

5-2017

Culturally Specific Interventions to Support Adolescent Immigrant and Refugee Mental Health

Lynn Whitfield

St. Catherine University, lynnholiindia26@gmail.com

Recommended Citation

Whitfield, Lynn, "Culturally Specific Interventions to Support Adolescent Immigrant and Refugee Mental Health" (2017). *Master of Social Work Clinical Research Papers*. 811.
http://sophia.stkate.edu/msw_papers/811

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact hltompkins@stkate.edu.

Running Head: INTERVENTIONS FOR ADOLESCENT IMMIGRANTS AND REFUGEES

Culturally Specific Interventions to Support Adolescent Immigrant and Refugee Mental Health

by

Lynn Whitfield, B.A.S.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
University of St. Thomas and St. Catherine University
St. Paul, Minnesota
in Partial fulfillment of the Requirement for the Degree of

Master of Social Work

Committee Members
Mary Nienow, MSW, Ph.D Candidate (Chair)
Amy Kamel, MA, MSW, LICSW
Dr. Pa Der Vang, Ph.D, MSW, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate faculty with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Table of Contents

Purpose Statement.....	6
Introduction.....	7
Literature Review.....	8
Conceptual Framework.....	26
Research Design.....	28
Findings.....	33
Discussion.....	48
References.....	63
Appendices.....	67
A. Consent Form.....	67
B. Interview Questions.....	69

Abstract

This exploratory qualitative study examines various culturally specific interventions practitioners use to support the mental health needs of adolescent immigrants and refugees. Studies have noted that resilience, family involvement, peer support, art-based interventions, school-based interventions, and accessible community resources are all protective factors that promote positive mental health outcomes for adolescents adjusting to a new host country. The researcher conducted eight semi-structured interviews with three licensed clinical social workers (LICSW), one licensed graduate social worker (LGSW), one psychotherapist with a doctorate in psychology, a school counselor, and two clinical counselors. All of the participants of the study serve the refugee and immigrant adolescent population directly. The author used an analytic induction method, transcribing and coding the interviews with the research Chair for reliability checks. Seven themes emerged in the literature to analyze for this study: 1) Protective Factors 2) Parent/Family Involvement in the Adolescent's Therapeutic Process 3) Expressive Arts Interventions 4) Multi-Disciplinary Teams 5) Group Work 6) Cultural Brokers 7) Culturally Responsive Clinician. There were four additional themes that emerged from the data collection: 1) Not enough providers 2) Parents misunderstanding of the mental health provider's role 3) Physical Discipline 4) Mindfulness Interventions. The study found culturally responsive clinicians are using interventions that acknowledge the protective factors and build off of these factors in their treatment of adolescent immigrants and refugees. Clinicians who are immigrants themselves, bilingual, or bicultural were found to be more culturally competent. However, the systemic barriers that immigrant and refugee families face, the cultural stigma, language barriers and parents' lack of education make it challenging for immigrant and non-immigrant clinicians to implement culturally relevant interventions such as involving parents in the treatment. The

study found the use of multi-disciplinary teams and group work interventions are rare, despite clinicians' awareness of their efficacy and desire to implement them in practice. Additional practice-based and evidence-based, empirical research pertaining to the efficacy and effectiveness of culturally appropriate, applied treatments specifically for the adolescent immigrants and refugees is greatly needed.

Key Words: Refugees, immigrants, adolescents, resilience, mental health, PTSD, culturally sensitive

Acknowledgements

I sincerely thank my Chair, Mary Nienow, for her support, care, patience and competence while guiding me along the researchers' path. Additionally, I would like to send gratitude to Mary for eagerly helping me to find my committee member, Dr. Pa Der Vang. I would also like to thank Dr. Pa Der Vang and Amy Kamel for being a part of my research committee and sharing valuable feedback and resources to make my research project possible. A thank you to them for taking time out of their busy schedules to share their professional expertise. It has been a pleasure to consult and learn from them. Finally, I would like to thank my classmates and family for their love and support during my research process.

Purpose Statement

My research topic is culturally specific interventions practitioners are using to support adolescent immigrant and refugee clients' mental health. I chose this topic because I am passionate about adolescent mental health, particularly within immigrant and refugee populations. Also, I am an AEIR (Area of Emphasis practicing with immigrants and refugees) scholar student. My goal as a social worker is to work with immigrants and refugee adolescents and families, possibly in a school or community-based setting. With the high rates of immigrant and refugees resettling in the United States, I want to be aware of their experiences and how to competently deliver services to them. My passion for learning about other cultures and how to appropriately serve individuals from diverse cultural backgrounds is another driving factor for choosing this topic. I have traveled and lived in multiple countries, and I can relate, at some level, to the hardships these populations experience.

In my research thus far, I have found non-verbal therapies such as art, music, and psychomotor therapies to be effective for this population (Yankey & Biswas, 2012). I want to investigate how aware therapists serving this population are about these particular interventions. Also, I have found interesting literature supporting cultural competency (George, 2012), spirituality (George, 2012), resilience, (Xu, Bekteshi & Tran, 2010) and strengths-based components (Betancourt et al., 2015) as a foundation for refugee mental health interventions. My research can help better inform social workers and other mental health providers delivering services to adolescents in schools and community settings.

Introduction

Worldwide, 65.3 million persons were forced from their homes because of political conflict, war, and persecution (United Nations High Commissioner for Refugees UNHCR, 2016). As a result, research indicates at least 30.6% of refugees and asylum seekers suffer from significant mental health disorders such as Posttraumatic Stress Disorder (PTSD), depression, and anxiety-related disorders (Kowitt et al., 2016). According to the UNHCR (2016) report, an astounding 10.7 million of these refugees are under the age of 18 years old. Research suggests a history of mental health problems in childhood is a strong predictor for developing mental health problems in adulthood (Ugurlu, Akca & Acarturk, 2016). It is vital immigrant, refugee, and asylee youth mental health needs be addressed early and with effective and culturally-specific interventions (Walker, 2005).

Refugees represent one of the largest at-risk groups with mental health problems, specifically PTSD, across the world. The United States is the host country of more refugees and immigrants than any other country in the world (Ellis et al, 2010). Almost 90% of refugee youth are in need of some type of mental health care and do not access it (Fazel, Garcia & Stein, 2016). It is estimated that approximately 40% of refugee youth have a mental illness diagnosis, with the most prevalent being PTSD, depression, and anxiety-related disorders (Kowitt et al., 2016). A current research study noted 66% of adolescent refugees seeking asylum without a parent or legal guardian scored high on PTSD assessments yet only 17% received services from mental health providers (McGuinness & Durand, 2015). Research shows the supply of mental health services lack quality care; currently it is inequitable and oppressive for this ethnic-minority population (Walker, 2005).

Mental health practitioners need to learn continuously about the different experiences refugees and immigrants have, the complexities of their trauma, and what interventions work best for them as our nation becomes more diverse (George, 2012). My hope is to disseminate my research findings in an effort to inform clinicians on culturally sensitive practices which can foster resilience within this population. This will assist the adolescents, their families, schools, and community environments in overcoming the effects of trauma and acculturation stressors. Clinicians can support adolescent resilience by identifying their individual strengths, family strengths, and school and community support systems.

This research is relevant for social work professionals because they work in close collaboration with refugee and immigrant communities. Therefore, social workers play an important part in the mental health service delivery for this population. Social workers need to be informed by empirical research about what culturally targeted interventions are most effective so they can be the culturally competent practitioners their clients deserve.

The purpose of this research is to answer the question: What culturally specific interventions are practitioners using to support the mental health of immigrant and refugee adolescents? I conducted semi-structured interviews with eight mental health professionals who work with immigrants and refugee adolescents in school and out-patient settings. I used qualitative research methods to answer the research questions: What are experiences practitioners have when working with immigrant and refugee adolescents? What culturally specific interventions and adaptations do practitioners use and find most helpful when working with this population? How are families involved in the intervention process?

Literature Review

This literature review examines how and why adolescent immigrants and refugees can overcome mental health problems due to complex traumas from pre-migration, migration and post-migration experiences. The literature addresses how mental health practitioners working with adolescent immigrants and refugees need to focus on fostering resilience and support the strengths of their clients. Mental health clinicians who put their adolescent refugee client's specific cultural values and practices at the forefront of the therapeutic process are said to be promoting resilience-based interventions (Theron et al., 2011). Establishing culturally responsive interventions, which are family-centered despite the challenge of family dynamics and community system conflicts, are imperative when working with this population.

The ecological perspective Brofenbrenner (1997) is used as a framework for this study to understand how an individual is impacted by their family, community, and environment. Adolescent immigrants and refugees can best be supported by identifying the quality of interactions they have with these micro, meso and macro systems. Addressing the ecological perspective for mental health intervention is a critical component for culturally appropriate practice. The micro-system considers the individual and their family; their private environment. The meso-system acknowledges the individual and familial relationships and interactions with their school and community and considers the supports they have or lack within these settings. The macro-system focuses on the broader community, programs, assessments, training of professionals, and policies which impact the lives of youth and their families. When the ecological perspective is in the forefront of clinicians' work with adolescent immigrants and refugees, they are served in a more holistic and culturally responsive manner.

Micro-based Interventions: Individual and Family

Blanco-Vega et al. (2008) studied a developmental model using the ecological framework to address risk and resilience among Latino immigrant youth and to foster healthy socio-emotional development. The study found predictive factors of negative or positive outcomes of migration include age, level of acculturation, previous education, level of danger in journey, family acculturation factors, family acculturation gaps, ethnic identity, and school belonging. Protective factors that promote social and emotional resilience, found in the study, were positive self-concept, parent/familial involvement, positive community support, biculturalism, and positive school engagement (Blanco-Vega et al., 2008). Clinicians must consider all the ecological factors which have the potential to impact adaptation to the foreign country including language barrier, socio-economic status, trauma from immigration experiences, and family intergenerational gaps (Blanco-Vega et al., 2011; George, 2012; Miller, 2011 & Walker, 2005).

Culturally specific mental health interventions at the micro level focus on the adolescent and their family. Research suggests mental health clinicians have a duty to make sure parents, important family members, and/or caregivers are involved, especially for youth who are more at-risk of developing PTSD, anxiety, and depression symptoms due to a history of trauma and acculturation stressors (Ehnholt & Yule, 2006). When involving parents in the therapeutic process, interpreters are a crucial component not only because of the language barrier, but they can also act as cultural brokers during mental health interventions, putting refugees at ease while participating in the dynamics of therapy (Weine et al., 2006). However, Ehnholt and Yule (2006) note clinicians often lack skills on how to meet the specific needs of unaccompanied asylum-seeking and refugee adolescents. These include how to work with interpreters, how to attend to cross-cultural differences, and how to engage in self-care practices. Collaboratively

working with interpreters, as though they are bilingual colleagues with cross-cultural knowledge and skills who facilitate cultural consultation, is essential to meet the culturally diverse needs of asylum seekers, refugees, and immigrant adolescents and their families (Ehnholt & Yule, 2006).

Ehnholt and Yule (2006), in reviewing literature on mental health difficulties among refugee adolescents, found that although refugee adolescents are resilient, a holistic approach is imperative to reduce PTSD, anxiety, depression, and grief symptoms. Cognitive Behavioral Therapy (CBT), testimonial psychotherapy, Narrative Exposure Therapy (NET) and Eye Movement Desensitization and Reprocessing (EMDR) are promising evidence-based treatments for this population using a Phased Model Approach: Establishing safety and trust, trauma-focused therapy/treatment, reintegration. For treatment to be holistic and effective, and for trust to be established, family members are included in the clinical interview. Unaccompanied asylum seeking youth should have their social worker or foster parent at the initial assessment (Walker, 2005). Furthermore, adolescents should never be used as interpreters when receiving any type of therapeutic services (Walker, 2005). Clinicians who implement evidence-based treatment and include family members in the therapeutic process are practicing a holistic approach that is culturally responsive.

