A Family-Based Intervention for Newly-Resettled Syrian Refugee Children

Kim Abi Zeid Daou

Department of Educational and Counselling Psychology

McGill University, Montreal

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Abstract

The Syrian conflict is one of the largest humanitarian crises of our time. With over 5 million individuals resettled worldwide, the Canadian Government has welcomed just over forty thousand Syrian refugees. Indeed, the stressors caused by the instability of the conflict and the resettlement process put refugee children at an especially high risk for mental health problems. Specifically, anxiety is a common problem experienced by refugee children. Therefore, mental health is a primary concern for newly resettled refugees, which must be addressed by host countries. Thus, early intervention is crucial to promote their adequate adaptation and development. This study evaluates the feasibility and effectiveness of a culturally-specific family-based storybook intervention for newly-resettled Syrian refugee children. Six Syrian refugee families ($M_{child\ age}$ = 9, SD = 1.26) living in the Montreal area were recruited, and participating parents were instructed to complete the intervention with their child. Anxiety symptoms were measured using the Revised Child Anxiety and Depression Scale (RCADS) both before and after the intervention, and families shared their experiences, thoughts, and feedback regarding the intervention in journal logs. The intervention yielded significant results. Indeed, there was a significant decrease in the children's level of anxiety symptoms. Furthermore, qualitative analyses demonstrated that the intervention was culturally-relevant to Syrian refugee families, and that it was effective in promoting children's overall well-being, agency, and family connectedness.

Résumé

Le conflit Syrien est l'une des plus grandes crises humanitaires de notre temps. Alors que plus de 5 millions d'individus ont été relocalisé à travers le monde, le gouvernement Canadien a accueilli plus de quarante mille réfugiés Syriens. En effet, les enfants réfugiés sont à un haut risque de développer des problèmes de santé mentale car ils sont exposés à divers facteurs de stress causés par l'instabilité du conflit et du processus de relocalisation. Donc, la santé mentale est une préoccupation primordiale chez les réfugiés nouvellement relocalisés. Conséquemment, il est crucial d'intervenir promptement dans les pays d'accueil, afin de promouvoir leur adaptation et leur développement adéquat. Cette étude évalue la faisabilité et l'efficacité d'une intervention prenant la forme d'un livre d'histoires culturellement spécifique pour des familles Syriennes nouvellement relocalisées. Six familles Syriennes ($_{age\ enfant}M = 9,\ ÉT = 1.26$) vivant dans la région de Montréal furent recrutées. Les parents participants ont reçu des instructions pour compléter l'intervention avec leurs enfants. Les symptômes d'anxiété furent mesurés en utilisant la Revised Child Anxiety and Depression Scale (RCADS) avant et après la durée de l'intervention. De plus, les familles ont partagé leurs expériences, idées et opinions en lien avec l'intervention, en utilisant des journaux de bord. L'analyse statistique a révélé des résultats significatifs. En effet, les symptômes d'anxiété ont diminué de façon significative. Ensuite, les analyses qualitatives ont démontré que l'intervention est culturellement pertinente pour les réfugiés Syriens, et qu'elle promeut le bien-être général des enfants, leur sens d'agence, la connexion familiale.

Acknowledgements

I would like to thank my parents, Roger and Tania, for encouraging me since I was a child to engage in critical thinking and to deconstruct dominant narratives and the structures that maintain them. In addition, I want to thank them for instilling in me the values to partake in knowledge-gathering in an ethical, responsible, and humane way.

I would like to thank my sister Léa for our late-night conversations on power dynamics, positionality and feminism.

Finally, a big thank you to the families who shared their invaluable experiences with me, and my supervisor Steven Shaw for his guidance and support.

Introduction

Over the past seven years, the conflict in Syria has forced millions of individuals and families to flee their country and seek asylum (UNHCR, 2013). This represents the one of the largest current humanitarian crises. As of 2017, over 5 million registered refugees have fled Syria to neighboring countries including Turkey, Lebanon, Jordan, Egypt, and Iraq (UNHCR, 2017). However, these numbers are underestimates as they do not account for non-registered asylum seekers. According to the United Nations High Commissioner for Refugees (UNHCR), host countries for Syrian refugees are the first and most important responders to the present crisis, delivering shelter and support (UNHCR, 2017). Global displacement has been increasing each year over the past five years, representing tens of millions of individuals removed from their homes.

As millions of Syrians continue to be displaced, the Government of Canada in collaboration with private sponsors, non-governmental organizations and provincial, territorial, and municipal governments worked to welcome Syrian refugees in Canada. According to the Canadian government, 40,081 Syrian refugees have been welcomed in Canada as of January 2017 (Government of Canada, 2017). The main objectives of the Canadian Government towards Syrian refugees' adaptation to their new life in Canada focus on employment and income support. It is important to note that systematic governmental income support on these aspects are limited to a 12-month period (Government of Canada, 2016). However, while refugees are eligible for health care as permanent residents, their psychological health is not addressed by the Canadian Government as a primordial concern for Syrian refugees' resettlement. However, many other organizations such as the UNHCR and the Canadian Collaboration for Immigrant and

Refugee Health (CCIRH) identify mental health as an imminent concern that must be prioritized in newly resettled Syrian refugees (Colborne, 2015; Hansen & Houston, 2016)

Syrian refugees are a highly vulnerable population who are subject to many risk factors for developing mental health problems. Therefore, early intervention is essential. Based on my fieldwork with newly re-settled refugee children in Lebanon over the years, and refugee families' inputs, it became evident to me that refugee children have an array of difficulties in managing and expressing their emotions. Indeed, refugee youth are at-risk for affective disorders. Therefore, based on my positionality as a Lebanese woman, my fieldwork, and my education, I felt it appropriate I create a culturally-specific intervention, titled "The Educational Storybook for Cognitive-Behavioral Mechanisms". The goal of this culturally-specific intervention is to get the children to recognize and manage their and others' emotions. Furthermore, as I build rapport and trust with the community, my goal was to listen to their needs and integrate their feed-back and make sure that the intervention is accessible and cost-effective for them. In the following sections, I will outline the relevant literature, present study, research question and hypotheses.

Literature Review

Refugees' Mental Health

Refugees experience various challenges when resettling in host countries, such as social and cultural adaptation, language barriers, finding a home and securing adequate income. While the aforementioned factors are pressing concerns for newly-resettled refugees, it is important not to neglect their psychological well-being when addressing their needs. Indeed, challenges experienced prior and following resettlement strongly impacts refugees' mental health, which can in turn deteriorate their adaptation (Agic et al., 2016).

