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University of Nebraska at Omaha

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EXPLORATORY STUDY OF A SCHOOL-BASED REFUGEE MENTAL HEALTH PROJECT

By

Anne Marie Boose

A DISSERTATION

Presented to the Faculty of

The Graduate College at the University of Nebraska

In Partial Fulfillment of Requirements

For the Degree of Doctor of Education

Major: Educational Leadership

Under the Supervision of Dr. Kay Keiser

Omaha, Nebraska

December 2018

Supervisory Committee:

Kay A. Keiser, Ed.D.

C. Elliott Ostler, Ed.D.

Jeanne L. Surface, Ed.D.

Rebecca Pasco, Ph.D.

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ABSTRACT

EXPLORATORY STUDY OF A SCHOOL-BASED REFUGEE
MENTAL HEALTH PROJECT

Anne Marie Boose, Ed.D.

University of Nebraska, 2018

Advisor: Kay A. Keiser, Ed.D.

Immigrant and refugee youth are in our schools in greater numbers than ever. Educators are required to educate all students to the same standards, even though they have often been exposed to violence and other difficulties throughout their journey to a new home. Many continue to face many on-going barriers as they arrive in our schools. Although this population is resilient and has many strengths, for some the burden of trauma is overwhelming, threatening their mental health and school performance. A small percentage of these students are unable to cope and make devastating, life-ending decisions. Schools with large numbers of refugee students in Nebraska are addressing the mental health needs of these youth with a variety of programming. Thirty-nine immigrant and refugee students in the research district were identified based upon past trauma, recommendations of school staff and parental reports for involvement in a short-term school-based intervention of cognitive behavioral therapy. A formalized measure of stress symptoms confirmed a mental health need and trained bilingual liaisons was utilized for weekly cognitive based therapy sessions with a licensed mental health practitioner. Analysis of archival data was conducted to treatment impact upon three indicators of academic engagement; behavioral engagement (attendance data), cognitive engagement (number of failing grades), and relational engagement (office referrals). No

significant impact was found upon any of the indicators of academic engagement, however, positive outcomes were reported by some of the treatment therapists, parents and teachers of the involved refugee students. The key aspects of providing school-based mental health services to refugee youth are discussed, including how to measure the impact of an intervention, the use of bilingual liaisons and cultural brokers to ensure culturally responsive mental health services, and the effective use of resources through partnerships.

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To my sister, Kate Goodman, for helping with my children during this long process and for pushing me to keep my head in game. Jamie Przybylski, thanks for your support with our children and for helping me pursue my goal. Without your flexibility I would not been able to take the classes and spend the many hours needed to reach the end of this journey. Thank you to Shari Anderson for proofreading and your feedback. Thank you to my children, who really don’t understand what all of the fuss is about. I hope that someday you think of me and this process and realize you can do anything, as long as you never, never, ever give up. To the hundreds of students and families I have been fortunate enough to serve. You teach and inspire me every day. Thank you for the gift of joy. Finally, thanks Mom. You always wanted a doctor in the family. I hope I made you proud.

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CHAPTER 1

INTRODUCTION

According to the 2010 US Census Bureau, 22% of school age children have at least one foreign-born parent (U.S. Census, 2010). Within the next few years, it is possible that as many as 30% of children in the United States may live with immigrant families (Sibley & Dearing, 2014). The number of immigrant children in the national public education system, and in Nebraska, is higher now than ever. Shifting immigration trends between 1990 and 2000 saw Nebraska having the fourth most rapid growth in elementary school enrollment of immigrant children, increasing by 125% (Capps et al., 2005). Some of these immigrants arrived as refugees, fleeing unstable nations, while others have had a different journey resulting in their arrival, sometimes with undocumented status. Many have experienced trauma on the way. The reader is referred to the film, *Seeds of Hope*, created by the I Love Public Education foundation (<https://iloveps.org/films/topics/immigrant-and-refugee-education>), for first person accounts of immigrant and refugee education in the state of Nebraska, discussion of relevant issues and interviews with educators in our public schools who are addressing the needs of these students here in our state.

State and federal laws require public schools to provide an education to all children in the United States (*Plyler v. Doe*, 457 U.S. 202; 1982). There is intense pressure on the education community for all children to achieve academically, regardless of how they arrived in school. (Eklund & Rossi, 2016). Ensuring a child performs proficiently on a high-stakes exam in a new language, after recently migrating to a new

country, is complicated at best. Refugees are survivors, however, many of these children arrive in crisis and cannot learn what they need to succeed without interventions that address the impact and stress of the refugee experience upon one's mental well-being.

Regardless of the exact path taken, the migration experiences that immigrant and refugee children have lived through contain a variety of stresses (Coll & Magnuson, 1997; Suarez-Orozco & Suarez-Orozco, 2001). Immigrant and refugee children are at risk of exposure to violence in their country of origin, during their migration and resettlement, because they are often impoverished upon arrival (Jaycox et al., 2002). In one study, 32% of immigrant children, who were not refugees, scored in the clinically significant range on a measure of post-traumatic stress disorder, while 16% of those screened also demonstrated significant symptoms of depression (Stein, et. al. 2002). Once here, children in immigrant and refugee families are more likely to live in more crowded urban areas, to experience food insecurity (Takanishi, 2004), have significantly higher rates of poverty rates (23% versus 18%) (Passel, 2011; Center for Health Care in Schools, 2011; Takanishi, 2004) and to be in poorer health (Takanishi, 2004) than non-foreign born children. Immigrant and refugee children are more likely to lack health insurance and to have parents with limited education experience (Child Trends, 2014). Additional barriers include learning a new language and discrimination, which may have to be overcome, at least initially, with limited resources, (Pumaregia, Rothe & Pumaregia, 2005).

Loss, trauma and deprivation are each common experiences of refugees, and refugee children specifically, and impact psychosocial and cognitive functioning (Athey & Ahearn, 1991). Arellano and Danielson, (2008), found that children coming from

traumatic backgrounds “are at risk for negative outcomes including Post Traumatic Stress Disorder (PTSD), anxiety, depression, substance use and health risk behaviors.” (p 56). Pynoos and Eth (1985), suggest that refugee children are particularly susceptible to the additive effects of dealing with trauma and grief. Bloom (2016), cautions that children who do not receive intervention to protect them from the effects of overwhelming stress, may experience “life-long adjustment problems that take a toll on the individual, the family, and society as a whole.” (p. 9). It is well established in research that the learning of children who have experienced trauma is at risk, and becomes diminished if these children do not receive interventions to help cope with the burdens of trauma.

Fortunately, research tells us that when we do provide intervention for trauma, these children improve in overall stress related symptom reduction and are more available for learning (Stein et.al., 2003). Several types of trauma intervention models have been implemented in schools. For the purpose of this study, we will focus on Cognitive Based Intervention (CBI). CBI focuses on providing coping strategies, rather than addressing the actual trauma experiences, as is done in other narrative interventions (Sullivan & Simonson, 2016). Through a randomized controlled trial, short term Cognitive Based Intervention for Trauma in Schools (CBITS) has been shown to be effective in helping students with backgrounds of trauma (Stein et al., 2003; Jaycox, et al., 2003), including Latino immigrants (Kataoka et al., 2003). There is limited, but emerging, research of the effectiveness of school-based cognitive based therapeutic interventions on the diverse immigrant and refugee student populations. This study aims to explore this research gap.

Theoretical Framework

This paper will view this research through the lens of the ecological theory of human development (Bronfenbrenner, 1977). Bronfenbrenner theorized that everything around a child, in his or her environment, impacts that child's development, including interpersonal relationships. Bronfenbrenner's theory has four levels: the Macrosystem, the Exosystem, the Mesosystem and the Microsystem. Of these levels, the microsystem is the most influential on individual development because of the direct influences an individual's relationships (e.g., family, peers, school and caregivers), have upon the individual. The Mesosystem consists of the interactions of relationships within the microsystem which have an indirect influence on an individual. Examples include parents participating in family literacy through the school and parent-teacher conferences. The Exosystem includes events and relationships that the student is not a direct part of, but that do have an impact upon him or her, such as a parent's employment. Finally, the Macrosystem, contains the cultural elements of one's environment and other systems that influence an individual, such as economics, politics and societal norms. Elements of the refugee experience fall within each of these levels, thus impacting every aspect of the development of these youth.

Problem Statement

O'Brien (2005), in his review of literature on the needs and barriers of refugee students in the United States proposed that, "if not for the sake of the individual refugee child, then for the stability of society as a whole, helping refugee children to succeed in school should be of importance to educators, administrators, and policymakers." (p.358). Society functions at its best when as many of its members as possible are functional, engaged and productive contributors. The job of our K-12 educational system is to

produce knowledgeable and productive citizens upon graduation, regardless of the obstacles each one has faced. If our ultimate goal is to have immigrants and refugee students become productive and engaged members of society, then it is our responsibility to provide them with access to the tools one needs to achieve that end, including mental health interventions to overcome the effects of migration, resettlement and trauma that often negatively impact one's academic performance.

Research Question

What is the impact of the short term provision of cognitive behavioral therapy, a mental health intervention focused on providing and practicing coping strategies, have on the stress symptoms and indicators of school engagement of K-12 refugee school children in a Midwestern school district?

