Therapy with Refugee Children

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Abstract
Refugee children living in Australia have usually survived a multitude of traumatic experiences in their country of origin. Exposed to war, persecution, extreme deprivation and sometimes torture, they are prone to post traumatic stress disorder and physical ailments. Omar, a nine-year old refugee from Afghanistan, was a boy who had undergone such experiences. He presented for counselling at a service for refugee survivors of torture and trauma as deeply traumatised. Omar was restored to health through a series of 58 individual counselling sessions, relying extensively on art therapy techniques. His recovery was also facilitated by his attendance at a recreational camp for refugee youth, and the establishment of psychological and practical support for his family.

I. Introduction
Since the end of World War II, 5.5 million people have migrated to Australia, including more than 560,00 people who arrived under the Humanitarian and Refugee programs. The Australian government currently accepts up to 12 000 Humanitarian entrants to Australia each year (Bowles, 1999) and, although the number of places is never filled to full capacity, there is still a constant flow of thousands of refugees into Australia annually.

It is estimated that 50% of the world refuges are children under the age of 15. Children under the age of 18 comprise 27% of the caseload in torture and trauma services through Australia (Refugee Health Policy Advisory Committee, 1997). These traumatised children also come into contact with a diverse range of professionals from doctors to teachers who are often ill equipped to deal with the problems they are facing. The following paper addresses these problems and discusses options for treatment, drawing extensively on a case study. The case study is based on the treatment of a refugee child from Afghanistan at the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS).

II. Background Information on Refugee Children
Who are the world's refugees?
A refugee is defined by the United Nations as any person who is outside their country of nationality and is unable to return due to a well founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion. (UN Convention relating to the Status of Refugees, 1951)

The United Nations High Commission for Refugees (UNHCR) reported in 1999 that there are 50 million people who have been forced to leave their home either as refugees or internally displaced persons (cited in Bowles, 1999).

Traumatic experiences of refugee children

Refugee children are frequently exposed to prolonged or multiple traumas. It is rarely the case that they encounter only a single traumatic incidence. This has been extensively documented through the literature. (Macksound et al, 1993; Richman, 1993; Yold, 1998 Amnesty International, 1998 and Refugee Health Policy Advisory Committee, (RHPAC 1997) It is common for refugee children to experience the violent death of one or both parents, witness the massacre or casualties of friends and close relatives, go through the experience of forced separation and displacement or suffer extreme poverty, starvation, physical injuries and disabilities. Often children are exposed to direct combat; they may be kidnapped, arrested, imprisoned, tortured, sexually abused or forced to participate in violent acts (Macksoud ET al, 1993). Some children are born in prisons, or conceived in prison as a result of the rape of their mothers (Cunnigham 1991). There is evidence that very young children have been raped or massacred and these horrific events are often witnessed by other children (Cunningham, 1991).

Refugee children may also be traumatised by the escape experience, when they flee their country of origin and relocate to refugee camps in neighbouring countries. Here, they can still be exposed to danger, starvation and death (Amnesty International, April 1998).
Many children are victims of mine explosions. In Afghanistan alone more than 30% of mine victims are children under the age12. Every day around seven children are killed or injured by mines (Amnesty International, April 1998).

Children are often forced to join the army became child soldiers. According to Yoldi (1998), during 1995-1996, children participated actively in 33 armed conflicts. They are often given extremely dangerous tasks, for instance, mine detection or spying.

Many male supporters of the family are killed in the war, imprisoned or forced to participate in combat. Consequently many refugee families lose the male head of their family. This leaves refugee children, particularly boys, to lose their childhood prematurely as they take up the responsibilities of their fathers. They become the breadwinners of the family, protectors of their younger siblings and are actively involved in finding food or shelter for their remaining family (Frederick et al, 1991).

