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The Life of a Child Refugee: How Host-Country Schools Can Create Positive Growth

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The Life of a Child Refugee:
How Host-Country Schools Can Create Positive Growth
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Abstract

The numbers of children affected by war continues to grow as conflicts around the globe begin, continue, and are reignited forcing them from their homes in search of safety.

Children currently make up more than half of the worlds refugees. These children are at risk of poor psychosocial development as a result of the traumatizing experiences of their migratory process. Upon arrival to high-income host-countries, children are placed in the school systems, as a primary place of first contact schools can be a place of sanctuary for children and develop positive psychosocial growth. This study seeks to understand the experiences and outcomes of being a refugee on a child and the impacts schools can have on their lives.

Keywords: refugee children, in-service teachers, high-income country, education, trauma

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Chapter 1: Introduction

The world we live in has never been one of peace; throughout history conflict has led people to flee their homes in a quest for safety. This has not changed in current times, and every day people, roughly half of who are children, are embarking on treacherous journeys to escape violent and protracted conflicts, seeking refuge in countries more stable than their own. For many of these migrants this means making their way to nearby countries with the hope of being selected for resettlement in high-income nations. Those who are selected for resettlement are thrust into a new country likely to be vastly different from their own. Recipient countries must be prepared to work with these children so that they may build their capacity and thrive in their new society. In order for this to happen it is important that settings are available for these children that provide them with a positive, safe environment that fosters positive psychosocial development.

War has changed drastically over the years and civilians are becoming victims of war in astonishing numbers. Contemporary warfare is no longer fought on the battlefield but in every possible avenue. Wars are now waged in the head, heart, and home with the ultimate goal of immobilizing citizens through despair, anxiety, and fear (Cole & Farwell, 2001). The shifts in the way wars are fought have contributed significantly to the increase in the global refugee population. As wars transition from being fought on battlefields to taking place in public spaces, they are what research calls *civilian-based civil wars*. These wars are fought in villages, markets, schools, and other prominent public areas (Anderson, 1999); even people's homes are no longer of limits (Banks et al., 2013). This has been the greatest change in military tactics this century (Goldstein, Wampler, & Wise, 1997). The changes can be exemplified through increases in wartime

civilian casualties. In World War I 10% of all casualties were civilians. This number increased significantly in World War II, where 50% of wartime casualties were civilians. Fast-forward to the late 20th and early 21st centuries where on average 80% of casualties are civilians (Cole & Farwell, 2001). Not only has this dramatic shift in war tactics increased civilian death tolls, it has led to the forced migration of massive amounts of people (Goldstein et al., 1997).

The number of forcibly displaced people has increased by 75% since 1996. Over the past 10 years (2006 to 2016), the number of resettled refugees has doubled annually (UNHCR, 2016). From 2010 to 2015, fifteen new conflicts began or were reignited, and the number of conflicts lasting over five years continues to grow (UNICEF, 2016). The United Nations High Commissioner for Refugees' (UNHCR) most recent Global Trends report states that in 2015, 65.3 million people were forced to flee their homes creating 1.8 million new refugees. To put this into perspective, in 2015, twenty-four people were forced to flee their homes every minute, that's roughly 34,000 people a day. In 2016, if the total global population of refugees were considered to be a country, it would have a population greater than that of the entire United Kingdom. At the end of 2015, roughly 33% of all forcibly displaced people were granted refugee status, and 3.2 million asylum seekers (a person waiting to be granted refugee status) remained displaced (UNHCR, 2016).

Annually, countless numbers of children experience war. Wartime experiences affect adults and children alike, however it is children who are increasingly becoming targets of wartime activities, both directly and indirectly (Joshi & O'Donnell, 2003). Save the Children (2016) reported that roughly 250 million children live in conflict affected

regions. Around 98,400 of all new asylum applications in 2015 were presented by unaccompanied or separated children, the highest number recorded since 2005 when the UNHCR began collecting data on unaccompanied minors. Children comprise 51% (10.9 million) of all refugees worldwide, an increase from 41% in 2009 and 2014 (UNHCR, 2016). Since 2008, almost 200,000 unaccompanied minors submitted applications for asylum in Europe alone. It is estimated that in 2015, 68,600 unaccompanied children submitted asylum applications to European Union (EU) member states. The United States (U.S.) does not collect data specifically on the numbers of child refugees, hampering out understanding of the scope of the problem in the nation, and creating challenges for U.S. organizations attempting to serve this vulnerable population (Save the Children, 2016).

The U.S. accepts more refugees for resettlement than any other country in the world. In recent years, the number of refugees admitted to the U.S. ranged from 70,000-80,000. In the 2015 fiscal year, President Barack Obama raised this ceiling and in 2016, pledged to resettle 85,000 refugees. The administration also proposed that the ceiling be raised to at least 100,000 for the 2017 fiscal year (Capps, Fix, Hopper, & Zong, 2016). Based on statistics released by the Department of Homeland Security (DHS) during 2014, the U.S. resettled 69,975 refugees, the majority of who are from Somalia, Bhutan, Iraq, and Burma. A further 23,533 were granted asylum, primarily, individuals from China, Syria, and Egypt (Mossaad, 2016).

In 2015, Oregon resettled 1,357 refugees and between 2012 and 2014 took in 2,598 refugees (Oregon Department of Human Services, 2016). Data is not available on refugee children or refugee students in Oregon or in the Portland Public School (PPS) district. However, statistics on ethnic background are provided by the district which from

2002-2015 has experienced a decrease in its population of white students by 5.7% and an 8.9% increase in students with multiple or unspecified ethnicities (Portland Public Schools, 2016).

Table 1
Race/Ethnicity of Students in the Portland Public Schools District

<u>Race/Ethnicity</u>	<u>2002</u>	<u>2009</u>	<u>2015</u>
Asian/Pacific Islander	9.6%	9.8%	8.1%
African American	16.5%	13.6%	10%
Native American	2.3%	1.5%	0.9%
Hispanic	10.2%	15.4%	16.2%
White	61.5%	54.2%	55.9%
Multiple/Unspecified	0%	5.6%	8.9%

Portland Public Schools, 2016

As can be seen in Table 1, over the past 16 years PPS has experienced fluctuations in the ethnic background of its students, but overall has experienced an increase in students from diverse backgrounds and regions of the world; these numbers are likely to increase. In a report in *The Oregonian* the local nonprofit, the Lutheran Immigration and Refugee Services, claimed it expects to welcome at least 100 Syrian refugees in the upcoming year and 80 from other nationalities (Zarkhin, 2015).

In the past year, terror attacks in high-income countries, such as those in Paris and Brussels, have left many fearful of accepting refugees, especially from the Middle East, and throughout the country state governments have been expressing trepidation about accepting refugees for resettlement (Brumfield & Fantz, 2015). Oregon's government has expressed opposition to these feelings, and has pledged to continue its acceptance of refugees. In 2015, following the attacks on Paris, Oregon Governor Kate Brown communicated via Twitter, clarifying the state's opinion, tweeting, "Clearly, Oregon will

continue to accept refugees. They seek haven and we will continue to open the doors of opportunity to them.” (@OregonGovBrown, 2015). Based on previous demographics, it is likely that many of these refugees will be children, some unaccompanied, others with their families.

Upon entry into the U.S. children are placed in the public school system. Due to legislation in high-income countries requiring all children attend school, the classroom is where a child spends a significant portion of their time (Donkers, Kraykamps, & Levels, 2008). School can act as a means to encourage positive growth upon arrival to the host-county because of this, but new school settings can be traumatizing for refugee children (Chiumento, Dutton, Hughes, & Nelki, 2011). In order for schools to foster positive psychosocial growth in these potentially traumatized children educators must be equipped with the skill set necessary to address their unique circumstances. This means that professional development programs need to be created that focus solely on refugee children and their experiences (Kirk & Winthrop, 2008).

Studies suggest that one of the best ways to assist resettled refugee children is to integrate them into community environments (Fazel & Tyrer, 2014). Most high-income countries have passed legislation that requires children to enroll in school making it a location that has the potential to foster positive psychosocial development, especially considering the amount of time children spend in their school setting. However, research indicates that schools run the risk of inhibiting psychosocial growth. Because of this, it is essential that teachers be prepared to work with the increasing number of refugee students in their classrooms. This can be particularly challenging for in-service teachers who have less time than students in school preparing to be teachers to learn about the

issues concerning refugee children. Professional development programs must be implemented for in-service teachers so they are able to promote positive instead of negative psychosocial growth upon resettlement (Severiens, 2014). As a result, of their interactions with children teachers may be better able to address the mental health needs of refugee children, but they must be trained to see what lies beneath the behaviors some children display and not mistake them for something else. In mistaking something like PTSD for ADHD, as is not uncommon, teachers run the risk of exacerbating existing mental health challenges in their refugee students (Elumour & Thabet, 2014).

The necessity of teachers who are properly trained to work with refugee students has become increasingly acknowledged. In recent years there has been an increase in professional development workshops on issues surrounding diversity within classrooms. Some of these programs go a step further, emphasizing immigrants, and language learners (ELL), however programs that specifically study the plight of refugee students are limited. In order to address the struggles endured by refugee children professional development programs must go beyond English language acquisition (Essomba & Siarove, 2014; Severiens, 2014).

Definitions

In its document *The Convention and Protocol Relating to the Status of Refugees* (1951) the United Nations (UN) defines a refugee as:

A person who is outside his/her country of nationality or habitual residence, has a well founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable or

unwilling to avail himself/herself of the protection of that country or to return there for fear of persecution. p. 14

In 1980, the U.S. ratified this convention (Mossaad, 2016). Due to this and the international acceptance of the definition, any person referred to in this paper as a refugee can be understood as a person meeting the above requirements.

Because this paper will focus on refugee children in Portland, Oregon, those referred to as child refugees will meet the guidelines established by the Oregon state legislature. A child refugee is defined as:

A person under 18 years of age who has entered the U.S. and is unable or unwilling to return to the persons country because of persecution or a well-founded fear of persecution on account of race, religion, sex, sexual orientation, nationality, membership in a particular group or political opinion, or whose parents entered the U.S. within the preceding 10 years and are or were unwilling or unable to return to their country because of persecution or well-founded fear of persecution on account of race, religion, sex, sexual orientation, nationality, membership in a particular group or political opinion (Child Welfare Services, 2015).

Thus, any person referred too as a refugee child will incorporate those considered youth or adolescents.

This paper will address the traumatic experiences refugee children endure prior to migration, during their migration, and those they continue to experience within their host-country. It will also discuss the necessity that teachers are prepared to work with children who have lived through or are living through these events. As such, a traumatic

experience is defined as any stressful event that elicits a physical or emotional response, or both, in a child because of a perceived threat in their life or the life of someone who is critically important to them (American Academy of Pediatrics, 2015).

In order to understand the causes of this trauma, children's migratory experiences will be studied. Migratory experiences include those prior to fleeing their country of origin, their flight, and their arrival and initial period of time in their host-country. This paper will focus on high-income host-countries. The term host-country will be used only to describe final destination countries, and all host-countries referenced will be high-income countries. High-income countries are those countries considered to be developed nations: Western Europe, Australia, Canada, and the United States (Fazel, Panter-Brick, Reed, & Stein, 2012).

This research will focus on teachers that work within public school systems because most refugee children enroll in the public school systems upon arrival to a host-country (Armario, 2016). A teacher, as defined by Oregon Administrative Rules (OAR), is a licensed or registered employee in the public schools, charter schools or employed by an education service district that has direct responsibility for the instruction and coordination of educational programs or supervision, or evaluation and those who are compensated with public funds (Oregon Administrative Rules, 2016). Since OAR does not define in-service teacher, the definition will be based on the one provided by TeacherVision (n.d.). It defines an in-service teacher as a person hired by a school district that is actively teaching (TeacherVision, n.d.).

As reports of increases in the number of refugee children enrolled in PPS grow (Sottile, 2015) the district must find ways to cope. With the increase in refugee students

entering PPS, it is essential that the in-service teachers of PPS be prepared to work with these students whose needs are different from those of native, and even immigrant students. The research seeks to describe the specific needs that impact the academic and social-emotional growth of refugee children enrolled in public schools in the United States. The purpose of this research is to identify potential areas of professional development and support for the teachers and schools that serve these children, specifically the Portland Public School district in Portland Oregon.

Chapter 2 – Literature Review

The Refugee Experience

War brings about numerous, potentially traumatizing experiences. These experiences occur prior to a refugee's flight from their home and during their migration, and it is becoming increasingly evident that the trauma does not end upon arrival to perceived safety in their country of resettlement. The stress resulting from arriving and attempting to integrate into a new host-country also brings about stressors that can be equally traumatizing for children (Angel, Hjern, & Ingleby, 2001; Albertyn, Bickler, Millar, Rode, & van As, 2003).

Experiencing violence is one of the most prevalent, potentially traumatic experiences in a refugee's life. In the past during times of war, children were left out of this violence, but this is no longer the case. In the conflicts of the 21st century children have become targets and tools in the game of war. High-income countries are receiving an increasing number of child refugees who have experienced violence themselves or have witnessed violence be inflicted on another; some children have even been perpetrators of violent acts (Fazel et al., 2012). Children are significantly more likely to experience separation or abandonment from loved ones and primary care givers, abduction and forced soldiering, as well as health problems and hunger during, before, and after violent conflicts furthering their risk of traumatization (Albertyn et al., 2003).