Definition of Terms

Behavioral engagement specifically reflects students' participation and efforts to perform academic tasks including regular attendance, appropriate classroom behavior, satisfactory classroom participation and turning in assignments on time (Suarez-Orozco & Carhill, 2008)

Childhood Stress Disorder Scale (CSDS). The Child Stress Disorders Checklist (CSDC) is an observer report measure designed for use as a screening instrument for traumatic stress symptoms in children. It measures symptoms of Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD). National Child Traumatic Stress Network (2017)

School engagement. The degree to which students are "connected" to what is going on in their classes (Steinberg, Brown & Dornbusch, 1996)

Children's Revised Impact of Event Scale (CRIES-13). The Children's Revised Impact of Events Scale is a reliable and valid measure that has two brief versions (13 items and 8 items) to assess reactions to traumatic events/stress symptoms among young people (Deeba, Rapee, & Prvan, 2014)

Cognitive Behavioral Therapy. Cognitive behavioral therapy (CBT) focuses on exploring relationships among a person's thoughts, feelings and behaviors. During CBT a therapist will actively work with a person to uncover unhealthy patterns of thought and how they may be causing self-destructive behaviors and beliefs. National Alliance on Mental Illness (NAMI) .

Cognitive engagement. The degree to which the students are engrossed and intellectually involved in what they are learning (Suarez-Orozco & Carhill, 2008)
Coping- behavior that protects in individual from internal and external stresses (White, 1974.)

Culture. Culture is broadly defined as a common heritage or set of beliefs, norms, and values (US Surgeon General, DHHS, 1999).

Cultural broker. This is an individual who translates language, as well as culture, between individuals of different cultures (Brenner and Kia-Keating, 2016)
Immigrant children and youth- individuals who are aged 3 through 21 who; were not born in any State; and have not been attending one or more schools in any one or more States for more than 3 full academic years. (Federal Government Definition Section 3301(6) of Title III). For the purpose of this study, unless otherwise stated, this term refers to school age children, aged 5-18.

Ecological Systems Theory. Theory of child development within the context of the system of relationships that form his or her environment. Bronfenbrenner's theory defines complex "layers" of environment, each having an effect on a child's development. (Bronfenbrenner & Morris, 2006).

<p>Mental health. Mental health includes emotional, psychosocial and social</p>
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wellbeing. It affects how we think, feel and act. Also helps determine how we handle stress, relate to others and make choices .

Post-traumatic Stress Disorder (PTSD). According to the United States Department of Veteran affairs and the National Center for PTSD (2017), there are four types of symptoms of post-traumatic stress disorder: re-experiencing, avoidance, hyperarousal and negative changes in beliefs and feelings. To meet formal criteria, these symptoms must last for longer than three months, cause great distress and interfere with life functioning.

Refugee. Refugees are people fleeing conflict or persecution. They are defined and protected in international law, and must not be expelled or returned to situations where their life and freedom are at risk (United Nations High Commissioner on Refugees, 2018).

Relational engagement. The extent to which students feel connected to their teachers, peers and others in their schools (Suarez-Orozco et al., 2008)

Traumatic stressors- an overwhelming event resulting in helplessness in the face of intolerable danger, anxiety and Instinctual arousal. (Eth & Pynoos, 1985)

Assumptions

It is assumed that the involved participants provide truthful and honest responses on the screening interview and the follow up questions. It is assumed that the bilingual liaisons provide accurate translations of materials.

Limitations

This study is limited in its small sample size and in the exploratory nature, so the potential for generalization is minimal.

Delimitations

Indicators of engagement were chosen as a measure of the effectiveness of the intervention rather than strict academic achievement because of the second language status of the participants.

Significance of the Study

The population of immigrant/refugee students in the K-12 educational system continues to grow. These students need to be educated in an inclusive manner that benefits society in the long run. They often face additional risk factors that impact their performance in school including second language acquisition, recent migration events, adjustment to a new country and culture, and possible discrimination and trauma. These students require additional services to help them adjust to their new environment, learn the language of instruction, and achieve in school. Currently there are programs in place, as required by law, to support students in language acquisition and content mastery while they are learning a new language. While there is an increasing trend of school districts providing research-based interventions to support students with a history of trauma, there is a gap in the provision of these services specifically for the newcomer population. There is some funding available to address of unique needs of the newcomer population

through Title III, which may be used to investigate this issue. The results of this exploratory study will contribute to the emerging body of practice-based evidence informing best practices in Nebraska and potentially identify factors that may increase the scope of students reached by this type of support. Additionally, through thoughtful analysis of the intervention program and results, a discussion of the allocation of resources to better address the needs of students with additional risk factors can be deepened. Implications from resource allocation could better address the staffing and workload demands of teachers and staff in similar Title 1 schools that serve a high needs population, including refugees. There may be information that impacts recommendations for some aspects of professional development and pre-service training of teaching candidates and other school staff working with refugees and immigrants.

Results from this exploratory study were used in several ways to make recommendations for further research and begin establishing best practices for supporting the mental health needs of immigrant and refugee students in our schools. Findings were used to educate key stakeholders at the district and state level regarding best practices in providing school-based mental health services to meet the needs of these students. Findings may be used in future grant applications to secure additional funding to expand access to similar services and pursue further research in this area. At the district level, the evaluation of the intervention was used to adjust services and plan for expanding access to interventions with the target population.

Outline of the Study

Methods are discussed in depth in chapter three. Data gathering will be discussed in terms of barriers encountered and an evaluation of attempts to overcome the

barriers. Data analysis shows trends in the data and the discussion of potential relationships between the treatment and educational indicators of engagement.

Implications for next steps in research will be discussed. The urgency of immigrant and refugee students will be highlighted to suggest a compelling reason to continue research in this area.

CHAPTER 2

Review of Literature

State and federal laws require public schools to provide an education to all children in the United States (*Plyler v. Doe*, 457 U.S. 202; 1982). Some limited provisions exist in federal education legislation to address the needs of English language learners (ELL). While helpful, these provisions do not address the complex needs of refugee students, which often go beyond second language acquisition. There is intense pressure on educators for all children to achieve academically, regardless of how each one arrives at school. (Eklund & Rossi, 2016). Ensuring a child performs proficiently on a high-stakes exam in a language they are just learning, and after a recent migration experience is complex at best. Although resilient, many of these children arrive in crisis and cannot learn what they need to learn without interventions that address the mental health barriers before them. Brenner and Kia-Keating (2016), propose that, “schools have the great opportunity to play a central role in leading the effort to support refugee youth resilience.” (p. 245).

Risk, trauma, psychosocial stress and the refugee experience

Each immigrant and refugee’s experience is unique, and not everyone experiences the burden of various types of stress and trauma; however, exposure to these factors are well documented in immigrant and refugee research (De Haene, Grietens & Verschueren, 2010; Coll & Magnuson, 1997; National Child Traumatic Stress Network, [NCTSN], 2003; Suarez-Orozco & Suarez-Orozco, 2001). The National Child Traumatic Stress Network Refugee Trauma Task Force (2003), in their white paper titled, “Review of

Child and Adolescent Refugee Mental Health,” identify a variety of stressors refugee children may experience such as exposure to violence, disruption of schooling and traumatic loss. Specifically, during the flight from a country of origin, these children may be exposed to displacement, time spent in camps or detention, and separation from caregivers. The Victorian Foundation for the Survivors of Torture, (2005), in a study of school age refugee children in resettlement communities in Greece, the United Kingdom and the United States, found that 28-60% had a parent killed or were separated from their parent for a month or more. This type of disrupted attachment, or the loss of a primary caregiver, adversely impacts a child’s development in many areas and their impact differs by developmental age level (Davies and Webb, 2000).

Once in the resettlement phase of their experience, these youths and their families may often be subjected to additional traumatic experiences such as loss, acculturation, economic insecurity (NCTSN, 2005), and lack of access to necessary services (Child Trends, 2014). For example, 32% of children in resettlement, who were not refugees, scored in the clinically significant range on a measure of post-traumatic stress disorder, while 16% of those screened also demonstrated significant symptoms of depression (Stein et al., 2002). Bronstein and Montgomery (2011), in their comprehensive review of literature on psychological distress in refugee children, found that between 19-54% of refugee children in resettlement communities met the clinical diagnosis for post-traumatic stress disorder (PTSD), as compared to 2-9% of children in the general population. Higher rates of anxiety (33-50%) and depression (3-30%), were also found in refugee children than in host populations. Furthermore, Bronstein and Montgomery

describe that PTSD has been shown to persist in this population for up to 12 years after resettlement.

The immigrant and refugee resettlement experience is often one of daily struggle with language acquisition, perceived discrimination, and an increasingly hostile political and social climate. Recent US headlines illustrate the hostility some refugees face, such as the separation of immigrant and refugee children from caregivers after crossing the border into the United States. Any of the previously discussed stressors of the preflight, flight and resettlement phases of the refugee experience may also exist in addition to any personal factors related to trauma, such as those specific to a given individual and their experience within their own family (Davies and Webb, 2000).

Trauma and psychosocial stress

Higher incidences of PTSD and other mental health difficulties in refugee children are well documented (Henley & Robinson, 2011; Hodes, 2000; Thomas & Lau, 2002; Yule, 2002; Davidson, Murray, & Schweitzer, 2008; Ethnolt & Yule, 2006; Ethnolt, Smith & Yule, 2005). Symptoms of these disorders interfere with learning through a variety of cognitive functions, including memory, concentration, attention and abstract reasoning (Beers & DeBellis, 2002; Eth & Pynoos, 1985; Rousseau, Drapeau & Corin, 1996), poor concentration and the acquisition of new information (Streeck-Fischer & Van Der Kolk, 2000), creative play, emotional and behavioral self-regulation, motivation and self-confidence. (Kaplan, Stolk, & Valibhoy, 2015). When left untreated, children with PTSD who do not receive intervention may have limited psychosocial functioning and are increasingly at risk for developing other disorders (Bolton, O’Ryan, Udwin, Boyle & Yule, 2000; Weber et.al., 2008, as cited in Deeba,

Rapee & Prvan, 2014). These individuals may experience “lifelong adjustment problems that take a toll on the individual, the family, and society as a whole,” (Bloom, 2016, p. 9). Kinzie et al. (1986), found that half of the group of Cambodian refugee students in their study continued to experience major symptoms of PTSD four years after their experience of trauma. Fortunately, when we know that when we do provide appropriate trauma intervention, these children improve in overall stress related symptom reduction and are more available for learning (Stein et al., 2003), and able to benefit from an improved school experience (Kia-Keating & Ellis, 2007).

