-related symptoms and impairment. This is not to say that the interventions reviewed might only be appropriate for the focal populations here—as opposed to other groups that have experienced trauma or migration—or that only interventions tested with refugee samples will be effective for this population. Indeed, one of the most notable findings here is how limited the current body of research is. As such, we encourage a critical realistic evaluation approach grounded in the imperative understanding of “how, for whom, and under what condition interventions will work . . . to examine how context and intervention mechanisms interact to generate outcomes” (Bonell, Fletcher, Morton, Lorenc, & Moore, 2012, p. 2299).

In this vein, studying interventions applied with refugee populations is a necessary step to establishing their applicability and social validity in context even when we might assume the applicability of strategies given similarities between groups of traumatized youth. Where general positive effects are known, scholars should recognize the difficulty clinicians and educators face when evaluating the
potential effectiveness of any given intervention outside of the particular socio-cultural context in which it was developed and tested. Layne et al. (2001) emphasized that educators should ask, “Is this the best program for this population at this point in time, given the resources available?” (p. 287).

In the studies reviewed, researchers utilized a variety of experimental and quasi-experimental designs in implementing creative expression, CBT, and multimodal intervention frameworks to improve refugees’ mental health and social-emotional functioning. Creative expression interventions were the most commonly used but had the least consistent results. Given the negative effects of music therapy in particular, more studies are needed before educators should consider attempting to implement this intervention. However, the other studies presented lend some support to the use of writing, drawing, and dramatic interventions in schools. One limitation of this type of intervention was the reliance on specially trained therapists—or even teams of trained therapists—to implement treatment, which undermines the social validity of these interventions for most schools, where such interventionists could be cost-prohibitive. Creative expression therapies are generally beyond the scope of school counseling or psychology training programs (American School Counselor Association, 2012; Ysseldyke et al., 2006) but may be an area for supplementary preservice training or continuing education, consultation, and supervision. The results of the multimodal interventions were also mixed, and it is also likely the interventions themselves may not be practical for schools wishing to implement services internally because they also relied on the provision of clinicians from outside agencies.

The CBT interventions showed more consistent outcomes and were consistent with broad practice recommendations for treating trauma in children and youth (AACAP, 2010). However, these interventions were also primarily implemented by clinicians with special training, though at least two of these manualized programs were intended to be implemented by individuals without clinical training (Ehntholt et al., 2005; Fox et al., 2005). Indeed, Ehntholt et al. (2005) emphasized this particular strength of their intervention, noting that teachers could be trained in the psychological techniques needed to implement with fidelity the interventions in classroom settings.

Although teachers might not be prepared or available to deliver interventions, this particular feature makes CBT more feasible for many schools where school psychologists, school counselors, social workers, or other educational specialists already on staff may be able to use the manualized program to implement the intervention appropriately. These individuals tend to have some specialized training in psychopathology, social-emotional intervention, or mental health. Utilization of educational professionals, rather than external clinicians is recognized as a cost-efficient means of providing interventions to students who have experienced trauma (Wolmer, Hamiel, Barchas, Slone, & Laor, 2011). With proper training and support (e.g., supervision, coaching, consultation with mental health clinicians), these professionals may be able to implement CBT or other interventions with fidelity.

Only one study investigated the applicability of a multitiered framework for intervention (Ellis et al., 2013). This approach may be useful in school systems serving large populations of refugees or other traumatized youth, as resources can
be directed to students based on their particular levels of need. Furthermore, this framework is increasingly familiar to school psychologists, administrators, and educators with the proliferation of public health models of academic and behavioral supports in schools (i.e., response to intervention and positive behavioral interventions and supports). This common understanding and the widespread use of consultation and problem-solving teams to address students’ academic and behavioral needs may facilitate adoption of similar frameworks to address refugees’ needs. Alternatively, use of trauma-focused interventions may be incorporated into existing multitiered support systems. In doing so, it is important to provide broad-based prevention and psychoeducation to the community of interest (i.e., refugees or other immigrants with similar needs; Ellis et al., 2013).

