

## Chapter 11: Evaluating Social/Emotional Functioning and Mental Health Resiliency of English Learners

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### Chapter Overview

Evaluating the social/emotional functioning and mental health resilience of English learners (ELs) may be indicated in some cases because of their impact on the student’s ability to benefit from instruction. This chapter addresses social/emotional functioning evaluations as part of the determination of eligibility for special education services. It also highlights considerations about the mental health of ELs who are immigrants and refugees from both a resilience and an impairment perspective. The chapter offers guidelines for teachers, school counselors, and school psychologists to use in determining whether there are socio-emotional factors or mental health issues that may impede learning and for which special education services and supports are warranted.

### Social/Emotional Functioning

A student’s ability to experience, express, and manage emotions, and to establish positive relationships with others, is an important aspect of school success. When a student exhibits poor social/emotional functioning, learning is generally impaired, and the possibility that a student has an “emotional disorder” is considered. Minnesota’s definition of emotional or behavioral disorders is included in its Administrative Rules:

"Emotional or behavioral disorders" means an established pattern of one or more of the following emotional or behavioral responses:

1. withdrawal or anxiety, depression, problems with mood, or feelings of self-worth;

2. disordered thought processes with unusual behavior patterns and atypical communication styles; or
3. aggression, hyperactivity, or impulsivity.

The established pattern of emotional or behavioral responses must adversely affect educational or developmental performance, including intrapersonal, academic, vocational, or social skills; be significantly different from appropriate age, cultural, or ethnic norms; and be more than temporary, expected responses to stressful events in the environment. The emotional or behavioral responses must be consistently exhibited in at least three different settings, two of which must be educational settings, and one other setting in either the home, child care, or community. The responses must not be primarily the result of intellectual, sensory, or acute or chronic physical health conditions.<sup>i</sup>

Evaluating a student for possible “emotional disorder” is difficult for native English speakers,<sup>ii</sup> and even more so for ELs.<sup>iii</sup> This may be part of the reason for the under-representation of ELs in this disability category in Minnesota. Research indicates that status as an EL often is related to other characteristics sometimes associated with social-emotional problems, which makes it especially complicated to understand the influence of second language learning and acculturation on the EL’s behaviors.<sup>iv</sup> Some behaviors that are considered “disordered” may be typical based on cultural teachings, heritage, or community expectations.

As with all evaluations of ELs for special education services, evaluations of social/emotional functioning should be in the EL’s first language. Further, consideration of evaluation results must be considered in light of the EL’s background (see the section of this chapter on Immigrant English Learner Resiliency and Difficulties), cultural influences, and current environmental context. Information should be obtained from parents or family members. Unintended bias (making assumptions about individual ELs based on their belonging to a population group) must be avoided because it can result in inappropriate under-identification or over-identification of a need for special education services.

It is generally recognized that some behaviors may be common as part of typical development, the development of a new language, and acculturation. These behaviors may include:

- Playing in isolation.
- Not following directions.
- Not participating.

When these or other behaviors seem to be exhibited over a long time period, affect peer relationships, and impede the student’s ability to learn, an evaluation may be warranted. Nevertheless, it is always recommended that a preventive problem-solving approach or Multi-Tier System of Support (see Chapter 7) approach be undertaken first, so that problem behaviors are immediately addressed. Functional behavioral assessment/analysis is another approach that has been used with some success;<sup>v</sup> it involves clearly defining the problem behavior, identifying the conditions under which it occurs, then developing an intervention plan.<sup>vi</sup>

Interviews of parents and systematic observations of the student generally are recommended as important aspects of a multidimensional assessment of social/emotional functioning. Tool 11.1 provides parent interview questions suggested by the National Association of School Psychologists.<sup>vii</sup> Another tool that may be useful is the Strengths and Difficulties Questionnaire to which teachers could respond for use as part of an evaluation of

social/emotional functioning or for a general screening tool.<sup>viii</sup> The questionnaire is available online in numerous languages, and for children ages 4 to 17. Although it is copyrighted and cannot be modified, the developers indicate that paper versions can be downloaded and photocopied for non-commercial purposes.<sup>ix</sup>

In some cases, more serious mental health issues may be considered as part of the evaluation. It is important to understand the factors related to possible mental health issues in ELs, and avenues to follow if a mental health issue is suspected.