Such experiences put children at risk for poor psychosocial development that can play a detrimental role throughout their lifetime (Joshi & O'Donnell, 2003). The current refugee crisis has resulted in the resettlement of refugee children in high-income countries. However, it can be challenging for those in Western countries to truly

understand what has happened to these children because the last time refugees fled a Western nation was during World War II and the Holocaust (Cole & Farwell, 2001).

Pre-Migration

The intensity of war-related trauma experienced by refugee children is situational (Shaw, 2003). Refugee children and their families often endure threats to their well being; prior to their arduous migration they commonly anticipate and cope with potentially traumatizing events knowing that threats to their life will not end once they are in route to safety (Ellis et al., 2004). In some circumstances, refugees have time to plan their departure from their war-torn environment allowing them to escape traumatizing wartime activities. However, they are frequently unable to escape before they are targeted (Lener, 2012).

Children in areas impacted by war are often exposed to direct war-related trauma, which includes first hand experiences with danger, watching violence inflicted on others or watching their deaths, physical threat, loss of possessions, loss of home, and separation from loved ones through death or forced flight (Ellis & Kia-Keating, 2007; Goldstein, Wampler & Wise, 1997; & Lener, 2012). Their experiences range from being a victim of violence to hiding in ones' home as bombs go off throughout the city to deprivation of basic needs (Shaw, 2003). Children may also be utilized as tools of war by combatants through the use of torture as a way to insight fear or collect information from community and family members (Plunkett & Southall, 1998). The violence children endure can be severe; children younger than twelve years of age have reported events of solitary confinement, during which they were held naked and, blindfolded, and given electric

shocks, and beatings. When children are placed in such situations prior to their flight they are unable to defend themselves, and some never escape (Joshi & O'Donnell, 2003).

In a study on Somali refugee children, researchers found that the most common experiences were witnessing someone extremely distraught, being separated for a month, or longer, from a loved one, having a loved one die, loss of the family's valuable possessions such as their car, furniture, or home, or having to abandon someone who was severely injured (Ellis & Kia-Keating, 2007). Syrian refugee children in the Islahiye camp in southeast Turkey reported their most common experiences were enduring a death in the family (79%), and witnessing someone get shot, kicked, or physical harmed (60%) (Rogers-Sirin & Sirin, 2015). Another study on Iraqi child refugees found that threats of being kidnapped, deterioration of education system, child labor and trafficking, religious persecution, and serving as active combatants as well as the same potentially traumatizing experience as the Somali children to be the most common (Banks et al., 2013). Elbert and Schaal (2006), in their study on the Rwandan genocide found that every child had some experience with violence, was exposed to life threatening events, or had been permanently separated from their parents or primary caregiver, through loss or death. Additionally, 97% saw mutilated or dead bodies, 77% watched someone be killed, and 41% watched one or both of their parents die (Elbert & Schall, 2006). In a similar study on war-related stressors endured by Bosnian children, 80% had experienced damage or loss of their home and property, having to leave behind an important person or having a family member under protracted threat. Roughly 60% were forced to take shelter and lost community spaces that were once safe (play areas and schools), and 50% had experienced the death of a central person in their life (Angel et al., 2001).

Recent years have seen a significant increase in civilian casualties, this means the destruction of communities has also spiked; in modern warfare combatants are increasingly likely to target communities as a way to attack the entire life of those they deem as opposition to their cause. By targeting communities militants are able to use violence to their advantage to instill terror, fear, and despair in community members, with the intention of immobilizing the minds and hearts of people (Cole & Farwell, 2001). The destruction of homes, community centers, and entire villages are typically brutal in an attempt to create chaos and fear (Banks et al., 2013) and disrupt community members' sense of safety. Attacking communities not only destroys the physical community but the intangible parts of community life. It separates citizens from community resources and their means of livelihood, preventing social organization, leading to the breakdown of supportive relationships. This disruption of communal life creates enemies out of those who were once friends and combatants out of those who were once civilians (Cole & Farwell, 2001).

Prior to their flight to safety, children find their most basic daily routines disrupted. They experience the deterioration of social networks and health services, and the destruction of their homes, schools, and communities (Angel et al., 2001). The social disruption and chaos that characterize the pre-flight phase of refugee children's lives typically result in limited access to school (Ellis et al., 2004). Schools have increasingly become central targets for militant groups attacking communities because of their role as centers for these aspects of communal activity (Joshi & O'Donnell, 2003). These spaces are crucial in the formation of a child's development and identity formation due to the

extensive amounts of time spent within the walls of these structures (Joshi & O'Donnell, 2003; Ellis et al., 2004).

Schools play a central role in the life of any child, and this limited access challenges scholastic and social development, often putting them behind other children upon resumption of classes (Ellis et al., 2004; McBrien, 2005). However, it is challenging to provide education within conflict settings. Many teachers make efforts to keep schools open and functioning regardless. They create makeshift classrooms in homes, basements and damaged buildings, and sometimes outside in the fields. The challenge of providing education in conflict settings is ensuring that it does not put children in dangerous situations (Sinclair, 2002).

Schools can also be used as shelters of sanctuary for families who have fled their homes and villages. Because of their multiple uses and meanings schools are targeted for destruction by militant groups in times of armed conflict. For example, by 2000, in the conflict in Burundi, at least 391 elementary schools were destroyed, roughly 25% of all elementary schools in the entire country (Jackson, 2000). Teachers and peers may also take advantage of the school setting in a negative manner. Often, in times of armed conflict, educators and participants of violent groups will use schools as a tool in the indoctrination of children or as a means to abuse and exploit them (Kirk & Winthrop, 2008).

Migration

Forced to flee their homes, refugees embark on long, arduous journeys to find safety and have their most basic needs met. In a study on children of the Bosnian genocide, 50% had a strenuous flight (Angel et al., 2001). Their journey puts them at risk

for continued violence and extortion (Banks et al., 2013). When fleeing violence and persecution refugees have little time to be concerned about the future, and are only able to think about immediate escape (Stein, 1981). Refugees have little time to gather the provisions necessary to facilitate their journey and often travel with next to nothing and are thus unprepared for the long journey ahead (Angel et al., 2001; Stein, 1981). One study on Vietnamese refugees reported that 85% decided to leave their home two days or less (some two hours) before fleeing (Stein, 1981).

During the migration process children are prone to many of the same stressors experienced prior to their flight as well as a host of new potentially traumatizing experiences specifically related to forced migration. They continue to live in an atmosphere of threat, uncertainty, and terror (Angel et al., 2001). Many refugees are forced to find sanctuary in forests, jungles, and fields putting them at risk for capture and attack by combatants as well as attacks from dangerous animals. Throughout this journey refugee children are susceptible to being forced into an armed group, being separated from or losing a loved one, and being raped, abducted, or trafficked. Many children who did not lose their parents prior to migration become separated from their parents during flight. They may be separated from their loved ones due to death or abandonment, forcing them to become heads of their families. This additional stressor adds to their risk of poor psychosocial development because they are forced to take a role that they are not developmentally prepared for (McBrien, 2005).

Refugee Camps

Those who manage to endure the long journey often find themselves in refugee camps, generally refugees are not directly resettled into high-income countries, but are

housed temporarily in camps set up in neighboring countries, which may not possess more stability than the country they have left behind (McBrien, 2005; Roxas, 2011). In a study on refugees resettled in Sweden, Angel et al. (2001) found that families passed through an average of 2.3 camps before being permanently resettled.

Living conditions in camps are typically harsh. Upon arrival to camps basic survival needs become the priority for families, and restoring the community and social systems necessary for the healthy development of children are placed on the back burner (Fazel & Tyrer, 2014). Stein (1981) listed the main characteristics of camp life as segregation from the host population, lack of privacy, overcrowding, shared facilities, and a limited, restricted area in which a person can live their daily life. Camps vary in size and resources, but the majority are unable to meet the basic needs of their residents due to limited funding and resources availability (Roxas, 2011). During the Rwandan genocide refugee camps were targeted, blocked, or controlled by militant groups. The groups often laid claim to the resources brought in by humanitarian aid agencies, further limiting the resources of the refugees living inside the camps (Barker, 2004).

In camps children continue to be exposed to on-going insecurity, limited access to education, malnutrition, poor health, and continued violence and abuse (Fazel & Tyrer, 2014). Coupled with the continuation of past stressors and the challenges of life in a camp, refugees tend to be hit with the realization that they have lost their former life and their homeland (Stein, 1981).

Many international organizations have acknowledged the importance of continuing education in times of conflict, especially upon the arrival to perceived safety of refugee camps. However, in camps it is challenging to educate children due to lack of

qualified teachers and there is limited ability to train teachers in camps. In addition to lacking the human capital necessary to educate children in camps, most camps lack the tangible resources necessary to facilitate education (Sinclair, 2002). The United Nations High Commissioner for Refugees (UNHCR), in 1995, stated the importance of continuing education in refugee camps, claiming that it is essential in supporting positive psychosocial development. Education in refugee camps allows children to re-claim balance in their destructed lives. Providing education in camps provides children with the skills, knowledge, and stability necessary to be successful in the next education system they enter (Leblanc & Waters, 2005). The poor quality of education continues and children find themselves falling further and further behind students outside of refugee camps (Sinclair, 2002).

Applying for Resettlement

Since 2005, the number of refugees requesting resettlement through the UNHCR has doubled. There has also been an increase in the number of countries accepting refugees for resettlement. In 2014, twenty-seven countries accepted refugees for resettlement, the following year thirty-three countries accepted refugees. A child's greatest hope for safety is to be selected for resettlement in a high-income country and be able to leave behind the violence they have experienced. This process typically starts while the child is still living in refugee camps and can take months, even years to begin (UNHCR, 2015).

In order to be considered for resettlement a refugee must meet the UN definition of a refugee and the UNHCR must determine that resettlement is the only option to ensure the individual's or someone in their family's safety. To move through this part of

the process, a refugee must fall into one of the following seven categories: 1. be in need of legal and/or physical protection; 2. be a survivor of violence and/or torture; 3. have medical needs; 4. be an at-risk female; 5. will be reunited with family members; 6. be an at-risk child; or 7. have no foreseeable alternative durable solutions. Once determined to be in need of resettlement by the UNHCR, refugees are referred to UN member countries for resettlement (UNHCR, 2015). A recommendation for resettlement by the UNHCR does not guarantee resettlement. Following approval by the UNHCR, a refugee must meet the requirements set forth by each country for resettlement. Refugees resettled in high-income countries are no longer considered in need of support from the UNHCR and are turned over to their respective host governments (UNHCR, 2015).

Prior to the start of every fiscal year, in the U.S., the President and Congress determine a ceiling on the number of refugees that will be admitted, the places refugees will be admitted from, and the amount that will be accepted from each country or region for the upcoming year (Mossaad, 2016). In order to qualify for refugee status within the U.S. an applicant must meet the criteria stated in section 101(a)(42) of the Immigration and Nationality Act (INA), which defines a refugee in the same manner as the UN. In addition to this, a refugee must be considered to be of special humanitarian concern to the U.S., and must not have previously been resettled in any other country. The United States Refugee Admissions Program (USRAP) is responsible for determining whether a person meets these criteria (Immigration and Nationality Act, 2013).

USRAP uses three criteria to determine if a person will meet these qualifications. First, the UNHCR, a U.S. Embassy, or partner nongovernmental organization (NGO) must refer the person; the person must be considered to be a part of a group of special

humanitarian concern to the U.S. government; or they must be eligible for family reunification. Meeting these criteria still does not ensure that a refugee will be selected for resettlement. In 2014, 55% of refugees admitted were selected because they met the requirements of being in need of special humanitarian concern, and 43% were admitted following referral from a U.S. Embassy, partner NGO, or the UN (Mossaad, 2016).

After meeting USRAP qualifications a refugee case is transferred to a Resettlement Support Center, which work under an agreement with the U.S. Department of State (DOS) to facilitate the remainder of the resettlement process. These centers conduct pre-screening interviews with applicants and assist them in the completion of the application for resettlement, which is submitted to the United States Citizenship and Immigration Services (USCIS). Before the application can be processed the refugee must participate in an interview with USCIS. If a refugee is able to meet these requirements listed above and prove their need for resettlement in their interview they undergo a medical examination to prove they have no easily transferrable diseases. Once a refugee has completed this entire process and is deemed as legitimate refugees they are granted permission for resettlement (Mossaad, 2016).

Post-Migration

Upon arrival to the U.S. a refugee is assigned to a resettlement organization that assists them in settling into mainstream society. The agency helps them find housing and employment, and navigate systems necessary to receive other government services (Mossaad, 2016). Resettlement agencies provide refugees with some financial, social and work-related support for a short period of time, generally six month to one year (Roxas, 2011; UNHCR, 2015). Following the period of initial help, refugees are left to their own

devices to rebuild their lives when they are still unlikely to understand the processes, systems, and cultural norms of their host nation (Roxas, 2011). In addition to assistance from sponsors, a refugee is eligible for some public benefits such as employment assistance, a social security card, and access to social service support (Mossaad, 2016). Ultimately, the resettlement process should result in permanent resident rights and in some instances, citizenship (UNHCR, 2015).