Culture and Stress

Culture impacts everything we do, who we are, and how we move through life. Marsella and Christopher, (2004), in their meta-analysis of literature related to cultural considerations and disasters titled, “Ethnocultural Considerations in Disasters: An Overview of Research, Issues, and Directions,” describe the significance of culture in this way:

Culture is more than ethnicity and ancestry. It is the manner and content in which human beings construct their realities, meanings, and identities. It is the template that is placed over reality to give it order and define what is morality, health, illness, and an acceptable way of life. (p. 533)

The lens of culture impacts the perception and reactions of individuals to specific events, how one interprets emotion (Holodyski & Friedlmeier, 2006), how one expresses emotions, the number of emotions one feels and the context in which one handles these emotions (Hoffman, 2009; Mauss, Bunge & Gross, 2008). Human response to stress has some universal biological and psychological similarities across

cultures, but there are also culture-specific PTSD responses (McFarlane & DeGirolamo, 1996; Marsella & Christopher, 2004). In a meta-analysis of quantitative literature on disasters (1981-2002), Norris et al. (2002), found that ethnic minority youth were at greater risk in 66% of the samples due to “culturally specific attitudes that impede help seeking.” (p.525). When discussing stress and trauma within a population as diverse as the refugee youth being educated in Nebraska’s schools, culturally sensitive mental health services are an essential consideration.

Canino and Spurlock (2000), in their book, *Culturally Diverse Children and Adolescents: Assessment, Diagnosis, and Treatment*, explain when considering mental health treatment, norms do not always translate from one culture to the next. Thus, there are increased risk for complications in addressing the mental health needs of individuals with diverse cultural backgrounds, especially when client and service provider are not from the same cultural background. Canino and Spurlock (2000), advocate for improved cultural diversity training of mental health professionals and offer a framework of guidelines from their own experiences as “practice based evidence” to assist practitioners working with similar populations in minimizing possible complications. The growing body of “practice-based evidence” in working with the mental health needs of refugees is also supported by the National Child Traumatic Stress Network (2005), as a way of developing and improving mental health services for refugee youth while waiting for additional high quality research in relevant areas, such as best practices for assessing, diagnosing and treating this vulnerable population.

From their review of research and clinical studies, Marsella and Christopher (2004), recommend increasing culturally competent mental health services through

addressing clinical, training and research needs. Clinical needs include the use of integrated social and mental health services, incorporating language and communication patterns of victims, and cultural certification of service providers based upon yet-to-be-developed national competencies. Identified training needs include identifying widely accepted cultural competencies, using culture brokers available within local communities, and developing a culture training resources center for disasters. Identified research needs include creating a cultural disaster research archive that houses systematic research for teaching purposes, the implementation and study of preventative programs across cultures, systematic study of cultural variations in grief, loss and bereavement in specific cultures, and the development of culturally sensitive measures of trauma and mental health for working with refugees.

Immigrant and Refugee Education

As Chimamanda Ngozi Adichie cautioned in her TED Talk (2009), we must be cautious of the “danger of the single story” in educating and working with refugee students. Not all immigrants and refugees have psychopathology (Davies & Webb, 2000). For example, Roy and Roxas (2011), discuss how the needs of the Iraqi youth are not identical to those of the Somali Bantu just because individuals from both groups fled war torn countries. One group has migrated from a country with a well-established formal educational system, while the other group has arrived with little formal educational experience, increasing the challenge of adapting to their new school lives. These differences in formal educational experiences in a country of origin, are one example of the complexity of addressing the mental health needs of refugee students in Nebraska’s schools today.

The film, *Seeds of Hope*, created by the I Love Public Education Foundation (<https://iloveps.org/films/topics/immigrant-and-refugee-education>), provides first person accounts of immigrant and refugee education and related issues. Interviews with educators illustrate how our public schools are currently addressing the needs of these students within their districts and how our refugee students are adjusting. While English Language Learners (ELL) make up 6.87% of the total student population in Nebraska, five school districts within the state have ELL populations of 36.52%, 28.52%, 17.3%, 16.49%, and 11.44% of their total student population (Nebraska Department of Education, 2018). The largest district reports over 19,000 students who speak 119 different home languages and the second largest district has 125 different home languages spoken by students. The refugee population in this district has increased by 125% over the past few years. Foreign born students comprise a significant number of the students in Nebraska's schools and we must meet their educational needs.

Schools and Mental Health

According to the Center for Health and Health Care in Schools (2011), “between 14-20% of young people in the US have one or more mental, emotional and behavioral disorders at any given time,” (p. 2). The government website MentalHealth.gov describes that 10% of all school-age youth as having experienced a major depressive episode in 2014. As many as 5% of students demonstrated an “extreme functional impairment” (Macklem, 2011), that negatively impacted their learning. An estimated 75% to 80% of students who need mental health services do not receive any (Desocio & Hootman, 2004). These students with unmet mental health needs struggle in school with inconsistent attendance (Desocio & Hootman, 2004), poor academics and focus (Desocio

& Hootman, 2004; Frojd et al. 2008), and difficult social relationships (Frojd et al, 2008). Academic struggles and a lack of engagement are early symptoms of mental health issues in school age students. Often, behavior and discipline referrals can also be an indicator of a student's mental health needs for schools, putting students at risk of failing to graduate. While foreign-born youth make up 10 percent of the total population, ages 16-24, they make up 17 percent of the high school dropout population (Child Trends, 2018).

Historically, to address student mental health needs schools have provided guidance counseling, social and academic counseling groups, special education services for students who qualify, and social work services. These services are typically provided by social workers, counselors and school psychologists, in reaction to ongoing issues. These staff are often only at a given school on a part-time basis, and work at several schools at a time. This limits their availability and decreases consistency by a single provider in responding to students in crisis due to mental health needs. A paradigm shift toward preventative, tiered services is growing in school-based mental health to address some of these issues.

In a meta-analysis of school-based mental health programs, Durlak and Wells (1997), found prevention programs in schools to be at least as effective as preventative interventions in medicine, providing an empirical basis for the shift toward school-based mental health interventions. Birman and Chan, (2008), in their issue brief for the Robert Wood Johnson Foundation (RWJF) titled, "Screening and Assessing Immigrant and Refugee Youth in School-Based Mental Health Programs" stated that, "schools provide a cost-effective, family-friendly opportunity to identify and treat mental health problems

among immigrant and refugee students.” (p.1). Furthermore, schools are a familiar, accessible and more comfortable place for children and their families to receive these services (RWJF Caring Across Communities Briefing Kit). Kugler (2009), in her article for the Center for Health and Health Care in Schools, School of public Health and Health Services, entitled, “Partnering with Parents to Support Immigrant and Refugee Children at School,” discusses the importance of the school-family partnership in addressing the psychosocial impacts of stress and trauma upon refugee youth.

Between 2007 and 2010, the Robert Wood Johnson Foundation, through the Caring Across Communities (CAC) initiative, funded 15 projects in eight states involving partnerships between families, students, schools, mental health agencies and other community organizations. The goal of these initiatives was to “reduce the emotional and behavioral health problems among school children in low-income, immigrant and refugee families.” (p.2). The initiative was managed by the Center for Health and Health Care in Schools at the George Washington University. Each site participating within the initiative created and implemented programming designed to meet the mental health needs of the immigrant and refugee children and families unique to their communities, utilizing different methodology and community partnerships. The result of the CAC initiative is a growing body of “practiced-based evidence,” on the essential components of providing school-based mental health services to immigrant and refugee children.

Researchers at the Center for the Study of Youth and Political Violence and Department of Public Health at the University of Tennessee, Knoxville were contracted to perform a process evaluation of the key components of RWJF’s Caring Across Communities initiative, (McNeely, Sprecher and Bates, 2009). Their findings are

detailed in the 2009 article titled, “Comparative Case Study of Caring Across communities, Identifying Essential Components of Comprehensive School-Linked Mental Health Services for Refugee and Immigrant Children.” for school-based mental health services for immigrant and refugee students. Five of the fifteen CAC sites were selected for in-depth stakeholder interviews. The findings of the process evaluation identified the challenges facing the target populations (see figure 2.1), the necessary components for comprehensive school-based services for refugee and immigrant students (see figure 2.2), and elements of effective community partnerships.

