

STARTTerS Collaborative Early Childhood Services for Refugee Families Drumming, Dancing and the Wobbly Wall

Rosemary Signorelli

MBA, Grad. Dip Counselling and Psychotherapy, RMT, LTCL., Dip. OT.

Counsellor and Music Therapist, New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), Principal, Our Music Place

Mariano Coello

Clinical Psychologist, Clinical Services and Research Coordinator STARTTS

Abstract

Refugee children may present with developmental delays, or other processing or behavioural disorders, arising directly or indirectly from their experiences. Their normal development may be impacted by their own traumatic experiences and those of their family members. These may include torture and other human rights violations, losses, split family situations, deprivation of food, water, shelter and medical care. Many families have spent long periods in refugee camps without schooling and services to address their developmental needs.

The parents' emotional availability to their children and the quality of their interactions may fluctuate because of their trauma symptoms, compounded by resettlement stresses. Families and community support networks have been disrupted by war, civil unrest and exile, and access to formal and informal education, including culturally normative parenting practices, may have been restricted or distorted.

At STARTTS, early observation of refugee families with infants and pre-school aged children can help to identify possible developmental issues and risk factors to enable the provision of culturally appropriate collaborative interventions and/or referrals. STARTTS' bio-psychosocial model for working with refugee families with young children will be briefly explained with reference to various trauma recovery models (Herman 1997, Scheidlinger 2004; Kinniburgh, et al 2005), and developmental approaches (Perry 2009) (Greenspan 2010).

Some examples will include the exploration of collaborative approaches with early childhood and family support services, and direct work with single parent-child dyads, and groups of families. Music, movement and play activities will be demonstrated which enhance attachment, self-regulation and competence and address emotional and sensory processing needs of very young traumatized children.

This paper will describe work with refugee families with 0-6 year old children. Examples of refugee trauma and their potential impact on children will be discussed, in reference to recent relevant neuroscientific theories. The STARTTerS Early childhood model will be described and illustrated in the light of holistic and systemic recovery models and developmental models. This will include collaborative activities and consultation with communities and other service providers.

THE IMPACT OF TRAUMA

Setting the Scene

A twenty five year old woman is whispering urgently with her four year old son Ali, in a prison in a country of first asylum on the way to Australia. They have been held captive for forty five days, with only rice to eat, and often deprived of sleep. She whispers:

“What do you want to do? Do you want to stay here and then be sent back to our country? Or do you want to run as fast as you can, so we can escape?” Ali says “I’m going to run as fast as I can Mummy”. So they run as fast as they can. When Ali stumbles his Mummy helps him up again, and says “Keep running Ali, it’s dangerous to stop running”, and he keeps running. They get to a boat, and go on a frightening journey, until they arrive at their new country. Eighteen months later, Ali still runs as fast as he can, but now Mummy calls out “Stop running Ali. It’s dangerous to run in the street.”

Is Ali’s dysregulated behaviour a sign of PTSD, or does he have a developmental disorder?

Six year old Yusuf plays quietly and independently in the counselling room while the counsellor talks with his parents. His mother is busy attending to his 2 year old brother who seeks a lot of attention. His father has to take Yusuf to a children’s hospital for blood tests every two days to monitor his recently diagnosed auto-immune disease. At first the counsellor thinks Yusuf’s quietness is because he is feeling unwell. It’s not until the third session that his father discloses that Yusuf had been kidnapped twice, at the age of five.

Is Yusuf’s quiet, unobtrusive and compliant behaviour a sign of independence and maturity, or is it a sign of withdrawal and dissociation?

Samira is nine months old and is sitting supported on the floor during the assessment session. Her mother was three months pregnant with Samira, when Samira’s parents took the perilous boat journey to Australia. Her mother lost twelve kilograms of weight during the boat trip. Samira has eye contact with the counsellor, smiles, and vocalises happily, but she does not sit unsupported, or roll or crawl.

Is Samira displaying developmental signs of an intrauterine event? Does she have a physical delay, or is her development within her culture’s normal patterns?

Four year old Dawood’s mother Sara is having to manage as a single parent with no relatives in Australia, until her husband gains an Australian visa. Sara is very anxious about Dawood’s signs of separation anxiety, and bed wetting. In her homeland, Sara has witnessed the results of extreme torture and trauma.