For children, the rapid social change and terror experienced in their adaptation to their host-country may destroy their sense of home and community, upon which children's identity is based. This can have negative effects on the development of a child's personality and personhood, both of which are crucial for normal childhood development to occur (Cole & Farwell, 2001). The host-country communities, including school, can play a central role in supporting refugee children. Schools and other community settings are amenable to supportive interventions for children who may be struggling to adjust to their new environments (Fazel & Tyrer, 2014).

The exposure to war-related trauma may have been confined by time and space for refugee children; however, the vast range of secondary stressors that come in the aftermath of war will continue to impact the child and their family upon resettlement in a high-income country (Shaw, 2003). Refugees continue to experience traumas and stressors that come along with acculturation (Roxas, 2011). In resettlement children encounter massive social, cultural, and linguistic differences (Ellis & Kia-Keeting, 2007; Fazel et al., 2012; Fazel & Tyrer, 2014) as well as economic barriers resulting in the loss of social and economic capital (Ellis, & Kia-Keeting, 2007).

Local integration is considered the aim of resettlement, where refugees are able to pursue sustainable livelihoods, contribute to the economy, and live in the host-country without discrimination or exploitation (UNHCR, 2015). Refugee children have traveled for extended periods of time in dangerous, life threatening environments only to arrive in a country with a culture and language that is considerably different from their own (Fazel et al., 2012). Their struggle with the host-country culture and language can be exacerbated by their lack of stable residence upon arrival. Many refugee children continue to move around once they are resettled, and it tends to take a long time before they stay in a location for an extended period of time (Hart, 2009). A study on refugees resettled in Sweden found that the children had moved six times in the first two years of their resettlement (Angel et al., 2001).

Acculturation

As defined by McBrien (2005), acculturation is “the change in an individual or culturally similar group that results from contact with a different culture (p. 330).” Acculturation affects each person differently, but for refugees it is often associated with feelings of anxiety and depression (McBrien, 2005). Adjustment to new cultures and ways of life is often challenging for refugees and typically lasts long past the end of the social support they receive from resettlement sponsors (Fazel et al., 2012). They must cope with their previous experiences (violence, separation from loved ones, economic-social disruption, malnutrition, and illness) (Shaw, 2003) all the while dealing with the new stressors associated with resettlement, further loss or separation from loved ones, poverty, xenophobia, the loss of language and customs, and downward mobility both socially and economically (Brown, 2004; Kugler & Price, 2009; Shaw, 2003). One

refugee reported that upon arrival to the United Kingdom (his host-country) he had to deal with poor living conditions, sudden relocations, mental health problems among family members, bullying, and feeling unsafe at school (Brown, 2004).

Acculturation can place a lot of stress on the dynamics of refugee families. Refugee children acculturate at different rates and different degrees than their parents and often find it easier to adapt than their parents and older members of their families. Their ability to more rapidly integrate into their host-society often results in the premature adoption of an adult role. Many times they serve as translators for their parents in situations, such as doctors appointments or legal matters that are years beyond their level of maturity. Refugees are split between two cultures, that of their country of origin and that of their host-country. Yet while trying to make a whole identity based on both cultures, refugees are relegated to the margins of the society in their host-country because of their obvious cultural differences (Chiumento et al., 2011).

Discrimination

One of the most common features of arriving in a new country for refugee children is discrimination. Experiencing discrimination plays a significant role in the amount of acculturative stress they feel. Law in high-income countries prohibits ethnic and racial discrimination, however, law does not eliminate more subtle displays of discrimination, and many refugees encounter this on a daily basis (Donkers et al., 2008). Refugees can be viewed as out-groups that pose a real or symbolic threat to the host-country resulting in feelings of prejudice and acts of discrimination. This is especially true for refugees who come from cultural and political backgrounds that differ more noticeably from the host-country. For many years, the majority of refugees came to the

U.S. from places, such as the Balkans, that shared similar appearance and perceived cultural values to those held by U.S. citizens. Since the 1990s, there has been an increase in refugees from Iraq, sub-Saharan Africa, and Afghanistan who are less likely to blend into mainstream culture. Refugees from these countries are typically associated with their Islamic faith, which many Americans have come to associate with terrorism (McBrien, 2005). New refugee children who are from disadvantaged groups in the U.S., like those of the Islamic faith today, and in their native countries must overcome greater obstacles in order to find the same success as other immigrants (Glick & Hohmann-Marriott, 2007). Many new refugees are viewed as criminals who are queue jumpers and terrorists. These sentiments have led to new forms of racism and feelings of distrust and fear, resulting in discrimination (Matthews, 2008).

In their native countries refugees were often subject to discrimination and trauma (typically this is a basis for their flight), which follows them to their host-countries (Roxas, 2011). Children can become targets of prejudice and discrimination based on the feelings held by citizens of their new homes based on nothing that is personal. This can be more challenging for children than adults because they cannot understand the connection being made between them and the militants in their country of origin. This can lead to increases in their uncertainty, resulting in increased likelihood of psychological trauma. Such prejudice and racism affect children in a multitude of ways and it can limit their occupational mobility and social integration and affect their view of themselves, and their motivation (Costello, Masten, & Pine, 2005).

School

Often one of the first and most influential systems that refugee children encounter after resettlement is school. Children who are enrolled are forced into whatever educational opportunities available to them, generally without consideration of their circumstances (Joshi & O'Donnell, 2003). Wartime experiences, such as exposure to violence, murder, and rape, widen the gap between refugee children and other students. Additionally, many refugee children, especially those in rural areas, have received no or very limited formal education prior to flight making it difficult for them to participate in host-country schools (Jackson, 2002; Roxas, 2011).

Upon arrival to their host-country, it is difficult for children to bridge the gap in their previous learning, which is often characterized by multiple, long-term disruptions in education, and expectations of what their new school will be like (Fazel & Tyrer, 2014; Rogers-Sirin & Sirin, 2015). Learning to navigate a new school setting is essential to the overall success of refugee children. This often proves to be challenging for refugee children who have experienced gaps in their education (Ellis & Kia-Keeting, 2007). Refugee children, due to these gaps in education and language barriers, tend to be placed in classes with children younger than them, which further alienates them from their peers (Roxas, 2011). This is especially true for children facing language barriers, new societal and educational cultures, and new curriculum (Fazel & Tyrer, 2014; Rogers-Sirin & Sirin, 2015).

McBrien (2005) noted that discrimination appeared to be the greatest barrier to integration for refugee children. In school, refugee children, often already struggling to learn a new language and adapting to a new culture, must now combat the negative

attitudes of teachers and classmates that result from cultural misunderstandings (McBrien, 2005). They may experience physical or verbal abuse in addition to discrimination (Rogers-Sirin & Sirin, 2015). Such forms of bullying are not uncommon for refugee children and they commonly report being bullied at school and perceive that their schools do little to combat the bullying being experienced (Lener, 2012). If school staff members are not careful, discrimination and prejudice can be reinforced due to their pre-existing stereotypes about the cultures and backgrounds of their refugee students (Rousseau, 1996).

Refugee children can benefit greatly from the communal environment schools offer them because it gives them a sense of belonging (Fazel & Tyrer, 2014). Education is equally as important to restoring normalcy for refugee children as meeting their needs for health care and shelter. It helps restore a normal life, prepare them for what comes next and for adulthood (Sinclair, 2002). However, for many refugee children this is not the case because of the bullying they endure, further distancing them from the host-communities (Fazel & Tyrer, 2014).

In addition to bullying, language is a significant barrier faced by refugee children upon entry into the school systems of host-countries. Not being proficient in the host-country language is believed to be one of the primary reasons children struggle to assimilate in their new society (Essomba & Siarova, 2014). Mastery of host-country language is the most important factor in determining academic success and assimilation for refugee children. Scholastic achievement, educational attainment, and economic mobility are undermined when refugee children are not successful at mastering the host-country language. Children that start kindergarten with limited ability in speaking the

host-country language are more likely to fall behind in reading and math. Such gaps continue throughout the rest of a child's schooling. This continues the trend of separation from their peers further dividing the two groups (Haksins & Tienda, 2011).

Outcomes

Mental Health

The disruptions in normal development resulting from wartime experiences often result in mental health challenges for refugees. Negative responses to stressors occur as a result of frequent, strong, or extended experiences with adversity (American Academy of Pediatrics, 2015), characteristics often used to describe traumatizing events endured by individuals in conflict-affected societies. War and violence result in social chaos in which demolition of the infrastructure of daily life is intense and overwhelming at a time in a child's life when they need the social structure communities provide to comfort and give them the guidelines necessary for the development of a moral code. The chaos and loss of normalcy challenges their developing sense of personality and personhood, both of which are necessary for normal development (Cole & Farwell, 2001). Living in war-zones has an array of implications on mental health and concept of well-being (Banks et al., 2013). Exposure to bombings, mutilated bodies, and frequent shootings are common during time of war and according to the World Health Organization (WHO), are likely to result in poor mental health outcomes (Bell, Bosch, Martínez, Méndez, & Pablo, 2012). Experiencing violence of this nature creates an environment where children feel their lives are constantly in danger (Joshi & O'Donnell, 2003).

Rupture is a central element of trauma, for refugees this means ruptures in the continuity of time, relationships, individual's view of the self and others, the basic

meaning of life, and expectations about the future. During and following war individuals experience behavioral and cognitive changes in order to deal with what is going on around them. Responses to such ruptures are highly dependent on the individual and the culture they are part of (Abed, Thabet, & Vostanos, 2004; Cole & Farwell, 2001), but nonetheless leave individual's at an increased risk of negative psychosocial development (Cole & Farwell, 2001). In Iraq, almost 36% of adults experience psychological trauma as a result from exposure to direct or indirect violence. It is estimated that this number is even higher in children, who make up 50% of the population (Banks et al., 2013). As a result, victims of war are likely to demonstrate selective inattention, paranoid defensiveness, increased hatred, desires for revenge, skeptical escapism and an increase in rigid ideologies, prejudices and absolute idealism (Cole & Farwell, 2001).

Traumas experienced effect prosocial behavior and sense of belonging in their various communities and at home (Joshi & O'Donnell, 2003). Children and adults have similar psychological responses to traumatic experiences (Shaw, 2003). The key difference is that exposure to wartime traumas forces children to deal with the task of growing up and at the same time cope with loss, this pulls them in multiple directions, which can warp and stall development (Joshi & O'Donnell, 2003). Experiences of trauma during times of war and violence are seldom single events of disruption, they involve multiple, and sequential events that can lead to negative mental health (Angel et al., 2001). Wartime experience can challenge children's capacity for positive psychosocial growth. Environments characterized by violence and deprivation on economic, political, cultural, religious, and social levels severely challenge children's psychological development (Joshi & O'Donnell, 2003).

When such horrific events are experienced in ones' country of origin a person's individual attributes may be protective for them, but can also serve as a risk factor (Cole & Farwell, 2001). Each child perceives traumatic events differently, and events that are severely traumatizing for one child may have little impact on another. Such outcomes are situational and can be understood based on experiences of past trauma, support from social structures, and predisposition (American Academy of Pediatrics, 2015). Traumatic experiences can leave a host of cognitive, behavioral, and health problems in their wake. If such symptoms are not acknowledged they can result in school failure and dropout, interpersonal violence, chronic unemployment, and drug and alcohol abuse (Mandell, 2014).

In conflict zones, children tend to constitute a large amount of those suffering psychological illness (Banks et al., 2013). Children differ from adults because their reactions to stress are still developing; they are still in the process of maturing physically, cognitively, emotionally, and socially. Adults have already formed their identity, and while adults are more likely to fully understand the traumatic experiences and their severity, children must understand of the events while developing their personality structures, forming their identity, making sense of what is right and wrong, and learning to control their emotions. This can have a significant affect on the child's ability to develop strong coping mechanisms (Shaw, 2003). The cumulative effects of which can have detrimental outcomes on children's psychosocial development (Joshi & O'Donnell, 2003; Shaw, 2003).

Costello et al. (2005) suggest that a child's response to trauma is dependent on four different categories. The first category relates to children's exposure to traumatic

events. Exposure to the event includes experiences like a famine after the war, losing a loved one, being victims themselves, or watching traumatic events occur. Injury to oneself, parents or loved ones is included in this category, and is a signifier of greater negative outcomes. The next category considers the amount of support a child received from their parent or guardian during their wartime experiences. Children who lose a parent or guardian or have a parent or guardian that is psychologically unavailable are more likely to struggle to cope with their traumatic experiences. Thirdly, the amount of life disruption experienced during the traumatic experiences play a role in a child's response. Situations in this category include being an unaccompanied refugee, being a refugee that has had their safe spaces (family home, school, or community centers) destroyed or violated, and the degree to which their routines are interrupted. Finally, the amount of social disorganization that results following traumatic experiences such as the collapse of infrastructure affects a child's response (Costello et al., 2005).