Miller (2013) studied the use of grief work to support the mental health of two adolescent immigrants. A common theme emerged from the study that adolescents felt they had to minimize their grief expressions due to the traumatic losses from immigration because they felt they had to accept the changes and be responsible for their mothers. Miller (2013) found adolescents needed to grieve and mourn their former and reserved selves, and accept that the process to transition into a new identity is slow, not immediate. Miller (2013) affirmed grief

work interventions have been highly effective and a key component of coping with the loss of identity and journey forward, especially with adolescent Latino immigrants.

When developing micro-level and culturally responsive interventions, that establish trust and safety for adolescent refugees and immigrants, it is important to build on their strengths and resilience. Researchers have explored resilience in adolescent refugees (Carlson et al., 2012; Pipher, 2002; Theron et al., 2011 & Walsh, 2006). George (2012) asserts that immigrants hold resilience in their cultural roots and emphasizes the importance of building on cultural pride when developing therapeutic interventions.

Individual resilience. Practitioners who are aware of how refugees are resilient can greatly promote culturally responsive care for a positive mental health trajectory. Pipher (2002) argues psychology does a great deal of focusing on and refining human deficits referenced in the *Diagnostic and Statistical Manual*, but human strengths have not been well inventoried. According to Pipher (2002) there are twelve individual attributes of refugee resilience. She found refugees who have many of these attributes were successful in adapting to American life; those with only a few or none had a difficult time adjusting to the United States. The twelve attributes of resilience include: future orientation, energy and good health, the ability to pay attention, ambition and initiative, verbal expressiveness, positive mental health, the ability to calm down, flexibility, intentionality (being thoughtful about choices), lovability, the ability to love new people, and a good moral character (Pipher, 2002). Pipher (2002) shares many stories demonstrating these attributes among refugees she has served. For example, one refugee named Bintu, had the capacity to orient to the future by attending computer classes to strengthen her skill set to build a better life as well as to remain hopeful she would reunite with her children (Pipher, 2002).

Protective factors. As resilience research has evolved, researchers have identified protective factors which help youth overcome adjustment difficulties and psychological distress. Walsh (2006) argues resilience is at the core of how families operate and function in general. He claims there are three main forms of resilience stemming from refugee families structures: belief systems, organizational patterns, and communication processes. These provide coherence and help organize life events so people can make meaning out of crisis situations. First, belief systems set a foundation for a positive outlook, and provide encouragement and courage to cope well during adversity; they provide a sense of spirituality or a larger meaning of life. Second, organizational patterns in a family are like the shock absorbers of a crisis (Walsh, 2006). The patterns that create resilience in the family dynamics are flexibility, connectedness, and social and economic resources. Flexibility allows family members to adapt to changes caused by adversity. Connectedness allows people to forgive one another, provide mutual support, collaboration, and commitment to one another despite changes in the family system. Social and economic resources provide people with support from the community, balance in the work-family dynamic, relationships with mentors, and financial security. Third, the communication process within the family system can promote resilience. Walsh (2006) asserts that clear consistent messages with speech and actions, open emotional sharing such as mutual empathy, avoiding blame and sharing a wide range of emotions, collaborative problem solving such as creative brainstorming, having a proactive stance, and shared decision making are all key components to promote family resilience. Resilience plays out in different ways, depending on the situations that immigrant and refugee adolescents are faced with.

Theron et al. (2011) studied cultural factors as the foundation for resilience in four impoverished adolescents; two were Mexican immigrants and two were South African orphans.

Theron et al. (2011) affirmed close family ties, a culture of sharing, religiosity, and use of mother tongue are protective resources essential for navigating daily life in a new place or foreign culture for immigrants. In one study, Mexican youth in Vancouver spent more of their time each day with parents and siblings than their peers (Theron et al., 2011). Mental health treatment focused on protective factors may be key to preventing PTSD and other related mental health disorders (Cordoso & Lane, 2016 & Theron et al., 2011).

Research scholars studying unaccompanied refugee minors (URM) from Sudan used a risk and resilience framework to identify their strengths, coping strategies and adaptation to American culture (Carlson, Cacciatore, & Klimek, 2012; Luster, Qin, Bates, Rana & Lee, 2010). What they found was URM typically strive for three common goals in adapting to their host country: getting an education, helping people back home, and rebuilding Sudan (Carlson et al., 2012 & Luster et al., 2010). Some of the protective factors identified in Sudanese URM include having an overall positive outlook on life, using healthy coping skills, spirituality, and meaningful connection to the community.

Betencourt et al. (2015) studying Conservation of Resource theory (COR) with Somali refugee youth and families in Boston found resilience was supported through protective resources such as religious faith, healthy family communication, support networks, and peer support. According to Betencourt et al. (2015), these protective resources can offset acculturation and resettlement stress. Many other researchers agree these protective factors support a positive mental health trajectory for adolescent refugees (Dutton, 2012; Ehntholt & Yule, 2006; Ellis et al., 2013).

Meso-Based Interventions: School and Community

School-based programs

Culturally specific interventions at the meso level include the school and other community settings and resources. Current research shows schools are an important location for adolescent refugees and asylees to receive mental health services (Beehler, Birman & Campbell, 2011; Fazel, Hoagwood, Stephan & Ford, 2014; Ellis et al., 2013; Fazel et al., 2016; Yankey & Biswas, 2012; Hughes, 2014). Schools play a significant role in the development of youth, and in-school mental health services are often more accessible to youth and their families.

Immigrants and refugees are often reluctant to seek out mental health services because of stigma regarding the need for such services (Ellis et al., 2016). A school environment provides a safer and less stigmatizing place for refugee youth and their families to feel emotionally and psychologically supported. School-based interventions help adolescents and their families settle into their host country and school community more efficiently (Ellis et al., 2013).

Schools can often reinforce proactive behavior for teen refugees. Fazel et al. (2016) studied how adolescent refugees and asylum seekers felt receiving mental health services within a school setting. There were nine mental health service locations in England and researchers drew data from three of the service locations. The study found two-thirds of newly arrived adolescents preferred to receive mental health support at school because they felt safer and more comfortable being in a familiar place rather than in a clinic setting (Fazel et al., 2016). The adolescents expressed appreciation for learning relaxation techniques such as breathing exercises, journaling about feelings, counting to 10, and visiting a friend or talking with someone else because they felt calmer and able to concentrate better on academics (Fazel et al., 2016). Furthermore, the adolescents valued their teachers' role of collaborating with the mental health

clinicians to make engagement more efficient (Fazel et al., 2016). This study shows schools can be an important place for refugees and asylum seekers to access mental health services.

Multidisciplinary teams can also provide an effective and holistic approach to meeting the diverse cultural needs of adolescent refugee and immigrant youth and their families (Ellis, et al., 2009; Fazel et al., 2016; Ellis et al., 2013). Dutton (2012) studied The Haven Project (THP), an early assessment and intervention service in Liverpool, England. THP is an interdisciplinary team of professionals delivered a school-based therapeutic program responding to the needs of refugees and asylum seeking children and families (Dutton, 2012). Part of the intervention requires clinicians to identify the strengths among families and youth as well as make use of non-verbal interventions such as art, music, psychodrama, and horticulture. THP is effective in helping adolescents build friendships, manage school-life stress, and develop a sense of self needed for successful acculturation. THP consists of a project director, child psychologist, psychodrama psychotherapist, mental health nurse specialist, and art psychotherapist. The project is found to be an effective and accessible intervention because the multidisciplinary team develops an allegiance with the families. Furthermore, the team works together effectively to promote healthy social, learning, emotional, and behavioral development among adolescent refugees and asylees (Dutton, 2012). The program also addressed parental concerns by inviting them to attend a meeting to discuss acculturation issues they were experiencing and how they think their child is doing (Dutton, 2012). An evaluation of the program in 2005 found consistently positive results. Respondents stated the school-based program “has helped children and families to settle in and build relationships with the school” (Dutton, 2012, p.223). THP is an effective way to use a non-pathologising intervention which respected the complex nature of immigrant youth trauma while reducing the cultural stigma.

Research asserts the benefits of art therapy to strengthen refugee family resilience (George, 2012; Hughes, 2014; Yohani, 2008 & Dutton, 2012). One example of an art-based therapy approach is the Hope Project (HP), a community-based after school program in Canada. It is designed for inner city refugee children and adolescents, ages 6-18, who came from a variety of countries, including, Sierra Leone, Iraq, Sudan, Pakistan, Philippines, and China. The program used photography, hope quilt making (inspired by Hmong culture), oral narratives, and sharing of art to help youth cope during resettlement stressors (Yohani, 2008).

To evaluate HP, Yohani (2008) used observations over the six months of intervention and the preliminary results from children's and staff's data. After parents engaged in a discussion exploring personal hope, hopes they have for their children, hearing their children share their hope perspective, and then parents engaging in a reflection discussion about what it was like to hear their children's expressions, they appeared to be more hopeful and engaged. Yohani's (2008) intervention research found both parents and children felt a sense of belonging, gained insight into their resilience, and incorporated hope into their new lives after the migratory journey, while still embracing their cultural roots (Yohani, 2008 & Hughes, 2014). The HP shows how the human ecological theory and hope theory were incorporated into the development of the program interventions that had "direct and indirect positive impact on immediate family members and community members" (Yohani, 2008, p.321).

Group work can also be an effective meso level intervention connecting refugee families to the school community (Hughes, 2014; Yohani, 2008). Group therapy has been found to help build trust, foster a sense of belonging and cultural pride in refugee communities. Hughes (2014) studied the "Tree of Life" (TOL) groups for Afghani immigrant and refugee youth and their mothers in a school setting located in London. TOL is a group-based narrative intervention

where youth share their life stories as a means to heal from trauma (Hughes, 2014). It uses the drawing of a tree as a creative metaphor to empower youth to create and share life stories that are grounded in their cultural roots and history of social connections (Hughes, 2014). Children trace their cultural roots and past social interactions in the roots, followed by mapping their current life at the ground level. Strengths and abilities are written or drawn on the trunk while hopes and dreams are mapped out on the tree branches. Prior to starting the group, the TOL group participants complete an evaluation to identify what they hoped to get out of the group and to rate on a scale how far they are from reaching the goal. At the end of the group, they did the same rating as the beginning and shared what else they have gained from the group. The evaluations consistently showed that the TOL groups helped children to develop cultural pride for their heritage and increased self-confidence and peer support (Hughes, 2014). The school community was also impacted by hearing positive stories about refugee students and the students' self-esteem increased in the telling of stories evident by expressing their hope and pride (Hughes, 2014). Hughes (2013) notes the Afghani parent link workers were a significant component of the TOL intervention for both parent and youth groups. The parent link workers educated the refugee families in need of mental health about the importance of the group and what it is meant to do, and to understand how to reach out to and engage refugee communities in a culturally responsive way (Hughes, 2013). Effective approaches to school-based interventions are important for connecting this highly vulnerable population to the support of the school community in a non-stigmatizing way. This benefits both the child and their family members.