Physical Health of Refugee Children

In both my professional experience and the literature (Amnesty International, April 1998,RHAPC 1997,Siddiqi 1997) I have found evidence that refugee children are not only exposed to traumatic experiences but their physical health is also at risk. They suffer overcrowded living situations with poor nutrition, poor hygiene, unclean water and lack of access to immunizations and primary-health care. As a result of these factors, refugee children under the age of five, have an extraordinarily high mortality rate. For example, since 1995 in Afghanistan, the mortality rate for infants less than two was 165 per thousand live births and the mortality rate for 2-5 year olds was 257 per thousand live births (Siddiqi, 1997).

The education of refugee children

The education of refugee children is often disrupted. Schools are either destroyed or closed during the war and teachers are often persecuted and forced to escape. In the camp situation, due to limited resources, the opportunity for an adequate education is very low. In one Pakistani camp for Afghan refugees there was only one school for the 15 000 child residents

and the school went to primary school level only. Girls were not allowed to attend. There were no chairs or tables so student had to sit on the ground. (Mehraby, 1999).

In refugee camps, the parents of children are usually too distracted with the arduous tasks of basic survival to ensure their children are educated.

Settlement difficulties in country of permanent asylum

Refugee children face a multiplicity of settlement problems such as language difficulties, loss of identity, adaptation to the new culture and new educational system and the processing of their traumatic memories. Many refugee children are placed in school within 48 hours after arrival to Australia without any period of adjustment to the new country (RHPAC, 1997). These problems are often underestimated in comparison to those of their parents; therefore, the needs of the child can be neglected. The child's parents are often preoccupied with their own traumatic experiences and settlement problems and their ability to be an effective parent is diminished. Refugee children are affected not only by their own traumatic experiences, but those of their parents. This may cause them to exhibit post-traumatic symptoms which create problems at school and elsewhere. (Aroche, 1998).

During the settlement period in a new country, children are again under pressure as they are the main link between their parents and the new society. For a traditional Middle Eastern family, the process of adjusting to Western culture can be lengthy and difficult. Refugee children from Middle-Eastern backgrounds not only experience a role-reversal but also find themselves juggling the demands of two very different cultures. In the process, they become insecure about their identity.

Impact of war on children

Although there is a paucity of research on the impact of multiple traumas on refugee children, evidence suggests that the sequelae are severe physical and psychological problems (Cunningham, 1991). The psychological symptoms after a traumatic event is defined in the Diagnostic and Statistical Manual of the American Psychiatric Association forth edition (DSM IV) as post traumatic stress disorder. (PTSD). PTSD develops after exposure to an extraordinary traumatic stressor such as actual death, life threatening situation, serious injury, or violence. PTSD in children is similar in many ways to that in adult but there are some differences according to age (Cunningham, 1991).

PTSD symptoms are divided into three categories. (DSM IV 1996) see Table I

Table 1: The symptoms of PTSD

I : *Re-experiencing Symptoms*

- Recurrent thoughts and intrusive, distressing recollections of the event such as, imagine, thoughts or perception .In young children repetitive re-enactment of the events in play expresses the theme of the trauma.
- Recurrent distressing dream of the traumatic experiences (nightmare). In children terrifying dreams may occur with unrecognisable content.
- Acting or feeling of recurrence of the trauma including, reliving of the experiences, illusions, hallucinations, flashback…etc. In young children possibly trauma-specific re-enactment occurs.
- Extreme psychological distress when exposed to symbolized events.

II: Avoidance Symptoms - Effort to avoid feelings and thoughts related with the trauma - Effort to avoid activities, places, people that triggers recollection of the trauma. - Unable to recall a significant part of the trauma. - Diminished interest or participation in remarkable activities - Detachment or estrangement feelings from others. - Restricted affects. - Sense of a foreshortened future.
III: Hyperarousal Symptoms - Difficulty falling asleep or staying asleep. - Tension irritability or outbreak of anger as they were constantly expecting danger. - Concentration and memory impairment. - Hypervigilance - Exaggerated startle response.

Children may exhibit these symptoms of PTSD, but other symptoms are also found, which are not identified in Table 1.