The aim of organized violence is to inflict damage and pain onto its victims causing them to be vulnerable and feel helpless (Mandell, 2014). Each child views such experiences differently, and responses exist in a broad spectrum. Some children may feel very little effects of experiencing the traumas associated with organized violence, while another may experiences some of the more severe effects, such as severe Post-traumatic Stress Disorder (PTSD) (American Academy of Pediatrics, 2015). Children who are exposed to repeated or multiple traumatic events are more likely to experience the more severe effects following their experiences than children who only experience a single traumatic event (American Academy of Pediatrics, 2015; Cole & Farwell, 2001). Responses in children tend to be dependent on the previous amount of traumatic

stressors, social-emotional support, and genetic predisposition. These factors facilitate or hinder a child's feeling of the out-of-control physiological arousal that initiates an adaptive reaction to the stressors that frequently becomes destructive and maladaptive (American Academy of Pediatrics, 2015).

Children that have experienced traumatizing events are at a greater risk of having learning and behavioral challenges. This is exacerbated by the prolonged exposure to stress experienced by refugee children. Extended periods where the stress response systems are activated can disrupt development of brain structure and other internal systems as well as lead to an increased risk of disease and cognitive impairment that continues into adulthood (American Academy of Pediatrics, 2015). Significant time spent in refugee camps has also been found to increase a child's risk of mental health challenges. Refugee children who spent a year or more in a refugee camp were more likely to develop mental health disorders than those resettled more rapidly (Fazel et al., 2012).

Post-migration events, such as discrimination, social isolation, and rigorous border controls also have a significant impact on the psychosocial outcomes of refugee children (Fazel & Tyrer, 2014). In their research, Fazel et al. found that in most studies, post-migration stressors were positively correlated with negative psychological outcomes (2012). As a result of post-migration stressors, it has been found that among refugee children resettled in the U.S. around 40.5% have high rates of psychological problems (Lener, 2012). It is also common for children to move multiple times upon resettlement before they find long-term residence in their host-country. Those children who experienced four or more moves after being permanently resettled were three times more

likely to have mental health difficulties than those who experienced three or less relocations (Fazel et al., 2012).

An intense experience of migration and cultural change has been shown to intensify normal developmental crises for refugee children (Aronowitz, 2009). Extended forced migration and the resulting disruption in development and cultural continuity, can result in negative long-term damage for refugee children. This disruption not only affects refugee children later in their lives but can also have a negative impact on unborn generations (Eisenbruch, 1988). Psychological challenges resulting from war-related traumatic experiences lasted years after the events occurred. A study of Khmer children discovered that 48% continued to have trauma related symptoms 8 to 12 years following the conclusion of traumatic experiences (Barenbaum et al., 2004).

Children with any exposure to war have been found to have higher rates of mental health problems. Following the Bosnian genocide, 56% of children in Croatia were found to be in need of mental health support (Shaw, 2003). A study conducted in the Middle East and Latin America found similar results, 35-50% of children suffered, to some extent, from poor mental health (Angel et al., 2001). Child survivors often demonstrate symptoms associated with PTSD, depressive disorders, and anxiety disorders, such as avoidance, insomnia, irritability, sleeping disorders, nightmares, lethargy, confusion, aggression, fear, and an inability to concentrate (Albertyn et al., 2003). Further, it is common for refugee children to experience dysregulation, disruptive and aggressive behaviors, attachment patterns that are insecure and atypical, poor relationships with peers characterized with aggression and social withdrawal, and academic underachievement (Joshi & O'Donnell, 2003).

The age of a refugee child plays a significant impact on the mental health outcomes. Lebanese children exposed to conflict ages 5 to 7 were found to react to trauma based on the reaction of their mothers, especially in instances where their mothers suffered from depression (Shaw, 2003). Latency-age (ages from four to post puberty) children have been found to be at a greater risk of developing negative mental health outcomes because their capacity to understand and process events is in its fundamental growth phase. At the same time they have not developed consolidated identities and the defense mechanisms necessary to cope (Barenbaum et al., 2004). In Croatia, the older a refugee child was the more likely they were to report symptoms related to PTSD than younger children, however, among all age groups symptoms were found to increase six months following migration. Depression had no significant correlation with the age of refugee children (Joshi, O'Donnell, 2003).

Refugee children that are unaccompanied are at a greater risk for negative psychological outcomes than those arriving with others (Fazel et al., 2012). This is a result of the nature of their migration because they endure these experiences without protective support systems. Children traveling alone are more likely to experience traumatic experiences than those protected by a community during their migration. They are also likely to struggle more than their accompanied counterparts because they lose connections to the past and must navigate a new culture without the assistance of those who can relate (Fazel & Tyrer, 2014).

The most widely acknowledged outcome of the traumas and stressors experienced by refugees beginning with the wartime experiences to their acculturation and resettlement in high-income countries is their vulnerability to negative mental health

outcomes. Stressful experiences related to forced migration (persecution, flight, and resettlement), or changes (familial, communal, and societal) that result from forced migration makes refugee children susceptible to various psychosocial problems (Albertyn et al., 2003; Fazel & Tyrer, 2014) and they are at risk for psychological distress, behavioral problems, PTSD, depression, and academic failure (Lener, 2012).

Post-Traumatic Stress Disorder

Children who find themselves directly in harms way are more likely to develop PTSD (Costello et al., 2005). Often these traumatic experiences result in posttraumatic stress that can last for years, and is likely to be reactivated by continued stressful events (Joshi & O'Donnell, 2003). The most current version of the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-V) provides eight criteria which can be followed to diagnose a person with PTSD. First, the person in question has had exposure to real or threatened death, serious injury, or sexual violence. This can occur by direct experiences with potentially traumatic events, witnessing others experience the events, learning that the events have happened to a loved one, and/or encountering repeated or severe exposure to the traumatic events. Next, the criterion states that the person must experience intrusive symptoms following the traumatic experiences. Intrusive symptoms include: recurrent and involuntary distressing memories, dreams, or both, dissociative reactions, for example flashbacks, where an individual feels or acts as though the events are still occurring, continued stress from internal or external cues that symbolize aspects of the traumatic events, and avoidance or attempted avoidance towards aspects that resemble the traumatic events. Another criterion to be met is a continued avoidance of things connected to the traumatic events. People who fall under this criterion display

avoidance or attempted avoidance of distressing thoughts, feelings, or memories related to the event or avoidance of external reminders. For a diagnosis of PTSD, a person needs to have the presence of one or more of these symptoms or experiences (American Psychiatric Association, 2013).

A person meeting the criteria for PTSD will also experience changes in cognitions or moods beginning or becoming worse following the event(s). For a diagnosis, a person must experience two or more of the following: an inability to recall key components of the traumatic event(s); continued and hyperbolic negative beliefs or expectations of oneself, others, or the world; distorted, continued cognitions related to the cause or outcomes of the events that lead an individual to blame themselves or others; an unyielding negative emotional state; detachment or estrangement towards others; and a continuous inability to feel positive emotions. Next, a person experiencing PTSD will have clear changes in awakening and reactivity coupled with the traumatic events, starting or becoming worse following the events. This criterion must also be met by the presence of two of the following factors: outbursts that are angry, and irritable behavior; self-destructive and reckless behavior; hypervigilance; heightened startle response; challenges concentrating; and sleep disturbances. The disturbances mentioned above must persist for a minimum of one month, the reactions must be caused by clinically significant distress or damage to social or occupational functioning, and must not be connected to substance abuse or another medication (American Psychiatric Association, 2013).

PTSD can occur in anyone over the age of one. Generally, symptoms start within three months following experiences with traumatic events, but in some it can be months

or even years before symptoms present themselves. Children are less likely to demonstrate a fearful reaction during exposure or re-experiencing. The most common symptoms reported by parents in their children are an increase in behavioral and emotional changes. They may experience terrifying dreams and they are more likely than their adult counterparts to express re-experiencing symptoms through play that relate to the traumatic event (American Psychiatric Association, 2013). Symptomology presented with PTSD generally begins when children begin to process the traumatic events they have had, or continue to experience (Joshi & O'Donnell, 2003). While some mental health disorders in refugee children may be difficult to differentiate because of common manifestations, the manifestations of PTSD have been found by some scholars to be significantly different especially from depression and other adjustment problems (Ellis & Kia-Keating, 2007).

In a study on Cambodian children, Ellis and Kia-Keating (2007) found depression to be connected to continuous daily stressors, unlike PTSD, which is associated with separate traumatic events. While PTSD is likely among refugee children percentages vary significantly when studying its prevalence, Brown (2004) found a wide range in outcomes with studies suggesting anywhere from 15%-90% of children exposed to traumatic war related events went on to develop PTSD. Events that threaten the survival of children or their loved ones more often result in PTSD than those related to forced removal from their home or time spent in refugee camps (Costello et al., 2005). A study on children exposed to terrorism in Israel discovered that 30-50% experienced PTSD to some extent (Shaw, 2003). Additionally, the shame and loss of self-confidence that is

associated with acculturative stress are linked to PTSD (Fazel et al., 2012; Mandell, 2014).

Events most associated with the development of PTSD in refugee children are separation from primary caregiver, exposure to violence, and perpetual feelings of danger (Elbert & Schall, 2006). The role of the primary caregiver is one of the primary protective factors determining a child's likelihood of developing PTSD, children who are separated from their loved ones are more likely to have PTSD than those who were not (Fazel et al., 2012). Refugee children with parents who demonstrated PTSD or posttraumatic symptoms were at a higher risk for developing PTSD (Abed et al., 2004). Additionally, a connection to others from one's host-culture plays an important role in a child's development of PTSD. This is evident in a study on Sudanese children that found those living in a group home without other Sudanese were more likely to develop PTSD than those in foster care with other Sudanese children (Fazel et al., 2012).

A study conducted on Rwandan children that were victims of the genocide found that ten years after the event 44% of participants met the full DSMV-IV measures for PTSD (Elbert & Schall, 2006). Following an assessment of Bosnian child refugees it was reported that 68% fell within the clinical range for PTSD symptoms (Brown, 2004). After the Gulf War, 70% of children in Kuwait were identified as having moderate to severe symptoms of posttraumatic stress (Shaw, 2003). Thabet and Vostanis (1999), in a study of 239 children, found that 174 (72.8%) suffered from posttraumatic symptoms. Anhedonia, impaired concentration, avoidance of situations that spurred memories of traumatic experiences, and fear and thoughts connected to the trauma were the most common PTSD symptoms these children reported (Thabet & Vostanis, 1999). Angel et

al. (2001) studied PTSD-related symptoms of 99 Bosnian children in Sweden and found hypervigilance (30%), conditioned fears (20%), and war-related dreams (15%) to be the most common.

While the majority of the research considers refugee children to be at an increased risk for developing PTSD it has been suggested that younger children may be less likely to demonstrate symptoms of PTSD. This result is due to the fact that the younger the child the less developed their cognitive abilities are, making them less aware of the severity of the events they have lived through (Elbert & Schall, 2006). Child refugees that experience negative psychological outcomes due to traumatic experiences may experience many of the PTSD symptoms but not meet the full criteria for a PTSD diagnosis (Hart, 2009).

A diagnosis of PTSD for refugee children can make assimilation into a host-country more challenging because it affects the way others interact with them (Hart, 2009). Further, refugee children experiencing PTSD were more likely to feel uncomfortable in their host society and new culture, to feel lonely or isolated in their new homes, and were less likely to participate and express satisfaction in-group activities (Fazel et al., 2012). Not all children exposed to war trauma will develop PTSD following the cessation of traumatic experiences. There is disagreement amongst scholars as to the amount of refugee children that suffer from PTSD. Joshi and O'Donnell (2003) reported that some research suggested that as many as 39% of refugee children develop PTSD while others found that behavioral, emotional, and social difficulties are more prevalent.

Depression

In child refugees, depression is more closely linked to loss of family and community ties, greater encounters with violence, and poor mental health outcomes in primary caregivers (Abed et al., 2004). A study on Bosnian children exposed to traumatic wartime experiences 47% met the criteria for clinical depression (Hart, 2009). The commonality across all depressive disorders is the persistent presence of sad, empty feelings, or irritable moods, coupled with cognitive and somatic changes that interrupt a person's ability to function at full capacity. The differences among depressive disorders relates to timing, duration, and presumed causes. Major Depressive Disorder (MDD) is the classic example of a depressive disorder. It is understood as the presence of discrete episodes that last at least two weeks, which include obvious changes in affect, cognition, and neurovegetative functions with remissions between episodes (American Psychiatric Association, 2013).

In order for a person to be diagnosed with MDD they must display at least five of the following symptoms, one of which must be a loss of interest or pleasure, or a depressed mood. A depressed mood must last the majority or a person's day for numerous days, in children or adolescents this may be displayed in an irritable mood as opposed to a depressed one. The length of time for lessened interest or pleasure is the same as for depressed mood. Significant weight loss or gain, or daily fluctuations in appetite serve as another indicator for MDD. Daily or almost daily presence of insomnia or hypersomnia, and fatigue or loss of energy serve as additional indicators. Feelings of worthlessness, and inappropriate or unnecessary feelings of guilt are also common symptoms. Challenges concentrating and indecisive feelings are prominent features.