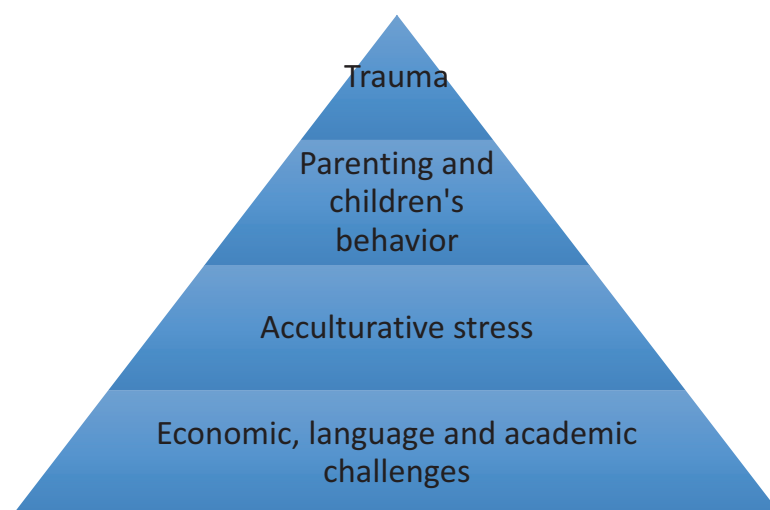


Figure 2.1 Challenges facing refugee and immigrant students (McNeely, Sprecher and Bates, 2009).

Immigrant and refugee families face the challenges of economic, linguistic and academic factors, acculturative stress, parenting skills and children’s behavior, in addition to the impact of trauma. The daily challenges need to be able to be addressed in

order to deal with acculturative stress, and so on.

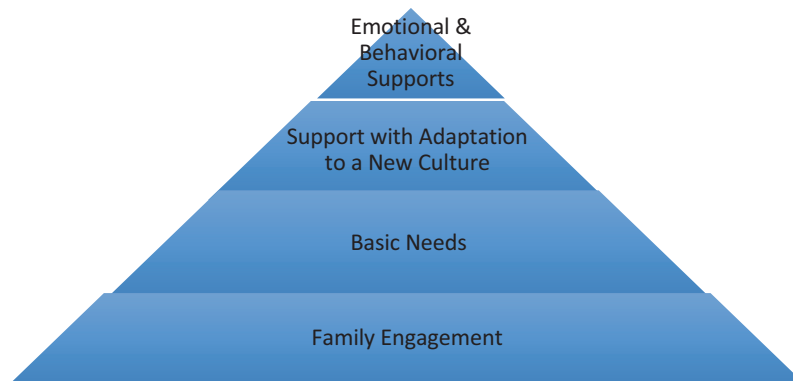


Figure 2.2 Necessary components of school-linked comprehensive mental health services for refugee and immigrant students (McNeely, Sprecher and Bates, 2009).

McNeely, Sprecher and Bates (2009), proposed a hierarchical prioritization of services (figure 2.2), beginning with family engagement. The family is a crucial component to providing school-based mental health services to refugee and immigrant students. Once the family is engaged, helping meet basic needs and providing support in adapting to a new culture, need to be addressed before emotional and behavioral needs. These services need to be comprehensive, integrated and the family needs a single contact person to go to for access to supports.

Assessment of the Mental Health Needs

Hollifield et al. (2002) conducted a critical review of the commercial measures available for measuring the trauma of this unique population and found them to be lacking in the use of sound measurement principles. Eight commercially available measures have been used with refugee populations in research studies. The Impact Event Scale (IES) was one of the eight measures and met four of the five study criteria. The Children and War Foundation developed thirteen item version of the IES for children called the Children's Revised Impact Event Scale, or the CRIES-13. The CRIES-13 is

easily accessible, available in many different languages and is free, making it an attractive option for measuring stress symptoms in children. This is the primary measurement tool for stress symptoms in the current study.

Cognitive Behavioral Therapy

While several models of school-based trauma interventions exist in the research, for the purpose of this study, we will focus cognitive behavioral therapy (CBT). Cognitive Behavioral Therapy (CBT) is a well-researched evidence based practice that focuses on problem-specific behavioral and cognitive interventions. CBT has demonstrated effectiveness in prevention and intervention work in schools (Macklem, 2011), and with students from trauma (Stein et al, 2003; Jaycox, et al, 2003), including Latino immigrants (Kataoka et al., 2003). A review of CBT studies indicates consistent results showing that 65% of individuals report improvement after receiving cognitive behavior therapy in schools (Macklem, 2011).

Cognitive Behavioral Therapy is a good fit for schools for several reasons. The intervention is typically around 10 weeks and short term in nature. Additionally, the competencies required to conduct CBT are within the training and experience of school-based mental health providers and it has been shown to have a positive impact on anxiety and depression (Macklem, 2011). Typical CBT interventions are 8, 12 or 16 sessions (once or twice weekly) in length. Many different CBT programs and strategies are packaged and available for use in schools following a similar structure to each session. Kinsella and Garland (2008) describe the components that comprise the structure of a typical CBT session as check-in and triage for a student's current mental state, setting the agenda, which includes reviewing prior learning and any homework, reviewing the

homework in detail, teaching a target skill, summarizing the session and asking for feedback and negotiating new homework (as cited in Macklem, 2011). Often, CBT in schools is delivered in small heterogeneous groups of 5-8 students (Friedberg & McClure, 2002) with one therapist or two co-therapists. Bieling, McCabe & Anthony, (2007) recommend two adults so that one can lead discussion and make process decisions while the other can take notes and monitor individual students (Macklem, 2011). CBT sessions cover both behavioral skills (i.e., relation techniques, reducing avoidance and graduated exposure training), and cognitive skills (i.e., thought recording, reducing negative thinking, attention training, self-monitoring, reframing and problem solving). A limited, but emerging, body of immigrant and refugee-specific research exists evaluating this type of mental health intervention and its effectiveness. Langley, Sugar, Solis, Gonzalez and Jaycox, (2015), in a study of the BounceBack version of cognitive behavioral therapy with multicultural youth, found it to be effective with this student population.

Academic Engagement

While the impacts of trauma on cognitive skills and academic performance is well documented, very little refugee specific research exists detailing the direct relationship of psychosocial stressors and academic engagement, or performance of school age refugee children (Kaplan et al., 2016). Kim and Suarez-Orozco (2015), argue that academic engagement is a strong predictor of academic performance. For children at risk, indicators of school engagement may be a more personal and sensitive manner to show evidence of positive growth in school than grades and achievement data, especially

if language acquisition is a confounding factor. This study aims to explore this research gap.

Local School Based Mental Health services for Newcomers

The largest school districts within the state are each providing mental health services and specific supports for the newcomer population in a variety of ways. The largest urban district in the state provides student and parental support intended to boost the quality of lives of the newcomer student and their families (personal communication Alana Shriver, Refugee Specialist, June 22, 2017 and Susan Mayberger, ESL Coordinator, Migrant and Refugee Education, June 23, 2017). At the district level, all students, whether refugees or not, have access to School Based Health Centers sponsored by sliding fee scale clinics through which they can receive counseling and psychiatric services. Referrals to the free Community Counseling program is available through all schools, but not all schools have counselors on-site. This district also has a parental involvement program in which refugee and immigrant parents can attend classes at a community center six days a week, including a citizenship class on the weekend. Interpretation is provided in multiple languages for parental involvement. At the high school level an after school leadership club is available for immigrant and refugee students. Each high school's club chooses a community service project for the year. An example of one school's project was to educate the community about mental health issues. The club produced a video as part of their project, writing, filming and acting in it themselves. The video is available on social media and the clubs share their own social media pages. The third component of support provided by this district is the English as a Second Language Teen Literacy Centers (ESL TLC). These are alternative

education programs for newly arrived youth with little to no previous formal education (so not learning disabled, but never had a chance to learn ABCs/123s). At the high school level, the ESL TLC has an on-site counselor provided by a local community counseling center that is free for students. At times, a mental health class is incorporated into the students' PE time at the ESL TLCs.

Another local school district offers mental health services to all students, which include the immigrant/migrant and refugee populations (personal communication with Bill Jelkin, Director of Student Services, June 8, 2017) through school based counseling groups (i.e. Support for Students Exposed to Trauma (SSET), Expressive Art, Children of Divorce, etc.). Outside mental health service referrals are available through a community-based organization's Connections Program. School Counselors and Social workers can refer a family to Connections for case management of mental health services with therapists outside the school district. These therapists work with the family independently, but can also make arrangements to work with the student at school if necessary. Some of the specific programs they use are Cognitive Behavior Therapy for Students Exposed to Trauma (CBITS), expressive art therapy and other proven mental health practices.

Innovative Programming

The research district is the second largest school district in the state, educating approximately 42,000 students annually. All students (K-12) whose parents speak a native language other than English register their children for school at the Welcome Center where bilingual liaisons and multilingual resources are housed. Through a developing Refugee Mental Health Project of this local school district in a refugee

resettlement community, parents are given a general screening to determine if their children potentially meet initial program criteria; country of origin (or ethnicity)—Syria, Iraq, Afghanistan, (Yazidi, Kurdish) Burma, (Karen, Karenni), or refugee camps in nearby countries. This developing project is possible, in part, due to an innovative grant award from the State Department of Education utilizing Title III funding. Title III funding is money specifically for funding programs that address goals that “improve the education of limited English proficient (LEP) children by assisting them to learn English and meeting challenging state, academic and student academic achievement standards and to provide enhanced instructional opportunities for immigrant children and youth.” (Nebraska State Department of Education website, 6/15/17). According to this state’s Department of Education, no other districts in the state have been awarded a grant of Title III funds for the specific purpose of providing direct school-based mental health services to immigrant/refugee students (personal communication, 6/12/2017). In addition to the use of Title III funds, additional funding is supplied through Title 1 funds, grants from Regional Behavioral Health Authorities and partnerships with community agencies with similar goals and interests.