Mental health is a crucial topic of concern for refugee children. Indeed, various factors related to their displacement put them at risk for elevated psychological distress and psychopathology. They are exposed to a variety of difficult and possibly traumatizing experiences, which can influence their development and their psychological and emotional development and well-being. Such factors include exposure to traumatic life experiences, violence, losses, and war, socioeconomic adversity, migration, and resettlement (Hodes, 1998; Sack, et al., 1998). Indeed, as a result of such difficult experiences, refugee children are highly vulnerable to mental health difficulties, including anxiety, depression, and symptoms of post-traumatic stress disorder (PTSD) (Crowley, 2009) Mental health is therefore an important area of concern which much be addressed in host countries.

Specifically, refugee youth have elevated levels of anxiety and depressive symptoms, and a lesser capacity to engage in strategies to manage stressful situations (Crowley, 2009). Anxiety is a common concern among refugee populations. Various studies have found elevated rates of anxiety in African, Asian, European, and Middle Eastern refugees (Jamil et al., 2007; Keyes, 2000). A study investigating the prevalence of mental illness among refugee youth in Québec found that that 21% met criteria for a psychiatric diagnosis, compared to 11% of their non-refugee counterparts (Toussignant et al., 1999). Other studies evaluating level of distress, and not specific diagnoses, found even higher rates: Sanchez-Cao and colleagues (2012) found that 29.6% of refugee youth in their sample suffered from elevated emotional symptoms. Moreover, 50% of refugee adolescents report experiencing symptoms of severe psychological distress (Reed et al., 2012).

Prevalence estimates of mental health problems in refugee youth vary due to differences in methodology, such as methods and criteria of evaluation, population of interest, and context of displacement. However, studies consistently find significantly higher rates of mental health problems in refugee youth than in the general population, and identify refugees' mental health as a primordial concern (UNHCR, 2015; Hansen & Houston, 2016).

The Effect of Displacement and Resettlement on Mental Health

Being exposed to war and violence has long-term psychological affects on youth, which can influence their life. A study investigating different types of therapy in Syrian refugee youth revealed that they displayed significantly elevated symptoms of PTSD, avoidance, hyper arousal as well as other psychological symptoms, which required follow-up and intervention (Dhamrah & Abueita, 2014; Damra, Nassar, & Ghabri 2014). Concurrently, the process of displacement is a stressful experience filled with loss that involves leaving home behind, and possibly losing family members (Edwards, 2017). Moreover, resettlement in Canada is a complex process for Syrian refugees. In addition to the psychological distress of living in a warzone, refugees experience the stress and challenges related to post-displacement circumstances. Indeed, securing appropriate housing and employment, managing linguistic barriers, and coping with feelings of social isolation is extremely challenging (Hansen & Houston, 2016).

More specifically, such intense life changes and instability experienced by refugee children may have adverse influences on their development. Children's relationship to their physical environment and to their social surrounding are important determinants of healthy psychological development (Masten & Gerwitz, 2006). For instance, a study evaluated the

impact of ecological instability on children's behaviors; ecological instability comprises various factors such as family stress, connection to extended family, parental employment, and residential mobility. The study found that children experiencing high levels of ecological instability displayed especially high levels of externalizing behaviors, including tantrums, rule-breaking, and aggression (Fomby & Mollborn, 2017). This finding is critical as Syrian refugee children experience a dramatic level of ecological instability.

Parental Mental Health. Considering the impact of being a refugee on parents' mental health problems is also important. Indeed, Refugee parents are likely to suffer from mental health problems, which represents an additional risk factor for mental health problems in refugee children to the aforementioned factors.

Adult refugees also suffer from the aforementioned experiences related to their refugee status. Refugees from different populations, including Syrian refugees, are at elevated risk to suffer from post-traumatic stress disorder (PTSD), anxiety, depression and other mood disorders, as well as substance use and abuse (e.g., Keyes, 2000; Pumaregia et al., 2005). Although the present study is not focusing on parental mental health, children's well-being can also be negatively affected by the mental health of their parents. Indeed, parental mental health problems have negative impacts on children's adjustment, and is related to higher rates of child mental health problems (Leinonen et al., 2003).

The different experiences and difficulties associated with Syrian refugees' circumstances before, during, and after their displacement have cumulative effects on the well-being. Consequently, refugee adults show greater levels of psychological distress than the general population (Fazel, Wheeler, & Danesh, 2005; Porter & Haslam, 2005). Indeed, the

meta-analysis of studies evaluating the mental health of refugees who have resettled in Western countries indicated that they are ten times as likely to suffer from PTSD, as well as overall psychological distress and much comorbid psychiatric symptoms (Fazel, Wheeler, & Danesh, 2005).

Anxiety in Refugee Children. Anxiety consists of a frightened feeling in response to the perception of a threat, either real or imagined. As opposed to fear or worry, anxiety is a general emotional response. In youth, anxiety is often experienced over events or circumstances that they cannot control, leading to inflexible thinking, inability to think of solutions, and feelings of helplessness (Dacey, Mack & Fiore, 2016). Though some level of anxiety is normative and adaptive in certain difficult situations, children who experience anxiety for extended periods of time can become hyper-vigilant to possible threats. These elevated levels of anxiety can generalize into daily life, and impair child functioning and development (Dacey, Mack & Fiore, 2016). Indeed, Elevated levels of anxiety among youth are predictive of negative outcomes including academic failure and premature withdrawal from school, as well as social and emotional problems (Van Ameringen et al., 2003). Refugee children are therefore especially likely to experience anxiety but during and after resettlement, as they are faced with hardship and instability through the displacement process (Fazel & Stein, 2002).

Moreover, anxiety is not an isolated phenomenon, as it is comorbid with behavioral problems (Cuffe et al., 2015). Thus, anxiety is a risk factor for mental health problems among children. A longitudinal study evaluated the effects of anxiety on youth over the course of 15 months: 50% of children with an anxiety disorder developed other psychiatric disorders including somatoform disorders and depression (Essau et al., 2002). Intervening on

anxiety in youth is therefore critical as anxiety can lead to more psychological problems over time. Therefore, my intervention will focus on decreasing symptoms of anxiety and increasing overall well-being.

An important negative impact of anxiety in children is on social functioning. Anxiety has inhibitory effects on social behavior, which leads to poor social skills (Mikami et al., 2011). Furthermore, anxious children are more likely to be socially neglected by peers, be less liked by peers, and to have overall lower social status (Strauss et al., 1987; Verduin & Kendall, 2008). Concurrently, loneliness and social dissatisfaction are linked to more behavioral problems and poorer academic outcomes (Coplan et al., 2007; Galanaki et al., 2008). Social difficulties brought about by anxiety can further exacerbate problems with behavioral, emotional, and academic functioning of children, and hence deteriorate their overall well-being. This is why the intervention will tackle themes such as social rejection and loneliness.