Finally, thoughts of death and suicide are common among persons suffering from MDD. In addition to the presence of at least five of these symptoms the feelings must disrupt a persons daily functioning, cannot be attributed to another mental disorder or substance abuse, and the person cannot have experienced manic or hypomanic episodes. Those working with refugee children must also be aware of the possibility of children developing dysthymia (the presence of the symptoms of MDD for one year or more) or persistent depressive disorder (American Psychiatric Association, 2013).

In children, depression may manifest itself differently than it does in adults; a child that appears to be disinterested may actually be suffering from depression (Kugler & Price, 2009). In their 2004 study, Abed et al. cited the most common symptoms of depression reported by refugee children were: crying a lot; excessive fatigue; inability to sit still or lack of motivation to do anything; and feeling lonely. The next most common feelings reported by refugee children were feeling unhappy or sad, feeling unloved, challenges concentrating, feeling inadequate, and an inability to enjoy anything (Abed et al., 2004). Symptoms of depression are correlated with the amount of violence experienced by refugee children (Angel et al., 2001).

Anxiety

Another common reaction to traumatizing events are anxious feelings or anxiety disorders. Anxiety disorders can be characterized by excessive fear, and anxiety. Fear can be understood as a person's response to imminent threat (real or perceived) and anxiety as the anticipation of future danger. What makes anxiety disorders different from normal fear and anxiety is their excessive and persistent nature typically lasting six months or more. The differences in anxiety disorders are a result of the types and situations that

induce anxiety. The most common anxiety disorder found to be prevalent among refugee children is Generalized Anxiety Disorder (American Psychiatric Association, 2013).

Generalized Anxiety Disorder can be understood based on six criteria. The first criterion is that a person has an atypical amount of anxiety and worry, which occurs the majority of days within a six-month period. A person with generalized anxiety will find himself or herself unable to manage their worry, which becomes intrusive in daily life. Next, the anxiety and worry must be connected to three of more or the six following symptoms: restlessness or feeling consistently on edge; easily becoming tired; challenges concentrating or losing their train of thought; touchiness; muscle tension; and difficulty sleeping. However, in children the presence of one item is enough to receive a diagnosis of generalized anxiety. Next, the worry or anxiety, or the physical symptoms that result from these feelings must be debilitating in areas important to normal daily functioning, such as school performance. Finally, as with other disorders the symptoms cannot be connected to the effects of substance use or medical conditions (American Psychiatric Association, 2013).

Anxiety is most closely linked with the extent to which a child perceives personal threat throughout the potentially traumatizing event (Angel et al., 2001; Fazel et al., 2012) and to a sense of their security being undermined (Angel et al., 2001). The experience of living under threat for an extended period was linked to anxiety or anxious feelings. Anxiety or related symptoms were present in children who grew up in a family that was subject to oppression and persecution regardless of their exposure to violence (Angel et al., 2001; Bell et al., 2012). The rupture of a child's sense of security resulting from growing up in an environment where the child and their loved one were victims of

persecution and oppression was correlated with higher amounts of anxiety or anxiety-related symptoms (Angel et al., 2001).

Children who have more severe symptoms of anxiety are more likely to become “frozen” or aggressive because anxiety often results in extended activation of a child’s fight or flight response system. Frequently refugee children respond with a fight response and will become combative or violent over seemingly minor events (Joshi & O’Donnell, 2003). Some students may manifest their trauma with acts of violence. A refugee child who has violent outbursts may appear disruptive. However, such acts can reveal the turbulent emotions resulting from wartime experiences. Violent acts often indicate that the child is still experiencing the need to employ their flight or fight response system (Kugler & Price, 2009). Other common anxiety symptoms reported by children are stress, worry, and fear (Banks et al., 2013).

In Bosnian children, Brown (2004) found 29% met the diagnostic criteria for anxiety. A different study on Bosnian children found 95.5% had significant amounts of anxiety. High rates of anxiety has been found to have strong, negative effects on refugee children’s capability to participate in age-appropriate activities (Goldstein et al., 1997).

Behavioral and Conduct Disorders

Experiencing traumatic events has been shown to lead to behavioral problems such as Oppositional Defiant Disorder (ODD), and Attention Deficit/Hyperactivity Disorder (ADHD) in children (Costello et al., 2005). Conduct and behavioral disorders, which are common among refugee children, have been found to manifest themselves almost entirely in the school setting. Behavioral problems are also a common outcome of traumatic experiences in for children. Those transitioning to another culture are at an

increased risk for these disorders. This is due to the disruption of traditional practices and the values that bind communities and families (Aronowitz, 2009).

Disruptive, impulse-control and conduct disorders are conditions where an individual has challenges controlling emotions or behaviors. While other mental disorders may also have characteristics where the individual struggles with emotional or behavioral control, these disorders are distinct because they are characterized by actions that violate the rights of others and/or actions that put an individual in opposition with authoritative figures or societal norms. These conditions are most likely to appear in young people, and very rarely occur in adults (American Psychiatric Association, 2013).

ODD is one disorder likely to develop in refugee children. This disorder can be characterized by angry or cantankerous mood, defiant or confrontational behavior, or vindictiveness. Angry or cantankerous moods are manifested in frequent loss of temper, increased sensitivity, becoming easily irritated, and frequent anger or feelings of resentment. Confrontational or defiant behavior symptoms include increased argumentative nature with authority figures, active defiance or refusal to follow rules, deliberately annoying others, and blaming others for his or her mistakes. Finally, vindictiveness refers to the employment of spiteful behavior at least twice within the past six months. In order to be diagnosed with ODD a person must present at least four symptoms, combining all the above-mentioned categories, for a six-month period. The behaviors must interrupt a person's ability to function in day-to-day activities, and the symptoms must not occur during episodes of psychotic, substance abuse, depressive, or bipolar disorder. Individuals suffering from ODD frequently experience conflict with teachers, parents, supervisors, peers, and romantic partners, resulting in impairments to

an individual's social, emotional, occupational, and academic success (American Psychiatric Association, 2013).

Conduct Disorder (CD) is another disorder common among refugee children. Four categories exist to understand CD, under which there are fifteen behaviors. Of these fifteen behaviors at least three must be present for a person to be diagnosed with CD. The first category is acts of aggression towards people and animals. Behaviors demonstrating this include: bullying, threatening, or intimidating others; initiating physical fights; possessing a weapon that can inflict considerable physical harm to others; is physically cruel to people or animals; has stolen during a confrontation with another; and has forcibly committed sexual acts with another person. The next category pertains to the destruction of property where a person has intentionally set a fire with the aim of causing significant damage or deliberately damaged another's property in another manner. The third category relates to theft or dishonesty. Acts of theft or dishonesty include breaking into a home, a building, or a car; lying to get goods, favors, or get out of obligations; and stealing items of little importance without confronting the person. The final category refers to intentionally breaking rules, behavior of rule breaking includes: staying out past curfew without permission prior to the age of thirteen; running away overnight at least twice while living with a guardian or once for an extended period; and frequent absence from school before the age of thirteen (American Psychiatric Association, 2013).

ADHD is characterized by inattention, hyperactivity, and impulsivity. The DSM-V separates these symptoms into two sections, inattention, and hyperactivity and impulsivity. Inattention can be demonstrated through a lack of close attention to details, challenges maintaining focus, appearance of not listening, lack of following instructions

and failing to complete tasks, challenges managing tasks and activities, an unwillingness to engage in activities that require continued mental effort, is easily distracted, and generally forgetful. For a person to be diagnosed with ADHD they must demonstrate the presence of one or more of the symptoms mentioned above. Coupled with inattention, persons with ADHD also display symptoms of hyperactivity and impulsivity. These can be seen in a person who frequently fidgets with hands or feet or wriggles in their seat, leaves their seat at inappropriate times, runs or climbs in inappropriate situations, struggles to play or participate in leisure activities quietly, is often “on the go,” speaks excessively or blurts out answers, struggles to wait his or her turn, and frequently interrupts others or intrudes on their space. For both inattention, and hyperactivity and impulsivity, a person must demonstrate symptoms for a minimum of six months (American Psychiatric Association, 2013).

Research on children impacted by war confirms increased occurrence of ODD, CD, and ADHD in conjunction with common mental health outcomes of PTSD, depression, and anxiety. One study on Palestinian children found that 17.5% had CD (Elumour & Thabet, 2014). Joshi, & O’Donnell found that 30% of children of war had a lifetime diagnosis of ODD or CD (2003). In a study on Palestinian children living in the Gaza Strip, teachers reported 9.8% met the full criteria of ADHD (Elumour & Thabet, 2014). In another study on Middle Eastern children researchers found that 90% of children with ADHD also met the criteria for PTSD (Graham, Minhas, & Paxton, 2016).

Comorbidity

Comorbidity (the presence of more than one mental disorder) is common among refugee children. Joshi, and O’Donnell (2003) stated that high rates of comorbidity

existed between MDD, CD, ADHD, ODD, and PTSD. Those diagnosed with PTSD are 80% more likely to meet the criteria for one or more other mental disorders. Children who experience PTSD are at an increased risk for comorbidity the most common being anxiety and mood disorders, depressive disorders, and behavioral disturbances (Shaw, 2003). Comorbidity with anxiety disorders is most likely to occur with other anxiety disorders (American Psychiatric Association, 2013).

Comorbidity is common among those who have ODD. In general, ODD is most common in those who have ADHD and typically leads to the development of CD. Persons with this disorder are at a higher risk for developing anxiety and depressive disorders. Children with CD, like those with ODD, are likely to have ADHD or other neurodevelopmental challenges. It may also co-occur with specific learning disorders, anxiety disorders, depressive or bipolar disorders, and substance-related disorders. Additionally, children with CD are likely to struggle academically, especially in reading and verbal skills, which are often below grade level adding to the likelihood of the diagnosis of a specific learning disorder or communication disorder (American Psychiatric Association, 2013).

Culture Related Diagnostic

The beginning, severity, and expression of PTSD varies throughout cultures. For Cambodians and Latin Americans panic attacks are associated with PTSD, a symptom less common in the U.S. In other cultures MDD is more likely to manifest with somatic symptoms. Generalized Anxiety has significant cultural variations. Somatic symptoms dominate the manifestation of the disorder in some cultures; in others, cognitive symptoms are more prevalent. ODD, unlike other mental disorders, does not manifest

itself differently across cultures. CD on the other hand may be misdiagnosed in places where disruptive behavior is common, such as war zones (American Psychiatric Association, 2013).

Parents/Family

The response of refugee children to trauma is closely connected to the response of their primary caregivers (Angel et al., 2001). The formation of identity and development of children is greatly affected by a child's home environment. This environment suffers greatly as a result of war (Joshi & O'Donnell, 2003). In Angel et al.'s study, refugee children who had at least one primary caregiver needing treatment for psychological problems had higher rates of generalized anxiety (2001). Further, children with parents or caregivers who are traumatized are more likely to hide their negative mental health response from their caregivers or parents so as not to further the burden placed on the adults in their lives which can exacerbate their own symptoms (Angel et al., 2001). Children whose parents demonstrate guilt, depression, or stress more than a year after the potentially traumatizing events were at a greater risk of experiencing poor adjustment. Adults suffering from negative mental health outcomes often inadvertently project their symptoms onto their children (Joshi & O'Donnell, 2003).

The long-term effect of trauma in children is strongly correlated to the well-being of their parents or guardians. Adult victims of trauma that struggle to cope with their past experiences are likely to transmit their mental health struggles onto their children. Household relationships also play a significant role in refugee children's response to traumatic experiences. Weakening relationships amongst family members, specifically the relationship between children and their mothers play a significant role in the child's

response to trauma (Fazel et al., 2012; Joshi & O'Donnell, 2003). Living with caregivers that are disengaged or depressed can result in negative mental health outcomes for refugee children (Fazel et al. 2012; Kugler & Price, 2009). Parents struggling to cope are more likely to transfer their challenges onto their younger children who tend to draw their understanding of life events from their parents reactions. One study done in Croatia found that children's adjustment struggles were correlated to their mother's posttraumatic stress reactions commonly resulting in decreases in maternal efforts. Children who had positive, strong relationships with their parents were more able to cope with their experiences (Joshi & O'Donnell, 2003). Strained relationships between other members of the family, such as conflict resulting from role reversal between mothers and fathers are predicative of poor psychosocial outcomes for refugee children (Fazel et al., 2012; Joshi & O'Donnell, 2003). Familial support is predicative of the long-term mental health response to being a refugee in children (Shaw, 2003).