Yankey and Biswas (2012) researched a school-based life skills training (LST) group intervention implemented in Himachal Pradesh, India for 600 Tibetan adolescent refugees'. The LST program addressed psychosocial competencies for Tibetan adolescent refugees to achieve

mental, psychological, and social well-being. Yankey and Biswas (2012) found creativity (e.g. drama, art, music, traditional dance) and communication skills developed during LST brought school stress down significantly. An increase of self-confidence, assertiveness, and self-identity comfort promoted psychosocial development for Tibetan adolescent refugees (Yankey & Biswas, 2012).

School-based and family-supported interventions positively impact the overall well-being of adolescent immigrants and refugees as they adjust to their host country (Fazel et al., 2016; Ellis et al., 2013; Xu, Qingwen, Bekteshi, Tran, 2010; Yohani, 2008). It is unlikely that adolescents will seek mental health care unless their families are involved. Many studies assert the importance of building a supportive relationship between families and the school community. In one study, researchers compared Native-born adolescents (NBA) with Foreign-born adolescent (FBA) classmates and found FBA reported significantly less support from their family and school compared to NBA (Xu et al., 2010). Furthermore, low-income NBA and FBA adolescents both reported significantly less school and family support than those with higher incomes. However, for FBA where the parent or caregivers only speaks their native tongue, low family and school support was also correlated. Xu et al. (2010) found family support was the only factor that correlates to FBA psychological health. The study's implications highlight the need to consider interventions that strengthen families and school support for FBAs to promote a positive mental health outcome (Xu et al., 2010).

Community

Beehler et al. (2011) and Ellis et al. (2009) both note the importance of partnering with community agencies and ethnic communities in order to strengthen school-based interventions. Beehler et al (2011) studied CATS (Cultural Adjustments and Trauma Services), a

comprehensive school-based intervention that delivers multiple coordinating services. This study showed CATS was effective for decreasing adolescents' PTSD symptoms across two school districts (9 schools) in New Jersey. Furthermore, CATS provides community resources such as parent-training, family therapy, job/education, after-school support groups, psycho-education, relaxation training concurrently with TF-CBT (Trauma-Focused Cognitive Behavioral Therapy) in combination with CBT (Cognitive Behavioral Therapy). Bicultural or bilingual clinicians with a master's degree in social work or psychology facilitate the services (Beehler et al., 2011). CATS paraprofessionals located at the school are cultural brokers who support the teachers and immigrant students and serve as links to mental health services and case management activities of the program (Beehler et al., 2011). Researchers note the importance of going beyond the school environment when developing school-based mental health programs (Ellis et al., 2009; Walker, 2005). Schools, partnering with culturally specific communities, are effective and provide an appropriate response to the mental health needs of immigrant adolescents (Ellis et al., 2013; Ellis et al., 2009; Walker, 2005).

Culturally-specific group therapy interventions are also important for supporting a positive resettlement adjustment for immigrant and refugee youth and for reducing depression, PTSD and anxiety symptoms (Ugurlu et al., 2016). Ugurlu et al. (2016) measured the effectiveness of using interventions such as drawing, music, movement, and relaxation techniques to Syrian refugee youth to explore the prevalence and severity of their psychological symptoms. The art therapy program held in Sultanbeyli, a neighborhood in Istanbul, was conducted in Arabic with the help of Syrian volunteers to translate. According to Ugurlu et al. (2016) it is optimal for clinicians and assistants working with refugees to speak in their language as well as learn the culture of the refugee group. Ugurlu et al. (2016) studied Syrian culture in-

depth so they could schedule therapy activities around the Turkish and Syrian lifestyle and habits. Researchers found depression and anxiety symptoms reduced significantly post-assessment (Ugurlu et al., 2016). Implementing expressive art therapy that is group-based, can be an effective culturally responsive intervention to promote self-efficacy and reduce trauma symptoms among immigrant youth.

Weine et al. (2006) conducted a family-focused preventative intervention based off the Family Beliefs Framework (FBF). The FBF focuses on the parent and child relationship to find a common ground so intergenerational conflicts are reduced. For example, FBF emphasizes how to adapt parent family beliefs to child's family beliefs so that parents are in tune with their child and vice versa. The study used the empirical research from the Coffee and Family Education and Support (CAFES) model to develop Youth CAFES groups, which draws off the strengths and resilience of the family to positively impact the adolescent's mental health prognosis. Youth CAFES groups are facilitated in a community setting near where refugee families live. The focus of this intervention is to prevent high-risk behaviors, and truancy, and to reduce drop-out rates in refugee adolescents (Weine et al., 2006). FBF, noted by Weine et al. (2006) is a promising, culturally appropriate approach that gives clinicians the opportunity to fully understand specific ethnic cultures, family values, and beliefs. FBF-based interventions promote cultural competence among clinicians to reduce family conflict, and increase healthy parent-child communication, and increase parent community/social supports for at-risk groups (Weine et al., 2006).

Macro-based Interventions

Comprehensive and culturally responsive mental health care may help reduce mental health stigma for youth (Abdi, Baldwin, Ellis, Miller, 2011, 2008; Walker, 2005). The

involvement of cultural brokers, interpreters, trained lay persons, outreach workers, and community members networking to engage immigrants and refugees in mental health services is imperative to reach refugee youth and families (Abdi, Baldwin, Ellis, Miller, 2011 & Walker, 2005). Studies have shown that interpreters, cultural brokers, and outreach workers have been found to be helpful in reaching out to refugee communities and families as well as informing mental health practitioners about culturally sensitive practices (Cardoso & Lane, 2016 & Pipher, 2002). *Promotoras* is a term describing Latina community health workers who help Latino communities in the United States access health services and deliver health education to their community. However, *promotoras* interventions are not common for increasing access to mental health care (Cardoso & Lane, 2016). An intervention based on the *promotoras* called ALMA (Amigas Latinas Motivando El Alma) was found to be effective for reducing depression and acculturation stress as well as increasing social support and positive coping strategies among Latino women (Cardoso & Lane, 2016). The ALMA program is implemented close to the Latino women social networks for easier access.

Project SHIFA (Supporting the Health of Immigrants Families and Adolescents), a pilot project based in a middle school in Boston, Massachusetts, consists of a transcultural psychiatry team, which includes psychologists, anthropologists, and community organizers who work directly with the refugee population (Ellis et al., 2013). SHIFA assists refugee families, educators, and community members to work together to develop culturally specific interventions such as traditional healing ceremonies, which highly increase a family's first appointment attendance (Ellis et al., 2013). 74% of the youth whose family attended the first appointment, continued receiving treatment (Ellis et al., 2013). The SHIFA project functions by going beyond the school-based intervention program and partnering with community support systems to

strengthen the effectiveness of culturally responsive school interventions. Somali middle schoolers of Project SHIFA benefit significantly from the project because of the strong alliance SHIFA provides by involving refugee families, mental health team, host schools, and community agencies. Ellis et al. (2011) affirmed Project SHIFA had great improvements across all levels of the client's ecosystem including the micro, mezzo, and macro systems. Ellis et al. (2011) suggested the SHIFA project is a promising model for family engagement for adolescents to access mental health services. Culturally specific interventions in the SHIFA project involve community voice of the ethnic groups and cultural experts to address immigrant and refugee adolescents' ecology (Ellis et al., 2009).

Research indicates the importance of culturally competent clinicians to develop effective and meaningful interventions for immigrants and refugee youth (Ehnholt & Yule, 2006; George, 2012; Nicolas et al., 2009 & Walker, 2005). Nicolas et al. (2009) studied how to culturally adapt an evidence-based treatment (EBT) group cognitive behavioral therapy (CBT) intervention for American-Haitian adolescents to reduce depression symptoms. The study used cultural adaptations to engage and retain the adolescents in mental health treatment. The cultural adaptations used were creating an advisory board of professionals, community partnering with mental health centers, schools, parents and lay persons, focus group leader training related to cultural competency, conducting group sessions with adolescents, and integrating data from focus groups to make adjustments to the treatment manual (Nicolas et al., 2009). Nicolas et al. (2009) affirms that there is more evidence to consider with culturally adapted EBT interventions with immigrant groups to increase public and policy maker knowledge. Clinicians need to continue learning how to culturally adapt evidence-based interventions. Increased collaboration with researchers, practitioners and public health professionals to ensure policies and practices are

conducive to culturally sensitive treatments for immigrant youth is imperative (Nicolas et al., 2009).

George (2012) asserted the use of ritual or ceremony can be a spiritual tool promoting resilience when working with ethnic-minority counseling groups. Furthermore, immigrants and refugees value collective community so incorporating religious or spiritual traditions in group counseling is of benefit for clients (George, 2012). One example of the use of ceremony as a spiritual tool is having African coffee ceremonies with Ethiopian and Eritrean refugees during group counseling session (George, 2012). Ceremonies and other traditions cultural groups share helps strengthen group member bonds (George, 2012). Participation and access to psychological services increases when spirituality or religious practices are acknowledged (George, 2012; Nicolas, Arntz, Hirsch & Schmiedigen, 2009 & Walker, 2005).

Walker (2005) and George (2012) studied how imperative it is for social workers to develop a culturally competent practice. A multi-disciplinary and inter-professional response to diverse cultural needs when working with adolescent immigrants and refugees is required (Walker, 2005). Social workers need to be aware and acknowledge the multiple reasons needed for culturally competent practice. Diverse factors from pre, during and post migration can result in cultural and family conflicts that disrupt identity development, development of milestones, and transitions from one stage of development to another (Walker, 2005). Therefore, it is crucial for clinicians to develop a reflective practice comprising of,

awareness and acceptance of cultural differences, capacity for cultural self-awareness, understanding the dynamics of differences, developing basic knowledge about the child's culture, and adapting practice skills to fit the cultural context of the child and family (Walker, 2005, p.57).

Having a reflective practice strengthens the success rate of cooperation among professionals who work with vulnerable youth. Walker (2005) found social workers supporting the mental health of immigrant youth require strong group work and community social work skills to “enable families and young people to support each other and raise the collective awareness of shared issues” (Walker, 2005, p.59). There are many components to become a skilled culturally responsive clinician.

Gaps in Research

Research on interventions being used by mental health providers working with adolescent refugees and immigrants is scant. While some mental health clinicians (Blanco-Vega, Castro-Olivo & Merrell, 2008; Miller, 2013) have shared their experiences on interventions most and least effective for them, the lack of empirical research leaves little in the literature for clinicians to draw upon. Fazel et al. (2014) asserted the major weakness in research for school-based interventions is that the majority of studies are small. Additionally, these studies are not randomized and do not have reliable assessment measures. As a result, research on effective treatments delivered to adolescent refugees and asylees in schools is sparse. With more published literature, practitioners can learn to become more culturally aware and can attend to the mental health of this population in a more appropriate manner.

Conceptual Framework

My framework draws from both the family resilience (Walsh, 2006 & Pieper, 2002) and ecological models (Bronfenbrenner, 1997, Drumm, Pittman, & Perry, 2003) and applies the key principles of these models to mental health practitioners working with adolescent immigrant and refugees. To be successful, mental health practitioners need to look for resilience in adolescent immigrants and refugees as well as their family, school, and community systems. Practitioners

building on these systems and offering the most effective mental health interventions, include expressive arts-based, spiritual, cultural and school-based interventions, despite the challenges of family and community conflicts. Working in partnership with families is an effective method to promote healthy socio-emotional functioning among adolescent immigrants and refugees (Walker, 2005).

