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Cultivating Well-Being in English as a Second Language: Teaching Stress Reduction Techniques in the Adult ESL Classroom

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Sara Coronado
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MASTER OF ARTS

in

TEACHING ENGLISH TO SPEAKERS OF OTHER LANGUAGES

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Under the guidance and approval of the committee, and approval by all the members, this field project (or thesis) has been accepted in partial fulfillment of the requirements for the degree.

Approved:

_____	_____
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_____	_____
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ABSTRACT

Adult immigrant and refugee speakers of English as a Second Language (ESL) including California community college students may suffer trauma and stressors that can lead to negative mental health outcomes during the stages of migration, yet underutilize mental health services owing to cultural stigma, structural barriers, and a lack of English language proficiency. In addition, ESL speakers may also suffer from language anxiety evoked by speaking the less-developed language in the classroom as well as outside of the classroom during interactions with the majority language community. Both forms of anxiety share symptoms including tense muscles, rapid breathing, shortness of breath, rapid heart rate, sweaty palms, and an inability to focus. While ESL teachers may not feel equipped with mental health resources to support their students, stress reduction techniques including Mindfulness-Based Stress Reduction (MBSR) and progressive muscle relaxation have been taught to health studies undergraduate and graduate students with self-reported positive impacts. The project is a website for ESL teachers and students that presents these stress reduction techniques with the aim of teaching self-care while de-stigmatizing mental health issues, and it is informed by the Affective Filter hypothesis and the Input hypothesis of Stephen Krashen's theory of second language acquisition. The website is designed with scripts and recordings geared to adult ESL students, vocabulary, and a self-care plan with activities that support multiple intelligences as well as learning styles in order for adult immigrant and refugee students to attend to the psychological health of themselves and their families.

CHAPTER I
INTRODUCTION

Statement of the Problem

Attaining a quality of life that supports health and well-being is a universal human right (UN General Assembly, 1948, art. 25). The World Health Organization (WHO) elaborates, health is "a state of complete physical, mental, and social well-being" (WHO, 1948, para. 1) thus acknowledging the existence of mental health issues and the need for support. The WHO also recognizes the negative impacts on the present and future mental health of refugees and immigrants, "persons on the move," evoked by the exposure to trauma and stressors experienced in the pre-migration, transit, and post-transit stages of migration (Resolution 36/13, UNHRC, 2017; WHO, 2019; 2021; 2022). The exposure to trauma and stressors in all stages of migration are associated with negative mental health outcomes including anxiety, depression, psychological distress (Sangalang et al., 2018), as well as with post-traumatic stress disorder (WHO, 2022). Yet, immigrant and refugee populations in the United States and Canada, underutilize mental health support (Potocky & Naseh, 2019; Salami et al., 2019; WHO, 2022) attributed, in part, to cultural stigma, structural barriers, and the lack of English language proficiency (Krivitsky, 2017; Potocky & Naseh, 2019; Salami et al., 2019). As refugees and immigrants both with and without documented legal status also constitute a segment of the students in the California Community Colleges (CCC) credit and non-credit English as a Second Language (ESL) programs (Eastman, 2020; CCCCO, 2023), they too may experience the same types of barriers to mental health support for stress and trauma (CCCCO, 2018).

Trauma may be defined as "any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning" (APA, 2023) or as explained by Substance Abuse Mental Health Services

Administration (SAMHSA), "Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, n.d., p.1-1). Examples of traumatic stressors experienced during the pre-migration stage for migrants, including refugees and immigrants with and without documented legal status, consist of natural disasters, armed conflict, sexual violation, threat of bodily injury, and death (APA, 2019). Both immigrants and refugees may suffer these similar circumstances and reasons for leaving home, yet both have different legal protections.

A migrant is someone who lives outside of the country in which they were born, hence a refugee and an immigrant are both migrants. An immigrant leaves of his volition for family reunification, economic stability, education, or political freedom as well as to escape violence or armed conflict (MPI, 2019). A refugee is a type of migrant who must leave home as a result of human rights violations without protection from their government and who "…owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country… or unwilling to return to it" (UNHCR, 2010, Article 1, p. 14). The refugee has legal protection from the host country. Immigrants with or without documented legal status may face similar trauma in the home country evoked by exposure to violence or political conflict that forces departure and immigrants without documented legal status may be deported after arrival. In any case, all suffer denigration of mental health caused by the pre-migration stressors, decision to leave, and to withstand loss in the pre-migration stage (Potocky & Naseh, 2019).

Whether with or without documented legal status, many immigrants and refugees, students and non-students, suffer trauma and stressors that are associated with post-migration negative health outcomes of anxiety, depression, psychological distress, or post-traumatic stress disorder (Adkins et al., 1999; APA n.d.; APA, 2023; CCCCO, 2018; CCCCO, 2019; Eastman, 2020; Krivitsky, 2017; Potocky & Naseh, 2019; Salami et al., 2019; Sangalang et al., 2018). All groups may populate the community college adult ESL classrooms of the noncredit program. All groups may suffer from symptoms of anxiety or stress.

The transit stage also exposes immigrants and refugees to potential traumatic stressors that also negatively impact the future physical and mental health during adaptation of the new culture (Potocky & Naseh, 2019; Sangalang et al., 2019). While transit can result in an uneventful arrival of the immigrant with documented legal status, transit can also be the dangerous journey that is filled with threats to life and limb, sexual or gender-based violence, and robbery of other migrants. Refugees can flee through war-torn areas, suffer captivity, torture, injuries, lack of food and water, or disease from living in unsanitary camps (Potocky & Naseh, 2019), while other migrants can experience, extortion, physical and verbal abuse (Sangalang, et al., 2019) as well as kidnapping, Medecins , and torture (Médecins Sans Frontières, 2017). Undocumented immigrants on the way to the US border may also be assaulted and robbed by smugglers who leave them without delivery across the border or can die from suffocation in overcrowded smuggling trucks traversing the border (Potocky & Naseh, 2019). Once undocumented immigrants have crossed the border, they may face threats of deportation (Sangalang, 2019).

Hence, immigrants and refugees may share stressful migration experiences as increasingly, immigrants with and without documented legal status may also feel forced to flee armed conflict or can suffer violence similar to refugees while in the pre-migration and transit stages (MSF, 2017; Potocky & Naseh, 2019; Sangalang, 2019). Regardless, all groups

share loss. They suffer the loss of the common buffers of stress, family, friends, community, and the "familiar" (Potocky & Naseh, 2019). Ties to ethnic, political, and religious communities of both groups are broken. In short, refugees and immigrants, including California Community College students in the non-credit ESL program can suffer trauma during pre-transit, transit, and post-migration stages.

Furthermore, in addition to previously experienced traumatic stressors, migrants can endure post-arrival economic, social, and personal stressors as well as post-arrival trauma that also negatively impact mental health outcomes (Sangalang et al., 2019). Economic stressors of unemployment, poverty, and low income as well as social stressors of discrimination, racism, non-integration, social exclusion, stigma combined with personal stressors of family separation, limited social networks, and isolation, as well as a loss of status and income may negatively affect the psychological and physical health of all (Krivitsky, 2017; Potocky & Naseh, 2019; WHO, 2020). Some specific obstacles thwart refugees and immigrants from obtaining mental health care.

Cultural concepts of psychological distress differ between ethnicities and cultures (Substance Abuse and Mental Health Services Administration, 2014), and little understanding of Western concepts of psychological health and counseling combined with cultural stigma and structural barriers as well as language issues prevent immigrant and refugees from accessing care for psychological health (Eastman, 2020;; Krivitsky, 2017; Potocky & Naseh, 2019; Sangalang, et al., 2019; WPA, 2021). In contrast to Western and to White concepts of health and healing, some cultures do not distinguish between physical, mental, or spiritual health (SAMHSA, 2014). Non-western cultures differ in their perception of symptoms and diseases, causes, and treatments of mental illness (Krivitsky, 2017; Potocky & Naseh, 201; Sangalang, et al., 2019), and migrant groups may not grasp nor recognize the Western concept of mental health illness and symptoms. Hence, some groups may not have a

definition for mental illness, might not perceive persistent sadness, nor recognize depression, anxiety, or psychosomatic symptoms as part of mental health (Potocky & Naseh, 2019; Salami, et al., 2019).

Mental illness itself is perceived as acting aggressively or "acting crazy" (Krivitsky, 2017; Salami, 2019). Psychological distress may be expressed as physical somatic symptoms such as stomach pain, headaches, backaches, sleep disturbances, and shortness of breath (Krivitsky, 2017; Salami, et al., 2019). Individuals may also describe their symptoms of illness as a crisis of faith, a personal weakness (Salami, et al., 2019), or as malignant spirits (Krivitsky, 2017; Potocky & Naseh, 2019; SAMHSA, 2019). Talking to strangers about feelings or emotional problems may not be a cultural practice (Potocky & Naseh, 2019; SAMHSA, 2014). If migrant clients experience psychological distress, they prefer talking to family, friends, or spiritual leaders (Salami et al., 2019; SAMHSA, 2014).