## **Immigrant English Learner Resiliency and Difficulties**

Some ELs are immigrants to the U.S. Many immigrant students have resolved, can resolve, or will resolve distresses that may accompany their transition into U.S. schools. Some benefit from stable and supportive family relationships while others develop supportive connections with peers or community members. Others may need professional support through the school setting (e.g., social workers, counselors, psychologists) or through medical or community mental health providers.

Although resiliency and difficulties have been studied most often in ELs who are immigrants or refugees, the same concepts apply to those ELs who are born in the U.S., including those of parents who are immigrants and those who have emigrated from countries without strife. Some ELs who are immigrants or refugees may have encountered as many as three sources of distress: (a) departure from their countries of birth; (b) endurance of potentially traumatizing events that placed them in various degrees of jeopardy; and (c) distress when they began interacting with their new country.<sup>x,xi,xii</sup> These sources of distress may elicit risk factors or protective factors for ELs, which may be reflected in resilience, impairment, or both. Over time, some immigrants and refugees develop more persistent and distinctive mental health disorders.

### ***Protective Factors***

Many factors have been reported to protect children from distress, thereby supporting their psychological well-being. These protective factors are particularly evident at the family, community, and societal levels.<sup>xiii</sup>

Factors sometimes expected to be protective have been found to not be so. For example, for immigrants, neither a child's age at the point of migration, nor the length of the child's formal education, seems to be a protective factor.<sup>xiv</sup> Similarly, household financial circumstances do not necessarily serve as a protective factor.

**Individual level protective factors** include the limited exposure to violence. Exposure to violence only prior to departure from the country of origin, without subsequent violence exposure, seems to be a protective factor.

**Family level protective factors** include: (a) lack of or limited, exposure of family members to violence; (b) family composition and functioning at the time of departure or entry; (c) parent health, including mental health stability (especially in mothers), and the child's perception of parent support; and (d) parent education, especially longer periods of education for fathers.

**Community level protective factors** include a high degree of peer support and presence of extended family in the neighborhood.<sup>xv</sup> Children who spend time in childcare settings with caring relationships between staff and children tend to have positive mental health outcomes.<sup>xvi</sup> Additionally, if children have been engaged in formal

or informal education programs while in crisis or conflict circumstances, the predictability and security of the education programs tend to serve a protective function.<sup>xvii</sup>

**Societal level protective factors** include (a) frequent participation in religious activities or belonging to a religion common in the new country; (b) relatively few changes in location, especially for boys; and (c) increasing length of time since departure from the home country because depression tends to decrease (although this does not hold true for children experiencing posttraumatic stress disorder).

### ***Risk Factors***

Several factors may have an impact on the psychological well-being of immigrant and refugee children, potentially limiting their academic outcomes. These risk factors may also be evident at multiple levels: individual, family, community, and societal.<sup>xviii</sup>

As with protective factors, factors sometimes expected to produce risk have been found to not be so. For example, a child's age or educational experience seems to have little or no impact on risk. Parents' education has no effect on risk. Further, the effects of household socioeconomic status, including parent stress and unemployment, are not clear.

**Individual level risk factors** include: (a) exposure to violence;<sup>xix</sup> (b) pre-existing physical, psychological, or developmental disorders; (c) gender – girls tend to experience higher degrees of risk to their well-being compared to boys.

**Family level risk factors** include: (a) having family members with exposure to violence; (b) amount of separation among family members and the impact of that separation (which might include either parents leaving children behind when they travel to the U.S. to pursue work or education or parents sending children to the U.S. to live with relatives); and (c) family functioning and parent health, including parent divorce and parents with crisis-related stress.