During the first year of the Refugee Mental Health Program, the logistics of implementing sensitive support services to such diverse group of individuals was a complex process with many factors to be sorted, evaluated and addressed by a leadership team at the district level. Key stakeholders were identified, roles began to be defined and student and community needs, and corresponding resources, were explored. A small number of participants received actual mental health interventions from several licensed mental health providers with the assistance of bilingual liaisons. The systematic

collection of data was in its infancy and the preliminary results obtained, although encouraging, were not valid for true program evaluation (program administrator, personal communication, 12/14/2016).

The second year of the project increased the number of therapists and service providers, provided a cohesive and uniform training for service providers and bilingual liaisons, and included an emerging plan for systematic data collection through defined program inclusion criteria, pre/post screening for stress symptoms, and collection of specific archival data as indicators of student engagement. Additional components more firmly in place during this second year included a larger group of students participating and a more clearly defined therapeutic intervention, cognitive behavioral therapy.

The treatment consisted of 8-10 weekly sessions of cognitive behavioral therapy in individual settings by trained, licensed mental health practitioners. The intervention provided age appropriate cognitive skill/coping strategy instruction for elementary, middle, and high school students. Referred students and their families went through a brief intake process conducted by bilingual liaisons. The screening for entry into the program consisted of student/family interviews to determine urgency of need and students accepted in the program were given a formal screening measure to determine stress symptoms for prioritization of inclusion in the program.

At the time of this study, the Refugee Mental Health Project was in its second year of development. The research school district is located in a refugee resettlement community that has seen a 52% increase in the number of refugee students over the previous three years (Lincoln Journal Star, June 4, 2017). Almost two-thirds of the refugee students in this community fled war or persecution before arriving, making them

among the most vulnerable members of this community and among the most in-need of support and intervention. Additionally, during that same time period, three refugee students from different countries of origin (Burmese, Khurdish and Sudanese) committed suicide, illustrating the critical and fierce urgency of need for mental health services for this target population. The impact of children in crisis reaches beyond individual students and permeates the community at large. As one of the program coordinators recently stated in an interview with local media (Lincoln Journal Star, June 4, 2017), about the mental health needs of immigrant and refugee students,

There becomes a point where we said, ‘What are we doing to save lives? What are we doing culturally to understand what’s going on in our community?’

We have come to realize if we do not do something about it, the community will be hurting in the near future. We are going to lose our kids to drugs, alcohol, suicide — any coping mechanism they can find on their own, without professional help.” (p. 1)

The Fierce Urgency of Now

The words of Dr. Martin Luther King, Jr. are just as relevant today as they were sixty years ago:

We have also come to this hallowed spot to remind America of the fierce urgency of Now. This is no time to engage in the luxury of cooling off or to take the tranquilizing drug of gradualism. Now is the time to make real the promise of democracy.

Currently, an increasingly hostile political rhetoric directed at newcomers continues to carry over from the recent national election. This rhetoric creates an

atmosphere of fear and instability, further traumatizing immigrant and refugee children in the United States. For example, the morning after the national election during breakfast at one local elementary school, several immigrant and refugee students, some of them crying, asked teachers, “Do I have to go to back to my (country of origin) now?” Later the same day, in the same school, a fourth grade Yazidi girl confides in her teacher that if she is sent back to her country, they will kill her. These young children are very aware of the hostility in the national discourse regarding immigrants and refugees. As a result, some are again in fear for their lives in the very place they came to be safe. Further heightening the trauma, the current national deportation agenda is now making its way through the local immigrant and refugee community in real time, separating some of these children from one or more parents indefinitely. Learning is nearly impossible when one is focused on the very real possibility of this type of loss. For some, the fierce urgency of now is already too late.

Over the past three years, there have been three refugee/immigrant student suicides in the district where this study is being conducted. While there is little available data on the suicide rates of newcomer students, the National Child Traumatic Stress Network (2018), has identified these youth as being at particular risk because of their exposure to multiple risk factors known to be associated with suicide. The need is fierce. When the potential consequences of our decisions are life or death for some newcomer students, there is no time to wait. The results obtained from this exploratory study contributes to the growing body of practice-based evidence informing the emerging trend of providing school-based mental health services to some of our most vulnerable students.

CHAPTER 3

Methods

The purpose of this exploratory study is to evaluate the impact, if observed, of the provision of one cognitive based mental health support/intervention provided in a school setting to recent immigrant/refugee students on their symptoms of stress and indicators of school engagement during one semester of school.

Design

This exploratory study, via the lens of Bronfenbrenner's bioecological theory of human development (Bronfenbrenner & Morris, 2006), utilizes a mixed method embedded design to determine the impact of a mental health intervention on the reduction of stress symptoms and indicators of school engagement on the target population. The mixed method embedded research design is particularly effective when a second type of data is collected to augment or support the initial type of data collection (Creswell, 2015). In the current study, quantitative data will be collected in the form of a pre/post-test rating scales to determine the stress symptoms of the participants. Additional data will be collected on participant attendance, grades and behavioral referrals. This data is being provided to the researcher in a de-identified format by the MH Program Administrator. Qualitative data may be collected post-treatment, from subject and therapist-tracked progress on therapeutic goals and parent/teacher surveys. This de-identified data will be provided to the researcher in the same manner. Survey data may be used to provide additional information, from multiple stakeholders and perspectives, to assist in the analysis and interpretation of stress system rating scale data. The logistics of using bilingual liaisons impacted the decision to conduct a survey for additional qualitative data

on indicators of academic engagement and the subject's experience through family observations. The analysis of the survey data may also provide information to be used for program evaluation and program development by the school district.

Research Question

What impact does the short-term provision of cognitive behavioral therapy, a mental health intervention focused on providing and practicing coping strategies, have on the stress symptoms and indicators of school engagement of K-12 immigrant school children in a Midwestern school district?

Subjects

The sample is one of convenience. Through a developing Refugee Mental Health Project of a local school district, in a refugee resettlement community, all families (K-12) whose parents speak a native language other than English undergo school registration at the Welcome Center where bilingual liaisons and multi-lingual resources are housed. Parents will be given a general screening to determine if they meet program criteria. Initial criteria is country of origin (or ethnicity)—Syria, Iraq, Afghanistan, (Yazidi, Kurdish) Burma, (Karen, Karenni), (or refugee camps in nearby countries). Students of these parents will all meet the federal definition of “immigrants” or “refugees” and will be referred by school personnel for additional concerns regarding stress symptoms and risk factors related to academic engagement. Students from elementary, middle school, and high schools will be eligible. At no time during the process will participants be asked questions about their immigration status. The anticipated languages of the target population include Spanish, Kurdish, Arabic, Karen, Karenni and Vietnamese. Therefore, all aspects of the data gathering will include the use

of bilingual liaisons to provide translation services. The fifteen bilingual liaisons involved have undergone training in related background knowledge, such as the impact of trauma and the mental health intervention.

Sixty-six K-12 students met program criteria. The treatment was provided to 42 of them with 24 students placed on the waiting list to receive services at a later time. The subjects attend school in an urban and suburban Midwestern school district in which the researcher has been employed. The researcher does not have any personal or professional relationships with the subject participants or the subject's families of which she is aware. All subject data will be de-identified by the MH program administrator and provided to the researcher for the purpose of program evaluation and this dissertation. All subjects will participate in the program independent of the research being conducted, which is serving an additional purpose of program evaluation for the developing MH Program in the local school district.

Data Collection

Referred students and their families go through a brief intake process conducted by bilingual liaisons. The screening for entry into the program consists of student/family interviews to determine urgency of need and administration of a standardized rating scale. Scores are prioritized, as determined by the program social worker, and based upon this, prioritization of students will be scheduled for inclusion in the program. Students accepted in the program will be given a pre/post-treatment measure, the Children's Stress Disorders Checklist, (CSDC) or the Children's Impact of Event Scale-13 (CRIES-13), to determine stress symptoms. Selected students and their therapist will meet and form individual therapeutic goals to work toward. Progress toward these goals

will be monitored by the student and therapist during the intervention. The treatment will consist of 8-10 hour long weekly sessions in individual settings by licensed mental health practitioners that have been trained in the intervention, with the assistance of bilingual liaisons. The cognitive based therapy intervention will provide age appropriate cognitive skill/coping strategy instruction for elementary, middle and high school students. Parents, social workers/therapists and/or teachers of the students may also be interviewed or asked to complete an exit interview with Likert-type rating scales related to further investigate the impact of intervention. The dependent variables are the stress symptoms and indicators of academic engagement. The independent variable is the mental health intervention, cognitive behavioral therapy.

Instruments

The initial screening of a participant's family, as they go through the public school registration process at the district's Welcome Center is in the format of a brief, eight question interview conducted by a bilingual liaison. Once a subject has been referred by school staff due to the observation of stress symptoms and academic or related risk factors, one of two standardized rating scales, either the Children's Impact Event Scale- Revised (CRIES-13) or the Children's Stress Disorder Checklist (CSDC) are administered by the social worker bilingual liaison to determine the level of stress symptoms. The decision regarding which measure to use is based upon subject age and developmental level, along with consideration of home language. The liaison then shares this data with the program's "Gate Keeper", a social worker, who scores the device and determines the priority scores for inclusion was met.