As cultural stigma is one main barrier for migrants in seeking and obtaining psychological support (Krivitsky, 2017; Potocky & Naseh, 2019; Salami et al., 2019) clients conceal significant suffering and symptoms from family and extended support owing to a sense of shame and failure (Salami, et al., 2019) and fear of stigmatization by and isolation by the ethnic community. If mental illness of a family member is known, migrant clients also fear loss of social status, having fewer opportunities for marriage and business, as well as discrimination and social exclusion from their ethnic and the adopted community alike (Krivitsky, 2017; Salami, et al., 2019). In addition, migrants fear loss of custody of children, being deported, or having a termination of other resources for disclosing mental illness (Salami, et al., 2019). Besides cultural stigma, refugees and immigrants may also contend with structural barriers.

Some structural barriers to mental health services after arrival consist of the little local availability of mental health services, or if offered, services may run at inopportune

times when adults need to work, tend families, or when they cannot obtain childcare nor transportation. Moreover, an inability to afford mental health services, a lack of insurance, sometimes owing to jobs with low pay and without benefits, unclear residence, eligibility, or immigration status, and visa issues add further obstacles (Krivitsky, 2017; Potocky & Naseh, 2019).

Related to structural barriers are limited culturally sensitive services for migrants and refugees including issues of language. English proficiency of migrants is limited as are the availability of translation services. While translation can help, therapists may not possess an understanding of the cultural context of the behavior and the symptoms to help a patient (Potocky & Naseh, 2019; Sangalang, 2014). Even with translators, complete understanding is not always attainable. Moreover, translators who are usually drawn from the refugee community are not always trusted, confidentiality becomes an issue (Krivitsky, 2017; Salami et al., 2019). Burden on the family (Salami et al., 2019) and power issues in the family (Krivitsky, 2017) also arise when family members are bidden to translate, thus affecting family dynamics and causing stress (Potocky & Naseh, 2019). In sum, numerous cultural, structural, and language issues prevent refugees and immigrants from accessing mental health care and may contribute to negative impacts on their mental health (Sangalang et al., 2018). These barriers also affect California community college adult ESL students including those with uncertain legal status as well as those who are the children of mixed-status families (CCCCO, 2019, p. 3) in the non-credit ESL program.

According to the California Community Colleges Chancellor's Office, approximately 1.8 million students attended classes in the 2021-2022 academic year with 10% or 180,000 enrolled in adult education or adult ESL courses (CCCCO, n.d.). The CCC ESL students are a diverse population with equally diverse needs and goals in pursuing both credit and non-credit ESL courses. They have acquired more English proficiency than have immigrant

or refugee students in the adult community-based classes who possess little to no English language skills (Rodriguez et al., 2019). Hence, many CCC adult ESL students are immigrants with high school, college, or graduate degrees from their home countries, while others may have attended California elementary, middle, or high schools or are working in the labor force (Rodriguez et al., 2019). A number of students pursue ESL classes in order to improve job prospects, to obtain career certificates or associate degrees, or to attend four-year colleges. Many are taking care of families, and some learn ESL in order to communicate with their children who are acculturating using English outside of the home (M. Tostado, personal communication, 2022). Some may need emotional support.

The CCC Dreamers' Project Report estimated a segment of 50,000 - 70,000 community college students are with undocumented legal status which may place them in need of mental health support and trauma therapy (California Community College Chancellor's Office, 2018, p. 29) and with insufficient access to culturally competent mental health services (CCCCO, n.d., p. 26). Whether with or without documented legal status, some groups of immigrants and refugees, students and non-students, suffer trauma and stressors associated with post-migration negative health outcomes of anxiety, depression, or post-traumatic stress disorder (Adkins et al., 1999; APA n.d.; APA, 2023; CCCCO, 2018; CCCCO, 2019; Eastman, 2020; Krivitsky, 2017; Potocky & Naseh, 2019; Salami et al., 2019; Sangalang et al., 2018).

Related to language issues and anxiety caused by emotional trauma, adult refugee and immigrant second language speakers, both students and non-students alike can suffer from language anxiety (Garcia de Blakeley, et al., 2017; Horwitz, 1986; Sevinc & Backus, 2019). Language anxiety can negatively impact second language acquisition in the classroom as well as outside of the classroom in interactions with the majority language community or with the heritage language community by impeding language use, growth, and acquisition, and thus

social connection. (Garcia de Blakely et al., 2017; Pishghadam et al., 2016; Sevinc & Backus, 2019). CCC students in the non-credit ESL program are both students and workers or parents who may experience language anxiety in the ESL class or while outside of class interacting with the majority language culture.

Second language speakers, including community college adult ESL students may experience uncomfortable feelings in the classroom, “I feel more tense and nervous in my language class than in my other classes” second language student (Horwitz et al., 1986, p. 130), or have unpleasant social experiences in the community during interactions with the majority culture, “Some of them laugh at you if you use the wrong word…so you feel discriminated, and despised” second generation Turkish immigrant (Sevinc & Backus, 2017, p. 715). Hence, community college adult ESL students in the noncredit ESL program may suffer from symptoms of stress and anxiety as well as from language anxiety in class and out in the community using the target language (Garcia de Blakeley; 2015; Sevinç & Backus, 2017).

Chronic stress is unhealthy (Kabat-Zinn, 2013; Harvard Medical School, 2020). Research has shown it harms the body, engenders disease, and can ultimately lead to some forms of mental illness (APA, 2019). Stress is the continuous activation of the fight or flight response of the central nervous system which negatively impacts the body including the musculoskeletal, respiratory, and the cardiovascular systems (APA, 2019). Muscles constantly tense against a perceived threat. Shortness of breath and rapid breathing occur. The heart increases both the amount of and the rate at which it pumps blood. If the stress hormones released to provide extra energy during the short-term fight or flight response are continually released under chronic stress and not tended to, this can result in heart disease, chronic fatigue, immune disorders, diabetes, obesity, and among other diseases, depression and anxiety (APA, 2019). Jon Kabat-Zinn noted a real or self-perceived loss of control over

one's life contributes to stress (Kabat-Zinn, 2013, p. li). Refugees and immigrants, including adult ESL community college students, may feel continuously stressed during the transition from home to the adopted country during acculturation.

The statement of the problem, in sum, is adult community college students in the non-credit ESL program may suffer from symptoms of trauma and stress arising from pre- and post-migration trauma and post-migration stressors as well as from language anxiety, while simultaneously experiencing barriers to mental health support including cultural stigma, structural issues, and lack of language proficiency. Potential negative mental health outcomes may result (Sangalang, 2019).

Purpose of the Project

The purpose of this project is to provide ESL lessons in stress reduction techniques that ESL teachers can implement to support the well-being of learners and to reduce the symptoms of anxiety based in trauma and in language use experienced by adult immigrant and refugee community college ESL students as they acquire and use their English language skills within and without the ESL classroom. Addressing symptoms of anxiety and stress supports student well-being, reduces symptoms, and allows for the discussion of and normalization of mental health issues, and supports access to psychological help. Teaching stress reduction techniques in the classroom is aligned with ESL teaching methods of creating a low anxiety environment that lowers the affective filter and allows language acquisition to unfold as suggested by Krashen (1982).

The lessons begin with the stress reduction technique of mindfulness-based stress reduction (MBSR). Kabat-Zinn, one of the original researchers in the United States to present mindfulness skills as a practice to cope with pain and stress, noted feeling of a loss of control over one's life contributes to stress (Kabat-Zinn, 2013, p. li). He observed a loss of control over life’s circumstances can be real or perceived, but importantly, one’s reaction to this loss

can be controlled. Controlling one's response is an important coping mechanism. He found practicing MBSR techniques could provide choices in how to respond to a stressor and to find a more positive way to cope with it rather than react in a negative fashion. In short, the ability to influence one's circumstances depends on how one perceives those circumstances and where one chooses to invest energy to cope with the issues beyond one's immediate control.

Hence, the practice cultivates disengagement with negative thoughts, emotions, or sensations by focusing on the moment and on the breath. This step back from the immediate or automatic engagement with unpleasant thoughts or reactions to a stressor presents the individual with a choice of how to respond, with some choices being more helpful than others. In addition, the techniques return physiological symptoms of stress such as rapid breathing, Aspects of this stress reduction technique are also promulgated by the CCC system.