Is Dawood's bedwetting within normal limits, or is it triggered by his mother's post-traumatic symptoms? Should intervention be directed towards Dawood, or his mother?

These vignettes illustrate some of the complexities in the assessment of babies, toddlers and pre-school children in refugee families. As trauma and developmental issues can coexist, they may be difficult to distinguish, and child rearing practices may vary between cultures.

The setting for the work presented in this paper is the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) in Western Sydney. STARTTS has offices and outreach locations scattered across NSW. It is an affiliated health organisation which provides services for refugees, asylum seekers and people from refugee-like situations who have survived torture or other traumatic experiences associated with organised violence. Many have been internally displaced within their country of origin before coming to Australia.

Refugee Trauma

The three broad areas of refugee experience include trauma, deprivation and losses. Clients have experienced human rights violations, in the context of organised violence.

Trauma may include violence such as kidnapping, imprisonment, torture, war, disappearances, rape, persecution or being forced to flee. In some countries people may also have been exposed to a toxic environment through the use of chemical weapons, or other environmental hazards.

Refugees may have been deprived of security and shelter. Some have lived in refugee camps for many years or have been forced to live illegally in countries of asylum, separated from family and with no access to employment. The resultant poverty adversely affects access to meals, schooling or health care, safety and provision of growth opportunities (CDCHU, 2007). Poor access to proper nutrition, or pre-natal care, can result in toxic stress for the baby (CDCHU, 2007).

They have lost their country, wealth or possessions, status, education or career path, and many have lost relatives who have been killed or have disappeared. Disruption to the parent-child attachment can be caused by death of a parent, splitting of the family as one parent flees in order to find a place of safety for the whole family, or the emotional unavailability of a traumatised parent, who may show signs of dissociation, anger or fatigue.

Trauma Symptoms in very young children

All of these experiences impact directly or indirectly on the infant, toddler or pre-school child, as the traumas may be experienced by themselves, their parents or their whole community. The child's trauma response depends on his or her cognitive and developmental level, and resulting ability to understand what is happening. It is also dependent on the mediating effect of family, previous experiences, whether the trauma is relational or war-related, whether it is recurrent, the length of time of the trauma, and if

there are multiple events and types of trauma experienced by the child (Van der Kolk, 2005; Van der Kolk and Saporta, 1991; Van der Kolk, 2010). The younger the child is, the less able he or she is to make sense of what is happening, except through the parents' responses (Van der Kolk, 2010)

To cope with trauma, survival mechanisms activated in the brain produce automatic and necessary responses in order to deal with the immediate danger. These mechanisms may lead to post traumatic stress disorder symptoms of avoidance, dissociation, hyperarousal, and recurrent intrusive phenomena including re-experiencing and flashbacks. The trauma responses can become hard wired into the brain and then reactivated in other situations that are not relevant, hence becoming maladaptive behaviours. These behaviours may seem, to the onlooker, to be arbitrary or unrelated to current events.

Hyperarousal symptoms can include sensory and behavioural dysregulation, hyperactivity, aggression, impulsivity, attention disorder, risk taking behaviours (Van der Kolk and Saporta, 1991; Van der Kolk, 2005), anxiety and distrust (Van der Kolk, 2010; Tunnecliffe, 1996) or impairment of memory, inhibitory control and cognitive flexibility (CDCHU, 2011). There may be language delay or selective mutism (Van der Kolk and Saporta, 1991). Many school children referred to STARTTS for assessment of their IQ, because of cognitive deficits and underperformance at school, have demonstrated normal cognitive skills after receiving trauma related therapy (Coello, 2011).

Hypoarousal and avoidance may be expressed as day dreaming, withdrawal and isolation (Tunnecliffe, 1996), lack of motivation, listlessness, apathy or helplessness, or the child may seem mature or compliant (Van der Kolk, 2010).

Intrusive phenomena may be evident in frightening dreams, day dreams or re-enactment during play, repetitive violent play or drawings of traumatic experiences (Tunnecliffe, 1996).