Mental Health Services for NEW Refugee Students

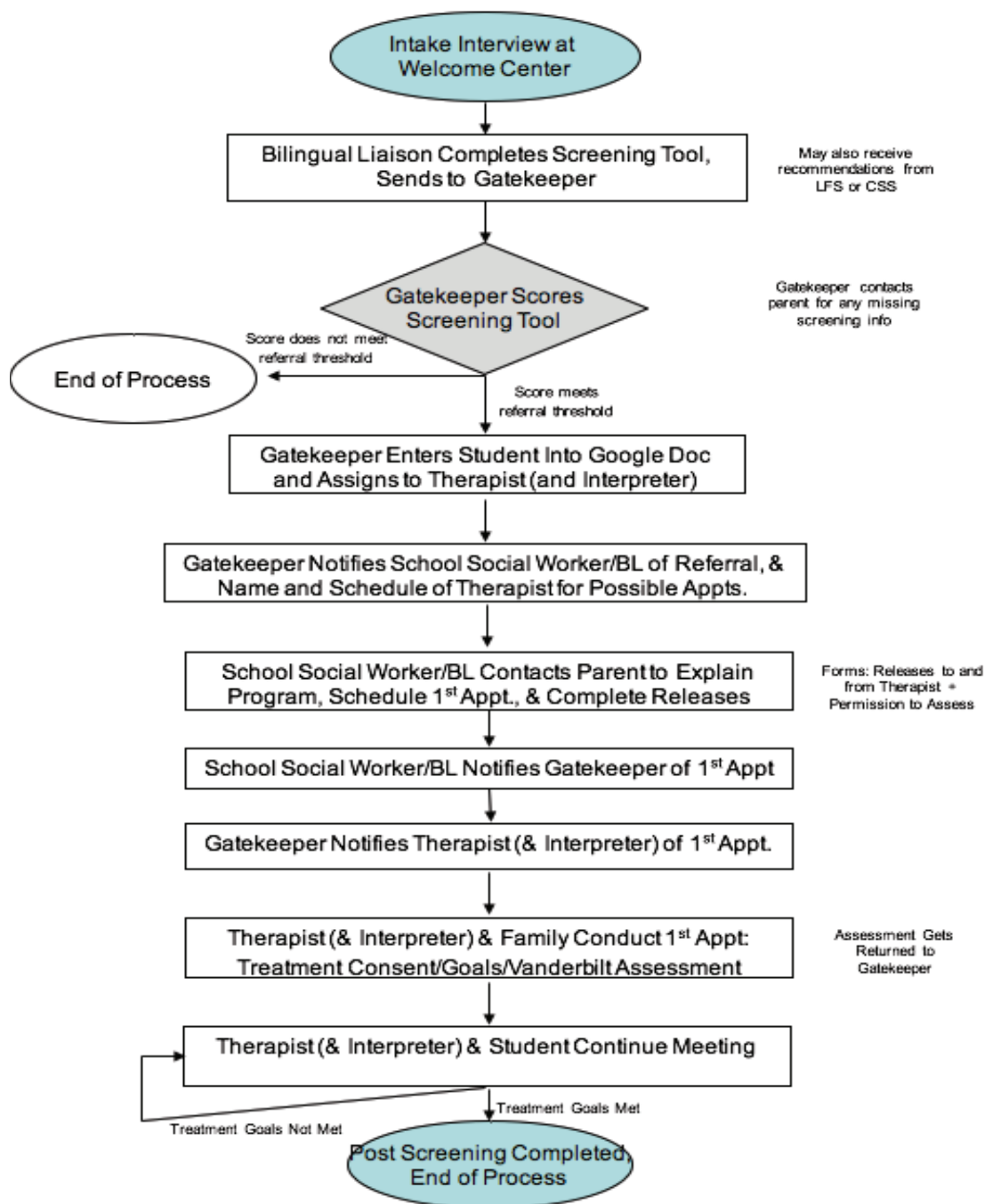


Figure 3.1 District algorithm for the program

The Children's Impact of Event Scale (CRIES) was originally developed in 1979 by Horowitz et al. to examine the re-experiencing and avoidance of traumatic events in adults. The original CRIES is a fifteen item self-rating measure with subscales of Intrusion and Avoidance (American Academy of Pediatrics, 2003) to screen adults at risk for post-traumatic stress disorder. In 1986, Malmquist used the CRIES to screen children who had witnessed a traumatic event. In the 1994, the CRIES-8 was developed by Yule et al. as a revision of the original CRIES for use when screening children. The CRIES-13 was developed later to address the growing literature on post-traumatic stress disorder, specifically five items were added by Yule et al. to address the arousal cluster in the DSM-IV (Children and War Foundation, 2005). Currently, the CRIES-13 is available on the web for free in twenty-eight different languages from the War and Children Foundation (www.childrenandwar.org). Developed in 2001 by Saxe, The Children's Stress Disorders Checklist, (CSDC), is a 36-item observer-rated measure of stress symptoms in children who have experienced trauma. A four item screening version, the CSDC-SF, has also been developed but was not used in the current study

Data Analysis

A paired t-test will be used to analyze pre/post treatment data from for significant changes in stress symptoms ($\alpha=.05$). Further analysis will be completed after treatment completion to determine possible correlation with 3 indicators of engagement (behavioral- attendance data; cognitive- grades and relational- teacher report). Behavioral engagement will be assessed through the comparison of attendance data from Semester 1 (pre-treatment) to that of Semester 2 (during/post treatment). Cognitive engagement will be assessed through the comparison of grades/grade point

average from Semester 1 (pre-treatment) to that of Semester 2 (during/post treatment).

Relational Engagement will be assessed through the comparison of behavior referral data from Semester 1 (pre-treatment) to that of Semester 2 (during/post treatment).

Access to academic records and archival data specific to the evaluation of the Refugee Mental Health Project will be provided, as agreed upon via a formal application process, by a local public school district, of which I have been employed. The Refugee Mental Health Project administrator and Assessment/Research Department have engaged with me in the development of this proposal and have agreed to partner with me in this project.

Findings will be reported via my dissertation and a report to the Title 1 department of the school district. It will be determined at a later time how results may be shared with key stakeholders, such as partnering community organizations, the district's Board of Education and other interested parties. Use of the study may include articles for publication at a later date.

One hypothesis is that a positive impact, or reduction in stress symptoms, will be observed. If so, this will be empirical evidence of the effectiveness of this intervention and may be used to assist the school district in improving the delivery model to accommodate more refugee students who demonstrate the targeted need.

An alternate hypothesis is that there is no reduction in stress symptoms or that there is an increase in stress symptoms. If there is no reduction in stress symptoms, the service delivery will need to be evaluated for process variables to determine if this was the right intervention but length or intensity need to be adjusted, or if another intervention

might be more appropriate. The latter would definitely need consideration if an increase in stress symptoms is seen.

CHAPTER 4

Results

The purpose of this exploratory study was to determine the impact, if one exists, of the short term provision of cognitive behavioral therapy, a mental health intervention focused on providing and practicing coping strategies, has on the stress symptoms and indicators of school engagement of K-12 immigrant school children in a Midwestern school district.

Subjects

Forty-three subjects from 12 different countries of origin speaking seven different languages were referred to the program. Four participants were excluded from this analysis; two because of incomplete data and two participants who did not complete the referral process because an interpreter was unavailable, leaving 39 participants from which to analyze data.

Subjects represented every grade level, pre-kindergarten through 12th grade, except 1st grade, and attended eleven different schools in the research district. Subjects were slightly more male (59%; 23 males) than female (41%, 16 females). More females were referred in middle or high school versus elementary (6 elementary vs. 10 middle/high school). Males were referred evenly in elementary (n =11) and middle/high school (n=12). Subjects participated in the treatment in seven different languages, utilizing trained bilingual liaisons. The most frequent language utilized was Khurdish (26%), followed closely by Arabic (23%), Karen (18%), Farsi (15% each), Spanish (12%) and Pigdin English and English (2.5% each). Subjects came from eleven

countries of origin. The largest groups came from Iraq (46.15%), and Thailand (17.95%), both countries that have experienced extended periods of unrest. The remainder of participants came from Afghanistan and El Salvador (7.69% each), Iran (5.12%) and Cameroon, Guatemala, Lebanon, Mexico, Pakistan and the US (2.56% each). The subject whose country of origin is identified as the US was a secondary male student.

Table 4.1 Participants

					Intervention Sessions	Stress Symptom Measure		Behavioral Engagement	Cognitive Engagement	Relational Engagement
Gender	Grade	Used Interpreter	Country of Origin	Language	# Held/ # missed	CRIES-13 Total Score	CSDC - Score (Range 0-60)	Attendance (change)	Failing Grades (change)	office referral (change)
F	PK	Y	Lebanon	Arabic	16/4	0	15			
F	KG	N*	Iraq	Kurdish	5/6	30		-3	0	
M	KG	Y	Iraq	Arabic	4/1	0				
M	2	N	Pakistan	Farsi	6/0	35				
M	2	N	Iraq	Kurdish	7/7	0		4		-2
F	3	N	Iraq	Kurdish	8/3	16	18	-3	0	0
M	3	N	Iraq	Kurdish	11/2	28		-14		
F	3	Y	Thailand	Karen	3/2	24				
M	4	N	Iraq	Kurdish	12/1	25		28		
F	4	N*	Iraq	Kurdish	8/7	17		-7	0	
M	4	Y	Thailand	Karen	14/1	12				
M	4	Y	Thailand	Karen	6/0	19				
M	5	N	Thailand	Karen	6/0	28				
M	5	N	El Salvador	Spanish	4/3	26				-6
M	5	N	Iraq	Kurdish	11/3	45		-18		1
F	5	Y	Iraq	Arabic	7/1	34		1		
M	5	Y	Iraq	Arabic	13/3	16		-27	-1	0
M	6	Y	Iraq	Kurdish	15/4	5			-2	-3
M	6	Y	Iraq	Arabic	10/1	53		-19		1
M	6	Y*	Iraq	Kurdish	3/0	20				
M	7	Y	Iraq	Arabic	17/2	6		-63	-2	
M	7	Y	Thailand	Karen	14/4	0			2	0
M	7	Y	Thailand	Karen	17/3	26			2	0
M	7	Y	Thailand	Karen	16/3	22			0	0
F	7	Y	Iraq	Kurdish	15/0	18			1	-1
M	8	Y	Iraq	Arabic	7/4	36		66	0	3
M	8	Y	Iraq	Arabic	4/0	8		-14	0	5
M	9	N	U.S.	English	11/0	48		-13		-1
F	9	N	Cameroon	Pidgin English	10/2	43		-2		1