The California Community Colleges system is a trauma-informed educational system (ASCCC, 2021; Grant et al., n.d.) that seeks to support the mental well-being of all students with trauma-informed policies founded on safety protecting the "emotional, behavioral, physical, spiritual, and academic safety" of all students, faculty, and staff (Grant et al., n.d., p. 5). The CCC system promotes teaching stress reduction and healthful coping skills to students (Grant et al., n.d., p.3). Teachers are encouraged to create opportunities for "incorporating mindfulness, breathing, and focusing activities" (Grant et al., n.d., p. 6). At the same time, the CCC informs instructors that teaching is "…your current role and not as that of a professional therapist" (CCCCO, 2019, p.1) thereby relieving faculty of responsibility for the mental health diagnoses and treatments that are in the purview of mental health professionals. Teachers are encouraged to help students access campus and community low-cost and culturally responsive mental health organizations (CCCCO, 2019, p. 4).

For migrant ESL students, however, cultural stigma, differing cultural concepts of distress, and cultural behavior around the expression of symptoms, as well as structural barriers such as childcare, transportation, and documentation status, as well as language issues including lack of English proficiency and of culturally competent, native-language speaking counselors may interfere with accessing and obtaining available mental health support (CCCCO, 2018; Eastman, 2020; Krivitsky, 2017; Potocky & Naseh, 2019; Salami et al., 2019).

Teaching stress reduction techniques provides the vocabulary, language, use and meanings, with the cultural concepts and contexts of illness and healing, as well as the assertive, frank, and open communication style used in talking about emotions with providers of the adopted culture (Potocky & Naseh, 2019). Students have the necessary language that expresses feelings and emotions in which to engage psychological support and the confidence to do so. Stress reduction techniques are “portable.” They can be used in many social or speaking situations. Teaching stress reduction techniques presents the normalization of mental health issues through self-care. Learners can choose to embrace or reject mental health practices to any degree while not being marginalized owing to a lack of education or choices to cope with acculturative stressors.

Theoretical Framework

This field project is founded on the linguistic theoretical framework of the second language acquisition theory of Stephen Krashen (1982) that states the negative affect of a student prevents acquiring language. The linguistic theory includes five hypotheses, the Acquisition-Learning hypothesis where the speaker subconsciously acquires versus consciously learns the language and its rules; the Monitor hypothesis where-in the speaker constantly and consciously checks their speech for errors in language output; the Natural Order hypothesis that states language rules are acquired in a consistent order across all language learners; and the Input hypothesis which says language is learned at a level that is both understood and challenging, just above the speaker's language competence. Lastly, the Affective Filter hypothesis addresses anxiety and specifically recognizes that the learner's negative attitudes, thoughts, and emotions can interfere with language acquisition in the classroom. Krashen observes students who learn well in second language acquisition are "highly motivated and highly self-confident, possess a positive self-image, and suffer little personal or classroom anxiety" (Krashen, 1982, p. 31). In short, their affective filter is low, and they can more easily acquire language.

The Affective filter hypothesis works in conjunction with the Input hypothesis, which states that learners need to hear comprehensible input, that is, they need to hear English they can understand, plus a little communication that is beyond their comprehension (when taken together, it is also known as i + 1) and that it reach the part of the brain that absorbs language. This comprehension and learning take place when students' Affective filter, the negative attitudes, thoughts and emotions, do not interfere with language learning. Krashen exhorts ESL language instructors to teach by providing "...input and help make it comprehensible in a low anxiety situation" (Krashen, 1982, p. 32). As one of the goals of stress reduction is to lower anxiety, teaching stress reduction techniques in the adult English classroom is in

keeping with maintaining the low anxiety environment specified by Krashen. The curriculum is based on the trauma-informed teaching model of adult ESL community college students (Eastman, 2020).

Significance of the Project

Students can learn better when they are not stressed or anxious (Eastman, 2020; Greene et al., 2019; Horwitz et al., 1986; Krashen, 1982; Krivitsky, 2017; Medley, 2012; Pishghadam et al., 2016; Tollefson et al., 2018). They can be aware of anxiety and create positive learning conditions for themselves by using "portable" stress reduction techniques that allow classroom learning to be absorbed and second language acquisition to flourish inside and outside of the classroom. Stress reduction has proven to increase student engagement (Greene et al., 2019; Tollefson, et al., 2018). The activities and curriculum would benefit students with kinesthetic, intrapersonal, interpersonal, musical, visual and spatial multiple intelligences while developing English proficiency (Eastman, 2020; Medley, 2012). In sum, the project is intended to support mental health through self-care, appeal to multiple intelligences, lower the affective filter, support English language acquisition and proficiency, as well as meaningful communication within and without the classroom.

Limitations

Reading the scripts aloud as the teacher with the students following, repeating the words, and performing each practice has been tried and been successful. Students engaged right away, followed, and verbally shared their responses to each practice. The stated responses were all positive. No one disliked the practice or the feeling they developed from it. With that said, owing to time constraints, the rest of the exercises, practicing one technique for two weeks, journaling responses, recording times, creating visual expressions, giving group presentations, and creating a self-care plan was not performed by the students. Thus, how those exercises would be received by students is not entirely known. Students in other

studies (Deshpande et al., 2023; Greene et al., 2019; Kerrigan et al., 2017; Tollefson et al., 2018; and Yusufov et al., 2019) appeared to enjoy and learn from the assignments given by their teacher in those classes.

CHAPTER II - REVIEW OF THE LITERATURE

Introduction

The claim of worth for this literature review is stress reduction techniques should be taught in the community college adult ESL classroom to reduce symptoms of stress and anxiety during language acquisition, as well as de-stigmatize, normalize, and familiarize students with mental health issues, teach self-care, and provide support for mental health care access so that they may take care of themselves and their families. The body of scholarship that justifies this claim includes 4 sets of evidence that demonstrate that (a) immigrant and refugee adults may suffer from trauma and stressors during stages of migration and contend with barriers to mental health utilization (Potocky & Naseh, 2019; Salami et al., 2019; Sangalang et al., 2019) (b) immigrant and refugee adult community college ESL students may suffer symptoms of stress and anxiety from trauma and stressors and ESL teachers want to mitigate stress (Adkins et al., 1999; Eastman, 2020; Krivitsky, 2017; Medley, 2012); (c) ESL students may also suffer language anxiety (SLA) within and without the ESL or EFL classroom in their adopted community with negative impacts on the language acquisition and on acculturation (Garcia de Blakeley et al., 2017; Horwitz et al., 1986; Pishghadam et al., 2016; Sevinç & Backus, 2019); (d) graduate and undergraduate students suffer from symptoms of anxiety as well as perceived stress and self-report positive impacts of learning stress reduction techniques in and outside of the classroom (Deshpande et al., 2023; Greene et al., 2019; Kerrigan et al., 2017; Tollefson et al., 2018; and Yusufov et al., 2019).

The second language acquisition theory of Stephen Krashen founded on five hypotheses, including the input hypothesis and the affective filter hypothesis, can be used to frame the linguistic portion of this body of scholarship. Joint reasoning is used to justify the claim that given that adult refugee and immigrant students may suffer symptoms of stress and anxiety from trauma and may not obtain mental health support owing to barriers, and as they

may also suffer from the situation-specific form of anxiety called language anxiety (LA), and as stress reduction techniques have been taught in the undergraduate and graduate-level classrooms with students' self-reported positive impacts, stress reduction techniques should be taught in the community college adult ESL classroom because the individual sets of evidence/reasons cannot stand alone. However, when the sets of evidence/reasons are added together, they warrant the final conclusion. A visual representation of the logic equation is as follows: $(R_1, + R_2 + R_3) \therefore C$ (Machi & McEvoy, 2012, p. 97).

Mental Health Outcomes and Underutilization of Mental Health Services

Studies demonstrate migrants can suffer from pre- and post-migration trauma, as well as from post-arrival stressors that can negatively impact their mental health, yet they underutilize mental health support owing to cultural stigma, differing cultural concepts of distress, symptoms illness, and healing, structural barriers, and language proficiency (Potocky & Naseh, 2019; Salami et al., 2019; Sangalang et al., 2018). This research provides a brief overview and includes (a) a data-analysis study of the relationships between pre-migration trauma, post-migration trauma and stressors that affect anxiety, depression, and psychological distress of refugees and immigrants (Sangalang et al., 2018); (b) an overview informing best social work practices that identifies migration stressors and illness, differences between Western and other culture's concepts of psychological distress, and differences in behavior around disclosure of symptoms including communication styles (Potocky & Naseh, 2019); (c) a study identifying obstacles to the underutilization of mental health services by refugees and immigrants (Salami et al., 2019); This is important because taken together, these studies justify the claim that stress-reduction techniques as a component of mental health education and of self-care in trauma-informed teaching should be taught in order to reduce the symptoms of stress and anxiety of students in the community college adult ESL classroom for language acquisition and for daily interactions with the interlocutors of the majority culture.