Table 2: Others symptoms found in child survivors of torture and trauma

- *Regression* : behaviour including loss of already achieved skills, pathological dependency towards their parents and siblings, clinging behaviour ,thumb sucking, baby talking, temper tantrums, bed wetting, separation anxiety (often seen in pre -school children)
- *Depressive syndrome* such as, loss of appetite, lack of energy, severe apathy, feeling sad all the time, loss of interest, an increased in either passive or aggressive behaviour, social withdrawn, lack of confidence, survivor guilt (especially amongst older children), suicidal ideation, or attempt, refusal to attend school. And decline school performance and change attitude toward school.
- *Psychosomatic problems* including, stomach-aches, headaches and constipation. (Cunningham, 1991, Richmand1993, Pynoos et al 1996,Macksoud ET al 1993,Husain and Holocomb, 1993).

Children have sometimes been found to express their traumatic experiences by mimicking the symptoms of their parents (Raphael, 1986).

In the literature there are two debates about the consequence of trauma in children. Some argue that trauma in children has long term pathogenic affects, while others believe that the developing personality allows trauma to occur with less serious consequences than adults. (Cunningham, 1991). However, it is generally agreed that children are more vulnerable than adults and their future relationships may be threatened if there is not appropriate intervention and Treatment. (Cunnigham, 1991).

III. Treatment of Refugee Children

A wide variety of therapeutic interventions are utilized in the treatment and rehabilitation of refugee children. According to Richman (1993), more than one approach is necessary. Individual psychotherapy and counselling group work, family work, cognitive behavioural strategies, eye movement desensitisation and reprocessing procedure (EMDR), art and creative work, playing games and story telling are some of the interventions used in different rehabilitation centers (Richman, 1993,Husain et al1993). Pynoos et al (1996) suggests the use of pharmacological therapy in the treatment of traumatized children.

Judith Herman's model for the treatment of torture and trauma is widely used (Herman, 1992). She recommends the creation of a safe environment and the development of trust as the first stage in the recovery process of trauma survivors. The second stage is the in-depth exploration of the traumatic experiences, and the third stage of recovery process is social re-connection. (Herman, 1992).

Sensitivity and awareness of the client culture is crucial. Understanding about their history, political situation, society and custom is essential (Richman, 1993).

The prognosis for traumatized children is improved if the parents also have access to counselling and are motivated to deal with their own trauma.

IV. Conflict in Afghanistan

Afghanistan has been enduring occupation and civil war for the last 21 years, resulting in the depletion of its resources and infrastructure and the decimation of government and traditional society. The roots of internal conflict can be traced to 1978, when a Soviet backed military regime commenced systematic political repression against those it deemed "enemies of the revolution".

In 1979 the Soviet Union occupied Afghanistan and its army remained in the country until they were driven out a decade later. Following the Soviet retreat, a bloody civil war amongst the rival political and ethnic groups took place. During this period, tens of thousands of Afghans, primarily those from educated and middle-class backgrounds, were imprisoned, disappeared, tortured and killed.

At present, the Taliban militia, an Islamic fundamentalist group that has imposed severe restrictions on the rights and freedom of the general population, especially women, rules Afghanistan. The Taliban is not internationally recognised as the proper government of Afghanistan

Since 1978, two million Afghans have been killed, another two million internally displaced in their own country, and 6.2 million have become refugees in other countries. Consequently, Afghans comprise the world's largest refugee population (UNHCR, 1999). Many Afghans were able to flee to neighbouring countries such as Pakistan, Iran or India, and from there some obtained admission to the USA, Europe or Australia. However, at least three million remain in Pakistan, often in squalid conditions in refugee camps with little international protection.

V. Afghan Refugees in Australia

Afghans constitute the fourth largest group of arrivals to NSW under the Refugee & Humanitarian program. Between 1991 and 1999, 2420 Afghans have arrived in NSW and of

those, 1147 (47%) were children aged 18 or under (Department of Immigration & Multicultural Affairs, 1999).