According to Walsh (2006) the concept of resilience has become a significant focus in child development and mental health theory, as well as in research with refugees and immigrants. The traditional view of resilience focused primarily on individual strengths and family dysfunction. Mental health professionals using this framework often failed to draw upon and acknowledge the wealth of resources within the family system (Walsh, 2006). Modern research on family resilience emphasizes how distressed families are challenged, but not broken (Walsh, 2006). Family failures are not an appropriate target for intervention. Rather, a focus needs to be placed on how to help the family succeed using the resources already at their disposal (Walsh, 2006). This is accomplished when clinicians focus on identifying and strengthening family interaction patterns. This approach addresses individual strengths as well as the strengths among the family members' relationships, and results in effective communication. Walsh (2006) affirmed the family resilience approach does not exclude families with significant troubles at the expense of the presenting client. Rather, the approach encourages individual and family growth by focusing on key processes fostering family resilience, seeing the family as the "client".

The Ecological Systems Theory has been a framework used by many researchers who focus on immigrant and refugee mental health. Bronfenbrenner (1997) notes that the environment of a developing person is not only impacted by his/her home life setting, but also impacted by community resources, policies, and laws. This perspective takes into consideration that life's

challenges can arise in different places of an individual's environment and not only from personal pathology (Drumm, Pittman, & Perry, 2003). Instead of the primary focus being on the individual's functioning, this approach examines environmental stressors, which can significantly impact functioning of a person (Drumm, Pittman, & Perry, 2003). The ecological systems approach is holistic, and considers the micro, meso, and macro systems. The micro-system is the direct face-to-face work with the individual as they consider their place among the variety of systems surrounding them and their impact on individual functioning. The meso-system refers to the interrelations among important community places the person and their family interacts with which has a direct influence on the individual's life such as school, church, elders, neighborhood or larger cultural community (Bronfenbrenner, 1997). Finally, the macro-system refers to the larger institutional patterns which impact the political and cultural environment of the person, such as laws, regulations, dominant group norms, media and social policy at the local, state, national or international level. Sociologists view the ecological perspective as a way to understand how a client adapts and copes with changes, stressors and resources within their multiple environments. To promote resilience-based interventions, practitioners working with immigrant and refugee adolescents must attend to interactions happening within a family system as well as those outside the individual or family unit. Therapeutic interventions targeting multi-system interactions which influence the individual, family and community systems, play an important role in the mental health trajectory of immigrant and refugee youth (Blanco-Vega et al., 2008; Cardoso & Lane, 2016). My knowledge about these culturally sensitive elements has guided my current understanding which will support my research in the future. When I interviewed mental health clinicians working with adolescent immigrants and refugees, I found practitioners identified and assessed client

resilience and strengths and used this information to build off them to develop effective and culturally responsive mental health interventions. Furthermore, I found practitioners were aware of the importance of including family in mental health interventions, even if it was difficult to reach them.

Research Design

Methods

Qualitative research is an exploratory study design allowing the researcher to use interviewing to gain a deeper understanding of the underlying reasons, opinions, and motivations driving peoples' behavior (Patton, 2002). I conducted a qualitative research project on this topic because there is limited published literature on the use of effective, practice-based interventions to support adolescent immigrant and refugee mental health. I conducted semi-structured interviews to gain insight into why mental health clinicians use specific interventions with this population and what they found most effective. Qualitative interviewing assisted my understanding of why certain methods work best for clinicians and why others do not.

Sample

I interviewed seven master's level mental health practitioners and one Ph.D level mental health practitioner for the purpose of this qualitative exploratory research study. The respondents are practitioners who work directly with adolescent immigrants and refugees, in school, community, or out-patient settings. I used snowball and purposive methods for finding respondents (Monette, Sullivan, Dejong & Hilton, 2014). One respondent has a Master's in school counseling and works mainly with the Latino population at a school. She has worked as a school counselor for 17 years. Another respondent has an LICSW and is a school social worker,

serving the East African and Somali population. He has been working with elementary and middle school youth for four years. Another respondent has an LICSW and worked at a community outreach setting for four years and supervised a mental health program for Somali youth and families. He has worked with the Somali community for over 30 years. One respondent is a Latino immigrant and has a LGSW, who provides psychotherapy to Latino children, teenagers, and adults. Another respondent has a clinical counseling Master's degree and is bilingual in Spanish. She provides psychotherapy to the Latino population, mainly. She is also a certified play therapist, who works in the field serving the Latino community for 20 years. Another respondent has an MSW, is bilingual in Spanish, and works as an outpatient psychotherapist. She served immigrant and refugee adolescents in a day treatment setting before she started working as an outpatient therapist serving Latino youth and families. Another respondent who has an LICSW, is a first-generation Latina immigrant and conducts individual psychotherapy to all ages. She has a background doing in-home case management, and working for schools, child protection, and as a parent team worker. The last respondent has a Ph.D. in psychology and is a first-generation Hmong immigrant. He runs an outpatient mental health clinic and has been practicing with the East Asian community for nine years. Respondents were found by asking my current classmates, colleagues, internship supervisor, and academic advisor at the University of Saint Thomas to reach out to respondents. Interested subjects were given my email address by the person of contact. After interested respondents contacted me, I explained the study, reviewed confidentiality, and scheduled an interview time, date, and location that was most convenient for the respondents.

Protection of Human Subjects

I completed the Collaborative Institutional Training Initiative (CITI) training on March 12, 2016, engaging ethically during the research process to protect respondents from potential risks. In addition, I was approved by the University of St. Thomas (UST) Institutional Review Board (IRB) to protect the respondents' confidentiality and privacy throughout the research project, and minimizing the risks involved when participating in the study. The UST IRB requires the protection of confidentiality of all data for this research. Confidentiality was discussed with respondents over the phone prior to the scheduling of the interview. The respondents were provided with a hard copy of the consent form which was explained by the researcher immediately before the interview started. The consent form (see Appendix A) was modified for the purpose of this study. Confidentiality was properly practiced by leaving out the respondents' names in the transcribed document and the hand written field notes were kept in a locked filing cabinet. After transcribing the interviews, the researcher put the audio recordings on a password protected computer to store until the research project completion on May, 15, 2017. After completion of the transcribing, reliability check, coding process, and clinical research presentation day, the researcher will destroy the audio recording of the interview. Respondents' identification information (email, phone, name) was stored on my password protected computer and password protected Excel document to separate them from the interview transcripts.

Data Collection

The semi-structured interview (See Appendix B) was conducted at a location of the respondent's choice. Before the interview I informed the respondents, the interview was

voluntary and they had the right to not answer questions and would be allowed to terminate the interview at any time. After I explained the informed consent and answered questions the respondents had, I asked them to sign the consent form. Interviews lasted approximately 45-60 minutes. I asked seven open-ended questions (see Appendix B) for a more flexible and exploratory research process. The questions were developed in response to my research question, my conceptual framework, my literature review, and from my former professor, Dr. Robin Whitebird's, sample research questions. The questions were specifically related to adolescent immigrants and refugees, and mental health interventions. The questions were reviewed by my research Chair and research committee for face and content validity. Additionally, prompts were asked by the researcher as the qualitative interview conversation naturally progressed.

The interview questions were strategically sequenced, starting with more general questions about the mental health practitioners' experiences working with adolescent immigrants and refugees. Then, the questions became more specific on how practitioners chose interventions for their clients, the different types of culturally sensitive interventions and adaptations they used, and specific experiences practitioners had working with adolescent and immigrant adolescents. After each interview, I transcribed the interviews for the purpose of coding and finding themes. My research committee was asked to help with reliability and validity of the coding categories and themes. Results were written into a final report and presented at the St. Thomas MSW Clinical Research colloquium on May 15, 2017.

Data Analysis

I hypothesized that mental health practitioners working with adolescent immigrants and refugees would use resilience in order to build on protective factors, such as family, peer, school, community, cultural, and religious or spiritual beliefs, to aid in the therapeutic process. I also hypothesized that the use of art-based and school-based mental health interventions would be cited as being effective with this population, despite the challenge of family and community conflicts. Data collected was analyzed using the analytic induction method, allowing the researcher to confirm if the hypothesis had validity or not (Ratcliff, 2007). The transcribed interview was read and coded by me. Words, phrases, and themes based on the hypotheses were identified and recorded. Analytic induction calls on the researcher to develop an initial list of codes and themes prior to conducting analysis. The researcher then codes the interview transcripts using these codes, while also remaining flexible and open to the emergence of themes and ideas unique to the data (Ratcliff, 2007). For this study, the seven themes chosen for analyzing the data were further categorized to reflect what level of the system they addressed: micro, meso or macro. These themes included: protective factors (micro), parent/family involvement (micro), expressive arts interventions (micro), multidisciplinary teams (meso), group work (meso), cultural brokers (macro) and culturally responsive clinicians (macro). Three additional themes emerged from the data: 1) Not enough providers (macro) 2) Parents misunderstanding of the mental health provider's role (meso) 3) The use of physical discipline (micro). Interestingly, each of these falls into one of the three systemic levels used for categorization of the sensitizing concepts.

I worked with my Chair and research committee members to check codes, categories and themes within the transcribed interview to better ensure my coding scheme and data analysis methods.

Findings

This qualitative research report aimed to explore how clinicians support the mental health of adolescent immigrants and refugees by adapting their practice to be culturally responsive. For purposes of this report, the eight respondents were given the pseudonyms: John, Michelle, Sam, Mary, Susan, Marge, Sarah and George. Their thoughts, feelings and experiences are shared here under the seven themes of: protective factors (micro), parent/family involvement (micro), expressive arts interventions (micro), multidisciplinary teams (meso), group work (meso), cultural brokers (macro) and culturally responsive clinicians (macro).

Protective Factors. Protective factors can be individual attributes, family support, peer support, community support and cultural and religious support. All of the interviewees acknowledged their clients' strengths and resilience. They all noted the importance of acknowledging the bare minimum as strengths, such as getting out of bed and going to school or a friend wanting to share a secret with you. A few clinicians expressed the importance of building on cultural pride to promote positive identity development. The majority of clinicians noted how resilient their clients naturally are because of the trauma they experienced and the readjustments they have needed to make to a completely different culture, while continuing to go to school and manage day to day. Marge shared her experience identifying and supporting Latino adolescent's individual resilience. She found,

The persistence is incredible, like astounding. Like from coming, adjusting, helping parents, helping their siblings, um, dealing with changes with academics, dealing with changes in social environment. Like, teenager figure that shit out often without realizing they are doing it, so trying to highlight that.

All the clinicians affirmed family cohesion as a protective factor. Sarah shared a great example about how she has found family support, friends and role models to be important protective factors for Latino adolescent immigrants,

....strong support system is important to them. Being connected to people within their family who accept them regardless what they are doing right or wrong, whether that be their home country or here. Having someone who is able to advocate for them, um, that is extremely important, being able to have friends, friendships are extremely important, um for adolescents.....if they don't have that at home, like making sure they have someone in the community because in my opinion, and what I have seen, is that is what is going to make a difference in excelling, like getting that positive feedback from an adult.....someone that they look up to and get respect back...

These examples show how significant it is for adolescent immigrants to have social resources, especially if the family is not very supportive. Furthermore, most of the interviewees spoke about the importance of cultural community support. Many spoke about how a sense of belonging, resulting from a strong community support system, is a significant source of healing for adolescents within the immigrant population. Having access to culturally relevant community organizations is imperative for immigrants and refugees. It not only benefits the adolescent, but the whole family system, building family resilience for optimal functioning among all family

members. Mary, a Latino immigrant psychotherapist was unique among the interviewees I spoke with. She highlighted school support as a protective factor for her clients. She shared that,

I think school support. School social workers. I have been very lucky to have some school social workers that are culturally relevant and that were actually refer clients to (name of Mary's agency) because they know that we have culturally relevant clinicians and they also want the parents to be involved in the treatment plan.