**Community level risk factors** are related to limited social support and integration into the community. For example, repeatedly changing schools seems to be related to externalizing behaviors such as aggressive behavior or oppositional defiance toward authorities.<sup>xx</sup> A stressful life context in exile, including discrimination, seemed to predict psychological problems 8-9 years after arrival,

**Societal level risk factors** may be complex and variable. Belonging to a persecuted religion or disconnection from a previous religious background are associated with higher internalizing symptoms such as anxious withdrawal. In some cases, the immigration process can be a risk factor when there is a placement in legal detention or other restrictive setting.<sup>xxi</sup> Resettlement location, such as a temporary placement in a refugee camp does not seem to predict poor mental health, but frequent changes in location have been associated with internalizing symptoms. Ethnic origin is not necessarily a risk factor, in part because this societal designation is highly contextual, and varied by situation.<sup>xxii</sup> Nevertheless, experiences of racial discrimination, particularly for Somali refugee girls, seems to have a substantial impact on mental health status. Discrimination may be mitigated by a Somali female's level of bicultural acculturation as both Somali and American.<sup>xxiii</sup>

## ***Indicators of Resilience***

Schools should consider the risk factors for students, but then also look at resilience factors. A judgment will need to be made about whether the resilience factors are sufficient to enable the student to work through the risk factors.

Indicators of resilience are observable both in the behaviors of students and in the ways students talk about their perceptions. Educators should observe the interactions between a child and his or her social environments to identify the presence of resilience indicators. It is also important to consider the child's perspective on their interactions. The following have been identified as indicators of resilience:

**Social Support.** Students exhibiting this resilience indicator have friends, especially with a variety of demographic characteristics, including both children and youth from their own national origins as well as children and youth with other backgrounds. They talk positively about siblings, cousins, or other relationships with age-mates in the community. They interact with ease with adults in the school setting.<sup>xxiv</sup>

**Education values.** Students demonstrate interest in education. They might communicate that educational success has an instrumental purpose of "gaining control over their lives, as the key to a higher status."<sup>xxv</sup>

**Acculturation.** Students fit into the description of the fourth stage of acculturation (cultural integration) or possibly the third stage of acculturation (negotiation).<sup>xxvi</sup> They show simultaneous interest in American culture and their culture of origin.<sup>xxvii</sup>

**Orientation to religion.** Students indicate connections to religion. These connections may be a guide for living a good life, a source of meaning about adversities, a source of spiritual or material support, a foundation of stability and continuity, a source of distraction from difficulties,<sup>xxviii</sup> or a source of strength that helps them feel a sense of control over their lives.<sup>xxix</sup>

**Avoidance.** Students manage difficult feelings and thoughts, at times, by temporarily avoiding them, whether by suppressing them or distracting themselves with activities such as spending time with friends, schoolwork, or sports.

**Hope.** Students exhibit feelings of hope, including making comments about their expectations for the future, such as ideas about further education, work and career, and adulthood.<sup>xxx</sup>

## ***Problems Requiring Intervention***

Teachers of ELs should be aware of several possible indicators of impairment that require additional services or support through various services, including health care, social services, or school supports. Each of the indicators of impairment described here may be exhibited through externalizing behavior or internalizing behavior. Externalizing behavior includes quick and observable anger escalation, verbal and physical aggression, impulsiveness, and possibly not conforming to a current classroom activity.<sup>xxxi</sup> Internalizing behavior includes anxiety, loneliness, low self-esteem, and sadness.<sup>xxxii</sup>

**Social isolation. *Externalizing:*** Students who are socially isolated actively conflict with classmates or peers in school, or they indicate positive connections that seem to be one-sided (e.g., the others would not identify them

as friends). They might indicate that their relationships with child relatives or neighborhood peers are strained. Their interactions with teachers may be perceived as defiant. **Internalizing:** Students have no apparent friends. They seem uncertain about, or avoid interacting with, adults at school, and might distrust adults from different cultural backgrounds. They might have social connections with only one or a few people, particularly those from the same linguistic and cultural background.<sup>xxxiii</sup> These students can become excessively fearful about separation from parents.<sup>xxxiv</sup>