Children may present with a range of attachment disorders, separation anxiety, fear of abandonment, or generalized anxiety (Tunnecliffe, 1996). Separation anxiety can result from separation from the child's father, even when the mother is still present (Signorelli, 2011B). There may be socio-emotional immaturity, stealing and hoarding of food, bedwetting, sleep disorders and sleepwalking (Tunnecliffe, 1996), nightmares (Van der Kolk and Saporta, 1991) or self destructive preoccupations and behaviours (Van der Kolk, 2010). Children may show signs of regression in their previously gained developmental skills (Tunnecliffe, 1996).

Physical symptoms of traumatised children can include pain, injuries, illness, changes to appetite, poor nutrition (CDCHU, 2007), low weight and reduced growth. They may experience psychosomatic reactions, recurrent minor infections, auto immune disorders (Van der Kolk, 2010), gastrointestinal disturbances (Van der Kolk, 2005; Tunnecliffe, 1996) and respiratory diseases (Van der Kolk and Saporta, 1991). There may also be delays in developmental milestones relating to gross and fine motor skills (Signorelli 2011B).

Children may not be able to articulate their trauma experience or distress, because of their developmental level. They may be unable to formulate their experience in cognitive and language form, instead expressing disturbances in sensorial or somatised ways (Van der Kolk, 2005). Sometimes parents may be unaware of the child's traumatic experience or symptoms because the child is protecting the parents or perpetrator, with whom they may have formed a relationship. This inability to report an abuse or protect themselves may lead to compliance on the part of the child (Van der Kolk, 2005). The parent may only perceive silences, or unexplained behaviours in the child, or the parents may believe their child is not affected, and not perceive that the child's compliance is really a "surrender" response (Perry et al, 1995). Parents may be overprotective because of their ongoing fear of their children being harmed. The mother may be a very young mother, or may have had an unwanted pregnancy, as the result of rape.

Impact on the family and community systems

The family system may be impacted by changing roles and expectations, fragmented support systems, split families and marital breakdown. Newly arrived refugees may have difficulty understanding Australian norms, parenting practices, laws, system and rights, and there may be intergeneration or gender conflict because of acculturation. Families may experience confusion about service providers, or not be familiar with a western model of service provision. Refugee communities may be suspicious of government services, and may be having difficulty dealing with the breakup of traditional community structures or ongoing conflict and fragmentation within each community.

Nevertheless refugees may be resilient, and able to live full and productive lives with the appropriate initial supports. Many go on to contribute positively to the Australian community.

UNDERLYING PRINCIPLES FOR THE STARTTERS EARLY CHILDHOOD TRAUMA WORK

Impact of trauma on the brain and development

The STARTTerS early childhood work is informed by neuroscientific and clinical studies related to the impact of trauma on early childhood development.

Brain development is experience-dependent (Cozolino, 2006). Positive and negative impacts on the developing brain can arise from the interplay of genes, experience, environmental social environmental factors (Schoore, 2001). Attachment is important for the infant's continuing neurobiological development (Schoore, 2001).

Trauma, pre-natal stress (Schoore, 2001), and early childhood stress can change brain structure (CCHU, 2005, 2007; NSCDC, 2007A, 2007B). This may involve changes to the stress response mechanisms of the amygdala, vagal system, prefrontal cortex and right hemisphere, or left hemisphere from 18 months onwards (Cozolino, 2006). These changes particularly impact on socio-emotional information and bodily states (Schoore,

2001). Early trauma and stress can also undermine the development of the cardiovascular system, immune system, and metabolic regulatory functions (CDCHU, 2010).

Preventing or reducing the impact of trauma on the brain and relationships

It is possible, however, to prevent the disruption of brain architecture (CDCHU, 2007) and to repair disrupted attachment (Schore, 2001). This can be achieved in part by reducing the number and severity of early adverse experiences, and by strengthening relationships (CDCHU, 2010). Emotional availability of the caregiver (Schore, 2001; Cozolino, 2006), provision of a growth facilitating environment (Schore, 2001), and reciprocal interactions all serve to activate the growth of the brain (Cozolino, 2006), so therapeutic interventions should involve attachment and enrichment experiences for high-risk dyads (Schore, 2001).