Sangalang et al. (2018) investigated how psychological distress, anxiety disorders, and depressive disorders of Asian and Latino refugees and immigrants in the United States. were related to pre-migration trauma, post-migration trauma, and post-arrival stressors of acculturation, discrimination, and family conflict. The authors performed a comparative data analysis study and extracted data from the National Latino and Asian American study (NLAAS), that was conducted between 2002-2003 and that examined mental illness and mental health service utilization among Latino and Asian Americans in the United States. The participants of that survey included 2,554 Latino and 2,095 Asian interviewees who were 18 years old or older, not institutionalized nor in military service, and living in the coterminous United States and Hawaii. The original study distinguished refugees from immigrants based on the answer to the question, "Were you ever a refugee, that is, did you ever flee from your home to a foreign country or place to escape danger or persecution?" (p. 911). Hence, the answers were subjective rather than based on legal status.

From the original NLAAS study, Sangalang, et al. (2018) analyzed the data of 1,637 Asian and 1,620 Latino refugee and immigrant participants who were born outside of the United States. The study first used measures of depressive and anxiety disorders diagnosed within the previous year; frequency of psychological distress experienced within the last month with psychological distress including symptoms such as feeling restless or fidgety, depressed, hopeless, or "tired for no good reason" (p. 910). Next included were measures of trauma exposure such as witnessing death during pre-migration and experiencing the unexpected death of someone close in post-migration. Lastly, measures of stressors including discrimination, such as how often participants felt threatened, harassed, or treated with less respect than others; acculturative stress, whether participants had guilt for leaving family or were questioned regarding legal status; family conflict and dissonance between

cultural values, and neighborhood environment, regarding feeling safe in their neighborhood including questions such as whether people could be trusted or would help in an emergency.

The findings revealed impacts of pre- and post-migration trauma along with stressors of discrimination, acculturative stress, and family conflict negatively impacted mental health for all groups. Pre- and post-migration trauma led to poorer mental health for Asian refugees and immigrants and had harmful impacts on mental health outcomes of Latino immigrants compared to Latino refugees. The authors noted their results parallel refugee studies that find pre-migration traumatic events predict psychiatric symptoms, and that both Asian refugees and Latino immigrants had fled their homes under similar circumstances of violence, either state, institutional, individual, or regime based.

As to post-migration trauma, impacts for Asian immigrants increased the risk for depressive disorders and doubled the risk for refugees. Post-migration trauma, for Latino refugees, increased psychological distress, and for Latino immigrants, post-migration trauma increased both psychological distress and depressive disorders. The authors felt these negative impacts on mental health may partly represent the experiences of undocumented immigrants, a group not distinguished from others in the original NLAAS study, and who faced possible deportation, or were not eligible for government support services.

Post-migration stressors of discrimination, acculturative stress, and family conflict overall had negative effects on mental health. Acculturative stress for Latino refugees and immigrants increased risk of depressive disorders and negatively impacted psychological distress for Latino immigrants and Asian refugees. Family conflict was a predictor of and negatively affected mental health in all Asian and Latino refugee and immigrant groups. The authors thought displacement and migration stressors negatively impacted family relationships and dynamics and led to increased mental health issues, marking that

family-conflict interventions may reduce risk for future mental health issues in families (Sangalang et al., 2018).

These findings demonstrate that immigrants and refugees, in this case from both Latino and Asian groups, suffer from mental health issues of anxiety disorders, depressive disorders, and psychological distress rooted in pre- and post-migration trauma as well as in post-migration stressors. The authors concluded that to reduce risk of negative outcomes, understanding the prevalence of pre- and post-migration experiences of refugees and immigrants, regardless of documented or undocumented legal status, is important for understanding the impacts on the mental health outcomes of both groups. Moreover, social service agencies, community organizations, and mental health service providers, could provide trauma-informed, culturally grounded interventions that also attend to the additional stressors of race, ethnicity, and culture that continually influence post-arrival mental health. This work provides a background to the work of Potocky and Naseh (2019) who sought to inform social workers of best practices with refugee and immigrant clients at post-migration, highlighting traumatic stressors, mental illness symptoms, differences in cultural concepts of health, and behavior around disclosing symptoms.

Potocky and Naseh (2019) provided an overview of stressors, effects, cultural concepts of health, and behavior around disclosure of symptoms citing studies that inform best practices. In doing so, they illustrate the potential confusion for both migrants in obtaining and Western providers in giving psychological support. Emphasizing migrants are processing the profound loss of loved ones, coupled with grief and guilt for abandoning the family, as well as pre-, transit, and post-migration trauma experiences, the authors presented

the following mental health stressors refugees and immigrants endure:

> loss of family members, friends, home, and the familiar environment; traumatic experiences such as war, famine, violence, rape, imprisonment, and torture; a hasty and dangerous departure; dangerous transit experiences; loss of status; language problems; employment problems; legal problems; social isolation; family conflict; role changes; discrimination, racism, and xenophobia; and acculturative stress. (pp. 334-335)

The effects of stressors result in some mental health issues of somatization, loneliness, grief, guilt, and substance abuse, a loss of self-esteem owing to the loss of status and income, anxiety, depression, and PTSD. Yet, cultural concepts of health including mental health diagnoses and symptoms differ. First, some cultures consider well-being as a combination of psychological, physical health, and spiritual health, while others consider them separate aspects. Second, some cultures do not acknowledge depression or anxiety as the cause of somatic symptoms as the disorders may be culturally stigmatized. Third, identifying the problem or articulating the symptoms is difficult. Fourth, symptoms have a cultural context that differs between cultures. Lastly, some mental health problems are not attributed to trauma or stressors, but instead to karma or "spiritual, supernatural, or magical forces" (Potocky & Naseh, 2019, p. 191)

Cultures also differ in how to talk about mental health symptoms. To further paraphrase Potocky and Naseh (2019), some cultures do not believe in complaining or sharing mental health problems with non-family, outsiders, or strangers. Some cultures that associate mental illness with past misdeeds or karma do not reveal symptoms out of shame. Others accept that mental health suffering is part of the migration experience, hence do not speak of problems. If language is not an issue, the authors note interactions with strangers, mental health support providers, may not generate discussions of emotions or feelings, but

instead elicit formal responses, as the patients do not regard themselves in an equal partnership (p.179). If symptoms are communicated, the counselor may not understand their cultural significance. Crucially, the authors note these behaviors are in direct contrast with the American communication style of being assertive, straightforward, approachable, and relaxed with expressing emotions.

These observations illustrate that though stressors through-out stages of migration associated with negative mental health outcomes exist, the process of obtaining and of providing mental health support is unclear for both migrants as well as for Western mental health professionals. This research is related to the work of Salami et al. (2019) who wanted to increase the mental health well-being of migrants in Canada and asked immigrant service providers what they observed were the reasons for the underutilization of mental health services by immigrant and refugee clients.

To prevent negative mental health outcomes for refugees and immigrants in Canada, Salami et al. (2019), studied the obstacles to accessing and using mental health services that migrants may contend with post-arrival. They looked at access to and underutilization of mental health resources by immigrants and refugees in the province of Alberta, Canada to devise new strategies to deliver mental health service. The researchers interviewed non-profit, community-based immigrant service providers for their front-line observations on the issues of immigrants in need of and their attitudes toward mental health support as well as their barriers to mental health services.

The authors used a qualitative descriptive design study to collect and analyze the perspectives of 53 immigrant service providers that spoke English, were over 18 years of age, and worked in Alberta, drawn from nine agencies providing services for the period between November 2016 and January 2017. Six participants were individually interviewed, while 47 participants were interviewed in focus groups.

The providers identified barriers to use as stigma of mental illness, a difference in cultural concepts of mental health, an inability to recognize mental illness, a distrust of the services, as well as a lack of familiarity with the services, and language issues. More personally, clients felt shame and failure at not handling problems. Importantly, they feared a variety of negative emotionally painful repercussions for revealing mental illness such as a loss of social status and exclusion by both the native and the majority culture. Closer to home, some were afraid of losing custody of their children, feeling if their child had a mental issue, he could be taken away (p. 155). Additional worries included dismissal from work, being deported, or if family violence was an issue, having a spouse sent to prison. As a result of not perceiving, recognizing, or acknowledging mental health symptoms, they hid their illness from families and social networks, thereby increasing their isolation and not availing themselves of services.

Furthermore, clients did not understand the majority culture concept of psychological illness. Ongoing psychosomatic symptoms as well as persistent sadness and anxiety were not perceived as mental health symptoms. Instead, symptoms were described as "a crisis of faith, personal weakness, or evil spirits that invade the body" (Salami, 2019, p. 153) and talking with trusted spiritual leaders, family members, and friends was the preferred support.

The interviewees noted the use of therapy was also confusing. Some clients felt uncomfortable talking about their problems with and receiving support from providers. Some clients expected to get solutions or cures for their symptoms at therapy (p. 156) or to be "taught" what they must do (Salami et al., 2019, p. 157). They were surprised when asked about their feelings or their personal stories. In addition, some immigrant and refugee clients had privacy concerns, feeling if personal information was entered in a computer for healthcare, any person or any organization would have access to it.

Structural barriers to support included the high cost for therapy, the loss of pay in time spent away from work, inconvenient hours, high fees, as well as difficulty in using transportation. Moreover, childcare was difficult to manage. Men in many families regarded caring for children as women's work and did not watch the children for women to attend therapy.