**Education values. Externalizing:** Students actively oppose academic expectations, which they indicate are unwanted or imposed by others. Students imply that discrimination occurs at school or in the community.<sup>xxxv</sup>

**Internalizing:** Students demonstrate little interest in education through their statements or through their actions, but do not directly oppose academic expectations. They might indicate feeling substantial pressure to succeed.<sup>xxxvi</sup> Truancy, failure to complete schoolwork (especially homework), and lack of engagement in school events or activities are some signals of this concern.<sup>xxxvii</sup>

**Acculturation process. Externalizing:** Students may seem angry much of the time, or may express feelings of marginalization. They exhibit conflicts with adults in school and in the family. **Internalizing:** Students may seem overwhelmed or alienated from school, but do not directly express these feelings. Instead, they withdraw from most activities outside of the home, and may have poor school attendance. Some students who have internalized their struggles with the acculturation process may become suicidal.<sup>xxxviii</sup>

**Orientation to religion. Externalizing:** Students refuse to participate in their families' religious activities or practices. They might make a point of distancing themselves from others of their same national origins and religious backgrounds, yet do not also become involved in a different religious community.<sup>xxxix</sup> **Internalizing:** Students and their families are not connected to a religious community, possibly because there is not one of their religious tradition in the new community.<sup>xl</sup>

**Avoidance. Externalizing:** Students might have difficulties with self-regulation of distress, abruptly venting aggressively in ways that are out-of-proportion to situation.<sup>xli</sup> **Internalizing:** Students indicate lack of activity and boredom,<sup>xlii</sup> yet are likely not to become involved in school activities or organizations even if supported to do so. They might exhibit being preoccupied with distress, including complaining about pain that seems to have no basis.<sup>xliii</sup>

**Despair. Externalizing:** Students who experience despair may display strong emotions through repeated behavioral challenges that may lead to disciplinary problems at school. They might indicate expectations of ongoing problems and a foreshortened future.<sup>xliv</sup> Some students may become suicidal.<sup>xlv</sup> **Internalizing:** Students seem not to be able to see beyond whatever current problematic situation they are in, no matter its relative significance (or insignificance) when viewed by others. They seem mired in hopelessness, and with restricted range of emotions to negative ones, and passive in behavior.<sup>xlvi</sup>

## Formation of Mental Health Disorders

When the socio/emotional functioning of an EL suggests a mental health disorder, school psychologists or school counselors should be consulted. They likely are most familiar with the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*,<sup>xlvii</sup> which is used to categorize mental health

disorders. The disorders more likely to emerge in ELs, especially those who are immigrants or refugees, are adjustment disorders, acute stress disorder, somatic symptom and related disorders, post-traumatic stress disorder, depression, anxiety, and possibly substance-related and addictive disorders. See Tool 11.2 for descriptions of several mental health disorders that may be diagnosed in ELs.

Caution must be exercised in diagnosing any child with a mental health disorder. In the case of children particularly, due to the nature of human development, chronic conditions such as major depression or generalized anxiety disorder are indicated only when there is clear evidence of a symptom history prior to significant stressors, or over a substantial period of time.