Appropriate sensory input (CDCHU, 2007) and integrative sensory-motor activities can enhance normal brain development (Cozolino, 2006) and enhance the development of motor skills and motor planning (Perry, 2011). Intervention should take account of the differences in individual children's sensory modulation and processing (ICDL, undated). It is important for the child to use the available pathways in order to retain them (NSCDC, 2007B), as psychological problems can increase the extent of the pruning of neural pathways early in life (Schore, 2001).

Resilience and normal brain development can be enhanced by stable and responsive relationships (CDCHU, 2007), which provide social or emotional stimulation (NSCDC, 2007B), consistency and daily routine (CDCHU, 2010; Van der Kolk, 2005), affect management, attunement and praise (Van der Kolk 2005). It is also important to take account of the integration of emotional wellbeing, social competence and cognition abilities (NSCDC, 2007, and play therapy can help the child to make sense of his world (Cooper 2009). Several music therapy studies with non-traumatised dyads (Creighton, 2011, de L'Etoile, 2011) suggest that lullabies and play songs can facilitate emotional communication and attachment, and help the baby to "control, modulate and self-regulate emotional responses" (Creighton, 2011)

The importance of early intervention

Greater outcomes can be achieved with early assessment and attention to early childhood mental health (Schore, 2001; CDCHU, 2007) because of the greater plasticity of the neural circuits that deal with stress in the foetal and early childhood period (NSCDC, 2005, Ludy-Dobson and Perry, 2010). Early intervention is also less costly than treatment at a later age (NSCDC, 2007).

Early intervention may help to prevent Post Traumatic Stress Disorder and re-traumatisation later in life for people who have experienced developmental trauma (Van der Kolk 1989, 2005, 2010; Schore, 2001). It can also help to prevent adaptive trauma symptoms or states from becoming maladaptive traits or neuropsychiatric symptoms (Perry, 1995; Schore, 2001).

INTERVENTION MODELS AT STARTTS

The STARTTS bio-psycho-social model

STARTTS works in a systemic and holistic bio-psychosocial framework. Services embrace interactions with the individual, family and community. Verbal methods of counseling alone may be ineffective as cortical functions are temporarily offline during a stress reaction (Van der Kolk, 1994), so non-verbal and body work techniques are therefore important aspects of the overall approach to trauma work.

Body work and non-verbal techniques are influenced by the models of Van der Kolk (1994), Rothschild (2000), Gray (2000A and B, 2008), Clark (2000) and Williams et al (2007). They arise from recent neuroscientific theories about the polyvagal system and social nervous system (Porges and Gray, 2008), plasticity of the brain (Doidge, 2009; Cozolino, 2011; Siegel, 2009), integration of brain, mind, body and relationships (Siegel, 2009; Rothschild, 2003). The work is also influenced by clinically based research in work with traumatised children (Van Der Kolk, 2009; Perry et al, 1995; Herman, 1997).

The Current STARTTerS programme

Multi-modal interventions are also appropriate for early childhood work (CDCHU, 2007). The STARTTerS Early childhood programme integrates the recovery models of Herman (1997), Kinniburgh et al (2005) and Scheidlinger (2004), with the developmental models of Stanley Greenspan (ICDL, undated) and Bruce Perry (2006). At STARTTS this work includes assessment, music therapy or play therapy with individual children, parent-child dyads, the whole family, or groups. Some parents also receive individual or group counseling to address their own traumas and emotional functioning.

Psychoeducation and modeling are provided for the parent so that the parent can interact with the child in ways that assist the child's recovery and development, carry over similar appropriate activities at home, and modify their own responses to serve the needs of the child. Psychoeducation also includes the principles underlying recovery work, trauma related information (Gray, 2007; Porges and Gray 2008; Siegel 2009; Doidge, 2009), post-traumatic responses and coping strategies.

Collaborative early childhood programmes and services

Some joint programmes have been carried out with other services such as Auburn library, and Sing and Grow music therapy programme auspiced by Playgroup Queensland and NSW. Collaboration has involved Our Lady of the Rosary Public School Fairfield, The Mandeian Association, Immigrant Women's Health Service, Brighter Futures, and Barnardos Family Support Services.