Protective Factors

Children who have lived through violence, unstable environments, and disruptive experiences are likely to experience emotional distress and problems with self-regulation, leading to elevated anxiety (Tyson, 2005). Fostering the development of their sense of agency, their capacity to have a responsibility on their actions, and control on their emotions and environment, is important in the management of their emotional distress and anxiety (Tyson & Tyson, 1984; Tyson, 2005). Indeed, considering the high level of instability and that refugee children experience, it is important to foster their sense of agency and their ability understand and manage their emotions and to engage in problem-solving. Therefore, the intervention seeks to increase the child's sense of agency.

Family connectedness has been shown to be a protective factor for refugee youth (Fazel et al., 2012). Indeed, family support and communication is an integral part of refugees' psychosocial adaptation in their country of resettlement (Hansen & Houston, 2016). Consequently, interventions or services for refugee children should be integrated in the family setting to impact their well-being. Thus, the intervention will be family-based as family connectedness has been shown to be a protective factor.

Intervention for Refugee Children

Early intervention is important in this population, as it faces high levels of psychological distress and anxiety that may have negative impacts on their adaptation to a new environment, and their emotional and social development. Cognitive-behavioural therapy (CBT) is commonly used and generally effective for the treatment of anxiety disorders (Foa & Meadows, 1997), and is effective in treating symptoms of depression and anxiety in children (Fréchette-Simard, Plante, & Bluteau, 2017; Urao et al, 2016). CBT emphasizes the importance of individuals' cognitive processes, emotional experiences, and behavioral responses, and how they interact and produce real-life outcomes (Perini & Rapee, 2014). I have therefore incorporated principles of CBT such as modeling and problem-focused problem solving. For instance, the modeling aspect was incorporated as the child perceived a protagonist they related to choose an adaptive and healthy course of action to their problems. To facilitate modeling, the characters were conceived to be relatable to the participants in terms of physical attributes, experiences, and culture. The problem-focused problem solving aspect was incorporated as the child perceives a story where the protagonist is experiencing a problem and is then asked to visualize the problem, and visualize a prosocial solution to the problem.

Unfortunately, mainstream mental health services and resources are not easily accessible to young refugees (Ehntholt, Smith, & Yule, 2005). Such services may not be viable options for refugee families, as tend to be expensive and time-consuming. Moreover, they are mainly centered on western philosophies. Refugees tend to be reluctant to accessing mental health services, due to stigmatization and cultural differences in treatment approaches and philosophies (Rogers-Sirin & Selcuk R. Sirin, 2015). Indeed, the creation of culturally specific mental-health services for marginalized populations is crucial, as such services are scarce and marginalized populations are at risk. When working with refugees, specialists must re-examine their techniques or thinking models (Miller, 1999; Tribe, 2002) to accommodate clients' cultural backgrounds. Indeed, it is important they understand the context-specific meanings or connotations of emotion, trauma and support in both the pre-migration and host cultures to ensure that the treatments and interventions are appropriate. Mental health professionals working with Syrian refugees in Canada must gain a better understanding of their realities, and focus on developing a sense of agency, community and social network and support. This is especially important as it may be difficult for refugees to properly discuss their difficulties and distress in a new environment because of various factors such as language barriers, lack of platform, and complex intergroup relations. (Hansen & Houston, 2016). Moreover, current recommendations stress the importance of coping with distress and negative affect without probing or emphasizing trauma-related issues, to avoid making refugees relive their trauma (Colborne, 2015; Hansen & Houston, 2016).

An accessible and practical way to provide such services for children would be through a storybook intervention. Psychological interventions for children can take the form of storybooks, which integrate psychoactive education in a story. For instance, storybooks are effective forms

of social-emotional intervention. Indeed, storybooks have been used as an intervention to improve parent-child interactions in children with Autism Spectrum Disorders, as it helped children develop their abilities in social participation (Zimmer, 2015). Moreover, using storybook with children who had to undergo tonsillectomy was shown to be effective in reducing their levels of anxiety surrounding surgery and recover (Tunney & Boore, 2013). However, using storybook interventions have not been studied in the context of forced displacement until the present study.

Present Study

The present study evaluates the effectiveness of a family-based storybook intervention, titled The Educational Storybook for Cognitive-Behavioral Mechanisms, with Syrian refugee children and their parents. This storybook was created to both weave cognitive-behavioral therapy (CBT) principles into storytelling, and to ensure its cultural relevance to the reader. Based on principles of CBT, the storybook intervention guides children to identify their negative affect, and to use adaptive strategies to better regulate their emotional responses. The storybook depicts stories of children in difficult situations, and brings the reader to identify the protagonist's emotions, and to propose adaptive courses of action.

This intervention was developed following the Open-Source Analogy Model of evidence-based practice and intervention. This model uses open-source software as an analogy, in which users have the opportunity to adapt the material to their needs. In this sense, the OSAM proposes a participatory approach where research participants and recipients of evidence-based intervention are involved in its development, fostering an active communication with the researchers. Furthermore, such interventions should be modifiable and adaptable to the specific

needs of its user (Shaw & Gomes, 2014). Thus, this intervention adheres to the philosophy of the OSAM, as it was developed to be easily adaptable to different needs, by modifying the stories, and that participants were actively providing feedback on the content of the storybook and its usefulness. The present storybook intervention was designed to be directly relevant to the needs of the refugee families, and the methodology ensured a close communication between the researcher and participants.

As previously mentioned, mental health services are hard to access, and mainly centered on western philosophies. Indeed, the creation of culturally-specific mental health services for marginalized populations is crucial. When working with refugees, specialists must re-examine their techniques or thinking models (Miller, 1999) to accommodate clients' cultural backgrounds. In addition, it is important they understand the context-specific meanings or connotations of emotion, trauma and support in both the pre-migration and host cultures. Therefore, the storybook will be culture-specific and parallel the situation of adapting to a new environment. The story is tailored to the situation of displacement and features Syrian protagonists that readers can identify with. Indeed, the characters have Arabic names, and typically Arabic features.