## Recommended Steps for Conducting a Social/Emotional or Mental Health Evaluation

1. **Undertake a Multi-Tier System of Support (MTSS) or Applied Behavioral Assessment (ABA) approach to reduce the behavior that suggests the possibility of a social/emotional or mental health need for special education services.** This effort should be done in consultation with other professionals, including possibly a behavior management specialist, school counselor and school psychologist; it also may benefit from input from a psychiatric expert. Use of the Strengths and Difficulties Questionnaire may be helpful here.
2. **Collect information from multiple sources.** These multiple sources include reviewing the EL's educational history, interviewing parents (see Tool 11.1) and other educators who have contact with the student, classroom observations, and interviews with the student. When talking with parents and students, present the information and questions as neutrally as possible. The use of an interpreter or translator is needed when communicating with parents, and possibly also with students who have beginning levels of English proficiency skills.
3. **Compare, as appropriate, the EL's behaviors to those of peers from similar backgrounds and in similar circumstances.** This comparison can help in reaching a judgment about whether the EL's behavior reflects a common response to the lack of English skills, movement to a new location, or some other factor. Cultural liaisons can be a good resource to help interpret student behavior in a culturally appropriate context.

## Resources

- **Goodman, R. (2015).** *[The strengths and difficulties questionnaires](http://www.sdqinfo.com/)*. [Measurement instrument]. Retrieved from: <http://www.sdqinfo.com/>

The Strengths and Difficulties Questionnaire (SDQ), originally created in 1997, is a brief behavioral screening tool that is designed for children ages 4-17. It is available in a variety of languages.

- **Algozzine, B., & Ysseldyke, J. (2006).** *Teaching students with emotional disturbance: A practical guide for every teacher*. Thousand Oaks, CA: Corwin.

The authors of this book describe the cognitive, academic, physical, communicational, and behavioral characteristics of several forms of emotional disturbance and offer specific strategies for responding to them in the classroom.

- **Brown, J. E., Klingner, J., & Lamker, D. (2012, September 20).** [English learners who struggle in school: Strategies for response to intervention \(RTI\), referral to special education and academic evaluation](https://education.mn.gov/MDE/dse/sped/div/el/049273) [Webinar]. Retrieved from <https://education.mn.gov/MDE/dse/sped/div/el/049273>

Part 5 of this webinar series addresses how to assess the academic skills of English learners.

- **Fisher, W. W., Piazza, C. C., & Roane, H. S. (2011).** *Handbook of applied behavior analysis*. New York: Guilford Press.

This handbook provides detailed information on systematically using interventions to improve students' social behaviors in the classroom (i.e., applied behavior analysis). The authors present best practices in behavioral assessment and demonstrate evidence-based strategies for supporting positive behaviors and reducing problem behaviors.

- **Kohn, S., Scordia, D., & Esquivel, G. (2012).** *Personality and behavioral assessment: Considerations for culturally and linguistically diverse individuals*. In E. Lopez, G. Esquivel, S. Nahari & S. Proctor, (Eds.). *Handbook of Multicultural School Psychology: An Interdisciplinary Perspective* (pp. 289-308). Mahwah, NJ: Routledge.

This comprehensive handbook describes the field of multicultural school psychology. Chapter 12 provides an overview of cultural and linguistic factors in personality and behavior assessment, along with the pros and cons of commonly used assessment tools.

- **Salvia, J., Ysseldyke, J., & Witmer, S. (2017).** *Assessment: In special and inclusive education (13th ed.)*. Belmont, CA: Cengage Learning.

This resource provides comprehensive information on a variety of forms of assessment measures including assessments and observations of social and emotional functioning and student behavior, as well as interviews with students and families.

## **Tools**

***Tool 11.1: Parent/Family Interview Questions***

***Tool 11.2: Mental Health Disorders***

## Tool 11.1. Parent/Family Interview Questions

Interviewing the student's parents and other family member can help in understanding the EL's context from which his or her identity derives, the student's and family's values, and their goals for behavior.

The following questions were adapted from those suggested in an article in the National Association of School Psychologists *Communique Handout*.

1. Tell me about your daily routines when you were pregnant with [the student]. Who took care of you? Did you work? Did you experience any health problems?
2. Where was [the student] born – in a hospital, a clinic, or at home?
3. How different or similar are [the student's] first language skills, English, school achievement, social skills, behavior, etc., when compared to [his or her] siblings and/or other relatives?
4. Tell me about [the student's] daily routine after [he or she] gets out of bed in the morning. What does [he or she] like to do? Does [he or she] help you at home? Does [he or she] spend time with siblings or friends in the neighborhood?
5. Do you have any concerns about [the student's] health or past medical experiences?
6. Do you have any other information you would like to share with me so that we can help [the student] do better at school?