Most of the estimated 7000 Afghans, who currently live in Australia, came here via a period of asylum in a neighbouring country where they stayed in refugee camps. As with other refugees, Afghans face a range of settlement difficulties such as unemployment, lack of English, unsatisfactory accommodation and financial problems (Haidary R. & Bowles, 1995).

At STARTTS, 20% of clients receiving individual therapy are from Middle Eastern backgrounds, and of those, 18% are from Afghanistan. Nine percent of Afghan clients are children under 18 years of age whereas children only comprise 5% of the clientele of other nationalities. There are a total of 204 Afghan clients, who have received individual therapy and/or group therapy. (STARTTS internal statistics, January 2000).

VI. Case Study

In the remainder of this paper, I would like to present my work with a 9-year old boy whom I will call Omar (not his real name). I came into contact with Omar through my work as a bicultural counsellor for the Middle Eastern communities at STARTTS.

Agency Context

STARTTS was established in 1988 in accordance with the recommendations of a NSW Health Department report (Reid & Strong, 1987). The report found that there was a need for such as service due to the existence of large numbers of refugees who were survivors of torture and trauma and who lived in New South Wales.

STARTTS provides a range of services to assist refugee survivors of torture and trauma including individual and group counselling, youth camps and recreational activities, research, community development activities, an early intervention program and training of other professionals who work with refugees. Since its establishment, STARTTS has relied extensively on the services provided by bicultural counsellors. Bicultural counsellors are professionals (coming from an array of disciplines), trained in counselling or health related issues who share the language and culture of a particular client group. They serve as a linguistic and cultural bridge between clients and the service.

Family back ground and childhood history

Omar was born into a middle-class family in Afghanistan in 1987-. Both his parents were qualified professionals. Omar was the first of the family. His parents as well as the traditional extended family raised him with tremendous attention and care. His physical growth and mental development was normal. He was a happy, healthy little boy with no history of childhood diseases nor any other illnesses.

Traumatic Experiences in Afghanistan and Pakistan

Omar's father was politically active, in the resistance movement against the Soviet regime. His mother also joined a women's freedom fighter group. Because of their political involvement, Omar's parents were living in constant fear of being apprehended by the occupying forces and eventually, due to harassment and threats, they had no choice but to flee from Afghanistan with their family. It was 1990 when they left and Omar was two and a half years old . He had no understanding of the escape nor was he prepared for it.

The family spent eight days and nights walking through lofty mountains and desserts with a very small amount of food and water. Throughout the journey they ran out of food, and the few loaves of bread left were given to Omar. During their escape the family experienced shelling bombardments, gunfire and rocket attacks. Omar's father was tied to a tree and bashed by the military forces. After 9 days finally they arrived in a refugee camp in neighbouring Pakistan, where they were living in arduous conditions.

Nine months later, while still in the refugee camp, Omar's mother gave birth to a baby girl, Fatima.

It was only three months after this that Omar's father was murdered. Omar was the first one to find his body, after someone had strangled him with wire from a hostile political group. He screamed and yelled for help and tried to untie the wire from his father's neck.

Omar's mother was totally devastated by the death of her beloved husband. In addition, the murderers threatened her with death and with the kidnapping of her children to prevent her seeking justice. Omar's mother and her children had to hide to save their lives. They could not continue living in the camp, as it was too difficult for a widow to live alone without male protection. They were also unable to stay with relatives who lived in a nearby residential area as these relatives were concerned about their own safety and security rejected them. Therefore they went back to Afghanistan and, a month later, there was a renewed outbreak of fighting.

The family witnessed a variety of combat situations as well as rocket attacks and shelling. They also lacked basic necessities such as food, water and medicine. They remained in Afghanistan for another 10 months until they were again able to escape to Pakistan where they remained for a year.

It can be said that this child experienced continuous insecurity for six years. As he grew up, he gradually learned how to suppress his own feelings and take over some of the responsibilities of his father. The traumatic experience and problems were constantly discussed and told to Omar, which made him feel more responsible and caring, particularly for his younger sister Fatima.