Parent/Family Involvement in Adolescent's Therapeutic Process. Involving and engaging families in their child's mental health interventions was a significant theme that came up for clinicians. All of the interviewees noted the imperative to involve families in their child's therapy in order to build a foundation of trust and safety so that they keep receiving services. Half of the interviewees noted family therapy as the most important approach when involving parents and/or other family members in the therapeutic process. Most of the clinicians affirmed educating the parents about their children's mental health symptoms is effective so they can express more empathy for them to foster cohesive family relationships and reduce family conflict. Half of the clinicians shared that family conflict is high as a result of family reunification or parent-child cultural gaps. This is why family therapy is vital. Mary shared a story about reducing family conflict by involving Latino parents in their adolescents' mental health intervention and providing psycho-education to the parents about mental illness so they understand what is happening to their child and can have empathy for their experience.

If there is depression, a lot of parents might say, but he always cries, he doesn't want to go to school so they come off as aggressive to their children or the teen and I think it is helpful to help them understand these are the symptoms of the DA (Diagnostic

Assessment) and they are using their skills to cope and I think that educating them about their child's DA helps them to be more understanding and that is what we are looking for in therapy. To be understanding. Empathize with their teenager's behavior and mental health.

Over half of the interviewees spoke about the importance of parents seeing their children's vulnerability and the children witnessing their parents' vulnerability in family therapy sessions. Marge shared an example of how she facilitates a session including the adolescent and parents,

Balance in supporting the parent and supporting the kid. I think it is absolutely imperative actually....both sides getting educated on what has been experienced so parent tend to talk about what it was like in their childhood...like the kid gets to hear in a different context with me guiding the parent a little bit, um of how they felt, 'how did you actually feel when your parent said you weren't going to school anymore because you need to work on the farm and how did that feel?' you know and so they can hear and see their parents. Because many parents get very tearful and dads too, and that's really powerful for teenagers because that is a whole machismo thing for men.

Marge's work focuses on the family as the client, rather than just the adolescent.

Susan facilitates unique family interventions during family therapy. She uses play therapy interventions in family therapy frequently to study the dynamics of the family as well as to incorporate some fun into the family members lives so they can connect in a positive, engaging way. Puppet play, family painting activities, playing, and constructing things are family therapy interventions she has found effective when working with Latino families. Susan shared

an example of how she utilizes play therapy when communication is difficult between family members.

...when there is a lot of communication difficulty we don't talk so I have a parent go into another room and build something with blocks and then their children. Or the teens or whoever is with is usually an older and a couple younger, they have to go in without speaking and look at it and they get like a minute to look at it and then they come back into my office and they have to replicate it with the blocks or you have them go into the other room, this is another where I have it set up to find out how they converse with each. I will have blocks set up how I want them. I will have the family come in and look at it and they have to go in the other room and work together to try and do it.

Finally, Michelle shared a unique story about Latino outreach workers employed in a school setting that facilitates a 'Voices United Parent Program.' The program initiative is to involve families in their child's education experience to build trust and communication. The goal of the program is to provide parents education on the school process. Here is an example of Michelle sharing a story about how the Latino parents response to the program,

...they have a graduation ceremony and they try to make it a big deal so I think families are proud to be part of it....people who have gone through it seemed to have really appreciated it. The time and the information.

However, the attendance for the program is low due to the time commitment, as many parents have to work.

Expressive Arts Intervention. All of the interviewees expressed interest in implementing expressive arts interventions in their practice, especially when the adolescents are non-verbal or have a difficult time expressing themselves verbally. However, only half of the interviewees said they implement arts-based interventions regularly. One clinician does not use them because of the cultural stigma. Two of the clinicians are not aware of the benefits of art interventions. One clinician noted specific Somali families he serves do not approve of art-based interventions, such as music, because music is considered *Heram* or bad, so he limits the use of music with adolescents.

Music and coloring for relaxation were found to be the most utilized approaches for expressive arts interventions. One clinician uses art extensively in her individual therapy interventions, which include painting, clay use, mandala coloring, coloring sheets, making dream catchers when bad dreams occur, and vision board making. She also noted that sand tray play is a form of an art intervention. Susan explains the importance of arts-based therapy as an effective intervention.

Oh yes, I think expressive activities is a really important part...the more non-verbal we can do seems to be more safer and I am talking about adolescents specifically...often their maturation is not there at their age so they are not presenting at their chronological age, so if I have a 13 or 14 year old, I can easily use an art activity that we might use with a 6-7year old, so, um they really engage in that because they haven't been exposed to that.

Marge shared that expressive art interventions are effective with her teenage clients, especially because the Latino adolescents she works with value drama arts.

I try to. I really like it. I do a lot of music with teens, um, I do try to do

art with mixed results....um, often music, it is so easily accessible. So I use YouTube a lot..... especially for younger teens, to build some mastery, so I will like have them teach me a dance, partially because I like to dance...or teach me lyrics so that they are giving me something and seeing their own, their own culture as a source of mastery and strength.

Multi-Disciplinary Teams Only a few interviewees spoke about their participation on multi-disciplinary teams and two clinicians noted networking with a culturally focused community organization, but said their contact was limited. Susan and Marge spoke about their involvement in Spanish Consortiums where the clinicians consult among same or similar disciplines. Immigrant clinicians are involved in the Spanish Consortium which is helpful for Susan and Marge because they are learning more about Latino culture by Latino immigrant clinicians. Those clinicians who did speak about multi-disciplinary teams worked in a school setting. Sam and Michelle are involved in the Problem Solving Team (PST) where school staff identify specific problems students are facing and discuss interventions are discussed. PST is a step before special education referrals are made. Michelle, a school counselor, shared how helpful it is to work interprofessionally in the school system to support immigrant students. She shared a story about how she depends on,

...really learning a lot from the staff, you know, as they bring up issues like, the outreach workers and like the ESL teachers especially, you know, they are right there. They are working with our students, especially new to country kiddos and just really aware of some of the things I would not have picked up on.

Michelle shared it was especially important to consult with the outreach workers because they were essentially the “social workers” because the school did not have a licensed social worker on staff.

Mary shared another unique example of how her agency is working towards a more effective and holistic approach to serving Latino immigrant adolescents by going outside of their agency and exploring what other professionals are doing at their organizations.

Right now we are collaborating with other organizations. It is something new that uh, we are working um, but we will be collaborating with other organizations that are also providing psychotherapy for teens and children. Our goal is to use some of their models...also implement some of the cultural relevant um, models...to continuing on empowering the mental health of teens.

Group Work. Among clinicians in this study, group work is rare. Sam is currently facilitating group work. He spoke briefly about assessing client needs and then determining whether individual or group therapy is needed. George, a Hmong immigrant clinician, explained that group work was one of the most helpful approaches he has used to help East-Asian immigrant teenagers heal from depression, anxiety, and identity confusion. He emphasized how effective group work is for this age population to build confidence and clarity. However, the outpatient agency he currently works at does not offer groups for teenagers but does have them for adult women and the elderly population.

...So, it is a mix of solution-focused and CBT with individual. Therapy and a mix with that is having a group to be able to support one another. Having that sense of shared belief, if let's say that if it is all Vietnamese or all Hmong kids and such, or you know, also some things that is very important which is, I not only do that in

therapy, that I would do that, but also apply that in my own community. So, every Sunday we would go into a youth group and they would participate in that program so it is an indirect way to help them versus in a therapeutic setting. So, it has to be carried out in to the community and therapy is short, right?

George expressed not only the positive impact group work has had on this population, but how to carry it into their communities, outside of the clinic setting.

Cultural Brokers In this study, most of the interviewees expressed the great need to advocate for their clients by being cultural brokers as most are bilingual and three are immigrants. However, George expressed a unique story about his experience as a bicultural, immigrant clinician and cultural broker by educating the South-East Asian community to reduce cultural stigma.

I get invited to participate in their um, community programs...provide the education to the community..... and maybe even invite the parents and just to hear what is going on because these kids they know their depression is real but the parent or maybe the people in their own community say “No you are not. You are just being weak. Get over it, just buckle up and go for a ride and do things and you will be fine. Depression is not a mental illness...So a lot of times I have to educate the community about what is depression and what is anxiety and different types of mental illness and try to help them understand that this is a serious issue and we need to address this.

Most of the clinicians naturally fell into the cultural broker role since they are bilingual and bicultural. However, Michelle is a non-bilingual and a non-immigrant practitioner. She shared how beneficial it is to have outreach workers at the middle school she is employed at because

much of the student population is immigrants and refugee teenagers and the language barrier is significant. She explained the outreach workers also educate the parents about the school process so they are following the laws of children receiving education.

It is huge. We have two outreach workers full-time. They are both Spanish speaking. Actually, we don't have a social worker which is awful. She is kind of like that, basically. She is in charge of attendance, there is a whole lot of outreach, you know, and sometimes with our families, there are families, they haven't gone to school in the U.S. to understand more...the other outreach worker does a lot more of translating documents, a lot of phone calls home.....we do have a language line service that we use to use a lot more but now we tend to have them call. It seems to be more of a personal touch.....they (Somali outreach workers) are both districtwide and there's been some turnover with that which is kind of a challenge.....

Both George and Michelle shared important ways to reach the immigrant and refugee communities in a more holistic and culturally relevant approach to build trust, safety and understanding.

Culturally Responsive Clinicians. All the interviewees addressed being culturally aware and expressing the importance of learning their client's culture and experiences. All of the clinicians take active engagement in learning about the culture of their clients. Most of the interviewees try to incorporate their client's culture into interventions as best they can. A few interviewees spoke about using a solution-focused approach as the most effective intervention. A solution-focused, CBT and TF-CBT approach were also noted by three interviewees as effective therapeutic interventions. Susan mentioned using research-based curriculum, Ross Greene's framework on skill deficits, with a combination of cultural components such as Koran

proverbs and stories to be effective and culturally responsive. Half of the out-patient psychotherapist interviewees affirmed conducting case management tasks to address immediate issues is an effective and culturally responsive approach to working with immigrant adolescents and their families to build trust so they continue to seek mental health services. Clinicians noted addressing immediate concerns arising among the family because of language and systemic barriers as important to focus on before attending to family conflict and other problems that contribute to psychological and emotional distress. Sarah, the bicultural and bilingual clinician, affirmed Spanish families who do not speak English need help finding resources in Spanish because they do not know what support systems are available.

Only a few clinicians spoke about taking trainings that are more culturally responsive to the needs of youth. Another clinician interviewed said the cultural competence training offered at his school was not helpful because it lacked accuracy. He affirmed the East African and Somali population he works with have different cultural beliefs that were not congruent with the training information he received at the training. Susan noted taking multiple trainings that are culturally responsive and trauma-informed. She shared the trainings and professional group she has been involved in support a culturally sensitive practice.

...when trauma is involved we're often doing things like, the interventions I'm pulling from TF-CBT. So, I did a year long cohort with TF-CBT and that is where you do the iceberg modality so that is CBT so that is creating you draw an iceberg that what do people see on top and what is it really what you can see with an iceberg but look at all the stuff down below that no one gets to see.....I am a part of a Spanish consortium mental health providers so we often

talk about various interventions, lot of trainings, and I just finished a week long that is on attachment.