Salami et al. (2019) concluded new delivery strategies were needed with one of many possibilities being that immigrant service providers could be trained in basic mental health practices to help clients before the client's circumstances escalated into a crisis. Further solutions included cultivating relationships between the immigrant service providers and mental health service providers, creating community-based support, increased use of translators to relieve burden on relatives, and ameliorating financial costs. The results of this study demonstrate immigrants and refugees may suffer mental health symptoms and not seek access or utilization of mental health services owing to cultural stigma including fear of negative consequences; differences in concepts of symptoms, illness, and healing; and structural barriers of cost and language proficiency.

To recap, Sangalang et al. (2018) explored the relationships between pre- and post-migration trauma as well as post-migration stressors and found negative impacts on mental health outcomes for Asian and Latino immigrants and refugees. Potocky and Naseh (2019) sought to inform social workers of best practices with refugee and immigrant clients, highlighting traumatic stressors and cultural stigma, differences in cultural concepts of health, and behavior around disclosing symptoms that may interfere with obtaining support. Salami et al. (2019) addressed migrant underutilization of mental health services and also found, some reasons to be cultural stigma, fear of negative consequences, differences in concepts of symptoms, illness, and healing; language proficiency, and unfamiliarity with the Western concept of therapy as well as structural barriers of cost, childcare, and language proficiency.

The results of this study demonstrate that immigrants and refugees after arrival may suffer mental health symptoms and may not pursue treatment owing to a wide variety of reasons including cultural stigma; differences in cultural concepts of illness, symptoms, and treatment; structural barriers such as cost, transportation, childcare; language proficiency; and lack of familiarity with the resources; and fears of being deported or of losing custody of children. All contributed to the underutilization of services. Claim

The results of these studies demonstrate that immigrants and refugees may suffer from traumatic stressors and sustain symptoms of anxiety, depression, and post-traumatic stress disorder and not obtain mental health support owing to cultural stigma, cultural concepts of mental health, structural barriers including documentation, and language proficiency. They may be unfamiliar with Western concepts of mental health symptoms, illness, and healing; fear cultural stigma and negative repercussions for disclosing illness; or not have the language to express mental health issues or may express symptoms in a cultural context unfamiliar to Western providers. In addition, the culture may not allow speaking to strangers or outsiders of problems, not speak of illness attributing it to the migration experience, or not speak of illness owing to a sense of personal shame. This is important because these studies support the claim that teaching stress reduction techniques in the trauma-informed adult ESL classroom to immigrants with and without documented legal status and refugees may normalize mental health issues, impart familiarity with Western concepts of distress, create conditions of low anxiety for language acquisition in the classroom and for self-care outside of the classroom and lastly, support students in pursuing education and work as well as taking care of themselves and their families. Related to this is the importance of providing psychological health support in the form of reducing symptoms of stress and anxiety for language acquisition in the adult ESL classroom.

Need for Mental Health Education and Support in the Adult ESL Classroom

Immigrant and refugee adult ESL students have suffered trauma and continue to suffer from stress and anxiety inside and outside of the classroom, and for almost 25 years, ESL teachers have been aware of and suggested approaches to meet this unique student need. This includes (a) an article with a curriculum that discusses how immigrants and refugees suffer migrant, acculturative, and traumatic stress at a time when they can speak little English and thus must rely on teachers for connection mental health support (Adkins, et al., 1999); (b) an article that articulates how immigrant and refugee youth, the children of traumatized parents, in ESL classes can act out in class or withdraw from class participation because of migration, acculturation, or emotional trauma, and the practices teachers can use that cultivate healing (Medley, 2012); (c) a dissertation that explores the underutilization of mental health services by refugees and how ESL teachers see their potential role to support their students' mental health with a mental health curriculum component (Krivitsky, 2017); and (d) a thesis founded on using a trauma-informed teaching model for adult ESL community college students who suffer from trauma that may interfere with their second language acquisition, as well as the educating and training of ESL teachers in trauma-informed classroom practices (Eastman, 2020).

This work is important as taken together, these studies demonstrate that a need exists for education in mental health that de-stigmatizes and normalizes mental health issues and teaches self-care, and in addition may reduce symptoms of stress for language acquisition in the community college adult ESL classroom and in the target language community. Thus, stress reduction techniques that have been taught in the undergraduate and graduate level classroom with positive impacts, stress reduction techniques should be taught in the adult community college ESL classroom.

Adkins et al. (1999) observed refugees suffer migrant, acculturative, and traumatic stress at a time when they are vulnerable, experience loss of control over their lives, can speak little English, thus must rely on teachers for mental health support, and the authors related how teachers can help. Noting that ESL teachers can create the conditions that support and "enhance mental health" (p. 15), Adkins, et al. (1999) provide a lesson planning guide focused on mental health stressors with accompanying "preventative mental health activities" that address the stressors, as well as a list of materials that support the activities (p. 37).

The mental health stressors from 25 years ago are much the same as today in 2023. They include isolation, loss of support, ethnic harassment, acculturative pressure to change to culturally acceptable behavior, economic stressors, loss of self-esteem owing to loss of job or lifestyle from home, fear of applying for and of losing a job, transportation issues, health care costs, changes in family hierarchy, and an acculturative gap with children who can learn language and customs as well as identify more with the new culture more quickly than parents. As one major stressor is also the loss of control over life, the authors present a lesson plan to help re-establish a sense of control for the future, determining long-term and short-term goals. Steps for actions, setting realistic expectations for achievement, and developing a perspective that recognizes the job one obtains may not be equal in respects to the previous job at home, yet is important for survival are highlighted.

Adkins et al. (1999) also suggested that ESL teachers recognize symptoms of trauma and stress in their students, encouraged ESL teachers to become part of a larger community network for sources of knowledge, support, and information for dealing with mental health and related issues, and to develop relationships with local mental health providers and how the health system functions. The authors applied approaches at the time that are currently found in trauma-informed teaching such as creating an environment of safety, allowing students to participate when they can and withdraw as they need to, building

community, developing student relationships, sharing experiences, all of which can enhance mental health support in the adult ESL classroom. This is related to the work of Medley (2012) who articulated that immigrant and refugee youth, that is the children of traumatized parents and caregivers, in ESL classes can act out in class or withdraw from class participation also because of migration, acculturation, or emotional trauma.

Similar to Adkins et al. (1999), Medley (2012), observed reactions to trauma, in this case, surfacing in the behavior of refugee youth in his ESL classes, and he sought to educate ESL teachers how to promote emotional healing in the youth ESL classroom by using specific pedagogical practices he thought therapeutic that helped students process their ordeal. He noted three types of responses to trauma. Emotional responses to trauma included feeling fearful, moody, angry, or depressed. Their behavioral responses were to be hyper-vigilant, withdraw, or isolate, seek attention, as well as indulge in high-risk behaviors such as substance abuse. In addition, the students could act aggressively towards or display a distrust of others. Lastly, their cognitive responses were displayed as a disinterest in school, difficulty concentrating or remembering, or as an interest in understanding the causes of the trauma or thoughts of death.

In response, Medley (2012) allowed students to use musical, spatial, bodily-kinesthetic, naturalist, intrapersonal, and interpersonal multiple intelligences, collectively known as multiple intelligences, for outlets to express themselves while they are building their burgeoning English language skills. In addition, he emphasized teaching language of self-expression and of relationship-building with goals of creating a safe environment, without discord, for community to flourish. Similar to Adkins et al. (1999), he also espoused using content-based instruction to enhance mental health and engender healing. In short, Medley (2012) promoted a mental health component to teaching traumatized refugee and immigrant youth noting non-traumatized students also greatly benefit from these goals.

The findings demonstrate that the mental health of children suffers directly from the negative impacts of traumatic stressors as well as indirectly from impacts of traumatic stressors on their adult parents. Both groups need a unique approach to support their psychological health. Related to Medley's desire to promote emotional healing of refugee students in the ESL classroom and the teacher's role in providing that help is Krivitsky's (2017) ethnographic study of the potential role ESL teachers could play in supporting mental health of adult refugee students by incorporating a mental health component into the ESL curriculum.

Krivitsky, in her dissertation (2017), addressed the problem of the underutilization of mental health services by adult refugees suffering from anxiety, depression, and PTSD and explored introducing mental health and self-care concepts through ESL instruction. She identified barriers to mental health support that are also acknowledged in refugee literature, some of which include cost and availability of treatment, lack of native language translators along with the client's lack of English proficiency, cultural stigma of mental health, differences between the native culture's presentation of symptoms and Western understanding of symptoms and of causes, cultural concepts of distress, and lastly, the differences in treatments for mental health issues.