Treatment Plan

The therapy plan consisted of supportive counselling and psychotherapy, art therapy, playing games, story telling as well as social re-connection of the family by referring client to STARTTS children camps and children outings. Issues were precisely examined in the context of the counselling sessions, home and school.

Omar's mother was also suffering from severe PTSD, depression and anxiety. It was decided to offer her a holistic rehabilitation program, which included supportive counselling and dealing with settlement needs, physiotherapy and group work. These interventions with the mother gradually changed Omar's family life, providing a context in which Omar could grow and change.

Supervision

I developed expertise in art therapy with children through regular supervision and during therapy sessions where I applied new skills.

Presenting Problems

Omar and his mother and sister arrived in Australia in August 1995, and Omar' mother referred him to STARTTS in January 1996. He was nine years old at the time, and it was agreed that he would be seen on a weekly basis.

Omar was suffering from a sleep disorder where he woke up several times during the night. He also had a fear of darkness and noise. He was extremely isolated and withdrawn and had difficulties socialising with other children. Omar fantasised about how he would avenge his father's death and was often observed watching violent movies on television. He had poor concentration and, as a result, was experiencing learning problems at school. He was also having difficulties adjusting to the Australian school system, after his lack of formal schooling in previous years. Omar seemed to have lost interest in most of the recreational activities that a boy his age would normally enjoy.

Table 3: Omar's Presenting Problems

Sleep problems
Fear of darkness
Social withdrawal
Feelings of revenge
Obsession with violent movies
Concentration difficulties
Learning difficulties
Loss of interest in enjoyable activities

An interview was conducted with Omar's mother regarding his past history and present problems. It was evident that Omar had taken on responsibilities for exceeding his nine years. He was aware of all the families' problems, including financial problems and details of bills and other expenses that had to be paid. Omar was attempting to take on his father's role by caring for his mother and Fatima.

Omar and his family were initially unfamiliar with the Western concept of 'counselling', which is not uncommon among many non-Western cultures (Becker et al 1991; Haidary, 1994). In Afghanistan, older family members mainly conducted counselling and it usually includes advice and direction giving as well as emotional and other types of assistance. This was the view of 'counselling' held by Omar's mother, who was also in therapy. While she came to her own appointments regularly, Omar's appointments were cancelled very often. Gradually, as practical assistance was provided to the family along with education about the concept of counselling, trust and confidence were built up and Omar's therapy became more regular.

Initial interview and impression

In the first therapy session Omar was shy and was hardly spoke to me. He looked much smaller than his nine years. He had no idea why he was coming to see me and what he was supposed to do. His mother had told him beforehand that he was to meet his new ‘teacher’. After greeting the child and introducing myself, I explained that children who have gone through traumatic experiences, may experience some problems and it can be helpful to talk about these problems. Different sections of the child therapy room, which contains various toys, craft and drawing materials, were shown to Omar (for a detailed description of the child therapy room see appendix).

Omar sat on a small chair, similar to those in his school classroom .He remained quiet during the first session. Eventually he began to write and draw. One of his earliest drawings depicted two birds and a small story in his first language, which was sad with a happy ending. A translation of the story is as follows:

"Mum came into the house saw her children were crying and asking for food. She got upset went-out to search for food. She found some food and gave it to her children, they all became happy."

The story reflected his experience of lack of food both in Afghanistan and in Pakistan. However, in his fantasy world Omar wanted to have a happy ending for this story. He also remarked that he liked birds as they are "beautiful, they are innocent and they can fly". It is likely that, to Omar, birds were symbolic of peace and freedom and the ability to fly away from conflict.

Omar chose to work with soft pencils and frequently used an eraser and expressed his fear of making mistakes .I felt this anxiety about making a mess reflected his feeling that his whole life was a mess. When he finished drawing he returned the pencils to their proper place, cleaned up the table and turned off the light while leaving the room. This not only reflected the ‘responsible adult’ in him, but also the very real concern of his family to conserve resources and save money on bills.