School

Generally, refugee children flee their homes because of stressful and violent conditions only to arrive in refugee camps in neighboring countries unsure if they will ever be resettled (Roxas, 2011). Children commonly live for years in refugee camps before being resettled, where they have had little to no access to formal education (Kugler & Price, 2009). School, for refugee children, has typically lost its feeling as a place of security during times of conflict due to increasing attacks on schools and their use as places of recruitment or headquarters for armed groups in modern warfare (Kirk & Winthrop, 2008). This changes the way school is viewed by refugee children and what was once a place of safety becomes a place marked by traumatic experiences, shifting a

child's perception of school to a place of violence, effectively leading to a phobia of school. Phobia of school may be compounded upon arrival to host-countries resulting from concerns about social rejection because of cultural, racial, or economic differences between themselves and their native counterparts (Brown, 2004). Refugee children may manifest these feelings in a refusal to attend school, or through an increase in acts of aggression, defiance, and hyperactivity (Joshi & O'Donnell, 2003).

One study found that primary school aged children that had experiences of community violence were more likely to have poor academic performance and self-regulation, depressive tendencies, and disruptive behavior (Hart, 2009). Refugee children are likely to fall between the cracks in school because they often appear to be uninterested and unwilling to learn, further distancing them from their peers in terms of academic success (Kugler & Price, 2009). There are several explanations for the link between decreases in academic performance and experiences with trauma including: struggles with concentration due to intrusive material; the changing of a child's information-processing systems, especially when attention is focused on combating perceived threats; the slowing of cognitive functions resulting from depressive symptoms; decreases in motivation; challenges differentiating pertinent from irrelevant information; and, behavioral problems resulting from mood states that overcome a child's ability for self-regulation (Hart, 2009). Experiences with traumatic events can have a negative effect on school functioning. Often, children who experience trauma have challenges concentrating in class and remembering important material. (Lener, 2012) As students begin to settle in their new countries they start to show difficulties in adjusting to their new educational settings (Joshi & O'Donnell, 2003).

Experiences of repeated violence have been shown to lead to decreased academic attainment (Kugler & Price, 2009). Trauma, as seen above, has a significant effect on a child's ability to concentrate (Hart, 2009; Joshi & O'Donnell, 2003) in school, especially in subjects where high levels of concentration are necessary due detail-oriented nature (Hart, 2009). For example, Hart (2009) found that refugee students struggled most in math and grammar due to their tedious nature. Difficulties in school are often exacerbated by post-migration stress factors, in particular language barriers compounded with a disregard for learning, and familial expectations (Essomba, 2014). Refugee children have reported feeling lost, alone, and unsupported by their teachers, classmates, and neighbors. They are often unsure of the expectations and rules in the new school environments that tend to be drastically different from those in their country of origin (Roxas, 2011). Further, some refugee children will experience challenges accepting the authority of teachers and other school professionals. It is not uncommon for refugee children to become heads of households upon arrival to the host-country. When they serve as the authority figure in their home they are likely to feel more like adults than children and thus expect to be treated in a manner consistent with what they perceive as their new role (Brown, 2004).

In training, educators are taught to identify and solve problems associated with academia, such as Attention Deficit Disorder (ADD). As a result, they are unlikely to be trained to understand nonacademic mental health challenges faced by their refugee students. Depression and anxiety in refugee students, in particular, go unnoticed by school professionals. Thus, many refugee children are diagnosed with learning disorders when their perceived inappropriate classroom behavior may be a symptom of poor mental

health. Depression is another common outcome of traumatic experiences and is connected to academic outcomes, the greater the severity of a child's depression the lower their academic achievement (Hart, 2009). One study reported that 64% of refugee children with learning disorders suffered from depression (Rousseau, 1996).

Thriving Instead of Surviving: Protective Factors

Support for refugee children goes further than addressing the traumatic experiences of wartime environments, but also the potentially traumatizing stressors that come along with acculturation into a new society (Fazel & Tyrer, 2014). A return to normalcy is closer in line with the main concerns of individual survivors. For them, the resumption of normal daily routines, social networks, and economic and cultural institutions tends to be a priority over mental health (Cole & Farwell, 2001).

There are multiple ways in which negative outcomes of traumatic experiences can be managed that serve as protective factors for refugee children. Refugee children who have strong cognitive capacity, healthy relationships, motivation and ability to learn and participate in their environments, the skills necessary to regulate behavior and emotions, and systems that are supportive, such as faith-based, cultural, and educational communities are better able to cope and understand their experiences (American Academy of Pediatrics, 2015; Joshi & O'Donnell, 2003). Mandell (2014) found that a child who felt they had someone in their lives that understood the experiences they endured were less likely to have negative mental health outcomes and were two times more likely to claim they had fully recovered from their experiences.

Social Support

As a result of conflict children often become separated from their family. They are frequently separated by national borders, and isolated from familiar networks that serve as a strong coping mechanism to dealing with the ongoing trauma and uncertainty in their lives (Zhou, 1997). Like caregivers, communities play a central role in the outcomes traumatic experiences have on refugee children. Fazel et al. (2012) reported that children living with others from their country of origin were significantly less likely to be depressed than their counterparts living with local families. Children who receive nurturing and consistent care from members of communities where they are active participants are better able to manage the negative mental health symptoms associated with trauma (Agaibi & Wilson, 2005).

As a result of their experiences in their country of origin, where they, because of their ethnic, cultural, or political affiliation, were alienated from their community, or by the ambivalent circumstance of their arrival in the U.S., feel a lack community. This lack of communal belonging exists within their own communities, their resettlement communities and local school communities (Fazel et al., 2012). The destruction of communities that has become increasingly common in modern warfare and symbolically represents, for children, the destruction of life's stability. Coping abilities of their loved ones following the traumatizing events experienced during war are strongly correlated with a child's coping abilities. Wartime events can cause a breakdown in coping mechanisms for all those involved, a family that loses their ability to positively cope with events, increases a child's likelihood of negative outcomes (Cole & Farwell, 2001). Children from tightly knit, stable families and social networks are found to be more

equipped to deal with the potentially negative psychological outcomes of traumatic experiences (Zhou, 1997). Being an active participant in a community provides children with consistency. Once entrenched in a community, children find solace in the continuity of routine and the familiar settings and norms of their community ethos (Cole & Farwell, 2001).

To fight against the potentially traumatizing effects of wartime experiences, support must be provided in a way that offers children the opportunities to regain a sense of dignity, self-sufficiency, and necessary life skills (Cole & Farwell, 2001); school is a place that can serve as a means to an end for this. The community of a school serves as a primary community where acculturation for refugee children occurs. It serves as a unique location that provides more than an education. School assists in more than acculturation; it provides a safe space where refugee children develop social and emotional skills (Chiumento et al., 2011).

School

School can affect a child's well-being in four ways: 1. it is a tool for socialization; 2. it provides a nurturing environment; 3. it fosters constructive coping and the development of hope; and 4. it signifies a return to normalcy (Kirk & Winthrop, 2008). There are multiple reasons school is important during and following traumatic events associated with war. School helps meet the psychosocial needs of the children affected, it can offer protection from further harm, it promotes personal growth, and prepares children to be responsible citizens (Chiumento et al., 2011; Sinclair, 2002). Attending school helps rebuild children's lives because of the social interaction, the acquisition of knowledge, and the skills it provides them that will be useful for them later in life. The

alternative to this is a range of mental health conditions or symptoms, including depression and idleness, and anti-social behavior (Leblanc & Waters, 2005).

Additionally, schools provide an environment where mental health challenges can be identified earlier allowing for interventions that boost social, cognitive, and emotional development (Fazel & Tyrer, 2014).

In Western countries, even for native-born children, school is essential to social integration and economic success (Donkers et al., 2008). Schools create a common understanding of personhood based on what society deems to be appropriate expressions of economic activity, patriotism, and nationalism. Their role in society is to form collective communities that define the “we” which is necessary for a sense of belonging. Not only does the school define the “we” but also it unintentionally defines the “them.” This can be problematic for refugee children, who, in order to be successful in their host-country need to be included in the “we” but are often understood in terms of “them” (Leblanc & Waters, 2005). At school refugee children can get instant feedback on any societal questions they may have, and it provides them with a space where they can form friendships and have social interactions with natives. At school refugee children have the opportunity to experience reciprocal affection, emotional security, and positive attachments (Barenbaum et al., 2004).

Refugee children, upon resettlement, are placed in local schools. Regular attendance in school has many positive outcomes for children and can serve as the first line in defense from the psychosocial problems that commonly result from the traumatizing experiences endured throughout their migration. Being in school provides refugee children with routines, clear expectations, and unchanging rules, which have been

lacking throughout their flight (Barenbaum et al., 2004; Leblanc & Waters, 2005). Early educational responses are thus a key protective factor in the future success of refugee children because it is a way to support social and emotional healing (Fazel et al., 2012; McBrien, 2005). Because schools are often a place of first contact for refugee children they can be the first place that children feel secure, find consistency, and develop methods for emotional control (Hart, 2009).

In the education field it has been argued that in order to have a successful classroom environment communities must be built within classrooms and school-wide (Roxas, 2011). Schools are a vital community in the lives of children across the globe (Leblanc & Waters, 2005). In youth, school plays a central function in defining and affecting a person's sense of community (Ellis & Kia-Keating, 2007). A strong support system in the classroom can be a refugee child's sole sense of safety and structure (Roxas, 2011) and decrease the likelihood of negative psychosocial effects that can be a result of trauma (Leblanc & Waters, 2005). Schools are one of the first communities refugee children become active participants in, because strong communal ties are proven to reduce negative psychosocial outcomes, educational communities find themselves in a unique situation in which they can greatly enhance a refugee child's capabilities for success (Cole & Farwell, 2001). For some refugee children school serves as their "second family," especially for those who have become separated from their immediate family or primary caregivers. The sense of familial belonging refugee children derive from school creates numerous positive behavioral, academic, and psychological outcomes. A familial environment at school has been shown to improve a refugee child's self-concept, social

skills, motivation and academic achievement, and to combat depression, social and emotional distress, and social rejection (Ellis & Kia-Keating, 2007).

In addition to creating a stable community for children, school is the foundation of children's social world. It gives them an environment that is predictable and structured following a chaotic time where these fundamental comforts were lacking (Cole & Farwell, 2001). Further, the provision of structured activities of a school setting have been found to facilitate the healing process for refugee children and decrease the likelihood of development of negative trauma-related symptoms (Sinclair, 2002). Often, school is thought to be one of the best locations for interventions with child refugees because it is considered a safe, non-stigmatizing community that offers support to not only students, but also their families – who play an integral role in overall outcomes (Aronowitz, 2009; Fazel & Tyrer, 2014; Guzder & Rousseau, 2008).

Additionally, school serves as a mechanism to meet the psychosocial needs of children who have experienced war. Programs can be offered in schools that allow children the space to express their emotions, provide them individual, personalized support, and offer them ways to make sense of the traumatic experiences they have endured (Guzder & Rousseau, 2008). Positive school environments can be a place to tackle the negative outcomes that result from children's experiences. Refugee children who felt safe at school were more likely to experience decreases in depressive symptoms, PTSD and PTSD like symptoms despite adversities previously experienced (Ellis & Kia-Keating, 2007; Fazel et al., 2012).

However, there is one primary caveat with the importance of schools for positive growth: schools can be stressful and scary places for children; schools can be the opposite

of a place of sanctuary. This can result from trauma experienced at school in their native country and school in their host-country (Hart, 2009). While many scholars and practitioners suggest that school is an important tool in reconstruction of normal life following war, Kirk and Winthrop (2008) suggest that school can jeopardize a child's ability to return to normal function. This is because during times of war schools can be utilized as places of political contestation. In modern warfare schools are not only more likely to be attacked, but also are increasingly becoming used by armed groups to promote – through formal or hidden curriculum – their beliefs onto the students, with the aim of indoctrination (Kirk & Winthrop, 2008).

Schooling can also be negative in host-countries, further traumatizing refugee children. This is because though school provides a return to normalcy, it can be a place characterized by discrimination often encountered in host-country schools (Kirk & Winthrop, 2008). The transition to school can be fraught with challenges resulting from limited language proficiency, unresolved mental health challenges resulting from trauma, and a lack of academic and counseling support programs (Fazel et al., 2012). Though it is crucial to address second language attainment, teachers must be prepared to deal with all factors of what is currently happening in their refugee students' lives. They must acknowledge the issues of racialization and exclusion refugee children may be experiencing (Matthews, 2008). Because of disruptions in normal schooling it can be difficult to assess the grade level a refugee child should be placed in. Often they are placed in classes with students that are not the same age further excluding them. Being placed in classes with younger students can be embarrassing for refugee children and may result in a withdrawal from or avoidance of school (Barenbaum et al., 2004).

Teachers

Educators are important because they assist in the process of acculturation and socialization of refugee students (McBrien, 2005). Teachers are often the first line of defense for refugee students and they must be able to create classroom communities that are culturally responsive and allow them to focus on the individual needs of refugee students (Roxas, 2011). But teachers may have unintentional bias towards the refugee children in their classroom based on misconceptions around their culture and past experiences (Hart, 2009). Cultural norms affect all forms of behavior in a child's classroom environment, this can range from the way questions are answered in class to the way families interact with school professionals (Kugler & Price, 2009). Negative bias often relates to a child's academic abilities, and such bias can contribute significantly to poor academic achievement in refugee students (Hart, 2009).