Michelle said she wished there were more trainings on trauma because the school she works at has a higher population of refugee students and there are a lot more mental health issues occurring. Here is what Michelle had to say as a school counselor,

...when I think of refugees, the first thing that comes to mind is trauma and I have had some training in trauma and can't say I specialize in it. I feel pretty out of my competency pretty fast and dealing with you know really digging deep into some issues. I think it is always it is always great when there can be training opportunities for really quick and some you know brief therapy tools to use for school counselors.

The majority of clinicians showed cultural competence by not assuming all ethnic groups have the same beliefs, values, and worldview. A great example of this is when George shared his perspective on the importance of what clinicians need to be aware of to be culturally sensitive.

...be able to understand um, you know, their own culture and where they come from, know family structure and family dynamics so it helps you create a bigger picture about how this person is functioning in their home and community and we cannot assume that just because they are this particular culture that they should all share the same or similar experience, um, it is true to some degree but it is not totally true, so we just really have to look at their own acculturation...you treat a kid who has only been living in the United States for a year versus someone who grew up here are totally different treatments and different approach...

All of the interviewees addressed the significance of listening more, taking on a more narrative therapy approach, instead of giving advice to the client system. They expressed taking the time to ask more questions for clarification to learn about the culture and immigration experience of the client system and engage the family to best serve them in a culturally responsive manner.

Additional themes emerging from the data and not covered above are: 1) Not enough providers 2) Parent lack of understanding of the mental health providers role 3) Physical Discipline 4) Mindfulness Interventions

Not Enough Providers Half of the interviewees spoke about the lack of mental health providers for this vulnerable population. Clinicians either affirmed that there are not enough mental health clinicians, not enough professionals that want to work with the immigrant population or their agency does not have social workers or school counselors currently. Respondents expressed the desire to have more bicultural and immigrant clinicians and clinicians who strive to understand their clients' worldview. Here is an example of Susan who has been working in the field for 20 years sharing a story about the lack of providers for immigrant adolescents,

That there isn't enough providers. That it is not efficient to give assessments that have just been transcribed or translated and that having an interpreter is not gonna give a sense of trust and comfort to talk about extremely difficult things, not enough bilingual, not enough bicultural because I think that it is important to have more providers with immigrant status.

George also shared his thoughts about not having enough providers for Southeast Asian adolescent immigrants and refugees, “There are not enough providers out there who want to work with this population and then I got hired on as a case manager.”

Parents misunderstanding of mental health provider’s role. According to three of the interviewees, the lack of understanding and education about what a mental health provider’s role is prevents immigrant families from accessing services. Clinicians said immigrant parents are fearful that they will take away their children. Sam shared an example about how some Somali and East African parents do not authorize their children to receive mental health services from Sam, a school social worker, because of the lack of parents understanding mixed with the cultural stigma.

I think people are, you know, involuntary cause they don’t understand that all or I think I feel like they think a social worker needs you know, “my kids going to get labeled ‘crazy.’” “My kid might get taken away”...I still have some people think that a school social worker can remove children from their home and like, first of all, that is totally against what we practice and I can’t even do that in my role...

George also shared a story about a common belief some Hmong and Karen parents have on what could happen to their child if they seek mental health services,

A lot of time our family fear about well, ‘what if they go to treatment, what if they carry this diagnosis forever, what if they can’t find a job’, and you know, think about the potential consequences, you know if ‘my kid is crazy’, ‘will they take my kid away and then I will never see them again’ because the image our

family always think about is if this person is crazy they are going to get locked up and then they will live in this very poor condition and no one will look after them.

George shared that psycho-education and providing case management services at the beginning sessions with families helps a lot with client systems like the above example to build credibility.

The use of physical discipline. A majority of the interviewees spoke about how common physical discipline is in the ethnic communities they serve. One interviewee discussed the importance of educating parents about the U.S. laws and consequences of physically disciplining their children so they can avoid legal problems and learn new parenting skills. Half of the clinicians noted the importance of cultural sensitivity. Clinicians said discussing the issue before calling CPS to report an abuse is imperative. Here is an example Marge shared about a lesser form of physical discipline and how to be culturally responsive to the parents,

For some communities in Ecuador, a very common punishment is have been to have your child take a cold water shower...so to be able to understand that that is coming from a very specific tradition or knowing you should ask about it if you are not already familiar with it.... 'I don't think you are bad parents necessarily, I think you were using the tools you were given and we need to change them up a little bit here for the family's wellbeing. In this legal context and cultural context, all of it, that is why we need to change it up.'

The clinicians spoke about the importance of being respectful of the parents by understanding where they came from and knowing cultural differences and how those impacts ways of dealing with problems, rather than jumping to conclusions and assuming the parents are bad.

Mindfulness Interventions Five of the interviewees expressed the effectiveness of mindfulness interventions for adolescent immigrants and refugees. Clinicians affirmed the cultural relevance of using mindfulness interventions with the Latino and South-East Asian immigrant clients. A few clinicians affirmed the effectiveness of using mindfulness with the whole family during family therapy sessions. Susan shared an excellent example of how she uses mindfulness in a culturally sensitive way with Latino adolescent immigrants,

Guided imagery seems to be something that is fairly familiar with a lot of individuals that are from Mexico.....so it's being very still, being very quiet, being very reflective, envisioning what you want and that is a very powerful healing, um, like a forward movement for you, so like we would say goals but for them this is like 'ok, this where I am going because now I have incorporated as part of my meaning.' It's very similar to Native American practices...

The practitioners asserted how anxiety-reducing this approach is for their youth clients and how they become less defensive and more reflective.

Discussion

This study supports the importance of clinicians finding protective factors to be necessary in building the resilience of the adolescent immigrants they are working with. Clinicians in this study found it imperative to build off individual strengths and resilience to help develop the self-agency crucial for a positive adjustment to the new host country. Furthermore, the study found how important clinicians think it is to provide immigrant adolescents families social supports so they are receiving positive feedback from a role model frequently, whether that be from a family member or another valued adult who is in their life long-term and invested in them. School

support was also found to be a protective factor because school social workers are culturally aware of the mental health agencies in the community that specialize in specific ethnic groups. Finally, clinicians found community and faith resources to be significant sources of resilience for the whole family, which directly impacts the adolescent immigrant's psycho-social and emotional functioning.

Family involvement as a micro level intervention was noted by all respondents as the number one, culturally specific approach to developing interventions. The study found clinicians believe it is important to provide psycho-education to parents to help them develop empathy for their child. Clinicians use psycho-education to help families understand when inappropriate behaviors are occurring, especially when high family conflict is exacerbating the problem. Clinicians in this study found providing psycho-education to be the most effective way to build trust and credibility with families when the therapist is either bilingual or an immigrant clinician from the same ethnic population they serve. Finally, outreach workers were noted as helping to promote family involvement in their child's education.

Another way of involving family is by including parents and family members in the child's therapy. More than half of the interviews affirmed having families attend their adolescent's therapy is a highly effective approach to resolving family conflict and repairing relationships. Furthermore, play therapy is used as an effective and culturally responsive intervention for individual and family therapy with the Latino population. However, clinicians noted systemic barriers that have caused problems for parents, making it difficult to participate in family therapy because of job inflexibility and transportation difficulties.

Expressive arts interventions, as a micro level intervention, was also used by clinicians in this study. Clinicians affirmed expressive arts-based interventions are especially useful when adolescents are non-verbal or have a difficult time articulating their feelings. Music, singing, and dance were most widely used as culturally specific interventions for Latino adolescents. Susan found it effective to use these interventions with adolescent Latino clients because she believed dramatic arts are a common form of expression in Mexican culture. The study also found clinicians find expressive arts-based interventions during family therapy to be effective. Cultural stigma and time constraints can cause a setback to implementing expressive arts-based interventions.

At the meso level of intervention, having a multidisciplinary team approach was not mentioned as common. This sample of clinicians spoke mainly with other psychotherapists to support their clients, rather than working interprofessionally. However, respondents working in a school setting were more collaborative between disciplines such as consulting with outreach workers, ESL teachers, teachers, school counselors, and staff about their adolescent clients' mental health functioning and experiences. The school social workers are also involved in the PST to track adolescent skill deficits and discuss appropriate interventions. A few clinicians spoke about being part of a consortium group to consult about culturally relevant interventions. The group also provides training opportunities which support research-based practices.

The study found group work, as a meso-level intervention, was rarely used. Clinicians were more likely to do group work intervention working in a school setting than non-school settings. George discussed how he formerly facilitated group work for teenage adolescents and wished it were still part of the clinics program because it is beneficial. It was rare to see group work conducted in out-patient settings, where family therapy was the priority.

As a macro level intervention, cultural brokers were found to be useful for reaching out to families to support their adolescents' mental health, especially with the non-bilingual clinicians. For clinicians who are not bilingual, outreach workers were found to be an essential at helping families to navigate and understand the school system. The outreach workers are of the same culture of the families they serve. Furthermore, the study found that George provided community outreach to parents and their communities to reduce the cultural stigma around mental health and its impacts on adolescent immigrants. In the out-patient settings, it was rare for clinicians to consult with cultural brokers because most of the bicultural clinicians already hold that dual role.

It is evident in this study's sample that most of the clinicians have a high level of cultural competency because they are bilingual and/or immigrants themselves and from the same ethnic group they serve. However, only a few clinicians addressed trauma-informed workshops and trainings. One clinician spoke about a cultural training she participated in was useful because trauma was the topic of the training. Furthermore, one clinician spoke about wanting more cultural competence training opportunities, specifically focused on trauma because of the high dense population of refugee students. The clinicians used CBT, TF-CBT, solution focused and case management interventions as culturally responsive approaches. The study found some practitioners who are non-bilingual and non-immigrant are struggling with how to reach families so they can appropriately engage them in their child's mental health.

The study found four additional themes of significance that emerged during the data analysis which included: not enough providers, parent lack of understanding of the mental health providers role, physical discipline, and mindfulness interventions. Clinicians in the study stated

there are not enough providers to serve the immigrant and refugee population and interpreters are not adequate for assessment and therapeutic work.

Interviewees affirmed the misconception and misunderstanding parents have about what can happen to their children if they are involved in mental health services. Some of these misconceptions were having their children taken from them or belief that if their child has a diagnosis, they will never see their child again, or will never have a good life, or a comfortable place to live because they will be locked up. These fears and stigma serve as significant barriers to families accessing services.

Physical discipline has also been noted by interviewees as a common issue that can cause a great barrier for immigrant families. According to the study, some immigrant families do not trust social workers or other mental health providers because they have fear of systems or do not like Child Protection Services (CPS). The study found that, it is important to understand the client systems culture and traditions. To build trust and safety with parents, clinicians noted reframing physical discipline by telling parents they are not “bad” for acting in this manner, it is what they know to do, but to inform them with U.S. laws on child abuse consequences so they have the opportunity to change abusive behaviors and learn new skills for the betterment of the whole family. Furthermore, the study found talking to the parents before making CPS screens is imperative and culturally responsive to be respectful and to build trust. Furthermore, Susan affirmed that some clients fear systems like CPS, therefore, building trust can be more challenging. She is careful on what to report and what not to report to CPS when they have a case already opened. These are all culturally relevant ways the study found to be effective when addressing physical discipline while acknowledging systemic issues.

Finally, the last theme the study found was the cultural relevance and effectiveness of the use of mindfulness interventions, specifically in the South East Asian and Latino immigrant populations. With Latino immigrants, using guided imagery by envisioning goals while sitting still was found to be an effective intervention in this study. One clinician found teaching the parent how to teach her child deep breathing techniques also benefited her. Mindfulness interventions can be a bonus for the whole family system while also, responding in a culturally appropriate way.