Beyond the effects of the interventions reviewed, a notable finding here is the relative dearth of school-based interventions for these populations. This review underscores the need for the development and evaluation of school-based interventions to address refugees’ trauma and psychopathology in order to improve their mental health and school functioning. Interestingly, all studies identified in this review have been conducted since 2000, although refugee status is not new. The UN Commissioner for Refugees was first appointed in 1950 (Kraut, 1994), yet the available research is both limited and very recent.

The reason for the recent emergence of this body of work is unclear but may be attributable to the transitory and vulnerable nature of this population. The development of a research base may be challenging in light of the relatively urgent needs of the population, and their unique and dynamic characteristics that present logistic constraints for researchers (Birman, Weinstein, Chan, & Beehler, 2007). Furthermore, in many settings, students’ refugee status or previous trauma may not be known to educators or may be addressed through other intervention or support efforts. Researchers and educators may address these constraints through the development of practice-based evidence derived from small-scale studies in real-world contexts, utilizing single-case designs, mixed methods, quasi-experimental group designs, or regression discontinuity designs where experimental designs are not feasible (Kratochwill et al., 2012).

Although refugees may benefit from more generalized interventions designed to address trauma and reduce psychopathology, most of the interventions reviewed involved some degree of tailoring or modification to address the students’ cultures or trauma experiences. More research is needed to establish whether such personalization is needed or whether benefits are just as strong when general trauma-focused interventions are applied. This question provides an important avenue for study because of the implications for intervention implementation in schools. Where tailoring is needed, the potential number and diversity of students served at any given time is greatly reduced compared to interventions that can be delivered to students with a variety of cultural backgrounds and traumas.

When delivering interventions to refugee populations, it may be necessary to provide training to teachers and other staff on the unique backgrounds, experiences, and potential social-emotional issues of refugees and other war-traumatized youth. This training is especially important where refugee enclaves exist and should entail development of community partnerships to promote outreach, engagement, and intervention strategies consistent with the values and needs of
the community. One study utilized cultural brokers from the community targeted in the intervention to ensure the cultural appropriateness of implementation (Ellis et al., 2013). The degree to which use of such brokers or liaisons contributes to improved outcomes should be explored in future research.

Finally, this review is not without limitations. It is possible we inadvertently omitted relevant studies due to our search strategy, and we did not incorporate gray literature not available through refereed publications (e.g., dissertations, theses, books, book chapters, unpublished reports). As such, the sample of articles reviewed was small and there may be more known on this topic than this review presents. Despite these limitations, we offer a synthesis and appraisal of the existing research on school-based interventions to address the mental health needs of refugees and other war-traumatized youth. This information can inform educators’ efforts to bolster students’ well-being and, by extension, their academic development. Schools are well positioned to address the mental health needs of refugees and other war-traumatized youth. The emerging research reviewed here suggests promising practices to support these students’ mental health.

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*References marked with an asterisk indicate studies included in the systematic review. Achenbach, T. M. (2011). Definitely more than measurement error: But how should we understand and deal with informant discrepancies? *Journal of Clinical Child & Adolescent Psychology, 40*, 80–86. doi:10.1080/15374416.2011.533416


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Authors

AMANDA L. SULLIVAN is an associate professor of school psychology at the Department of Educational Psychology, University of Minnesota, 56 E. River Road, Minneapolis, MN 55414, USA; e-mail: asulliva@umn.edu. She employs a socioecological perspective to (a) understanding the school, family, health, and child factors that place children and youth at risk for educational disabilities and mental health problems; (b) identifying disparities in the educational and health experiences and outcomes of diverse students, including those with special needs; and (c) exploring professional issues related to the provision of culturally relevant psychoeducational services.

GREGORY R. SIMONSON is a doctoral student in school psychology in the Department of Educational Psychology and Special Education, University of Minnesota, 56 E. River Road, Minneapolis, MN 55414, USA; e-mail: gsimonso@umn.edu. His research interests include autism, mental health, and school-based interventions.