Referrals are made as appropriate to the Health Assessment for Refugee Kids (HARK) programme at Westmead Hospital, the Refugee Health Service or other medical practitioners, to enable screening of underlying medical causes for symptoms.

Sometimes housing or immigration support letters are written, to assist the family to address safety and settlement issues which impact on the child's trauma symptoms and on the family's ability to engage with other interventions.

Multi-modal approaches in the STARTTerS early childhood programme

Music therapy, sensory-motor integration activities and general play therapy are combined in an integrated bio-psychosocial programme to assist the child to manage their stress responses, release and express emotions, connect with others, work through their memories or regulate behaviours resulting from their previous trauma.

Music therapy sessions, which include activities such as singing, instrument playing, body percussion, conducting, rhythmic movement and dance, have resulted in an increase in participation and interaction, and improvement in behavioural skills of parent and child. Skills have been carried over at home with increases in competence and confidence for both parent and child (Signorelli R 2010).

Gaining a balance in the survival response system

Many of the children's symptoms are signs of an imbalance between hyperarousal (through the sympathetic nervous system) and hypoarousal (through the parasympathetic nervous system), or disruption of the social nervous system. The social nervous system engages mirror neurons and other structures to process the heart / face connection, voice, hearing, visual contact, and facial expression to enable the protective and nurturing mother-child relationship, communication and attachment (Cozolino, 2006).

These three integrated survival systems form a developmental level upon which later learning and development are built (Perry, 2006). Hence the child needs to have a balance between these systems, in order to participate in their developmental tasks, and relate successfully with other children and adults. The child who tends to react with a fight/flight response in a non-urgent situation needs to become more calm, while the child who tends to withdraw or tune out needs help to become more aroused and aware of his/her surroundings and activities. Music, movement and other sensorimotor activities can be utilised to help a child to gain this balance (Signorelli and Dawlatly 2010, Signorelli 2011A).

Singing can help to achieve that balance, because breathing in activates the sympathetic nervous system, and breathing out activates the parasympathetic system. The slower and more controlled breathing helps to slow down a racing heart rate, and the brain then gets the message that "everything is OK". Dancing can release the child's excess energy if hyperaroused, or energise the hypo-aroused child, and provide containment in the form of circle formations, organized steps, and steady beat. Circle dancing or movement to music also provides social engagement through touch, eye contact and seeing each others' facial expressions. Use of gentle vestibular stimulation in the form of swaying or rocking can be calming, while motor activities such as running, jumping and galloping provide proprioceptive stimulation, and can be slowed down to provide sensorimotor regulation.

Fast instrument playing can increase arousal while slow instrument playing can produce a more relaxed response. Simple melodic or chordal patterns in the underlying harmony can form a containing and holding pattern to calm an agitated child. Other play therapy activities that enhance the social system include parallel play, interactive play, ball games, and shared social problem solving.

Managing triggers that may occur with music and movement or other play activities

The stress or survival responses can sometimes be triggered by music, or other contextual or sensory experiences, which stir up traumatic memories and fear. These triggers are highly individual and may not be immediately obvious to the onlooker. Possible triggers may include songs such as “Row, Row, Row Your Boat”, for families who have taken the perilous boat journey to Australia, or “Five Little Ducks” for families who have family members missing or deceased. Auditory triggers may include ticking clocks, high pitched sounds, shouting, loud or sudden sounds, tapping, or fast drumming. Other sensory triggers may include being touched, body percussion, forced eye contact, vestibular sensations, finger painting, the use of red paint, or the use of open or vulnerable postures or movement. Contextual triggers may include the gender and/or ethnicity of the therapist or interpreter, rooms with no windows, closed doors, confined spaces, one way mirrors, cameras or recorders, uniforms, or toy guns.

It is important to have some awareness of the client's trauma history in order to anticipate what some of the triggers might be. Care is taken, therefore, to observe reactions to triggers in the child and caregiver. Initially known triggers are avoided, so that the child feels safe. Other safety strategies may include rituals and choice, breath awareness, deep breathing, awareness of the feet being supported on the floor and body supported in the chair, and other mindfulness activities in the room in the “here and now” (Gray, 2007B). At a later stage in recovery, the therapist may use gradual exposure to triggers, while providing support and grounding activities, so that the child can tolerate their emotions.