The objective of this storybook intervention is to provide an accessible and effective intervention that will promote refugee children's ability to identify and manage their feelings and decrease their anxiety symptoms. To evaluate the effectiveness of this storybook intervention, the following research questions will be explored: "does the emotion education storybook decrease anxious symptoms?", "does the emotion education storybook have a positive impact on

well-being?", "does the intervention increase feelings of agency and family connectedness?", and "Does the intervention succeed in being culturally relevant?"

This study will provide a holistic understanding through the usage of mixed-methods as it includes both qualitative and quantitative methods. The quantitative aspect of this project will provide reliable evidence regarding the effectiveness of my intervention in reducing symptoms of anxiety. The qualitative aspect of this project will enrich knowledge regarding the specific needs of the populations, and their lived experience of the intervention. To optimize the efficacy of the intervention, I will integrate participants' feedback by adjusting the content of intervention through a bottom-up participatory approach. Indeed, the intervention will be revised and modified based on the participants feedback.

Indeed, many forms of knowledge-gathering don't use participatory methodologies and are top-down rather than bottom-up. This can be problematic when the group being studied, such as refugees, is marginalized. Their feelings, thoughts or suggestions tend to not get a platform in the realms of academic research. As such, their standpoint is seldom present in the literature. Not including their personal accounts of their lived experiences is silencing and further marginalizing those members (Alcoff, 1991).

Method

Participants

The sample consists of 6 families. The children, four girls and 2 boys, are aged between 7 and 11 years old ($M = 9$, $SD = 1.26$). The families are newly-resettled Syrian refugees who live in Montreal, Quebec. Data was gathered with both the children and mothers. Indeed, both

mothers and fathers were invited to participate. At times, the fathers would comment on the interventions and questionnaires, however the mothers chose to be the principal contributor.

Intervention

I created the storybook intervention based on my review of the literature and my fieldwork in Lebanon, as I have worked with Syrian refugee youth before. The intervention consists of an illustrated interactive storybook, including four different stories. In each story, a different protagonist is depicted in a difficult situation. After each story, the reader is asked to identify the character's emotions, and to suggest a solution and course of action to solve their problems and improve their situation. At the end of each story, the child and the care-giver are then each asked to write about their experience with the intervention. Some parents expressed that they preferred answering guiding questions, such as "How did reading the storybook go?" and "Any additional comments?". Others preferred writing by themselves in their own notebooks or journals, while some preferred making an audio-recording of their thoughts.

The first story portrays a child, Yasmine, who is alone during recess-time, while other children are playing together. She appears to be sad about not playing with her classmates. The second story portrays George who appears to be nervous about his oral presentation. The third story portrays Yara, who is having an argument with her friend, after which they appear to be angry at each other. Finally, the fourth story portrays Karim, who is sitting alone in his bedroom, thinking of his house back home (see Appendix C).

Procedure

Participating families are all members of a non-profit organization. Potential participating families were first approached by the organization's director, with a summary of

the study. If they were interested, a meeting was set up with the parents to present the study in more detail. The intervention and data collection took place in participants' home. Each participating family was provided with a copy of The Educational Storybook for Cognitive-Behavioral Mechanisms that they can read and complete together.

The study followed a pre-test/post-test model. The following timeline of the study is restricted to the meetings needed for data collection and for explaining the study to the participants. However, it does not include additional meetings and communication with the participants which were crucial for building rapport with both parents and children, and providing them with resources when needed.

On the first meeting, consent was obtained, and parents were asked to complete a demographics questionnaire. During the same session, pre-test data was collected before the intervention sessions began. Each child completed the self-report version of the R-CADS, and each parent completed the parent-report version of the R-CADS to assess their level of anxiety symptoms. Then, participating families were provided with their copy of the storybook. The parents were instructed to read each story with their child and ask them a series of question that accompanies each story.

Following this first meeting, the collaborative reading of the book was done over the course of two weeks. After each story, the reader was asked the following questions: "How is [the character] feeling?", "Why is he/she feeling like this?", and "If you were in the character's place, what would you do to solve the situation and feel better?". Children answered the questions to their parents, and shared thoughts about the stories. The mothers and children also wrote in a journal after each reading. The journals included open-ended questions, to gather

information about the children's thoughts and feelings about the storybook, its content and its functionality and impact on children, and to provide spaces for them to express their own thoughts in the intervention on their own terms.

This qualitative data was especially relevant to this study, as qualitative research in social studies focuses on the manner in which a researcher construes and interprets others' experiences and the world around them (Sparkes & Smith, 2014). Therefore, such research must describe aforementioned experiences through the voice of its subjects (Sparkes & Smith, 2014). To this effect, the qualitative data gathered in this study represents a platform for the mothers and children to describe their experience and perception of the intervention, in their own terms. The different methods and aspects of qualitative research used in this study, journals, thematic analysis and trustworthiness, are discussed below (Braun & Clarke, 2006).

Finally, after approximately two weeks, another meeting took place to collect post-test data. Children and parents completed the R-CADS again to assess changes or improvements in levels of anxiety, and the journals were gathered.

Data Collection

Anxiety. Symptoms of depression and anxiety were evaluated using the Revised Children's Anxiety and Depression Scale (R-CADS; see Appendices A and B). The scale comprises 47 items identifying negative affect. For each statement, the child or the parent must select whether this is something that they experience '*never'*, '*sometimes'*, '*often'*, or '*always'*. The questionnaire holds excellent within scale reliability ($\alpha = .96$), as well as good to excellent internal validity ($\alpha = .75$ to $.90$) (Esbjørn et al., 2012).

Data Analysis

Pre-test and post-test data will be gathered in order to evaluate participants' improvement on their level of symptoms of anxiety. Paired-sample T-tests were used to assess whether participants' scores significantly changed between the two time-points. Furthermore, field notes and open-ended questions were analyzed.

Positionality

My previous time in the field working in Syrian refugee camps in Lebanon and my research ethics I have worked on cultivating and enhancing throughout the years helped inform the planning of my project prior to beginning it. I believe that my positionality as a woman of color and our shared culture and native tongue add integral perspective to the research (Alcoff, 1991).

Certainly, it is through our shared situated knowledge and lived experiences that I can efficiently provide the families with a safe platform for their thoughts and feelings in the realms of qualitative research and give their standpoint a presence in the literature (Haraway,1988).

Indeed, as the families are Syrian, and I am Lebanese, there was an instant feeling of familiarity. Our dialects are very similar, and Lebanon and Syria are neighboring countries and share Levantine culture. Their language and word usage were familiar and almost affectionate, sometimes comparing me to family members, and asking about my own family. They often asked how I adapted to living in Canada, and how I stay connected to my roots and my culture. At times, the participants told me about churches they have visited and loved in Lebanon, or Lebanese television shows they follow, and they appreciated connecting with me over matters that reminded them of home and made them sentimental.