Further sessions

During the early art therapy sessions, Omar’s work often drew on the theme of war. For instance, he would draw dead bodies, jet airplanes, rockets, guns, "muscle men", snakes and soldiers. He described guns as a tool, which can kill bad people, "muscle man" as a symbol of a strong person who can fight against bad people and snakes as dangerous animals that could bite other dangerous animals.

His drawing was mainly in pencil and it was well presented for his age. On some occasions paints and coloured pencils were used cautiously and in order to prevent any mess he would cover the table with tissues before painting. During some sessions he would be distracted and tired. This was often expressed in the session by being unable to finish his drawing. I felt this related to his underlying depression.

Omar relived many of his traumatic experiences and desire for revenge through his drawing. He often depicted the killing of "bad people". However, it was difficult for him to verbalize the trauma and he was not naming his enemies as of murderer of his father rather he was labelling them "bad people" .

In the sixth session, Omar chose to play with plasticine. He made a gun and a man and said that "bad people can be killed by a gun". He put a pistol on the chest of the man and explained that he killed a bad person.

Animal games were also played and I was asked to participate in the games. Omar was taking the role of the strong animals for example, lion or tiger, while I was asked to be in the role of a fox and later a deer. Omar killed all the animals and was the hero of the game. This game was played several times during the following sessions. He needed to be the strong one rather then the victim; I was to be the victim. This reflected his fixation with bringing vengeance to the murderers of his father.

After the 10th session Omar was referred to a STARTTS residential camp held at Rivendell Child, Adolescent & Family Unit at Concord Hospital. It was hoped that the camp would help to reduce his isolation and facilitate his interaction with other children. By doing so it would increase his self-confidence and his knowledge of the new country. He would also have the opportunity to participate in enjoyable activities.

It was felt that my presence in the camp would be supportive for both Omar and his mother, who were anxious about their separation from each other. Therefore, I attended the camp for the first two days.

Omar was initially withdrawn and shy and took time to engage with other children but he eventually mixed well with them. Omar enjoyed his time at the camp. He participated in almost all of the camp activities such as small group exercises, acting and games. This gave the opportunity to share his experiences, to feel he was not alone and that other children had similar experiences.

The camp gave him a break from his difficult environment and from his mother, who usually relied on him for support. It also gave him a chance to be a child, not an adult. Omar's participation in abseiling and rock climbing helped him to overcome some of his fears about noise, darkness and the likelihood of re-experiencing trauma. He was actively involved in a treasure hunt game, which assisted him to feel positive and empowered rather than victimised.

The camp also provided an opportunity for him to identify differences between refugee camps, places of sorrow and sadness, and residential camps, places of pleasure and joy.

In the first therapy session after the camp there was an obvious shift in Omar's mood. The silence was broken. He was very excited about the camp and talked throughout the session about it.

Gradually, through regular therapy sessions, his drawings and craftwork began to change. It became much more creative and lively with themes relating to his family, school and friends in Australia, colourful flowers, trees, gardens, the sun and sea, mountains and the Sydney Opera House. Also, Omar was no longer afraid of making a mess, and was no longer concerned about the cost of the electricity bill and the need to turn the lights off. He began sitting in a larger chair and he was also able to talk about different things at home and at school. He now described a gun as a toy and a snake as an animal that can be made easily from clay or plasticine. When he learned some new art or craft at school, such as book-covering, making fans, cards etc, he made examples of this during therapy and talked about what he had learnt.

It was obvious that he was much less preoccupied with his past trauma experiences and more focused on his present. An important therapeutic goal had been achieved.

Omar came to have trust in me and saw me as someone with whom he could share his happiness and success and talk about his problems. He enjoyed talking about sports, school carnivals, subjects that he likes or dislikes, friends and family. Often he brought his school reports with him and talked about his progress and weaknesses. One day he was very excited and told me: "I have a great news for you, l have been chosen for the special Art &Craft group". Another day he was able to express his feeling about his mother: "I don't like when my mother cries or gets upset, I feel sorry for her". In another session, when he was drawing a map of Australia, he said that he liked Australia because it is beautiful and there is no" fight" here.