Other play activities enhance all areas of development, and address socio-emotional challenges that may have arisen from trauma. An example of a resilience building activity is the collection of recycled boxes of different sizes which the child can use to build a “wobbly wall” or other building, knock them down and rebuild them. The inclusion of velcro spots can add a shared social problem solving element when the child is building the wall with the parent. This can then also be used to provide some psychoeducation for the parent about the role of attachment in building resilience. Obstacle courses can be constructed, for the child to develop problem solving and regulatory skills. The child may use figurines, props and toys to re-enact traumas, in a safe and supported setting.

RECOVERY MODELS

Working with Judith Herman’s recovery model

These STARTTers activities can serve all three components of Judith Herman’s trauma recovery model (Herman, 1997), including safety, remembering and mourning, and

reconnection. Scheidlinger's model (Scheidlinger, 2004) for working with traumatized children adds the use of body work.

When working to establish and maintain safety, activities will be guided by the child's musical preference for traditional or western music and play, where possible. Use is made of opening and closing songs or other rituals, which provide structure and a boundary for the session. Attention may also be given to the use of specific harmonies, scales, holding rhythms and repetitive, patterned rhythmic activity, drones, and avoidance of musical triggers. Major scales can be energizing or frightening, while minor scales can induce a calming effect or sadness. A pentatonic scale, used in many folk tunes, lullabies and children's songs, can produce a very calming effect, especially when combined with the holding rhythms and harmonies.

The child is prepared for endings of activities, through counting, or hand signs; and a "packing away" song helps the child experience separation from objects, which will be accessible again at the next session. Peek-a-boo and other separation games are played, and the child is gradually enabled to stay in the session without their parent, as appropriate to their developmental stage.

Once safety has been established opportunities for remembering and mourning may be provided. Children and parents may bring songs or games or stories that have special meaning for them, to share with the therapist or the group. Children may also re-enact trauma experiences in their play. This stage of the recovery process needs to be carefully monitored and managed to ensure that safety is maintained.

Shared activities will also contribute to the reconnection component of the recovery process. Music therapy and play therapy groups assist with reconnection, as they involve shared singing, playing, and problem solving.

Working with the ARC recovery model

The ARC model (Kinniburgh et al, 2004) gives a useful framework for this work with traumatized children, especially in the early childhood age group. ARC stands for Attachment, self-Regulation, and Competence.

Attachment is enhanced by engaging the parents actively in the sessions, and encouraging them to use modelling and hand over hand techniques to engage their child in the activities. Parents enjoy seeing and sharing in their child's enjoyment and engagement, and sometimes become more aware of areas of development which need more support. The use of peekaboo games, searching and hide and seek games, the beginning and end of activities, packing away of toys until the next session, falling down and getting up games help to build resilience and address separation issues.

Self-regulation and co-regulation activities can include stop-start songs and games, loud-soft, fast-slow, listening activities, and the use of steady rhythms. Hand signs can be used for "stop", "wait" "my turn", "your turn" and "finished". Children more easily follow instructions that are sung, and a pack-away song, using the simple soh-doh-la tune (like the "Rain, Rain Go Away tune) increases the child's cooperation and provides the parent with a strategy they can use and modify at home. The parent also gains confidence, calmness and self-regulation in coping with behaviour challenges with their children, and

their calm demeanour can then be more easily mirrored by the child. Self-regulation is also enhanced by the use of music and sensory-motor activities to bring about a balance in the sensory and stress response systems.

Energetic and loud music activity can be used to match the child's level of agitation, and then gradual changes to the tempo and volume can help the child move from the more agitated state to a calmer one. This can help the child to modulate their feelings, responses and expressions. They can also release some of the emotional and muscular tension in a safe and appropriate way, and they experience the fact that their feelings have been "heard" and acknowledged. Songs or stories may also contain story lines or ideas that help the child to express specific emotions.

Competency is enhanced through all these activities, as children gain fine motor, gross motor, social, emotional, cognitive, language and self-regulation skills. Social skills are enhanced by shared play, imaginative play, musical call and response techniques, and other imitative activities. These encourage listening, turn taking, interactive behaviour and communication in the "here and now".