Teachers are in the difficult position of understanding and supporting the unique needs of their refugee students while, at the same time, maintaining normal, everyday routines and activities their native students have become accustomed to (Barenbaum et al., 2004). When working with refugee children, not unlike when working with their native peers, teachers must prioritize their individual needs when making decisions regarding their education. Teachers that can recognize and be aware of the reasons why a refugee child may have challenges understanding certain ideas or participating in certain activities can adapt to make changes in their classroom cultures to address these issues in a positive manner (Roxas, 2011).

There is tremendous pressure on teachers to help refugee children cope with traumas of their past, adjust academically, and form the positive relationships with

parents that are necessary for students' success (Barenbaum et al., 2004; Hoot, Szente, & Taylor, 2006). But teachers may not be knowledgeable about the experiences their refugee children have left behind; they may misinterpret behaviors that cover up the intense grief their refugee students are dealing with and as a result, mental health challenges that could hinder a refugee child's ability to succeed in school may go undetected (Eisenbruch, 1988).

A common misconception among educators working with refugee students is that the trauma experienced prior to resettlement has been left in the past in refugee camps and country of origin (Hart, 2009). Trauma is likely to persist in host-countries because of language barriers, alienation and discrimination, and unresolved issues around their past traumatic experiences, which teachers may be hesitant to address (Roxas, 2011). Teachers who are conscious of and able to tackle not only the cultural and ethnic, but the social, emotional, and cognitive needs of their refugee students are more likely to improve academic success and facilitate positive psychosocial development. School professionals who place emphasis on building positive relationships with their students based on trust as opposed to fear or punishment for their perceived behavioral defiance or learning difficulties were more likely to see positive academic outcomes in their refugee students (Brown, 2004). Additionally, these relationships make students feel equally valued to their native peers, which results in a greater motivation to perform well in school (Roxas, 2011).

Creating a classroom that prevents additional psychological stress in refugee children is often a challenge for teachers. Teachers may see refugees as a single group, and ignore their identity as individuals fleeing a diverse array to conflicts. This is rarely

the case, and as conflict exists on a spectrum different groups flee at different times for different reasons. It is important that educators are aware of the different reasons for flight so they can address the different outcomes in each child (Guzder & Rousseau, 2008; Stein, 1981). Not only do educators make the mistake of considering refugees migration experiences as the same, they also have a tendency to view refugees as a heterogeneous cultural group. The reality is the exact opposite, as refugees come from diverse backgrounds. While refugee children may share cultural similarities, such as religion, they are likely to have different cultural interpretations as to how they carry out their religious beliefs (Guzder & Rousseau, 2008); for example, a practitioner of Islam from Somalia may practice their faith differently than one from Afghanistan. While teachers combat their own biases about the refugee students in their classrooms they are also responsible for dispelling rumors and misconceptions held by their native students (Barenbaum et al., 2004).

Having daily interactions with refugee children places school professionals in a position to identify struggles refugee children are experiencing because they observe the children in multiple settings (recess, lunch, class, etc.) (Fazel & Tyrer, 2014). It is important for teachers to understand the way mental health is viewed in a student's country of origin, in comparison to the way they are viewed in the high-income countries of the West (Hart, 2009). Teachers need to be able to identify these different cultural manifestations (Guzder & Rousseau, 2008). Well trained teachers who can address the mental health challenges that hinder a refugee child's academic achievement and meet their psychosocial needs will have stronger students. A teacher's ability to do this will increase the self-esteem of their refugee students thus allowing them to thrive in school

settings (Sinclair, 2002). Too often, teachers misinterpret mental health struggles in refugee children as behavioral disorders. It is important that teachers are aware of this because labeling a child with a behavioral disorder can accelerate their marginalization in school (Guzder & Rousseau, 2008).

Due to lack of preparation, teachers may be hesitant to prompt their refugee students to discuss their past, potentially traumatizing experiences (Hart, 2009). It is important that teachers be aware of the traumas of their past, and the possible traumas existing in their students' day-to-day life. In their study, Hoot et al. (2006) quoted one educator as saying, "When I get a refugee child and I have no background information on him or her I often feel overwhelmed. I want to help the child, but I don't know what he/she has been through. I believe that I should be provided with as much information on the child as possible (pg. 16)." It can be challenging to get information on an individual child due to legal issues protecting their privacy. By participating in a professional development workshops teachers can be introduced to the cultures, traditions, and language of their refugee students, so they may have a general idea of what their experiences have been. Further, when learning about these components as well as their migratory experience teachers can gain insight into what issues their students may be having (Hoot et al., 2006).

Studies have demonstrated that trauma experienced by refugee children can have detrimental effects on well-being and academic achievement (Barenbaum et al., 2011; Ellis & Kia-Keating, 2007; Hoot et al., 2006). Teachers across the globe have expressed anxiety about working with refugee students because they feel unprepared to handle the baggage they bring with them to the classroom (Esienbruch, 1988; Hoot et al., 2006).

However, participation in professional development can provide a setting in which teachers can address their concerns about working with refugee children and expand their knowledge on the complexity of their students past and present (Severiens, 2014).

Through the provision of professional development training, schools can prevent refugee children from developing mental health issues and promote positive psychosocial development, ultimately, enhancing their academic success and educational attainment. Educated, mentally stable children are less likely to drop out of school, engage in criminal activity, live in poverty, and participate in dangerous activities (drug use, alcohol abuse, premature sexual activity) (Roxas, 2011; Rousseau, 1996; Sidhu & Taylor, 2012).

Professional Development

Schools in general also serve a central role in the positive growth of refugee students. They can enact policies that focus on school-wide creation of curriculum and learning environment that incorporates diversity. This means providing teachers the materials, and assessment practices that are inclusive and stimulating for all students. Further, schools should provide teachers with the theory and skills to create positive classrooms (Severiens, 2014). Thus, school-wide approach must be created so that all staff can understand the post and pre-migration factors affecting students' ability to succeed.

Often refugee students are separated from their native peers before they are integrated into the mainstream classrooms. This can result in feelings of alienation and frustration for refugee children. While refugee students have different academic needs it is important that teachers find ways to integrate them into the school community from the

beginning while at the same time ensuring that they are in classes that allow them to acquire the language of instruction and catch up to their native peers (Matthews, 2008). Integration of refugee students therefore must be an effort made by all staff, not just teachers.

While schools have the capacity to address the multitude of issues faced by refugee children, they typically only have resources to address language acquisition and diagnosis of learning disorders (Hart, 2009). Schools can be changed in order to provide the social services necessary to facilitate positive growth in refugee children. This can be done through a variety of measures. They can adopt a standard curriculum that provides information on essential topics like health and safety. Curriculum can also provide refugee students the chance to process their experiences and express their feelings (Kirk & Winthrop, 2008). Currently, the majority of training and teacher preparation with refugee children emphasizes bridging the linguistic gaps so that children may more easily catch up academically to their native peers (Hart, 2009). However, focusing on linguistic challenges only skims the surface when it comes to meeting the needs of refugee children. Teachers should additionally be trained to understand migration, acculturation, social psychology phenomena, and ethnic identity issues applicable to their specific classroom (Severiens, 2014).

The absence of professional development for school staff, particularly teachers, to meet the diverse needs of refugee students can make it challenging for teachers to create warm, welcoming environments where students feel safe and thrive (Roxas, 2011). Any form of teacher training that does not incorporate education about the history and perspective of the refugee students will not be successful (Brown, 2004). If teachers are

not aware of these factors they are unlikely to understand the difficulties and experiences that have taken place in their refugee students lives. With successful professional development programs, teachers can be trained in ways that allow them to create positive classroom environments for acculturation, and can minimize environmental barriers that exist (McBrien, 2005). All professional development programs teachers are engaged in should inform them on topics prevalent to the refugee experience such as, migration, acculturation, ethnic identity, and the social psychology phenomena common in refugee children. Teachers have been found to have lower academic expectations of refugee children in their classrooms, but training them on these topics is likely to change their perceptions of these students (Severiens, 2014).

Professionals can create what Kirk and Winthrop call “child-friendly school” this means guaranteeing that methods of teaching and managing classrooms are focused on the child’s perspective instead of their own (2008). In doing this, schools can assist refugee students to cope with the challenges in their past and present and develop their hope for the future (Kirk & Winthrop, 2008).

Any professional development program focusing on refugee children must educate teachers to be culturally responsive (Brown, 2004) and focus on diversity (Severiens, 2014). It is necessary for the success of the student that teachers employ instruction strategies that are specific to their heterogeneous student population, ensuring that the curriculum is ethnically and culturally relevant (Brown, 2004). Programs that build on issues of diversity provide a starting point that allows teachers to learn how to integrate diversity into all classroom activities, and allows them to be experts on issues.

Integrating diversity into the classroom has been shown to help refugee children meet their full potential (Severiens, 2014).

Professional development training must incorporate cultural training for teachers, educating them on the cultural diversity of the refugee students likely to be in their classroom. Without an understanding of a student's culture they may misconstrue a student's attempts to succeed that were acceptable in their country of origin and not in their new host-country (McBrien, 2005). Training programs that begin with diversity and expand from there can address challenges of refugee children from multiple perspectives. Teachers that become experts on diversity are more able to effectively support their refugee students in their classroom, which ultimately assists refugee children to achieve their full potential. By understanding the diversity of cultures in their classrooms teachers can help students combine the culture from their country of origin with the culture of their host-country. It has been proven that students who are able to combine the two cultures have higher academic attainment than those who struggle to find balance between the two (Severiens, 2014).

Students who are able to combine their native culture with the culture of their host-country have higher academic achievement in comparison to their peers that cannot. If teachers understand the different issues relevant to their refugee students they will be better equipped to facilitate this and support their students. An understanding of such issues will help teachers assess their students' beginning academic levels and chart their progress. Providing teacher training on the issues most relevant to refugee children in their classrooms will also provide teachers with the knowledge to create a positive

classroom environment around diversity and use the diversity as an asset and educational tool (Severiens, 2014).

Teachers need to be trained in ways to interact with their students that allows both parties to communicate in a way that reflects their values and beliefs on education. This is because differences in communication styles affect the quality of relationships between students and their teachers (Brown, 2004). A key part in enhancing a teacher's ability to communicate with their refugee students is their competency in the language of instruction. Often only English Second Language (ESL) teachers are trained to facilitate language acquisition of the host-country language. Non-ESL teachers may not be able to assist the students in their language acquisition. Teachers who are competent in teaching English (or host-country language) can better help students struggling to understand the materials by using tools ESL teachers utilize (Severiens, 2014). It is essential that mainstream teachers also learn to address the needs of second language learners. In order to facilitate refugee children's academic achievement and more rapidly integrate them into classes with their peers, instruction in English language and subjects must be coordinated between ESL and mainstream teachers. Not only does this make refugee children feel more included in the school community, it also helps prevent academic delays that result from limited understanding of the language of instruction (Essomba & Siarova, 2014).

Lener (2012) suggests multiple strategies teachers of refugee students can employ so the two parties may communicate more effectively. Teachers can make use of gestures that may help convey meaning or act out what they are trying to communicate. For example, a teacher can mime the action of writing for a student who is unclear on an

assignment. They can learn some common words of the refugee student's host-language that are often used in classroom settings, such as the word for homework, and words for greetings and praise. Other strategies include, learning about the child's cultural and historical background, and using a lot of group work or activity based assignments (Hoot et al., 2006; Lener, 2012).

Teachers must be trained so that they are able to assist children in coping with the stress and trauma they may be struggling with in an effective manner that does not hamper their academic achievement and psychosocial development (Cole & Farwell, 2001). Their training must educate them on ways to foster positive mental health through the application of preventative and worthwhile psychological interventions. One way this can be achieved is by providing teachers with the skills necessary to build classroom environments that are supportive and caring (Fazel & Tyrer, 2014). In order to effectively create such positive classroom environments teachers must be able to recognize indicators of emotional problems, and assist them in ways to combat the negative emotions they may be experiencing (Cole & Farwell, 2001).

Parents and community are central elements of a refugee child's likelihood to succeed in school. In-service teachers should be trained on ways to engage the parents of their students so that student's academic achievement is supported outside of school. Parents who feel disconnected from their children's school are less likely to support schooling outside of the home (Severiens, 2014). Students' parents and communities play an important role to their overall success and thus it is important that teachers and schools make an effort to integrate them into the school community (Cole & Farwell, 2001). Parents that do not feel welcomed into the school community by staff are unlikely to trust

someone from school to address the mental health needs of their children (Kugler & Price, 2009). Severiens (2014) suggests that parents' play a central role in their child's ability to succeed academically, and as has been demonstrated their ability to cope with the experiences they have endured. Connecting with the parents of refugee students can be one of the most challenging aspects for teachers and school staff, but it is essential that they do so. Parental involvement supports academic success and provides preventative measures that teachers can build upon to increase their students' capabilities (Severiens, 2014).

Chapter 3 – Methodology

Design

The purpose of this research is to uncover the needs of refugee students and the best practices among existing training programs that prepare in-service teachers to work with refugee students. Research conducted was qualitative in nature and utilized thematic analysis. Qualitative research was selected due to the exploratory nature of the research. A non-experimental design with unobtrusive methods was employed. All data collected in the form of social artifacts was obtained through secondary research and was then used to complete a thorough review of existing literature about the refugee experience, the training programs available to in-service teachers, and the best practices of the identified programs. Collected data was then analyzed thematically to identify the most important components of a refugee child's experiences and their outcomes.