I would like to note that I was also conscious of the difference between our positions and the connotations of our disclosure, and I always made that fact salient. Many times, due to my respect for their privacy and my awareness of how they found familiarity in me, I offered for us to discuss certain issues off the record and regularly reminded them that I can stop documenting any time. In addition, there were cases where specific personal matters were disclosed to me, and I instantly reminded them that I can erase any information they are not comfortable sharing.

Results

Anxiety Symptoms. Paired-samples t-tests were conducted to compare the level of anxiety symptoms at baseline, before the intervention, and after the completion of the intervention. There was a significant difference in the parent-reported Total Anxiety scores before the intervention ($M = 56.00$, $SD = 5.55$) and after the intervention ($M = 48.17$, $SD = 4.71$), $t(5) = 4.55$, $p = 0.006$ (see *Table 1* and *Figure 1*). There was also a difference in the child-reported Total Anxiety scores before the intervention ($M = 50.00$, $SD = 7.46$) and after the intervention ($M = 44.33$, $SD = 4.732$), $t(5) = 4.10$, $p = 0.009$ (see *Table 1* and *Figure 2*). These results suggest that levels of anxiety symptoms decreased after the intervention sessions were completed, according to both parents' and children's report.

Table 1.

Paired Sample T-tests of Total Anxiety Scores at Pre-Test and Post-Test

Total Anxiety Scores	Pre-Test		Post-Test		n	95% CI for Mean Difference	t	df
	M	SD	M	SD				
Parent Report	56.00	5.55	48.17	4.71	6	3.41, 12.26	4.55*	5
Child Report	50.0	7.46	44.33	4.32	6	2.11, 9.22	4.10*	5

* $p < .01$.

Figure 1.

Parent Report: Total Anxiety Scores at Pre-Test and Post-Test

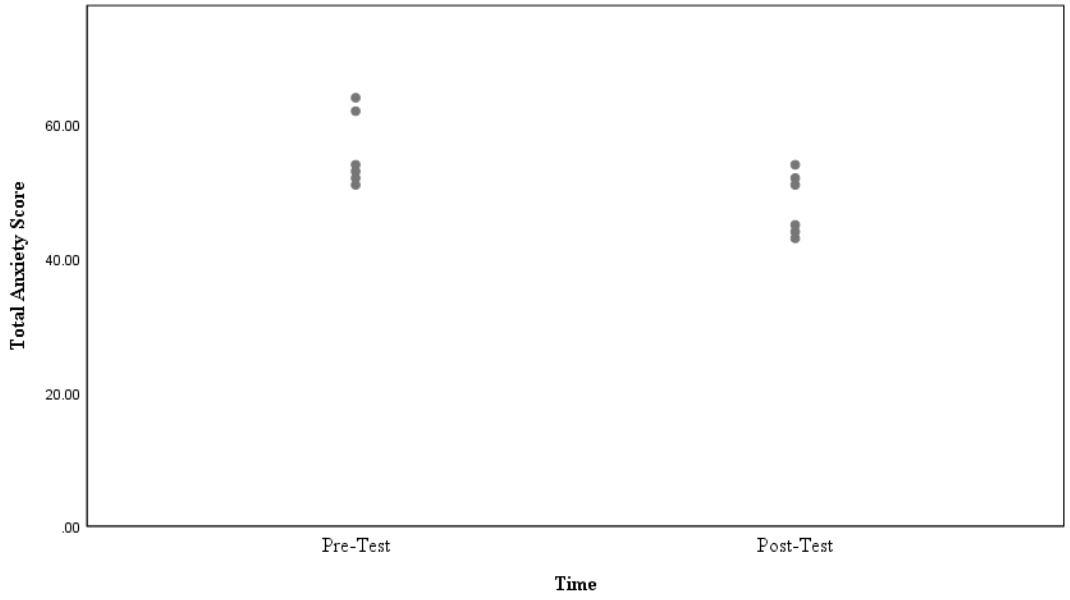
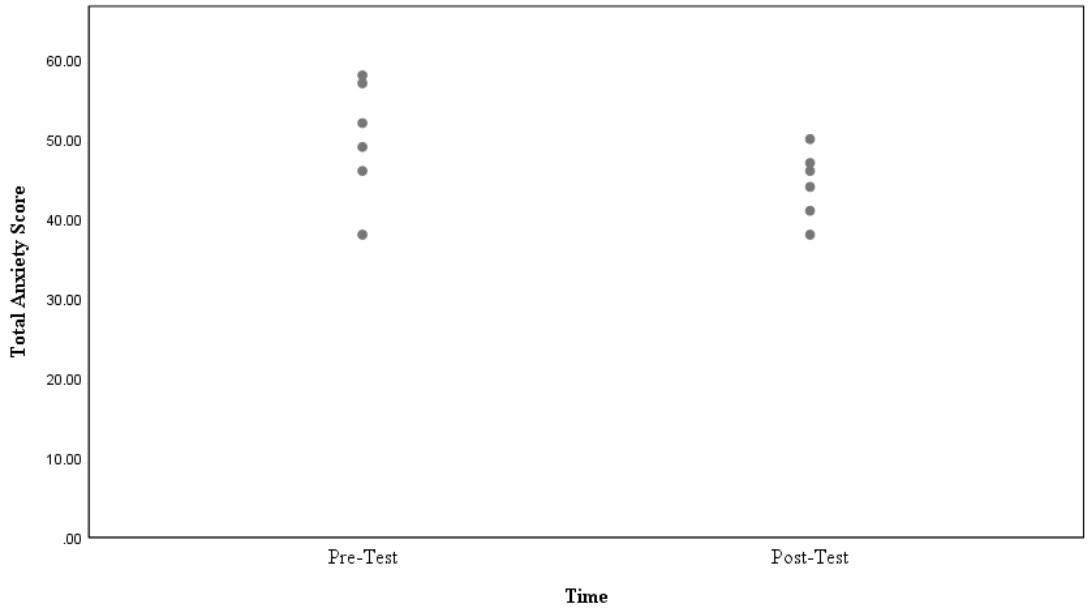


Figure 2.

Child Report: Total Anxiety Scores at Pre-Test and Post-Test



Other paired-samples t-tests were conducted to determine weather child report and parent report of level of anxiety symptoms differed. Total anxiety scores at baseline were not significantly different between parent report (M = 56.00, SD = 5.55) and child report (M = 50.00, SD = 7.46), $t(5) = -1.41$, $p = 0.218$. Total anxiety scores after the intervention were not significantly different either between parent report (M = 48.17, SD = 4.71) and child report (M = 44.33, SD = 4.732), $t(5) = -1.29$, $p = 0.253$ (see *Table 2*). These results indicate that parental report and child self-report both assessed level for anxiety symptoms similarly.