DEVELOPMENTAL MODELS

In keeping with the evidence that brain architecture and developing activities are built from the "bottom UP" (NSCDC, 2007A), the STARTTerS programme activities are developmentally tailored for the child, and influenced by such models as Stanley Greenspan's Floortime DIR model, and Bruce Perry's Neurosequential Model of Therapeutics (Signorelli 2011 B).

The Floortime DIR model

This team approach (ICDL, undated) was developed specifically for work with children with special needs, but is based on typical social-emotional development. It can be applied to work with children with emotional and social difficulties. Greenspan asserts that all emotional functional development is driven by affect and relationship. Each child is recognized to have individual differences in their central nervous system functioning, which are expressed in their sensory processing, motor planning, sequencing, and affective, cognitive and learning processes.

This model is very consistent with the neuroscientific studies on the social nervous system attachment theory (Cozolino, 2006) and the "serve and return" interactive nature of children's engagement and relationships" (CDCHU, 2007).

Activities are used which include shared attention, engagement and regulation, two-way purposeful communication, shared social problem-solving and eventually more complex cognitive and social abilities. When following this model, the therapist observes the parent's play with the child, and provides some coaching to the parent as appropriate. The parent is encouraged to play with their child at home, for several 10 minute sessions per day.

Neurosequential Model of Therapeutics

Within this model (Perry, 2006) the child's strengths and weaknesses are identified in relation to development at the levels of the brainstem, cerebellum, limbic, cortex and

frontal cortex. Therapeutic activities progress from the lowest brain level, upwards through the other levels. At each level activities may include music and movement activities, sensory integration activities, self-regulation, relational and appropriate cognitive activities. The first musical or sensori-motor activities, based on brainstem function, involve steady repetitive, patterned sensory input, such as massage to music, playing a steady beat on drums or other percussion instruments, swaying, bouncing, singing and humming. Activities at the level of the cerebellum include fine motor activity with age appropriate percussion instruments, and gross motor activities involving walking, running and jumping songs, dance and more complex rhythms. Activities related to the limbic stage of development include working in teams, taking turns, sharing, music games and more complex movement. Working at the cortical level includes singing, storytelling, music drama, and a range of free play activities. At the frontal cortex level, activities include reflection on the meaning of shared songs and the group's musical activities.

REFLECTIONS

Possible Barriers to Family responses and engagement

At STARTTS, family take-up of early childhood screening or group programmes, tends to be greatest where the child shows some obvious signs of trauma or anxiety, such as aggression, separation anxiety, sensory or behaviours dysregulation, bedwetting, sleep problems, or difficulty relating to other children. Settlement issues such as housing, financial issues, transport difficulties and immigration issues may impact on participation in the programme. These sometimes overwhelming challenges may take priority, and the parents' own trauma symptoms may prevent them from recognising the potential impact on their child.

There may also be denial because of the overwhelming guilt they would feel if they believed the child's symptoms stem from the choices they had made, or their inability to protect their children. It may be difficult for them to recognize that they were motivated by the safety and well-being of their children. They may also experience judgment from within their own community, and they may be influenced by their cultural patterns and traditions not to disclose these difficulties to others. Many families also have fears about the role of DOCS as they hear of children being taken away from their families (Schaffer, 2011), and this may make them reluctant to engage in an assessment and intervention programme.

Cultural variations related to early childhood development and parent support

Apparent reluctance by some parents to participate in assessment or therapy raises questions about cultural appropriateness of a programme based on western ideas. Interviews are currently underway with STARTTS bilingual counsellors (STARTTerS survey 2011) to review the current programmes in the light of different cultural practices and community roles, in caring for and playing with very young children. These interviews are also exploring ways to establish some community consultations to enhance culturally appropriate engagement in the STARTTerS early childhood programmes. This interview process is still in process but some preliminary findings can be outlined here.

In some cultures, attachment is established with several family members, not just the mother, and extended family members have a greater share in the day to day care of the infant and young child than in some western cultures. There may be a large number of extended family members living in the same house. In many refugee communities there are many single mothers, as the fathers have been killed. The child may not even know who their father is, but will know who their uncles are, so the role of the father in the country of origin may be less clear. In some cultures, mothers give more intense attention to the child until the child can crawl and then the child plays with the other children out in the open, rather than with the parents. The parent may only attend to the child if the child is hurt, and older children are held responsible for the younger ones.