Operationalization

For the first portion of the literature review, social artifacts were collected and systematically reviewed based on themes of refugee children's experiences, the potential outcomes of their experiences, and the role schools play in these experiences. The most relevant issues from refugee children's experiences that teachers must be aware of were identified.

The following section employed the use of the same techniques for the collection of social artifacts but will research different themes. This section will focus on teachers and their preparedness, or lack there of, to work with refugee students in their classroom and the avenues through which professional development training is provided, what is

included in the training, and what scholars and practitioners have found to be the most important components that should be incorporated into professional development.

Population/Sampling Method

Social artifacts were the sole population used in this research. They consist of peer-reviewed journals articles, and reports from governments, non-profit organizations, and non-governmental organizations. Themes researched focused on refugee children's experiences and the outcomes of those experiences, the role of schools and teachers in preventing the negative outcomes that can possibly result from these experiences, the role schools and teachers play in the outcomes following resettlement, and the practices that are considered to be essential when training in-service teachers to work with refugee students in their classrooms. Key terms in database searches included: "refugee children," "trauma," "acculturation," "in-service teachers," and "professional development."

Following an initial search for articles the most relevant were selected for use.

Data Collection Procedures

Using the key words listed above, social artifacts were collected through online databases such as, EBSCOhost, JSTOR, Google Scholar, and through government, nonprofit organization, non-governmental organization, international nonprofit organization and international non-governmental organization publications.

Data Processing and Analysis Procedures

Because this is a descriptive study, data processing and analysis was limited. Data analyzed was all secondary research on themes about the experiences of refugee children, and the outcomes of those experiences. The role of schools was also analyzed and the most important practices teachers should utilize to help refugee students were identified.

Training programs for in-service teachers in the PPS district were searched for, as well as other programs that exist within the U.S. and other high-income countries.

Ethical Considerations and Safeguards

Prior to the collection of data a proposal of the research was submitted to the Institutional Review Board at Concordia University – Portland for approval. All data collected was done through secondary avenues.

Chapter 4: Findings, and Analysis

Findings

The Oregon Department of Education (ODE) does not provide refugee specific statistics when mapping its student body demographics, but does provide information on the ethnicities of its students. As of 2015, 36.6% of all students in Oregon’s public school system were members of a minority ethnic group; in PPS this percentage is higher, with 43% of the student body members of minority ethnic groups. ODE classifies minority ethnic groups into five categories; Black, Hispanic, Asian/Pacific Islander, American Indian/Alaskan Native; and Multi-Ethnic. In general the percentage of the population of ethnic minorities is higher than those in the rest of the state, as can be seen in Table 2 below (Oregon Department of Education, 2016).

Table 2

Race/Ethnicity in Oregon Vs. the Portland Public School District

<u>Location</u>	<u>Black</u>	<u>Hispanic</u>	<u>Asian/Pacific Islander</u>	<u>American Indian/Alaskan Native</u>	<u>Multi- Ethnic</u>
State of Oregon	2.4%	22.5%	4.6%	1.4%	5.7%
PPS	9.7%	15.6%	8.1%	0.7%	8.9%

Oregon Department of Education, 2016

While this provides some idea of the backgrounds of the students in the school system it is still unclear as to the number of immigrants, let alone refugee students in the classrooms throughout PPS and the state of Oregon. It also leaves out some of the areas refugees are increasingly coming from, particularly the Middle East.

In 2009, legislation was passed in Oregon creating the Oregon Educator Professional Development Commission. The role of the commission is to provide statewide leadership education that focuses on school improvement through improved education of school professionals. To effectively carry out this mission, in 2011, the Commission launched a professional development website to provide educators with information on professional development opportunities, both state and federal, and share information with each other on resources that are helpful in improving teacher effectiveness. In addition to the website, the Oregon Department of Education provides its own professional development workshops (Oregon Department of Education, 2011). However, the website created does not currently work, and none of the professional development options available by the Oregon Department of Education provide teachers with training on refugee students.

PPS has implemented Trauma Informed Care (TIC) and English Language Development (ELD) initiatives. TIC focuses on preparing educators to work with traumatized children in a way that prevents re-traumatization (McInerney & McKlindon, 2014) it includes staff trainings and instruction design, including community-based partnerships (Concordia University, n.d.). District wide PPS also provides numerous services for ELL, which includes translation, and interpretation services (Portland Public Schools, 2015). While both these initiatives have benefits for refugee children, they do not focus on refugee children and can leave them marginalized making their traumas akin to that of native students or immigrant students. Further, the emphasis on English language acquisition does little to address many challenges faced by refugees (Severiens, 2014).

Analysis

Many public school systems provide access to resources, but again do not require training and districts typically do not offer the training advertised. Though PPS and other districts across Oregon are lacking in their provision of services and materials for in-service teacher professional development, districts across the U.S. and other high-income countries are taking steps, some smaller than others to address these challenges. The state of Washington has some resources for its teachers; in New York there is professional development workshops provided by a state entity, and in the EU, Greece and The Netherlands have created successful professional development for school professionals.

The state of Washington received the Refugee School Impact Grant and has used it to create its *School's Out Washington* (SOWA) program. This program provides many services that target families, students, community based organizations, and Seattle Public Schools. For Seattle Public Schools it works to offer staff opportunities to engage with refugees and understand their experience. One of the opportunities is to provide teachers with refugee cultural competency training. The professional development and teacher-training portion offered only provides school professionals with resources to expand their knowledge. These resources include the Bridging Refugee Youth & Children's Services Toolkit, a handbook created by an Australian program, a Canadian resource cite, and a file created by the National Child Traumatic Stress Network. None of which provide in person training for teachers (Seattle Public Schools, 2016).

The state of New York has professional development training for its teachers. While the training is not provided by the public school system it is provided by government entities, The Bureau of Refugee and Immigrant Assistance (BRIA) and The

Office of Temporary and Disability Assistance (OTDA). Unlike many counterparts, this training program is not only provided by the state but also is conducted in person, not via suggested online resources. The program is called *Welcome to Our Schools*. It offers numerous resources for parents, and professionals in addition to its in person professional development component (Bureau of Refugee and Immigrant Assistance, n.d.).

Greece has worked to counteract these problems by employing policies on school development and teacher training. The goal of the policy measures is to provide school professionals with the skills necessary to meet the needs of heterogeneous classrooms. In the workshops, teachers learn new teaching methods that are diathematic and provide examples of ways teachers can utilize group work. The school systems have also utilized regional and local workshops that focus on increasing teachers' knowledge on the different social, cultural, and linguistic backgrounds existing in their classrooms (Severiens, 2014).

Another example comes from the Netherlands where they have created *The Pharos Program*. The program is centered on the belief that school has the capacity to facilitate healing because children are provided with personal attention and the structure that has been missing from their lives throughout their migratory process. It encourages the use of schools as a tool for socialization with peers and adults to facilitate positive growth in their host-country (Guzde & Rousseau, 2008). ODE and districts with refugee students such as PPS may wish to examine these service models and others like them to identify ways to support the needs of their students.

Chapter 5: Significance and Limitations

Significance

This research sought to describe the needs of refugee students enrolled in schools in Oregon and the PPS district. By describing these needs and comparing them to the resources and professional development available, educators and districts may more readily identify next steps for their provision of training programs for in-service teachers and other school professionals. Identifying these needs allows schools to see the need of professional development to support their increasing population of refugee students. This acknowledgement allows them to adopt and implement professional development for their in-service teachers and other school staff members. Through the provision of professional development training schools can prevent refugee children from developing mental health issues and promote positive psychosocial development, ultimately, enhancing their academic success and educational attainment. Educated, mentally stable children are less likely to drop out of school, engage in criminal activity, live in poverty, and participate in dangerous activities (drug use, alcohol abuse, premature sexual activity) (Roxas, 2011; Rousseau, 1996; Sidhu & Taylor, 2012).

Fostering the positive psychosocial growth of refugee children does not solely benefit the individual child. Children are not the sole sufferers in the lower educational outcomes and mental health challenges. The entire society suffers from the loss of human capital, productivity, and creativity as workers and community members (Takanishi, 2004). Increasing a child's capacity allows them to contribute to society economically, and in a socially responsible manner where they are engaged in creating positive communities (Kugler & Price, 2009).

Limitations

The limitations of this study include the limitations to access on student demographics in the PPS district based on the Family Educational Rights and Privacy Act (FERPA), 1974. The study is further limited by its focus on refugee student needs. The study did not attempt to measure or describe the level of skills or professional development relating to refugee students needs that exist in Oregon or PPS (United States, 1974).

Chapter 6: Recommendations and Conclusions

Recommendations

Refugee children continue to migrate from countries still engaged in combat. As migration continues, future studies are needed to refine and update descriptions of the needs of refugee students. This cannot be done without understanding the amount of refugee children affected by poor mental health in a given school system. FERPA (United States, 1974), and the Health Insurance Portability and Accountability Act (HIPAA) (United States, 1994) it can be difficult to uncover specific numbers around mental health of U.S. refugee children. However, in order to move forward and address the needs of this vulnerable population, methods for collecting comprehensive data about these children is key to facilitating the creation of greater professional development for teachers.

Schools in Oregon, and specifically PPS, may benefit from further studies to understand the challenges faced in schools by their specific refugee populations. PPS may also benefit from an inventory of its existing resources, including the level of training teachers currently hold around the supports recommended for refugee students. Without understanding its resources moving forward will again be challenging.

An examination of the programs and methods implemented by other countries, states, and districts providing targeted support to their refugee students may prove beneficial for schools in PPS and the state of Oregon. After considering these needs, professional development for teachers should be developed to best support both teachers and refugee students as they settle into their new schools. Once the above mentioned data

sets on refugee children have been collected PPS can address the needs of their refugee students through their teachers.

Conclusion

The refugee experience is a complex one that involves multiple phases where trauma is likely to be experienced. Refugees must deal with the conflict in their country, fleeing that conflict, residing in refugee camps, and arrival to their host country. These events cause a disruption in everyday life activities such as, attending school, participating in social networks, and use of play facilities, nutrition, and health services (Angel, Hjern, & Ingleby, 2001). Experiencing such traumatic events can lead to psychiatric or mental disorders in child survivors, many of who experience anxiety, depression, and post-traumatic stress (Albertyn et al., 2003).

While all refugee children are at risk for developing mental health problems due to psychological strain from exposure to trauma, children are known to be incredibly resilient. One of the best vehicles for fostering a child's resiliency and easing their transition into a new society is education (Essomba, 2014; Sidhu & Taylor, 2012). For those children who are traumatized, research has indicated that early educational responses support emotional and social healing as they help restore a sense of normalcy and hope (Banks et al., 2013; Sinclair, 2002).

Children spend the majority of their weekdays in school setting, which places schools in a position to foster positive psychosocial development. This makes it essential that teachers, because they have the most face time with the children, are properly prepared to work with refugee children. Unfortunately, there is a lack of training for in-service teachers. Teachers can ease the integration process for children and foster positive

psychosocial development or they can make the experience equally challenging for them, putting extra strain on them and exacerbating existing traumas. Unfortunately, teachers are not typically trained to understand the experiences of refugee children, which can result in misunderstandings that place the child under further stress (Lee 2002; Olsen 2000). Overall, the need for adequate training to prepare teachers to work with refugee students has been acknowledged. However, little progress has been made in the creation of such specific programs. Most programs cater to preparing teachers to work with diverse populations or with students from immigrant backgrounds. Thus, a more concerted effort must be made so that refugee children may have a smooth transition into their future where they are not confined by the trauma experienced in their past.

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Appendix A

- 1 - Generated on IRBNet

DATE: July 21, 2016

TO: Maryclaire McIlwain

FROM: Concordia University - Portland IRB (CU IRB)

PROJECT TITLE: [911460-1] Preparing In-service Teachers to Work with Refugee Children

REFERENCE #: MAIDS-20160622-McIlwain-faculty

SUBMISSION TYPE: New Project

ACTION: APPROVED

APPROVAL DATE: July 21, 2016

EXPIRATION DATE: July 21, 2017

REVIEW TYPE: Expedited Review

Thank you for your submission of New Project materials for this project. The Concordia University Portland IRB (CU IRB) has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission. Attached is a stamped copy of the approved consent form. You must use this stamped consent form.

This submission has received Expedited Review based on the applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. The form needed to request a revision is called a Modification Request Form, which is available at www.cu-portland.edu/IRB/Forms.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please email the CU IRB Director directly, at obran@cu-portland.edu, if you have an unanticipated problem or other such urgent question or report.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of July 21, 2017.

You must submit a close-out report at the expiration of your project or upon completion of your project. The Close-out Report Form is available at www.cu-portland.edu/IRB/Forms.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Dr. OraLee Branch at 503-493-6390 or irb@cu-portland.edu.

Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Concordia

University - Portland IRB (CU IRB)'s records. July 21, 2016