Krivitsky offered acculturation issues with details that add insight into how refugees, for example, in Austin, Texas could experience acculturative stress being compelled to adjust to new norms in many aspects of daily life. In a preliminary study that obtained observations of refugee service providers including the director of the state-wide refugee services agency, the clinical director/psychologist of refugee mental health services, two social workers, an ESL coordinator of ESL language services, the clinical director of the resettlement agency, and a co-founder of an organization that develops refugee self-sufficiency, she had identified common themes and fleshed out the refugee experience.

Many refugees did not understand why practices from their home country were banned in this new home.

A few examples Krivitsky cited were that smoking was not allowed indoors, drinking alcohol was banned outdoors, and driving without a license was against the law and penalized (2017). She also noted many refugees used corporal punishment in the native cultural belief it was being a good parent which in their adopted country, the United States, can be considered abusive and unlawful. Additional acculturation issues cited were unmet or unrealistic expectations derived from American television shows such as everyone owns a big car, a large house, and has no need to work. She also observed that the qualifications of highly trained individuals were not accepted, and that lower-paying jobs resulted in emotional reactions of anger, resentment, and hopelessness. To solve these problems, she looked to ESL teachers as a possible first connection to mental health support.

Krivitsky started with her own observations as to why ESL teachers would be good candidates for teaching a mental health component. She was the child of immigrants, a volunteer ESL teacher at the Center for Survivors of Torture in New York, and a psychologist in Austin, Texas providing care to refugees who suffered torture. She remembered her ESL teachers from childhood as being "warm and kind," (p. 48) helping her to adjust well and going out of their way to meet her family. In her volunteer ESL teacher position, she found ESL teachers "highly engaged individuals" (p. 49) who performed duties to help students beyond just teaching. In her experience as a clinician, she found the refugees she counseled suffered the most from isolation and would not have come to her on their own because of cultural stigma. They were, instead, referred to her by immigration lawyers and she observed that the stress reduction technique of progressive muscle relaxation in particular helped these patients.

The purpose of her ethnographic study was to explore how English as a Second Language (ESL) teachers perceived the mental health issues of refugees, how they felt about their role as educators to bolster and support the mental health of their students, and if they were amenable to weaving a mental health component in their ESL curriculum. The ten participants from two urban areas of the Southwest included three ESL teachers and one program director from a community-based organization, four educators of refugees from one school district, a community college ESL Program director with previous experience in a community-based organization teaching work-force preparation to refugees, and a teacher/coordinator of adult education ESL programs not specifically intended for but attended by refugees. The participants taught either beginner, intermediate, or advanced ESL classes, and/or mixed-level refugee ESL classes for at least 3 times a week for a year. Krivitsky used a semi-structured qualitative interview with each participant and phenomenological analysis interpretation for the information elicited from the ten ESL educators.

Findings illustrated ESL teachers wanted to cultivate the emotional well-being of their ESL students. Many suggested practices they had found helpful for students. For example, one educator noted from a previous job in a job training program for students, where they learned about stress reduction, that the trainers witnessed a positive difference in how the students were feeling while involved in the class discussions of the causes of and coping strategies for stress and the process of acculturation. The engaging discussions created community in the class, and he observed the stress reduction component was closely linked with language learning and practice: students experienced it as an authentic language exercise and as having a positive impact on mental health.

The results also found that, in addition to willingly supporting the mental health of their refugee ESL students, the teachers had already discovered supportive classroom practices. The teachers felt for refugees to be able to talk about trying experiences in class was both a way to let go of difficult emotions, while connecting and belonging to the class community through sharing these challenging experiences. To be listened to and heard by others validated refugee experiences. In addition, the teachers also thought treating negative emotions as normal feelings was important. Other teachers also encouraged using art for self-expression. Lastly, the teachers encouraged the use of journaling for self-expression, as it can reflect change and the fleetingness of emotions, the good and the sad ones. Journals could help students see their personal history, as well as the development of English in their writing.

The teachers agreed learning about stress while learning the language had a positive impact on mental health. ESL teachers also felt they were also in the ideal position to teach mental health activities because they have close relationships and immediate rapport with students. Students see their teachers every day in the safety and stability of the classroom environment.

While the results of her study found that ESL teachers were willing to support the mental health of refugee students, Krivitsky also discovered that the teachers had identified barriers to providing a mental health component in the ESL classroom. The obstacles included a primary focus of the curriculum on jobs, not enough class time for mental health education and for teachers, not enough training, or time for teacher training in mental health.

These findings demonstrate a need for mental health support of refugees in the adult ESL classroom exists, and ESL teachers are well-positioned to teach students aspects of mental health in the form of self-care. ESL teachers have already discovered practices that support traumatized refugee and immigrant students. ESL teachers are a familiar friendly

support in a stable and safe place, the ESL classroom. Support for the mental health of adult immigrant and refugee students is related to the work of Eastman (2020), who developed a trauma-informed teaching model for adult refugee and immigrant ESL community college students.

Similar to the findings of Adkins et al. (1999) who focused on mental health stressors and the ways in which ESL teachers could support adjustment through language teaching, Medley (2012) who advocated for content-based instruction, creating a sense of safety and community in the classroom while promoting the use of multiple intelligences for self-expression, and Krivitsky (2017) who discovered ESL teachers were willing to teach a mental health component, Eastman also observed the unique need for mental health support in adult ESL learners who have suffered trauma which in turn, can interfere with their second language acquisition, and she sought to inform and support ESL teachers who do not use trauma-informed (TI) teaching practices owing to of a lack of awareness of and training. She created a model to support trauma-informed teaching of adult refugee and immigrant ESL students and produced materials that educate ESL teachers in trauma-informed teaching practices for adult ESL community college students. Eastman (2020) conceived of the model for TI Teaching to adult ESL students that is grounded in a combination of the trauma medical model theory, the Affective Filter theory, and the critical pedagogy of culturally responsive teaching (CRT). The key components of TI teaching to traumatized adult immigrant and refugee ESL students include trauma-informed care practices of creating a sense of safety, community, trust, choice, collaboration, and empowerment. The aims of the TI Teaching model are to support adult ESL students in language acquisition and in acculturation, as well as in mental health and well-being.

In summary, research demonstrates the need for mental health support in the form of self-care as part of trauma-informed teaching in the adult ESL classroom, and moreover, ESL teachers are willing to explore ways in which to help their students. The studies and articles reviewed in this area are related to one another because the authors believe that the ESL teacher has a role to lower anxiety in the classroom, to support mental health of those suffering trauma in the classroom, and to provide language and skills that are helpful to learners for taking care of the psychological health of themselves and their families. These authors include (a) Adkins, et al., (1999) who proposed the ESL teacher provide adult refugee and immigrant ESL students that are suffering from migrant, acculturative, and traumatic stress mental health support through content and through connections to mental health professionals; (b) Medley (2012) who articulated the ESL teacher's responsibility is to create a safe classroom so that traumatized youth may develop supportive relationships, to allow for alternative forms of expression using multiple intelligences, and to teach content designed to promote healing from trauma; (c) Krivitsky, (2017) who noted cultural stigma and differing cultural concepts of psychological distress may interfere with migrants utilizing mental health resources and who advocated for ESL teachers to provide a mental health educational component as they have close, stable, familiar relationships with students based on trust, and the steady support of the daily frequency with which they see students; and, Eastman (2020) who conceived of the trauma-informed teaching model for community college adult ESL students that is the combination of the trauma-informed medical model, the Affective Filter theory, and the culturally-responsive teaching model, and who provided ESL teachers trauma-informed teaching materials and resources that empower learners in the community college adult ESL classroom

This is important work because these observations and the study justify the claim that adding a mental health component that normalizes and de-stigmatizes mental issues,

teaches stress reduction techniques that reduce symptoms of stress and anxiety from trauma and language anxiety, lower the affective filter for language acquisition inside and outside of the classroom is necessary for refugee and immigrant students with and without documented legal status in the community college adult ESL program.

Language Anxiety

A body of scholarship demonstrates that language anxiety exists, can manifest while performing in the second language in the classroom or outside of the classroom during interactions with the majority language culture, and interfere with language acquisition and acculturation. This research includes a study by (a) Horowitz et al. (1986) that defines second language anxiety, its contexts, and effect on students, and encourages teachers to provide relaxation exercises and learning strategies to ameliorate it; (b) a study by Garcia de Blakeley et al. (2019) that demonstrates how language anxiety beyond the ESL classroom is related to self-perceived language proficiency, age, and extroversion and is experienced from moderate to very high levels by speakers potentially affecting major aspects of their lives; (c) a study by Sevinç & Backus (2017) that illustrates how language anxiety can interfere with language acquisition and acculturation or identity; and (d) a study by Pishghadam et al. (2016) that shows out of a range of positive and negative emotions associated with the four language skills, language anxiety is engendered when studying all of the four language skills of English, and the language teacher, in addition to rewarding effort, should create a low-anxiety classroom environment and methods that help students self-regulate. This research is important as it justifies the claim that teaching stress reduction techniques to refugees and immigrants with and without documented legal status in the adult ESL community college classroom may reduce symptoms from trauma and language anxiety for language acquisition and for interacting with the majority language culture.