In many cultures reading books to children is not a regular activity, but stories are passed on through story telling or songs, which have themes peculiar to their culture. Stories and songs may have frightening themes, which are used to build resilience.

In many settings, children make their own toys from items such as tins and sticks, but there are also activities in common with western culture, such as marbles, hopscotch, peek-a-boo, hide and seek and ball games. On coming to Australia many refugee children's playing has become more sedentary, with TV viewing becoming a main activity. They cannot so freely play active games in the street with other children, and there are not established patterns of the parent and child playing together within the family.

Following migration, many refugee families experience deep loss of the extended family support they had in their homeland, and the mother can feel isolated and exhausted. Some families may not seek help for themselves or their child because in their culture it is shameful to talk about their problems. The mother may feel guilty about bringing their children to this more isolated nuclear family environment, or she may experience pressure from within the broader refugee community for going out to work and placing the children in child care.

It is important, therefore, to explain to the parents that their child's behaviours or challenges are a normal result arising from abnormal events that have happened to the whole family. The therapist needs to approach the family with an attitude of being able to provide information about signs to look out for with their child, and useful strategies, which information the family can use without feeling they are being judged. For some cultures it may be important for the therapist to present as an expert rather than another parent, as this will also reduce the family's anxiety or perception that they are being criticised, judged or blamed. Participation in STARTTers groups has been greater and more consistent where there has been a key representative from the families' own community assisting with recruiting or linking with the participants and their community and STARTTS.

Further development of the programme

Some families participate in the STARTTS FICT (Families in Cultural Transition) ten week information workshop programmes. Consideration is being given to increasing the

content of those information workshops to include more information on Early Childhood issues for refugee families living in Australia, and encouraging them to engage with the STARTTers programme.

It is also planned to conduct other community consultations on early childhood issues over the next few months, to build on the existing collaborative approach. Subject to the outcome of those consultations, it may be appropriate to run workshops for specific refugee communities. These could include toy making workshops, learning to sing lullabies or play songs with their babies, information sessions on child development and trauma, and ways for parents to monitor their child's responses to family stress. Less formal play opportunities may then enable the counsellor or therapist to observe the child's developmental level, behaviours, and interactions with their parents, other adults and other children, and to screen for specific skills or issues which may require referral or other intervention. Workshops could also be developed to explore ways for parents whose children are still overseas, to enhance their children's development and maintain their attachment in long distance interactions, and to also prepare for their reunion. Some workshops could explore how best to engage fathers in the early childhood programme. This range of programme strategies is consistent with studies at Harvard University (CDCHU, 2007) which recommend a combination of broad programmes, screening for specific problems, and attention to the emotional functioning of the caregiver (CDCHU, 2008), so that the care given can be committed, consistent and responsive (CDCHU, 2010).

It is hoped that more sensory-motor equipment can be obtained, and a mobile service be provided to different refugee communities, in locations which are familiar and accessible to them. It is hoped to also employ a part-time occupational therapist, to provide more specialised sensory-motor integration programmes to enhance self-regulation and developmental capacities. Inclusion of occupational therapy, music therapy and child care students can also broaden the knowledge of early childhood work with refugees.

Bi-lingual psychoeducation fact sheets are being prepared, and it is hoped to create bi-lingual story books that incorporate culturally familiar concepts and literacy opportunities for children, while at the same time addressing trauma related concepts in age appropriate ways.

Conclusion

Music and movement activities, sensory-motor activities and a broad range of play activities can be tailored to utilise bio-psychosocial, recovery and developmental models in work with refugee families. These components and activities require monitoring and therapeutic facilitation to ensure safety and the appropriate outcomes for the child. Early childhood interventions need to be delivered in culturally appropriate ways in order to engage and support refugee families and communities. STARTTS early childhood interventions involve collaboration and engagement with the child, the family, the refugee community of which they are a part, and other service providers. This will increase social capital, enhance children's healing and ongoing development, and help to prevent repetition of trauma in their future life.

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