Table 2.

Paired Sample T-test of Parent Report and Child Report of Total Anxiety Scores

Total Anxiety Scores	Parent Report		Child Report		n	95% CI for Mean Difference	t	df
	M	SD	M	SD				
Pre-Test	56.00	5.55	50.0	7.46	6	-16.95, 4.95	-1.41 (ns)	5
Post-Test	48.17	4.71	44.33	4.32	6	2.97, -11,47	-1.29 (ns)	5

The usage of journal logs, or diary methodologies provide deeper insight into lived experiences. Furthermore, having such a platform can change the researcher-participant power dynamic, and encourage participatory approaches. Interviews and focus groups can sometimes resemble an interrogation, with the researcher asking questions, and being assigned the role of answering. Journal logs give the participants the autonomy to share what they want and express their thoughts at their chosen time and place (Meth 2003).

Therefore, the mothers were given journal logs to fill regarding each intervention session they had with their child. Though they were given recommended guiding questions, they had the space to write whatever the thoughts or feelings regarding the activity. Likewise, the children were given a journal log to fill individually. Some of the mothers and children preferred recording their input in their native language and used voice notes rather than paper and pen. Therefore, first I transcribed voice-notes and translated the journal logs that were written in Arabic. Secondly, I reviewed all journal logs and conducted a thematic analysis, following the six-step inductive process (Braun & Clarke, 2006). I selected the use of a thematic analysis for

this data, as it allowed me to explore and interpret it without ascribing to a specific theory. Indeed, adopting an atheoretical approach enables the researcher more freedom in interpretation (Sparkes & Smith, 2014). The first step consisted of reading all journal logs many times in order to gain a deep familiarity with their content. Secondly, meaningful sentences, or phrases, or words were selected and reviewed to generate initial codes. The third step consisted of categorizing and putting together codes collected from quotations or experiences described, and organizing them into themes. Fourth, I reviewed the themes with my co-investigator. Fifth, I revisited the codes and themes to see if sub-themes were present. The sixth step of the thematic analysis was the production of a report that presented the themes most clearly (Braun & Clarke, 2006).

The themes of "family connectedness", "cultural relevance", "agency", and "well-being" emerged from the parents' and children's journals. Each theme and its link to the literature will be described below by providing the reader with some direct quotations from the journals. The use of quotations in each theme is to show some of the relevant quotes to the story, rather than to present all the quotations relevant to the theme. Indeed, for the sake of brevity, I will adhere to a restricted number of quotes per participant or theme.

Cultural Relevance / Connection to the Characters

Both the mothers and the children highlighted the connection they felt to the book. They emphasized how they related to the character's problems, experiences, settings and physical attributes. For instance, one mother said,

> "[…] and Karim… we left the country and our house, it is part of our story too, and we also found happiness and the children adapted. Each story leads to multiple stories".

Another mother said,

> "I loved the book a lot, because it really resembles the things that happened with our children. The idea that the child is coming from another country, Yasmine for sure our children were like her, arriving in a new place… the first time you enter a place, the child is torn and then it works out. Yasmine resembles my children. George! You know, [my daughter] mentioned her fear of an oral presentation recently, and Karim… Karim resembles all of us. We have grown in our country, and I myself get homesick. Karim resembles us and our children, really. Those characters and stories are prevalent in each family that has left Syria and came here".

Furthermore, a third mother wrote about how her child related deeply to Karim, and the notion of being homesick.

The children also highlighted their connection to the characters and the themes. Indeed, many of the children were delighted to read about a protagonist with an Arab name, and with similar features. For example, one child wrote how,

> "Yasmine looks like me. She has tanned skin and brown eyes and hair"

Another child wrote,

> "I miss my old home but I have to get used to my new home"

Another child wrote how his best friend back home was named Karim.

Indeed, the themes, characters, and the storybook overall were relevant to the families' lived experiences and culture.

Agency

The theme of agency was prevalent in the journal logs. One mother wrote,

> "My child loved feeling responsible for helping the protagonist, felt responsible for outcome, and therefore really loved being the helper"

Another mother shared,

> "My child felt very motivated by feeling as though he can help the protagonist through his or her problem".

Furthermore, the mothers shared how the children enjoyed taking the lead on the activity and loved drawing the protagonists a positive outcome. One mother shared,

> "[…] his solving the problems of the protagonists seemed to carry on in other aspects of his life… which seemed to make him more optimistic".

Another mother wrote,

> "My daughter was very happy with the discussion because she was contributing in solving the problems of children such as George's shyness. That would help her in real life in overcoming problems and strengthening her personality."

In a different journal log, she added,

> "My daughter feels happy to assume responsibility as though she has responsibility towards the children in the book. […] the conversation was very interesting, and we were talking about Yasmine as though she is a close friend and we want to help her and that gave my daughter the love to help and the strength to integrate in her friend groups"

Children expressed that they felt very positively about taking a leading role in helping the protagonists in the different stories. For instance, one child wrote,

> "I felt very proud helping George resolve his fear",

and the rest of the children echoed those sentiments, by using words such as, "proud", "pleased", and action verbs such as "I taught the protagonist to…" "I advice the protagonist to…".

Indeed, the children took pride and satisfaction in being able to find positive solutions that would solve the characters' problems.

Family Connectedness

Both the mothers and the children expressed feelings of family connectedness because of the intervention. One mother shared,

> "I was happy we spoke through the book. She has been very at peace, I felt, since you gave us the story its been two weeks all we do is talk. We have gotten closer. We were close but have gotten closer. She started talking to me more comfortably, and I don't know why. Now, I know more things about her, and it makes me feel less anxious and more appeased. We would talk about Yasmine and Yara, and then it would turn into a long conversation about her life. Things she would have not otherwise told me".

Another mother wrote,

> "the intervention gave me insight into how my daughter thinks, and it made her more open to share her thoughts with me".

Another added,

"He communicated comfortably"

Thus, all the mothers highlighted that the intervention enhanced their family connectedness and communication with their children.

Improved Well-being

Both the mothers and the children expressed the children's heightened well-being with respect to the book. All mothers expressed that their child was "excited", "happy", and "optimistic" during and after the activity. For instance, one mother wrote,

"she was eager to read the whole thing in one day. She was very excited about the story, she even read them more than once. She really wanted to show her friends".