Implications for Social Work Practice

Micro. This research affirmed the significance of family involvement to building trust and credibility, however, non-bilingual and non-bicultural clinicians are struggling to make this happen. The language barrier keeps clinicians from interacting directly with parents and families to build a foundation of trust for culturally responsive interventions. In addition, the study found being a non-immigrant and non-bilingual provider also makes it challenging to reach families. Clinicians affirmed feeling unskilled in how to effectively involve the family of adolescents in the therapy process. Finally, the cultural stigma and systemic barriers such as transportation difficulties, lack of driver's license or health insurance, working two to three jobs without flexibility to take time off and support their child, are significant impediments involving families.

Mental health clinicians in this study found it was effective and culturally responsive to educate parents and caregivers on understanding their child's depression, anxiety, and PTSD symptoms. These psycho-educational interventions assist parents to develop skills on how to empathize with their child. According to findings in this study and Ellis et al. (2011), parent psycho-education reduces family conflict and promotes healthy family functioning, which

directly benefits the mental health of adolescent immigrants. Educating parents about mental health is also an intervention which can reduce cultural stigma and intergenerational gap (Blanco-Vega et al., 2008). Based on this study, these interventions can happen in family therapy sessions and it is most effective if there are bilingual or immigrant therapists because third party interpreters can get in the way of building trust and credibility.

Expressive arts interventions are important for non-verbal adolescents (Kowitt et al., 2016) and for verbal adolescents who experience anxiety and depression symptoms. However, in this sample, not all clinicians use these interventions because they do not know of the benefits, are new to the profession and have not explored it yet, or because the cultural stigma on arts-based interventions does not have parental approval. High caseloads with little time to prepare and plan arts-based activities is another barrier one clinician in this study cited. This study affirms arts-based interventions can be effective ways to reduce trauma, depression and anxiety symptoms. Expressive-arts interventions support a culturally specific practice.

Based on this study, play therapy for immigrant adolescents and their families is an effective intervention to implement during family therapy or individual sessions. However, only one clinician expressed implementing this intervention. According to Susan in this study, younger immigrant adolescents benefit from play therapy because they have had limited or no exposure to playing games, puppet play, and creating things of their own. Susan said factors contributing to the lack of play among this population stems from the constant need to help parents interpret documents, make phone calls, and pay bills. Furthermore, before coming to the new host county, many immigrant and refugee children were fleeing war-stricken countries for survival, so play was not on the forefront and may even have been a dangerous thing to do. According to this study, play therapy trainings should be explored more in research and offered

to mental health clinicians as a potentially culturally responsive intervention to working with adolescents and their families.

Meso. Group work for adolescent immigrants is sparse for clinicians in this study who worked in outpatient settings. Although some clinicians were aware of the importance and effectiveness of group work for adolescents to build shared beliefs and normalize their experiences, they were not happening for the majority of those interviewed. Group work trainings could be offered as culturally specific interventions for immigrant adolescents because research has shown that group work helps develop shared meaning among group members and fosters self-efficacy, cultural pride, and decreasing identity conflicts (George, 2012; Nicolas, 2009 & Yankey & Biswas, 2012). Group work treatment provided at school or at a place in the community where specific immigrant communities congregate, like at a community center, mosque, or church is ideal for accessibility (Fazel et al., 2016 & Pieper, 2002). Clinicians should involve parents and family members in the child's group therapy at some capacity so they have the opportunity to connect with other parents who are going through similar experiences (Hughes, 2014; Weine et al., 2006; Yohani, 2008). Involving parents gives them an opportunity to build shared meaning, promotes family resilience, and helps build positive connections (Yohani, 2008). Another way to involve parents is by offering adult discussion groups relating to their children's therapy group (Weine et al., 2006 & Yohani, 2008).

Based on the findings from this study, school-based mental health practitioners lack support and knowledge on how to provide high-quality mental health services for our immigrant and refugee youth, especially when considering their significant trauma history. The two school practitioners stated that they either do not have a social worker or a school counselor hired to support them with the high mental health needs of their immigrant students. One clinician

expressed concern that teachers are not making mental health referrals or reaching out to the school social workers. The study's findings also concluded that academics often take priority over their student's mental health. This study found that both the practitioners working in schools with a high population of immigrant and refugees, are not equipped to care for the high mental health needs of traumatized youth. Based on this study, for clinicians to deliver best practice to this vulnerable population, school districts with a high density of immigrant and refugee youth, should consider hiring more clinical staff to promote preventative interventions to support trauma and acculturation challenges. Fazel et al. (2016) affirmed refugee youth receiving mental health services in a school setting with professional mental health staff, had positive social functioning.

Macro. In one school, the study found that the outreach workers are replacing the social worker's role because the language barrier is high and the one mental health provider employed by the school is not bilingual. It is evident from the findings of this study that mental health staff do not always have the competency and skill sets to provide effective and culturally responsive care to this vulnerable population. The study also found there are not enough mental health providers to support adolescent immigrants and refugees. Additionally, based on this study, there are not enough immigrant mental health providers to build trusting and credible relationships with families so their teenagers continue to come to therapy.

There was a lack of multi-disciplinary teamwork for clinicians in this study who worked in community or outpatient settings. The study found both the clinicians working in schools are involved in the Problem Solving Team (PST); however, the team does not consult with parents, cultural experts or other community organizations working with refugees and immigrants to support culturally sensitive practice. According to Ellis et al. (2011) professionals of diverse

disciplines foster holistic mental health interventions so an adolescent's ecology is supported. These disciplines include psychology, anthropology, social work, case management, teaching, school counseling, and art therapy to support refugee and immigrant families (Ellis et al., 2011). Mental health professionals collaborating with cultural experts and community organizations are also contributing factors to refugee and immigrant families' acculturation success (Ellis et al., 2011). Schools are a more accessible setting for refugees to seek out mental health support; therefore, schools should partner with cultural organizations to develop multi-disciplinary teams as preventative interventions when working with traumatized immigrant youth or youth struggling with resettlement (Beehler et al., 2012; Ellis et al., 2011; Ellis et al., 2013 & Fazel et al., 2016).

To reach parents, families and community members of immigrant and refugee youth, bicultural, bilingual, and immigrant mental health professionals are finding themselves having to do more community outreach and cultural brokering in their ethnic communities (Beehler et al., 2011). According to this study, there is limited parent psycho-education conducted in the form of community outreach, therefore, cultural stigma perpetuates. George affirmed cultural brokering efforts can reduce the cultural stigma on mental health by educating communities on the role of social workers and other mental health providers, teaching parents depression and anxiety is real and children do need mental health support. This work should not be left only to clinicians who identify with particular immigrant and refugee communities. All clinicians should work in interdisciplinary teams to learn and to support the diverse needs, beliefs, and behaviors of the communities they are serving (Ellis, et al., 2009; Fazel et al., 2016; Ellis et al., 2013).

Based on this study, there is a great need for more bicultural, bilingual, and immigrant clinicians to build trust, safety, and credibility among parents and families so youth continue coming to therapy. According to clinicians in this study, immigrant mental health providers inspire hope in our immigrant youth, providing an example of success and leading by example. Furthermore, Sarah from this study affirmed the importance of providing child protection (CP) staff education on how to be culturally aware of the barriers immigrant families face. According to Sarah, many Latino families have open case plans that are not tended to because parents need to work and cannot take time off to meet with social workers, attend team meetings, or court dates. When CP staff are culturally competent, immigrant families are more supported emotionally, psychologically, gaining the skills to maintain a well functioning family dynamic.

Clinicians in this study affirmed immigrant adolescents are sometimes estranged from their family or ethnic community because of having a mental illness or having different beliefs and values than others in their family. As a result, they lack family support, which is a barrier to healthy functioning for these adolescents (Bentencourt et al., 2015 & Walsh, 2006). Community programs supporting those who are rejected from their community is critical for meeting the mental health needs of immigrant and refugee adolescents (Beehler et al., 2011 & George, 2012).

Implications for Policy

These findings have implications for future policy. More research needs to be conducted so school boards and county boards have the information they need to act on reducing the systemic barriers facing immigrant and refugee families. Housing, inadequate schooling, and punitive public policy are key contributors of negative outcome development within the adolescent immigrant and refugee community. Policies that fund research-based culturally adapted mental health programs in schools, outpatient, and community-based settings is urgent

so immigrant families feel a sense of belonging in their community while positive mental health of youth and their parents is fostered (Beehler et al., 2011; Ellis et al., 2011; Ellis et al., 2013 & Fazel et al, 2016). Policy that requires licensed professionals to receive cross-cultural and diversity trainings is essential, especially those who work specifically with immigrants and refugee adolescents to promote preventative interventions and to support continuity of care (Ellis et al., 2011). Furthermore, school-based preventative interventions using a family-centered, group work approach are programs worth investing in (Weine, 2006). More research on this population is essential to inform policy change in an effort to reduce multiple barriers.

Based on this study, county board members must support policy that informs a culturally responsive practice within the CPS arena to reduce the barriers many of the undocumented immigrant and refugee families face so that their basic needs are met, and they are then able to lead healthy life. This study found the need to support policy that increases adequate housing for immigrant families to promote safety and reduce child sexual abuse among immigrant youth. Furthermore, according to this study, policy that endorses employment programs that help immigrant parents find accessible daytime jobs is vital so parental monitoring can occur. As a result, child sexual abuse and family conflict will decrease according to this study. Policies that provide funding for community cultural programs with the goal to reduce cultural stigma on mental health is imperative to support immigrant families and individuals. Systemic barriers are a burden to immigrant families who are struggling with acculturative and resettlement stressors, decreasing their likelihood to succeed, unless policy changes.

Implications for Research

This study's findings has implications for future research. Further research is required in order to provide mental health practitioners with a firm knowledge base of how to appropriately

serve this population. Quasi-experiential and experimental research on clinical interventions for this population have been growing and have been tested for efficacy (Cardoso & Lane, 2016). However, there is a vital need for more evidence-based research on how best to adapt interventions for refugees and immigrants while considering their culture and the interactions at play between host and foreign culture (Cardoso & Lane, 2016). There has been far less research on what mental health interventions are most appropriate for adolescent immigrants. As mentioned before, Latino adult pathology and psychological well-being have been studied, but far less Latino immigrant youth have been studied (Blanco-Vega, Castro-Olivo & Merrell, 2008). Blanco-Vega et al. (2008) asserted the need to develop culturally sensitive interventions using multi-system interactions which take into account ecological factors impacting social and emotional functioning. Some of these factors include familial (intergenerational) acculturation gaps, trauma from immigration process, socioeconomic status, language barriers, education levels, discrimination, and identity conflicts. As a result, lack of housing, inadequate schooling and punitive public policy are key contributors of negative outcome development within the adolescent immigrant and refugee community. Mental health practitioners need to understand the complex cultural factors to appropriately advocate for this vulnerable population.

Strengths and Limitations

There are strengths and limitations to this research study. The strength of the study is that it was an in-depth exploration of mental health practitioners use specific interventions mental health practitioners use to best meet the unique needs of their adolescent immigrant and refugee clients. Over half of the respondents were bilingual, speaking the language of the client system majority and three of them were first generation immigrant mental health practitioners. Half of the respondents are immigrants of the same ethnic background as the client systems they

serve, so their perspective provides a different view of the needs and efficacy of mental health interventions with immigrant and refugee adolescents. The author interviewed providers with diverse Masters and Doctoral degrees in the mental health field who are currently working directly with immigrant and refugee adolescents. There was wide range of experience levels among the mental health clinicians, some newer, to the field and half with over 15 years experience. The diversity of experience provided a more comprehensive level of understanding for gaps to emerge. The ethnic groups studied were Hmong, Vietnamese, Karen, Somali, Oromo and Latino.