M	9	Y	Iran	Farsi	6/0	34		18		0
F	9	Y	Iran	Farsi	1/1	0				
F	10	Y	El Salvador	Spanish	2/0	0		12		
F	10	Y	Guatemala	Spanish	12/1	0		100		
F	10	Y	Afghanistan	Farsi	9/0	46		55		
F	10	Y	Afghanistan	Farsi	7/1	30		-106		
F	10	Y	Afghanistan	Farsi	6/2	44		-2		
M	11	Y	El Salvador	Spanish	4/0	0		2	0	0
F	12	N	Mexico	Spanish	4/1	0		2	1	0
F	12	Y	Iraq	Arabic	6/2	56				

Treatment

The number of sessions held for any one participant ranged from 2 to 20, with the average number of participant sessions being 11 (mean =10.5; mode =11). All sessions were individual (i.e., therapist, student and bilingual liaison/interpreter, as needed). Three hundred nine total sessions were held and 71 sessions were scheduled but not held (81.32% attendance). Sessions were missed for a variety of reasons, including school factors (40.14%, n = 28.5 for lack of space or school breaks, recitals, state testing), lack of program resources, such as a room or an interpreter (21.83%, n = 15.5%), and unknown reasons (.014%, n = 1). Student related factors were limited to one absence for a medical/dental appointment (.014%, n = 1).

Use of Bilingual Liaisons/Interpreters. Bilingual Liaisons were used to interpret during the treatment sessions with 26 of the 39 participants (66.67%). The remainder of subjects participated in sessions in English, their non-native language. No measure of the impact of participating in therapy while also learning a language was conducted at this time. The lack of a Khurdish interpreter, impacted the number of sessions for 3 students (1 male, 2 female) and prevented two more students from receiving the treatment at all.

Data Collection

Screening measures were administered by social workers or therapists, with the assistance of bilingual liaisons as needed, and reported to the program administrator. The program administrator provided de-identified scores and archival data to the researcher for analysis.

Instruments

A formalized measure of stress symptoms was administered to 32 (82.05%) of the study participants. The social workers/therapists overwhelmingly chose the CRIES-13 for this purpose. However, the Child Stress Disorder Scale was also an option as a measurement of stress symptoms. The CSDC was only used once as a post-treatment measure for a participant who was given the CRIES-13 as a pre-treatment measure. This one study participant was the only participant who was given both a pre and a post treatment measure of stress symptoms. Eight of the participants had no formalized measure of stress symptoms because the social worker/therapist did not feel it was appropriate to administer these measures.

Data Analysis

Stress Symptoms. According to the National Center for PTSD (September 2017), there are four symptoms of PTSD; intrusive, avoidance, increased negative feelings, and avoidance. Intrusive symptoms of PTSD are when one relives the event or has flashbacks. Avoidance symptoms are when an individual avoids situations that trigger memories of the traumatic event. The third symptom is increased negative feelings as compared to before the traumatic event. The final symptom, Arousal, is described as feeling “jittery or keyed up--like it is hard to relax” (p.5) and one startles easily.

The Children’s Impact of Event Scale (CRIES-13) is a thirteen item self-rating measure with subscales of Intrusion, Avoidance and Arousal. Each of the items on the CRIES-13 is scored on a four-point scale (Not at all= 0, Rarely= 1, Sometimes= 3, Often= 5). Scores are obtained by adding the items for each subscale (Intrusion= 1+4+8+9; Avoidance = 2+6+7+10; Arousal = 3+5+11+12+13). Although no cut score was used for participant inclusion in the study, scores were used to prioritize participants

for implementation of services. Higher stress symptom scores gave the participant a higher priority. Generally, a score of 17 on the eight items of the Intrusion and Avoidance subtests is considered an effective indicator of individuals who might gain a diagnosis of PTSD (Perrin, Meiser-Stedman, Smith, 2005). Twenty-one of the 32 participants (66%) who were administered a measure of stress symptoms using the CRIES-13 scored 17 or more on the first two subscales of the measure, which was coded red, indicated the highest level of stress symptoms. 25% of the participants scored in the yellow (moderate range; $n=8$) of stress symptoms and 9.37% in the green (mild range; $n=3$) of stress symptoms. The 32 study participants scored an average of 28 total on all thirteen items of the three subscales (minimum 5; maximum 58). A larger portion of females scored in the high stress range (67%) as compared to males (58%), although, the mean average stress score was lower for females ($M=32.27$) than for males ($M=44.72$). Means for both females and males were within the high stress symptom range. Students in high school (i.e., grades 9-12) scored significantly higher overall than either middle school or elementary school students.

Of the participants scoring in the highest level of stress symptoms (red), 76.2% ($n=16$) came from countries of origin in the middle east. All of the Farsi speaking students scored in the highest level of stress symptoms, regardless of country of origin (i.e., Iran, Afghanistan, Pakistan). 9.5% of the highest stress symptom scoring students had a country of origin in southeast Asia ($n=2$ from Thailand).

Eight participants scored in the moderate range of stress symptoms. Three were from Iraq and five from Thailand. All of the students from Thailand scored either in the high or medium range of stress symptoms (e.g., 2 red; 5 yellow). All three of the

students scoring in the mild range of stress symptoms came from Iraq. Across all stress symptom ratings (i.e., red, yellow, green) there was no significant difference in the Arabic speaking as compared to the Kurdish speaking participants.

Measures of Engagement. Analysis of archival data was completed after treatment completion to determine possible correlation with 3 indicators of engagement (behavioral- attendance data, cognitive- grades, and relational- number of office referrals). The number of students for whom archival data was available varied across each measure of engagement.

Behavioral engagement, as assessed through the comparison of attendance data from Semester 1 to that of Semester 2, indicated no significant treatment effect ($r^2 = .0068$; $\alpha = .05$; $n = 24$). Neither did Relational Engagement, as assessed through the comparison of behavior (office) referral data, from Semester 1 to that of Semester 2 ($r^2 = .0024$; $\alpha = .05$; $n = 21$). Furthermore, cognitive engagement, as assessed through the comparison of the number of failing grades, from Semester 1 (pre-treatment) to that of Semester 2 (during/post treatment) did not show a significant impact.

CHAPTER 5

Conclusions and Discussion

The increasingly hostile political and social atmosphere of our nation has an impact upon immigrant and refugee children, their families and surrounding school communities. This can add another layer of stress to the already complex trauma being experienced by a highly vulnerable population within our educational system. Schools may be interested in learning more about how to effectively support the mental health of these foreign-born students who are, ultimately, expected to achieve to the same academic standards as all other students.

Some school districts may have existing mental health programs that can be utilized by immigrant and refugee students. While these programs may meet a portion of the mental health needs of this unique and diverse population, they almost certainly require additional resources for service delivery for youth who do not speak English. Additional considerations, beyond the language barrier, may help develop effective and efficient mental health services within schools, that allow these youths to demonstrate their resilience, become productive members of our communities, and reach their full potential.

The purpose of this exploratory study was to learn more about the stress symptoms and response to a school-provided short term cognitive behavioral mental health intervention. This issue is being viewed through Bronfenbrenner's bioecological theory of human development (Bronfenbrenner, 1977, Bronfenbrenner and Morris, 2006), the theory that a child's development is influenced by the interactions of everything in her environment on multiple levels; the macrosystem (societal and cultural

belief systems), the exosystem (community and neighborhood factors), the microsystem (family factors) and the individual (ontogenic) level. When viewing the experiences of refugees through this lens, one may better understand why some carry trauma with them, and why the complexity of this trauma may require unique programming and special consideration for schools addressing refugee mental health needs.

Through an existing mental health program for newly arrived refugees and immigrants in the PK-12 research school district, an evaluation process was developed to determine the level of stress symptoms of participants and their response to provision of a short term school-based cognitive behavioral therapy intervention. This issue is especially timely and relevant because of the impact of immigrant/refugee student trauma and their resulting mental health concerns, including three recent student suicides of refugee students within the research district, in which the researcher is employed.

Thirty-nine participants, pre K through 12th grade, speaking seven different native languages, received individual cognitive behavioral therapy through school social workers or counselors, with the assistance of bilingual liaisons, as needed. Initially, participants were to undergo a pre and post treatment measure of stress symptoms and archival data was to be reviewed for pre and post treatment differences in three measures of school engagement; behavioral engagement (attendance data pre vs. post treatment), relational engagement (office discipline referrals pre vs. post treatment), and cognitive engagement, (i.e., the number of failing grades pretreatment as compared to post treatment). Due to logistical barriers with the data collection, pre-post comparisons of stress symptoms via the formalized measuring tool were not possible. However, measurement of the stress symptoms of the participants did indicate that 55% of the

participants met the generally accepted indicator of an individual who may be diagnosed with PTSD (i.e., a score of 17 or greater on the eight items of the Intrusion and Avoidance subtests). This aligns with the findings of Lustig et al., (2004), that post-traumatic stress symptoms occur at a prevalence of 50-90% among refugee children, as well as Bronstein and Montgomery (2011), who found that between 19-54% of refugee children in resettlement communities meet the clinical diagnosis for post-traumatic stress disorder (PTSD).