Furthermore, the children used words such as "happy", "excited", "contented", "optimistic", and "motivated".

For example, a child wrote,

"When I find a solution [for the protagonist] I am very happy"

Therefore, the participants emphasized that the intervention had a positive impact on the children's well-being.

Discussion

Storybooks have been used as a method of intervention in different populations such as children with ASD, and children before and after surgery (Tuney & Boore, 2013; Zimmer, 2015). However, such interventions have not been used with newly-resettled Syrian refugee

children until the present study. Indeed, the results of the study portray that such storybook interventions are useful with refugee populations.

A central element of the literature pertinent to this study is that refugees show greater levels of psychological distress than the general population (Fazel, Wheeler, & Danesh, 2005; Porter & Haslam, 2005). Specifically, the present results suggest that the intervention is effective in decreasing anxiety. Indeed, based on both the parents' and children's report of anxiety symptoms, there was a significant decrease in the children's anxiety following the storybook intervention. Due to the relatively small sample size, this result should be interpreted with some caution. However, this The Educational Storybook for Cognitive-Behavioral Mechanisms sheds light to a novel way of decreasing anxiety in refugee children.

Furthermore, qualitative data revealed that the intervention had a positive impact on the children's overall well-being. Both the mothers and the children expressed that the storybook positively impacted the children's well-being. For example, all mothers expressed that their child was "excited", "happy", and "optimistic" during and after the activity, and children used similar words expressing their positive emotions.

As previously mentioned, mainstream mental health services and resources are not easily accessible to young refugees, and they tend to be time-consuming and centered on Western philosophies (Ehntholt, Smith, & Yule, 2005). Through qualitative analysis, it was clear to us that I succeeded in creating a culturally-specific intervention. Indeed, the mothers and children emphasised how they related to the character's problems, experiences, settings and physical attributes. Indeed, many of the children were delighted to read about a protagonist with an Arab name, and with similar features. One child wrote how,

"Yasmine looks like me. She has tanned skin and brown eyes and hair".

The families' appreciation of these elements indicate that the storybook intervention is appropriate and relevant to Syrian refugees' culture and to their experiences.

Family connectedness has been shown to be a protective factor for the mental health refugee youth (Fazel et al., 2012). Through qualitative analysis, I appreciated that the intervention was successful in creating a bond between the mothers and their children. For example, one mother shared,

> "I was happy we spoke through the book. She has been very at peace, I felt, since you gave us the story its been two weeks all we do is talk. We have gotten closer. We were close but have gotten closer. She started talking to me more comfortably, and I don't know why. Now, I know more things about her, and it makes me feel less anxious and more appeased".

The storybook facilitated communication within the family and sparked deeper conversations about the children's lives.

Furthermore, having a sense of agency has been shown to be related to lower levels of anxiety in children (Tyson, 2005). I detected through thematic analysis different items that correspond to agency. Indeed, one mother shared,

"…his solving the problems of the protagonists seemed to carry on in other aspects of his life…which seemed to make him more optimistic".

Indeed, the storybook promoted children's sense of agency, as they took pride and contentment in taking responsibility for the characters and helping them solve their problems.

Finally, concordant to the principles of the OSAM, the intervention was reported to be time-effective, practical, appropriate for Syrian refugees, and enjoyable.

Caveats and Future Directions

One limitation of this study is the relatively small number of participants, as a larger sample size would reduce the risk of a type 1 error and type 2 error. Type 1 error consist of the rejection of a true null hypothesis, while a type 2 error consists of failing to reject a correct null hypothesis (Aron et al., 2012). The sample size was small because there are not many newly-resettled Syrian refugees with school-aged children in Montreal, and their time is scarce. Though it is challenging to recruit participants from special populations, and their time is invaluable, it is a privilege to work with them.

Due to the preliminary nature of this research, and the value of time for newly-resettled refugee families, I believed interviewing and building rapport with six families would be of outmost efficiency. Indeed, this population is at a very critical time of transition and it is therefore extremely important to ensure that their time investment is worthwhile. Furthermore, as I value bottom-up and participatory approaches, my priority was building rapport and investing time in the nurturing of mutual trust and accommodation with the families. For the same reasons, this study did not include a control group. As I am familiar with the challenges faced by newly-resettled Syrian refugees, I believed it was unethical to recruit families and for them to invest their time without receiving the intervention (Conner, 1980).

Indeed, many forms of knowledge-gathering do not use participatory methodologies and adopt top-down rather than bottom-up approaches to research and intervention. This can be problematic when the group being studied, such as refugees, is marginalized (Alcoff,1991). It was therefore a priority to give those families a platform to narrate their lived experiences, and for the methods to allow for flexibility in how participants wished to express them.

As the intervention comprised four stories, read on four different four times slots, the mothers and children kept journals where they logged their experience of each. As I believed that the mothers' experiences and wisdom is invaluable, my goal was to improve the intervention based on fieldnotes, the journal logs, and the mothers' verbal feedback. Indeed, future version of the book will be modified to take into account the participants' feedback. As refugee populations are at a very critical time of adaptation, my goal is for the intervention to be sustainable. Therefore, it is crucial to ensure it is practical and accessible for working parents and parents with many pressing obligations.

The mothers ensured us the intervention is time-appropriate, practical and useful. All mothers expressed that the situations in the storybooks are very relevant to their child, and parallel their situations.

A central principle of the OSAM is to ensure an intervention works and is useful and feasible for the population of concern. Now that it is established that the intervention is culturally-relevant, accessible and useful, the second step would be to examine if I succeeded in incorporating the CBT principles into the intervention. Indeed, the next step would be for me to examine whether or not those principles were effectively incorporated and whether or not the families engaged in aforementioned mechanisms, such as modelling and problem-focused

problem-solving. Once the proof of concept is conducted, the following step would be for me to contextualize the intervention and conduct it with other populations.

All the mothers expressed that their child fears going to bed alone and recommended I add a scenario about bedtime in the intervention. Consequently, I will be developing an intervention focusing on bedtime and sleeping based on the mothers' recommendation and aforementioned CBT principles.

In addition, consistently with the OSAM, it is important to us that interventions are accessible and adaptable. To this effect, I will be adapting the intervention to students in specialized classrooms, who are also youth at risk for elevated anxiety. Indeed, children with developmental disorders such as autism, intellectual disability, or emotional and behavioral difficulties are especially at risk of experiencing symptoms of anxiety and depression (Matson & Shoemaker, 2011; Deb et al. 2001). Indeed, children with a below average IQ and learning difficulties are especially prone to developing a late onset Generalized Anxiety Disorder at ages 10 to 13 (Jarrett et al., 2015). Aforementioned symptoms interact with and exacerbate the social impairments that those children are experiencing due to their developmental disorder(s). The intervention will be contextualized to the experiences and needs of those students. In addition, similarly to the present study, I will adopt a bottom-up approach, and incorporate the teachers' feedback and lived experiences.