Adapted from Blatchley, L. A., & Lau, M. Y. (2010). Culturally competent assessment of English language learners for special education services.

## **Tool 11.2: Mental Health Disorders**

### ***Adjustment Disorders***

According to the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders*, adjustment disorders “involve the development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).”<sup>xlviii</sup> Further, they are exhibited in a manner “out of proportion to the severity or intensity”<sup>xlix</sup> of the stressor itself, and their expression causes significant functioning impairment. Individuals with adjustment disorders may show depressed mood, anxiety, or both. Adjustment disorders are distinguished from normal bereavement and from other more lasting disorders in that they can be expected to resolve after about six months of the end of the stressor event or its consequences. Although adjustment disorders may at first not be apparent, careful observers generally can recognize a triggering event.<sup>l</sup>

### ***Acute Stress Disorder***

According to the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders*, acute stress disorder involves “exposure to actual or threatened death, serious injury or sexual violation.”<sup>li</sup> Symptoms develop within three days to one month of the event that lasted for least three days to one month. Five categories of symptoms characterize this disorder: intrusion (sudden and unintentional recall of the event), negative mood (presence of sadness or absence of emotions), dissociation (loss of awareness of surroundings), avoidance (effort to not remember anything associated with the event), and arousal, perception of and then avoidance of an external trigger that evokes the event. At least nine of the 14 symptoms listed within these categories must be met. Further, the symptoms disrupt important areas of functioning.

### ***Somatic Symptom and Related Disorders***

Somatic symptom and related disorders are characterized by the co-occurrence of significant distress and the sensation of bodily difficulties. These disorders may be expressed as a Somatic Symptom Disorder or a Conversion Disorder. There is often an overlap of these disorders and depression or anxiety.<sup>lii</sup>

### ***Post-traumatic Stress Disorder***

Post-traumatic stress disorder (PTSD) is associated with exposure to, or threats of, serious bodily injury, death, or sexual violence. These violent acts can include situations in which a child is exposed to parents or family members being threatened or harmed. PTSD is marked by ongoing, even chronic, manifestation of symptoms that fall into the same categories as those of acute stress disorder (intrusion, negative mood, dissociation, avoidance, and arousal), although the descriptions for children here are slightly different. For example, intrusive memories while awake and dissociative re-experiencing might be expressed in what appears to be play reenactment, or when dreaming there may not be clear connections between dream content and elements of the traumatic event.<sup>liii</sup>

### ***Depression***

Depression in immigrant and refugee children can occur when they experience significant distress from migration. Depressed mood may be evident “most of the day, and nearly every day.”<sup>liv</sup> There is also substantially

decreased interest in most activities. Physical body changes also occur, such as unintentional weight loss or gain, coupled with appetite changes; for children, this symptom may be manifested by lack of developmentally appropriate weight gain. There also may be sleep pattern changes, either decreased or increased sleep. Sufferers often experience decreased energy and increased fatigue. Thinking and concentration may be impaired. Children may feel guilty, believe they do not have value, or may think about death.<sup>lv</sup>

### ***Anxiety***

Anxiety disorders reflect excessive experiences of fear and anxiety. Symptoms may include restlessness, easy fatigue, concentration problems, irritability, tension in muscles, and sleep disturbance. For adults, three or more of these symptoms are typically present, and for children, one symptom is sufficient for diagnosis. Panic Disorder is one condition within the anxiety disorders group that may be evident in children, with sudden strong rushes of fear or distress that may last for several minutes.<sup>lvi</sup> After experiencing a panic attack, individuals become persistently worried about having additional attacks and then avoid circumstances assumed to provoke the panic attacks.

## Endnotes

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