Additional analysis of archival data related to several indicators of school engagement was conducted. No significant changes in behavioral engagement (i.e., attendance periods pre vs. post treatment), relational engagement (i.e., office discipline referrals pre vs. post treatment) or cognitive engagement, (i.e., the number of failing grades pretreatment as compared to post treatment) were observed. This is consistent with several school-based cognitive behavior therapy studies, as discussed in the second white paper by the National Child Traumatic Stress Network Refugee Trauma Task Force (Mental Health Interventions for Refugee Children in Resettlement, 2005). While the studies showed a varying impact upon symptom relief from a school-based mental health intervention, no direct impact upon school related factors was reported. This may speak to the unique nature and complexity of the trauma of this population, as well as special considerations needed when schools are developing programming to meet the mental health needs of these youth and measuring the impact.

Measuring the Impact

Further study with more clearly defined variables and methodology is needed to advance this emerging field. The CRIES-13 is easily accessible, available in many

different languages and is free, making it an attractive option for a school district with finite resources to identify youth in need of services. It has been used in a several studies with refugees, demonstrating validity in that children with more trauma received higher intrusion and total scores (National Center for Child Traumatic Stress Refugee Task Force Assessments for Trauma and Mental Health in Refugees, Hollifield et al., 2006). However, the data it yields is indicative of merely one aspect of the student's overall mental health needs and it is possible that measurement of stress symptoms that align with post-traumatic stress disorder may not be the most effective way for schools to approach the needs they can address. The reader is referred to the National Child Traumatic Stress Network (<https://www.nctsn.org>) for a list of assessment tools evaluated in refugee populations and further discussion of these tools.

It may also be that typical measures of “progress,” such as those indicators chosen for this study, are not sensitive enough to capture the type of impacts possible from the prescribed intervention with this population. For example, the variables of language learning, cultural adaptation, and the impact of complex trauma may be such that we must rethink how to assess and measure the impact of the mental health treatment. For example, while no statistically significant impact was found in the current study, anecdotal reports by the school-based mental health providers indicate observable changes in the study participants. Of the fourteen social worker/therapists who provided CBT to the participants in the current study, ten provided anecdotal notes on participant's positive engagement in therapy (e.g., Client has been observed in sessions to express feelings andstrengthening self-esteem; Client is positive when attending sessions; Client is verbalizing feelings & processing traumatic experience. Client has

demonstrated a positive demeanor; Client continues to demonstrate positive behaviors compared to previous year. Client is having a positive demeanor, smiling, polite, attentive and working hard, Client has developed a positive working relationship with the therapist.) Four therapists shared observations of improved skills (e.g., Client has reported using specific coping strategies techniques to deal with emotions such as, “I took a deep breath when I was feeling scared,” and “I spoke to my mom when I was feeling angry at my brother;” Client has been observed in sessions to express feelings and continues to increase appropriate social skills...; and Client has been observed to use coping strategies immediately upon a frustrating situation.) Several therapist observations also included reports from teachers and parents (e.g., Mom has reported client has not engaged in self-harm behaviors. The family has been supportive and encouraging of client and are using the techniques at home to help client stay calm;” and “client has decreased instances of attending the restroom during instruction time per teacher’s report; Mom reported she has noticed client's mood improving; client is positive and opening up by verbalizing feelings at home. Teacher and principal have reported client’s demeanor changed since the beginning of therapy. They have noticed improvements in client's mood from sadness to smiling, high energy & adjusted well to school.”)

Limitations

This study’s small number of participants limits generalization. Additionally, the study design may not be the best fit to measure the impact of the intervention. Perhaps pre/post measures of discrete coping skills would provide more relevant information. For example, in the current study a pre-intervention measure of knowledge and use of coping

skills as compared to a post-intervention measure, may have provided more information about how this school-based cognitive based therapy impacted the participants' ability to cope with stressors. This type of information could be used by schools when determining the value of the programming and decision making about resource allocation.

Partnerships: Effective and efficient use of resources

When considering the unique needs of this newcomer population, schools must, at a systemic level, evaluate the most effective and efficient use of resources to address the challenges these students face. Treatment barriers included limitations on school and community resources in addition to stakeholder understanding of the program. For example, at one school in the study, it was several weeks before a room was provided to the therapist for her sessions with a participant and valuable treatment time may have been lost.

Beyond the site level, districts may want to consider if the educational needs of refugee youth can effectively and efficiently be addressed in schools within existing systems, existing service delivery and with the existing resources currently allocated for mental health services provided in schools. For some districts, the addition of language supports to the existing mental health services may be an efficient and sufficient delivery model to meet the needs of these newcomers. If so, how can these programs be funded? What partnerships can be entered into with community organizations and resources to support this growing population and address their complex needs? As McNeely, Sprecher and Bates (2009), discovered in their evaluation of RWJF's Caring Across Communities project, "The programs that successfully engaged parents structured their program such that mental health providers worked hand in hand with bicultural family

liaisons whom the families trusted and whose specific task it was to help families with navigating a new culture, interpreting a new language, understanding a new academic paradigm, and accessing economic resources.” (P. 4). How will schools who have smaller populations of newcomers, such as those not in refugee resettlement communities, best address similar issues? What are the best most cost effective ways to measure the impact of interventions and evaluate programming for the future? How will logistical barriers of intervention delivery be addressed? Additional research is needed to answer these important questions.

Culturally Responsive Mental Health Interventions

The importance of intervention delivery needs to be further explored. The role of bilingual liaisons, who serve as much more than interpreters, is crucial to understand how to effectively, efficiently and successfully implement mental health services for newcomer students. While research has documented that some of the symptoms of trauma are similar across several cultures, the attitudes and beliefs about the mental health interventions necessary to overcome the effects of trauma vary with culture (National Child Traumatic Stress Network, 2005). Bilingual Liaisons, serving as cultural brokers, provide valuable information about the beliefs of a participant’s culture toward asking for help, admitting difficulties and other relevant mental health issues. These liaisons are actually cultural brokers, serving as a bridge between the intervention providers and the recipients. Their involvement is essential to reducing cultural barriers and giving the participant the best possible chance for success with any given intervention. Districts may want to evaluate the cultural consideration of the mental health services provided to newcomer youth.

Interpretations

The current results from this exploratory study provide some valuable “practice-based evidence” (Barkham et al., 2001; Margison et al., 2000; Stiles et al., 2003) for consideration. That is evidence, provided from local communities and their current practices with the target population, that is examined and used to considering future treatment and programming. While the evidence from current practices has not been rigorously and statistically tested, it does provide a wealth of knowledge based upon the experiences of practitioners within the field. The reader is referred to the second white paper, *Mental Health Interventions for Refugee Children in Resettlement* (2005), by the National Child Traumatic Stress Network for further discussion of practice-based evidence regarding school based mental health services for the refugee student population.

The current study provides valuable information about the stress symptoms of refugee youth from different geographical regions and cultural groups. This data may be utilized when examining the scope and intensity of needs given the cultural composition of a refugee community. Additional information regarding the logistics of providing school-based mental health services and the use of bilingual liaisons is also present. Finally, information regarding the development and emergence of the Refugee Mental Health Program may provide a framework from which districts and community organizations can develop partnerships to increase access of these types of services to meet the needs of the refugee youth in our schools. The current study’s participant population was very diverse, but not all refugee communities are structured the same way. Schools will need to weigh the critical features of refugee youth needs in terms of

numbers of students needing services in addition to the number cultures within a given refugee population to determine the best way to deliver the necessary supports.

Implications for Future Research

Because of their critical role in providing mental health services to refugee youth, schools and community agencies may want to investigate the type of education and outreach that is necessary to recruit a sufficient pool of bilingual liaisons to meet the needs of the refugee youth and their families. Bilingual liaisons who come from the local refugee/immigrant community, may need additional training to ensure confidentiality, appropriate boundaries and the skills necessary to navigate their involvement in providing mental health services to members of their own community.

Future research is needed to explore differences in specific cultural responses to trauma, grief and loss. The current study's participant population was very diverse. It would be interesting to research how each of the different cultural groups responds to trauma, grief and loss and then do a needs assessment based upon that information to increase access to these services. The information gained from such research could inform decisions about the types of services that might be most beneficial to specific groups within the refugee youth community. Furthermore, the information could be used for recruitment and training of potential liaisons and bilingual/bicultural practitioners. Finally, the number and types of community and agency partnerships with schools to provide similar services could be further explored for critical characteristics. The need for this type of school-based mental health intervention is well established within the refugee youth population and there are students who are waiting for our help.

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Appendix 1: Refugee MH Program Screener

REFUGEE MENTAL HEALTH TREATMENT PROGRAM SCREENING QUESTIONS

1. Country of origin:
2. How did you get to the United States/Lincoln?
3. Were you ever in a refugee camp or a border detention center? **Yes No**
If so, how long?
4. Do you have any relatives/friends that support you in Lincoln community? **Yes No**
5. Has your student or family experienced or witnessed violence (i.e. loss, separation, death of loved ones,)? **Yes No**
6. Anyone in the family have any chronic medical conditions? **Yes No**
Explain:
7. Compared to other refugees in similar situations, is your situation the:
Same, Better or Worse.
8. Have you seen any changes in behavior/mood? Please describe those changes. What are your concerns about your child?