There is scant research on mental health services for adolescent immigrants and refugees. However, this qualitative research study is rich in details about the practice-based evidence of mental health clinicians working with immigrant and refugee adolescents. It points to the great need for additional research and support of these clinicians and all vulnerable children they are serving on a daily basis. This study helped to fill in the gaps and to expand mental health practitioners' knowledge and skills by building off of the limited existing research addressing this topic.

As with any research, there are limitations to this study. All the respondents currently live in a large metropolitan area of the Midwest, so findings may not be representative of the experiences other clinicians have in other parts of the U.S. or even the state in which the study was conducted. The study was based on a small sample size of eight respondents. Respondents from multiple settings was lacking. The majority of the respondents work in an out-patient setting and serve the Latino population. Another limitation to this study was being the only researcher on this project. Additional research assistance would have provided a more comprehensive reliability check. These findings are from my perspective only and therefore may

be limited or biased. The literature review conducted prior to data collection consisted of studies with small sample sizes and single case studies. Some of the studies did not always specify adolescent age but rather gave a broad range (eg. Age 2-19) as well as some articles focusing on “children” without age specified. Longitudinal studies were lacking as well as efficacious research to support the effectiveness of intervention program evaluation.

Conclusion

Social workers and other mental health professionals play an important role in the mental health service delivery as the refugee and immigrant population continues to rapidly grow in the United States and across the world. Practitioners who support the mental health of this population must be informed by evidence-based research about what culturally responsive interventions are most effective so they can be the culturally competent practitioners their clients need and have the right to receive. A holistic approach is imperative to reduce PTSD, anxiety, depression, and grief symptoms. Developing culturally specific interventions that involve family as well as placing the ecology of the child at the forefront of the mental health intervention is a critical component for culturally appropriate practice. More practice-based and evidence-based research with large samples that pertain to the efficacy and effectiveness of culturally appropriate treatments for adolescent immigrants and refugees is significantly needed to inform clinicians on best practice and to change policy and programming.

References

- Beehler, S., Birman, D., & Campbell, R. (2011). The effectiveness of cultural adjustment and trauma services (CATS): generating practice-based evidence on a comprehensive, school-based mental health intervention for immigrant youth. *American Journal of Community Psychology, 50*(1-2), 155-168. doi:10.1007/s10464-011-9486-2
- Betancourt, T. S., Abdi, S., Ito, B. S., Lilienthal, G. M., Agalab, N., & Ellis, H. (2015). We left one war and came to another: Resource loss, acculturative stress, and caregiver-child relationships in Somali refugee families. *Cultural Diversity & Ethnic Minority Psychology, 21*(1), 114-125. doi:10.1037/a0037538
- Blanco-Vega, C., Castro-Olivo, S., & Merrell, K. W. (2008). Social-emotional needs of latino immigrant adolescents: A sociocultural model for development and implementation of culturally specific interventions. *Journal of Latinos & Education, 7*(1), 43-61. doi:10.1080/15348430701693390
- Carlson, B. E., Cacciatore, J., & Klimek, B. (2012). A risk and resilience perspective on unaccompanied refugee minors. *Social Work, 57*(3), 259-269. doi:10.1093/sw/sws003
- Dutton, C. (2012). Creating a safe haven in schools: refugees and asylum-seeking children's and young people's mental health. *Child Abuse Review, (21)*, 219-226. Doi: 10.1002/car.1197
- Ehnholt, K. A., & Yule, W. (2006). Practitioner review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of Child Psychology & Psychiatry, 47*(12), 1197-1210. doi:10.1111/j.1469-7610.2006.01638.x
- Ellis, B. H., Abdi, S., Barrett, C., Miller, A. B., Blood, E. A., & Betancourt, T. S. (2013). Multi-tier mental health program for refugee youth. *Journal of Consulting & Clinical Psychology, 81*(1), 129-140. doi:10.1037/a0029844

- Ellis, B.H., Miller, A.B., Baldwin, H. & Abdi, S., (2011) New direction in refugee youth mental health services: overcoming barriers to engagement. *Journal of Child and Adolescent Trauma*, (4), 69-85. Doi:10.1080/19361521.2011.545047
- Fazel, M., Garcia, J., & Stein, A. (2016). The right location? Experiences of refugee adolescents seen by school-based mental health services. *Clinical Child Psychology and Psychiatry*, 21(3), 368-380. doi:10.1177/1359104516631606
- George, M. (2012). Migration traumatic experiences and refugee distress: Implications for social work practice. *Clinical Social Work Journal*, 40(4), 429-437. doi:10.1007/s10615-012-0397-y
- Hughes, G. (2013). Finding a voice through 'The Tree of Life': A strength-based approach to mental health for refugee children and families in schools. *Clinical Child Psychology and Psychiatry*, 19(1), 139-153. doi:10.1177/1359104513476719
- Lee, J. S. (2012). *Unaccompanied refugee minors and their strategies to navigate a new world: A grounded theory* Retrieved from <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=83399&site=ehost-live>
- Luster, T. Qin, D., Bates, L., Rana, M. and Lee, J.A (2010). Successful adaptation among sudanese unaccompanied minors: Perspectives of youth and foster parents. (2010). *Childhood*, 17(2), 197-211. doi:10.1177/0907568210365664

- McGuinness, T. M., & Durand, S. C. (2015). Mental Health of Young Refugees. *Journal of Psychosocial Nursing and Mental Health Services*, 53(12), 16-18. doi:10.3928/02793695-20151116-01
- Miller, L. D. (2012). "I Am Not Who I Thought I Was": Use of Grief Work to Address Disrupted Identity Among Hispanic Adolescent Immigrants. *Clinical Social Work Journal*, 41(4), 316-323. doi:10.1007/s10615-012-0410-5
- Nicolas, G., Arntz, D. L., Hirsch, B., & Schmiedigen, A. (2009). Cultural adaptation of a group treatment for haitian american adolescents. *Professional Psychology: Research & Practice*, 40(4), 378-384. doi:10.1037/a0016307
- Patton, M.Q. (2002). *Qualitative Research & Evaluation Methods*. Thousand Oaks, California: Sage Publications, Inc.
- Pipher, M. B. (2003). *The middle of everywhere: Helping refugees enter the American community*. Orlando, FL: Harcourt.
- Ratcliff, D.E. (2007). Analytic Induction as a Qualitative Research Method of Analysis. Retrieved from <http://archive.is/FofSy>
- Theron, L., Cameron, C. A., Didkowsky, N., Lau, C., Liebenberg, L., & Ungar, M. (2011). A "Day in the Lives" of Four Resilient Youths: Cultural Roots of Resilience. *Youth & Society*, 43(3), 799-818. doi:10.1177/0044118x11402853
- Ugurlu, N., Akca, L., & Acarturk, C. (2016). An art therapy intervention for symptoms of post-traumatic stress, depression and anxiety among Syrian refugee children. *Vulnerable Children and Youth Studies*, 11(2), 89-102. doi:10.1080/17450128.2016.1181288

- United Nations High Commissioner for Refugees. (2016). *Figures at a glance*. Retrieved from <http://www.unhcr.org/en-us/figures-at-a-glance.html>
- Walker, S. (2005). Towards culturally competent practice in child and adolescent mental health. *International Social Work, 48*(1), 49-62. doi:10.1177/0020872805048708
- Weine, S., Feetham, S., Kulauzovic, Y., Knafl, K., Besic, S., Klebic, A., Pavkovic (2006). *A family beliefs framework for socially and culturally specific preventive interventions with refugee youths and families* American Psychological Association. doi:10.1037/0002-9432.76.1.1
- Xu, G., Bekteshi, V. & Tran, T. (2010). Family, school, country of birth and adolescents' psychological well-being. *Journal of Immigrant & Refugee Studies, 30*(8), 91-110. Doi:10.1080/15562940903379142
- Yankey, T., & Biswas, U. N. (2012). Life skills training as an effective intervention strategy to reduce stress among tibetan refugee adolescents. *Journal of Refugee Studies, 25*(4), 514-536.
- Yohani, S. (2008). *Creating an ecology of hope: Arts-based interventions with refugee children*. (No. 25).Springer Science & Business Media B.V. doi:10.1007/s10560-008-0129-x

APPENDIX A

**CONSENT FORM
UNIVERSITY OF ST. THOMAS****Culturally specific interventions practitioners use to support the mental health of adolescent immigrants and refugees**

My name is Lynn Whitfield. I am a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Mary Nienow. I am conducting a study about the culturally specific interventions practitioners are using to support the mental health of adolescent immigrants and refugees. I invite you to participate in this research. You were selected as a possible participant because you are a mental health professional who works with adolescent immigrants and/or refugees in a mental health setting. Please read this form and ask any questions you may have before agreeing to be in the study.

Background Information:

The purpose of this study is to gain knowledge about culturally specific interventions practitioners are using to support the mental health of adolescent immigrants and refugees.

Procedures:

If you agree to be in this study, I will ask you to do the following things: 1. Participate in an interview of approximately 7 questions within a 45-60-minute time period. The interview will be audio recorded and the data gathered will be presented at the Social Work Clinical Presentation Day on May 15, 2016. My research committee members will view my data for content validity and coding reliability.

Risks and Benefits of Being in the Study:

The only potential risk in this study is any emotional reaction you may experience to what we talk about. There are no benefits directly to you. There will be a benefit of improving knowledge about mental health work with adolescent immigrants and refugees.

Confidentiality:

The records of this study will be kept confidential. Research records will be kept in a password-protected file on my computer. I will delete all identifying information from the transcript. My de-identified findings from the transcript will be presented at Clinical Presentation Day. The audiotape and transcript will be destroyed by May 15, 2016.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to

participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used without your consent and immediately destroyed upon your request.

Contacts and Questions:

My name is Lynn Whitfield. You may ask any questions you have now. If you have questions later, you may contact me at 612-655-7266 or by email at whit2500@stthomas.edu. My instructor's name is Mary Nienow; her phone is 651-295-3774 and her email address is nien3538@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

Signature of Study Participant

Date

Print Name of Study Participant

Date

Signature of Researcher

Date

APPENDIX B

- 1.) What are your experiences working with immigrant and refugee adolescents?
 - What are some of the more common issues you see in your work with adolescent immigrants and refugees?
 - What are some challenges you face working with this population?
 - What do you find most rewarding about working with this population?
 - What are the ethnic backgrounds of your clients?
- 2.) What culturally specific interventions do you use with adolescent immigrants and refugees to support their mental health?
 - Tell me about how you practice cultural sensitivity when working with this population. What do you do to practice cultural sensitivity?
 - How do you develop interventions?
 - Do you consider the protective factors (strengths and resilience) you see in your clients? What does that look like for you?
 - Do you use art interventions or narrative interventions with your clients? Tell me why or why not.
 - How do you measure your mental health interventions effectiveness.
- 3.) How have you adapted your practice to meet the mental health needs of immigrant and refugee adolescents?
- 4.) Of these approaches, which are most helpful when working with this population?
- 5.) Tell me about how you involve the families in the intervention process.
- 6.) What is something significant that you have learned in your practice that has impacted your work with adolescent immigrants and/or refugees?

7.) Is there anything else you think would be important for me to know about your work with refugees?