At home, with Omar's mother receiving regular therapy for her psychological and physical problems, and for dealing with practical problems, things changed dramatically. Omar was the child of the family and he did not have to carry on the responsibilities of his father. He was allowed to be a child and behave like a child. He was watching cartoon films instead of violent movies. He was more involved in outdoor activities and sports.

At school, changes also occurred in terms of Omar's learning and behaviour. His school reports were a clear indication of his improvement. As previously mentioned, Omar was one of the 10 students who was chosen to attend a special Art and Craft class, and was very interested in sports and creative work. He was no longer the withdrawn child who could hardly communicate with other children.

As progress was noted in the clinical setting it was decided to discharge Omar from therapy. The termination process was discussed eight weeks in advance and a calendar was marked to prepare him for the ending.

In the last session Omar chose to draw. He drew a picture of himself and I together. He gave the original to me and said that I should keep it so I would remember him. He also wanted a memory of our relationship and he kept a photocopy for himself. At the end of the session Omar asked if he could take his previous drawings with him. I felt this reflected his need to take what he had learnt during therapy with him. He asked if he could go to future STARTTS' camps and inquired as to whether he could contact me if the need arose. These questions reflected his separation anxiety and his worries about the future. Was it going to be a permanent loss, as other losses in his life had been, or was it just the end of a positive experience?

This last session had a significant impact on me. I was worried about his well being and had my own feelings of separation, sadness and loss as therapy came to an end. Because of my own refugee experience, loss and separation is always difficult for me. I felt both of us were reliving the trauma and uncertainty. It was obvious that I experienced some counter transference reactions, but this was communicated and shared and, while this was painful, it was no longer overwhelming.

The therapy period was 20,months (58,individul sessions).

Conclusion

Omar had experienced enormous disruptions in his early life due to the war in Afghanistan and the murder of his father. A safe and trusting environment was created for him during his therapy sessions at STARTTS, which allowed him to explore these traumatic experiences. He

did this mainly through art therapy and play, where he was able to confront the demons of his past in a manner appropriate to his age. As he expressed his fears and the horrors of his past through artwork, and was given the opportunity to discuss what he had portrayed, the symptoms of his trauma gradually abated.

Appendix

The child therapy room at STARTTS is a simple room of average size with a large window and plenty of light. It has washable, vinyl floor, a tap with running water and a sink, a low table with a couple of small plastic chairs, two adult's chairs and a table, and a large cupboard. Toys and the drawing materials that can be used by children are as follows:

- Paper (with. drawing book or blank paper, large and small in size different colours)
- Coloured pencils, textures, paint with brushes, rubber, pencil sharper, scissors and toy scissors.
- Plasticine sticks
- Glue and sticky tape
- Sets of plastic farm animals
- Sets of wild /zoo animals
- Wooden blocks
- Fences and trees
- Cars, trucks, airplanes.
- Dolls (men, women and children)
- Clay
- Some containers, paper and plastic cups.
- Sand trays.
- String.
- Cellophane.
- Cardboard in different colours.

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Biography

Nooria Mehraby graduated as a medical doctor from Kabul University, Afghanistan in 1983. She worked as a teacher at Kabul University and as a general practitioner until 1987 when she and her family were forced to flee to Pakistan. A refugee herself, Nooria worked as a doctor in various refugee camps and taught medicine at a Women's University in Pesherwar for five years.

In 1993 Nooria and her family arrived in Australia where she obtained employment as a Health Educator Officer with South Western Sydney Area Health Service. Since 1995 Nooria has been employed with the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS). as a Bi-cultural Counsellor for Middle Eastern Communities. During this time Nooria has been involved in providing individual counselling for adults and children. She facilitates self-support groups for Middle Eastern men and women and is involved in ongoing community consultations and training to other service providers on refugee issues.