Language anxiety felt by an immigrant speaker in the ESL or second language classroom or in the adopted community is called second language anxiety (SLA). Language anxiety (LA) research has demonstrated that language anxiety exists distinguished from other types of anxiety, and educators and researchers have been aware of this learner vulnerability and have sought to identify the causal factors and impacts. Research in this area includes (a) a study that originally identified language anxiety in the foreign language classroom resulting in the Foreign Language Anxiety Classroom Scale (FLCAS) to measure FLA extent and severity (Horwitz et al., 1986); (b) a study that investigates the level and severity of language anxiety combined with demographic and personality variables in non-student Spanish-speakers in Australia using their non-dominant language, English, in the specific contexts of with friends, with strangers, at work, on the phone and in public, while speaking the dominant language in the target language community (Garcia de Blakeley et al., 2015); (c) a study identifying a negative language acquisition feedback loop with language anxiety as a key factor (Sevinç & Backus, 2017); and (d) a study investigating the positive and negative emotions, including language anxiety that English as a Foreign Language (EFL) students feel while listening, speaking, reading, and writing English (Pishghadam et al., 2016). The role of ESL\EFL teachers and their obligations to creating low-anxiety environments are also discussed. These studies are important as they justify the claim that teaching stress reduction techniques including breathing and relaxation exercises to adult ESL students creates a low anxiety environment for language acquisition in the classroom as well as provides a self-soothing tool for students to use in any communication situation including interactions in the majority language culture.

Horwitz (2010) called language anxiety (LA) or foreign language anxiety (FLA) a situation-specific anxiety that some people feel when speaking or learning another language, and she likened it to stage fright or test anxiety (Horwitz, 2010, p. 154). In an earlier study,

Horwitz et al. (1986) noted stage-fright is a type of shyness in communicating in front of people, while test anxiety is a fear of failure, and both are types of performance anxiety. Language anxiety has psycho-physiological symptoms of worry, dread, and inability to concentrate as well as sweating, heart palpitations, rapid breathing, and sleep difficulties. (Horowitz et al., 1986, pp. 128-129).

To identify suffering students and offer help, Horwitz et al. (1986) investigated the feelings of students in foreign language classes, identified anxiety related to language use, examined its extent and severity, and constructed the Foreign Language Classroom Anxiety Scale (FLCAS). Conducted using a qualitative survey questionnaire, The study took place at the University of Texas and was conducted using a qualitative survey questionnaire.

First, to pinpoint the student language learning issues and emotions, a support group for foreign language learning was held where 30 students could discuss their language learning difficulties as well as receive teaching presentations on effective language learning strategies and anxiety management practices. The resulting 33 item FLCAS was designed based, in part, on the students' responses and observations gleaned from the support group. The FLCAS was then administered the third week of the semester during class time to 75 total, 36 female and 39 male students ranging from 18 to 27 years of age, from four introductory Spanish language classes.

Items on the survey included questions that addressed "communication apprehension, test anxiety, and fear of negative evaluation" (Horwitz et al., 1986, pp. 127-128). The questions were written in terms of first-person statements of the speaker's feelings, physiological, or cognitive symptoms where students had choices for each statement of strongly agree, agree, neither agree or disagree, disagree, or strongly disagree (pp. 129-130). Some examples of the statements are the following: "I start to panic when I have to speak without preparation in language class" embraced by 49%; "I feel overwhelmed by the

number of rules you have to speak in a foreign language" indicated by 34% of students. The finding of particular note to the researchers was the response, "I feel more tense and nervous in my language class than in my other classes" expressed by (38%), as the authors thought it clearly characterized and identified language anxiety as a situation-specific anxiety distinct from general anxiety (Horwitz et al, 1986, p. 130).

The findings showed many students experienced language anxiety in one or more aspects of foreign language learning. Moreover, Horwitz et al. (1986) felt teachers must help students deal with language anxiety through teaching language learning strategies, encouraging journaling, behavioral contracting, and importantly, mentioned relaxation exercises (Horwitz et al., 1986, p.131). This research is related to the work of Garcia de Blakeley et al. (2015) who also investigated language anxiety, this time felt by non-students, in the contexts of social situations of daily life using the second language.

In 2015, Garcia de Blakeley, et al., wanted to know more about second language anxiety (SLA) experienced by adult immigrant non-student Spanish-speakers in Australia when they used their non-dominant language second language, English, in specific contexts of speaking with friends, with strangers, at work, on the phone, and in public (p. 18). The participants were 190 Spanish–English bilingual immigrants in Australia, from 21 to 73 years of age, from Latin American countries whose first and dominant language was Spanish. They were specifically chosen for not being students, tourists, or temporary workers, or actively engaged in the ESL classroom, and had resided in Australia for had resided in Australia for at least one year. The authors used two surveys written in English and in Spanish, the Dewaele and Pavlenko's (2003) Bilingualism and Emotions Questionnaire (BEQ), and the 50-Item Set of International Personality Item Pool Big-Five Factor Markers (IPIP-BFFM: International Personality Item Pool2002) in online and in paper-and-pencil formats. The anonymous surveys took no longer than 30 minutes. As these surveys had originated in English, they

were first translated to Spanish, then back-translated into English to aid with the accuracy of translation, according to the protocol of Knowles, Pond, and Clements.

Demographic questions included age, gender, country of origin, age of arrival, ethnic group, occupation, town of residence, and educational level ranging from primary school to post graduate studies. Additional questions inquired about the personality characteristics including emotional stability, "I am relaxed most of the time" as well as extraversion, "talk to a lot of different people at parties" (Garcia de Blakeley et al., 2017, p. 12). Further questions asked about the percentage of Spanish and English spoken in the home and at work, and the speaker's self-rated proficiency in English from 1, least proficient to 5, fully proficient, "…how do you rate yourself in USING the English language (a) speaking English, (b) reading English, (c) writing English, and (d) comprehending English?" (Garcia de Blakeley et al., 2019, pp. 11-12).

The researchers found the variables that predicted the most second language anxiety were ranked in the following order: 1) self-perceived second language (L2) language proficiency, if their L2 proficiency was perceived as low, their anxiety (SLA) was high; 2) extroversion, if their extroversion ranking was low, their SLA was high; 3) age, if the speakers were younger, their SLA was higher (Garcia de Blakeley, 2015). Self-perceived second language proficiency was the most compelling factor associated with SLA and manifested when speakers felt more anxiety while speaking English than in speaking their native Spanish across all contexts, and furthermore more, their SLA progressively increased across all contexts. In short, the bilingual speakers had the least anxiety when speaking English with friends, with anxiety growing higher and to the same levels in speaking with strangers and at work perhaps, the researchers thought, owing to a potential loss of making a good first impression or a positive work image respectively. Language anxiety increased even further on the phone, the authors thought, owing perhaps to not seeing more language and

nonverbal clues of interlocutors, and then to the highest level in public, perhaps owing to discomfort from displaying linguistic errors (Garcia de Blakeley et al. 2015). Moderate anxiety was reported in the L2 situations by over half of the 190 participants with some experiencing very high levels of anxiety (Garcia de Blakeley et al. 2015). This finding demonstrates second language anxiety exists from a moderate to very high level in immigrants who are not students while using their second language in their daily lives in the English-speaking community.

The authors concluded the choice of not to use the L2 can have the negative repercussions in all areas of an individual's life in that speakers may not make friends, choose a career, advance at work, or pursue education owing to self-perceived low language competence, thus reflecting the negative aspects of "the emotional consequences of living in a second language" (Garcia de Blakeley et al. 2015, p. 22). The authors further indicated that in terms of mental health, language anxiety may interfere with an accurate psychological assessment and treatment when a speaker seeks help for mental health. This demonstrates second language anxiety can exist in moderate to very high levels in immigrants who are not students in different speaking contexts. This research is related to the work of Sevinç and Backus (2017) who wanted to explore the causes of and ways in which language anxiety affects first-, second-, and third-generation Turkish immigrants residing in the Netherlands.

Sevinç and Backus (2017) wanted to investigate the causes of and ways in which language anxiety affects first-, second-, and third-generation Turkish immigrants in the Netherlands. They marked that language anxiety appears in two forms, majority language anxiety (MLA) felt by first- and second-generation Turkish-speaking immigrants while using Dutch with native Dutch-speaking interlocutors, and heritage language anxiety (HLA) experienced by second and third generation Turkish immigrants when speaking Turkish with family and friends both in the Netherlands and in Turkey. The authors used a qualitative

study with a semi-structured, open-ended interview conducted with each individual by a Turkish or a Dutch interviewer, depending on the subject's choice, and in which the participants could use both languages, to explore the causes and the impacts of language anxiety on the immigrants. The bilingual interviewees, 30 individuals, 21 female, nine male, between 12 to 43 years, included six first-generation participants, eight second-generation participants, and 16 third-generation bilingual speakers.