Conclusion

The Canadian Government has welcomed approximately forty thousand Syrian refugees in recent years. Anxiety is a common problem experienced by refugee children, as they are exposed to various risk factors. Therefore, early intervention is crucial for their adaptation and

healthy development. The Educational Storybook for Cognitive-Behavioral Mechanisms intervention yielded significant results as there was a significant decrease in the children's levels of anxiety symptoms. In addition, qualitative analyses revealed that the intervention was culturally-relevant to Syrian refugee families, and that it successfully promoted children's overall well-being, agency, and family connectedness. Consequently, future iterations of the intervention will be modified to take into account the participants' feedback. In addition, the intervention will be contextualized and modified to meet the needs of other at-risk populations.

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Appendix A

Parent Report Revised Child Anxiety and Depression Scale

Date: _____ **RCADS-P**
Name/ID: _____ Relationship to Child: _____

Please put a circle around the word that shows how often each of these things happens for your child.

1. My child worries about things	Never	Sometimes	Often	Always
2. My child feels sad or empty	Never	Sometimes	Often	Always
3. When my child has a problem, he/she gets a funny feeling in his/her stomach	Never	Sometimes	Often	Always
4. My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
5. My child feels afraid of being alone at home	Never	Sometimes	Often	Always
6. Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
7. My child feels scared when taking a test	Never	Sometimes	Often	Always
8. My child worries when he/she thinks someone is angry with him/her.	Never	Sometimes	Often	Always
9. My child worries about being away from me	Never	Sometimes	Often	Always
10. My child is bothered by bad or silly thoughts or pictures in his/her mind	Never	Sometimes	Often	Always
11. My child has trouble sleeping	Never	Sometimes	Often	Always
12. My child worries about doing badly at school work	Never	Sometimes	Often	Always
13. My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
14. My child suddenly feels as if he/she can't breathe when there is no reason for this.	Never	Sometimes	Often	Always
15. My child has problems with his/her appetite	Never	Sometimes	Often	Always
16. My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17. My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
18. My child has trouble going to school in the mornings because of feeling nervous or afraid.	Never	Sometimes	Often	Always
19. My child has no energy for things	Never	Sometimes	Often	Always
20. My child worries about looking foolish	Never	Sometimes	Often	Always
21. My child is tired a lot	Never	Sometimes	Often	Always
22. My child worries that bad things will happen to him/her	Never	Sometimes	Often	Always
23. My child can't seem to get bad or silly thoughts out of his/her head.	Never	Sometimes	Often	Always

24. When my child has a problem, his/her heart beats really fast	Never	Sometimes	Often	Always
25. My child cannot think clearly	Never	Sometimes	Often	Always
26. My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27. My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always
28. When My child has a problem, he/she feels shaky	Never	Sometimes	Often	Always
29. My child feels worthless	Never	Sometimes	Often	Always
30. My child worries about making mistakes	Never	Sometimes	Often	Always
31. My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32. My child worries what other people think of him/her	Never	Sometimes	Often	Always
33. My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34. All of a sudden my child will feel really scared for no reason at all	Never	Sometimes	Often	Always
35. My child worries about what is going to happen	Never	Sometimes	Often	Always
36. My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37. My child thinks about death	Never	Sometimes	Often	Always
38. My child feels afraid if he/she have to talk in front of the class	Never	Sometimes	Often	Always
39. My child's heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40. My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always
41. My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42. My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
43. My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always
44. My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45. My child worries when in bed at night	Never	Sometimes	Often	Always
46. My child would feel scared if he/she had to stay away from home overnight	Never	Sometimes	Often	Always
47. My child feels restless	Never	Sometimes	Often	Always

Appendix B

Child Report Revised Child Anxiety and Depression Scale

Date: _____ Name/ID: _____

RCADS

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

1. I worry about things	Never	Sometimes	Often	Always
2. I feel sad or empty	Never	Sometimes	Often	Always
3. When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4. I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
5. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6. Nothing is much fun anymore	Never	Sometimes	Often	Always
7. I feel scared when I have to take a test	Never	Sometimes	Often	Always
8. I feel worried when I think someone is angry with me	Never	Sometimes	Often	Always
9. I worry about being away from my parents	Never	Sometimes	Often	Always
10. I get bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
11. I have trouble sleeping	Never	Sometimes	Often	Always
12. I worry that I will do badly at my school work	Never	Sometimes	Often	Always
13. I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
14. I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15. I have problems with my appetite	Never	Sometimes	Often	Always
16. I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17. I feel scared if I have to sleep on my own.	Never	Sometimes	Often	Always
18. I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
19. I have no energy for things	Never	Sometimes	Often	Always
20. I worry I might look foolish	Never	Sometimes	Often	Always
21. I am tired a lot	Never	Sometimes	Often	Always
22. I worry that bad things will happen to me	Never	Sometimes	Often	Always

23. I can't seem to get bad or silly thoughts out of my head.	Never	Sometimes	Often	Always
24. When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
25. I cannot think clearly	Never	Sometimes	Often	Always
26. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27. I worry that something bad will happen to me	Never	Sometimes	Often	Always
28. When I have a problem, I feel shaky	Never	Sometimes	Often	Always
29. I feel worthless	Never	Sometimes	Often	Always
30. I worry about making mistakes	Never	Sometimes	Often	Always
31. I have to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32. I worry what other people think of me	Never	Sometimes	Often	Always
33. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34. All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always
35. I worry about what is going to happen	Never	Sometimes	Often	Always
36. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37. I think about death	Never	Sometimes	Often	Always
38. I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always
39. My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40. I feel like I don't want to move	Never	Sometimes	Often	Always
41. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
43. I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
44. I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45. I worry when I go to bed at night	Never	Sometimes	Often	Always
46. I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always
47. I feel restless	Never	Sometimes	Often	Always

Appendix C

Storybook Sample: Karim's Story

Today, Karim feels a little off.

He is sitting alone in his new bedroom, looking outside the window.

He lies down in his bed,
thinking about how he misses his old home.

Karim doesn't really want to talk to anyone
or to do anything.

How is Karim feeling?
Why is he feeling like this?

If you were in Karim's place, what would you do to solve the situation and feel better?