In this study, the first-generation participants migrated during the 1960s or after marriage with a second-generation Turkish individual. Second-generation Turkish interviewees were born in the Netherlands. Third-generation participants were children of one first generation parent migrating for marriage with a second-generation parent. Of the first-generation participants, three had an elementary school education, one had a high school education, and two had graduated university, all had attended school in Turkey. Second-generation bilingual interviewees had either a high school education or higher education. Third-generation bilingual participants at the time were in grade school or high school in the Netherlands.

The subjects were chosen from the 116 participants in a previous survey study conducted through questionnaires (Sevinç & Dewaele, 2016) that compared levels of language anxiety in HLA and MLA experienced by three generations of Turkish immigrants when speaking in the contexts of family, friends, and native speakers in both Dutch and Turkish. The individual interviews in the current study were up to one hour long, focused on the interviewees' answers found in the previous study's questionnaire that had asked, among other topics, about their experiences, their language anxiety, the language anxiety of other speakers, and the impacts of the language anxiety on everyday living.

In general, the results indicated that in mono-language use, the speaker's language anxiety and self-perceived limited competency leads to less language use and social interaction, which leads to less language knowledge and practice, which leads, in turn, to more language anxiety, and this cycle has larger negative repercussions for the speaker in connecting with or not connecting with his Turkish or Dutch community.

More specifically, the speakers felt their linguistic errors in either language prompted negative responses from their interlocutors, and these negative responses are laden with unfavorable social or psychological messages, which in turn, may make the L2 speaker feel anger, fear, shame or panic, as well as more anxious about their language use and less inclined to speak in the majority language with the Dutch majority community or in the heritage language with the Turkish immigrant community.

Turkish speakers of Dutch, for example, felt the following linguistic errors were causes of error correction by Dutch native interlocutors: incomplete mastery of the formal register of Dutch, "When I have to speak formal Dutch at an official place or so in the Netherlands, I still don't know all the words, then I panic, but with my friends it is OK, I can also use Turkish words" from a first generation immigrant (p. 714); and difficulties with Dutch grammar (articles), "… Dutch people have words used with de, het, een… written with d and t… these words don't exist in Turkish, I make a lot of mistakes with them…" from a second generation immigrant (p. 714); as well as the absence of everyday situations that solely required Dutch and that did not use code-switching or Turkish, "…I have Turkish friends, we use Turkish words a lot when we speak Dutch" from a second generation immigrant (p. 714).

How a Dutch direct language correction of linguistic errors generated a socio-emotional reaction in the speaker was revealed in the following comment by a second-generation immigrant: "At work, I experience that some Dutch correct every little

mistake of yours consciously just to show that they are Dutch, so they can do this to you. Some of them laugh at you if you use the wrong word…so you feel discriminated, and despised" (p. 715). In this way, Turkish first and second-generation speakers of Dutch felt such Dutch attitudes towards their language use were tied to ethnic exclusion, inequality, and prejudice and thus were the causes of their MLA.

Interestingly, some second-generation immigrants specifically noted the negative effects on their health, "It affects one's health totally! So I try not to care anymore, I don't bother myself. I am trying to speak Dutch as little as possible just not to make myself too stressed" or "I know it affects my health in bad way now, cause I gave up speaking it, but it is better for my health this way," (Sevinç & Backus, 2017, p. 715).

Third-generation Turkish immigrants, those who most felt HLA speaking Turkish, likewise attributed linguistic factors to language anxiety, in this case while speaking Turkish, to speaking more Dutch, communicating less in Turkish, lexical errors, and code-switching, They felt their Turkish did not measure up to standards. The researchers note the socio-emotional impacts of their HLA, in this case, dealt with pressure and identity. For example, in a second-generation daughter's socio-emotional reaction to her mother's Turkish direct language correction, she expresses fear, "Well, she corrects me immediately, sometimes gets angry. For instance, when I say something incorrect, let's say, when she gets angry and corrects me, I am thinking then, if I make the same error again I get scared. As a human being, I mean one gets naturally uncomfortable, stressed" (Sevinç & Backus, 2017, p. 717). Hence, HLA also creates language avoidance.

Notably, the parents' immediate correction of Turkish and the angry emotional reaction discouraged the daughter of the younger generation from speaking Turkish for fear of making mistakes. In addition, the researchers found, the Turkish parental advice in the form of "If you don't speak Turkish well, you cannot be a Turk," and "If you don't know

Dutch well, you won't be able to earn money" (p. 717) engendered conflicting feelings. When visiting and socializing with family and community and speaking Turkish in Turkey, many second and third generation speakers felt disconnected experiencing "foreignness, exclusion, and discrimination" (p. 717) in Turkey, attributing it to their imperfect Turkish. In either language community, the researchers noted, the interlocutors' rejection of the immigrants' language competence appears to have evoked uncomfortable feelings of rejection, anxiety, or humiliation. Sevinç and Backus (2017) also marked that gatekeeper speakers of the MLA or the HLA appear not to acknowledge that degrees of bilingualism exist and are "natural" (p. 719).

The authors concluded that language anxiety in the immigrant contexts is caused by socio-emotional responses to language error correction that are coupled with self-perceived limited language proficiency (Sevinç & Backus, 2017). Furthermore, both HLA and MLA are related to the social exclusion and sense of belonging by both the adopted majority language community and the native-tongue community. In MLA, interaction with the majority language community presents social inequalities, powerlessness, negative self-identity, and social distance, while in HLA, speaking Turkish in Turkey evoked feelings of discrimination, prejudice, and social exclusion (Sevinç & Backus, 2017). This research is related to the work of Pishghadam et al. (2016) who, similar to Sevinç and Backus (2017) wanted to study language anxiety, this time in the EFL classroom, and in addition, examine the range of emotions felt while studying the four language skills.

Noting that language anxiety in the context of EFL and second language classes has been much studied, Pishghadam et al. (2016) wanted to know what other emotions in addition to anxiety were evoked in Iranian EFL students when they were speaking, listening. reading, and writing English. The purpose of this quantitative study was to design and validate a scale that could measure students' emotional responses to all four language skills, and then to

administer the 20-item EFL Skills Emotions Questionnaire, to a large group of Iranian EFL students and study the results.

To create the scale, the authors selected emotions based on Pekrun et al.'s 2005 Achievement Emotions Questionnaire (AEQ) from linguistic literature in general, as well as from interviews with 20 male and female EFL students in EFL classes who disclosed the emotions they felt while learning in the EFL classroom. The researchers then used nine emotions on the scale, characterizing anger, anxiety, shame, boredom, and hopelessness as negative, and relief, enjoyment, hope, and pride as positive. The students had choices of choosing no emotion, any emotion(s), or potentially all emotions for each question. A sample question from the reading sections asks, "What emotions do you have when you are doing reading skills tasks?" with all the options for emotions listed below in the following order: anger, anxiety, shame, relief, enjoyment, hope, pride, boredom, and hopelessness (Pishghadam et al., 2016, p. 526). The study took place in Mashhad, Iran with 308, 150 female and 158 male, native Farsi-speaking students, aged 12-37. The student participants volunteered from intermediate conversational EFL classes at eight private language schools.

Pishghadam et al. (2016) found each language skill was associated with specific emotions, and one language skill could engender opposing emotions, as for example, listening skills evoked both hope and hopelessness. Moreover, listening was the only language skill that evoked all the negative emotions of anxiety, shame, anger, boredom, and hopelessness. Speaking roused the least boredom and hopelessness of all the language skills, and instead, evoked feelings of pride and enjoyment, the authors felt, perhaps owing to the reciprocal engagement of conversation being enjoyable. At the same time, speaking was also associated with shame.

Writing evoked higher levels of anger, boredom, and hopelessness, the authors explained, perhaps because students must work independently and are not in mutual

engagement. Reading was considered neutral in evoking emotions and did not engender as much boredom as listening and writing. The authors believed this response was owing to appealing material in reading sections that presented celebrities, life events, and interesting places, coupled with photos that helped provide context for comprehension and that captured student interest.

As for language anxiety, anxiety was “intensely” evoked in all language areas (p. 519). The authors thought the results demonstrated language anxiety was evoked in part by the fear of negative evaluation also confirmed in other studies. They cited possible sources for the fear as listening to native English accents on audio clips without the benefit of a visual context; being expected to write using correct spelling and grammar, to understand readings, and to answer follow-up questions error-free, as well as to speak in front of fellow classmates and the teacher.

`The role of the teacher, suggest the researchers, is thus to create a teaching environment where students can feel safe, calm, and positive about performing language skills tasks. The teacher can additionally instill confidence and reward the effort that goes into comprehending and producing language, and not just the product that can result in a sense of failure evoking hopelessness. Furthermore, the teacher can help students articulate their feelings and concerns about each language skill task as they are doing it. In short, the teacher needs to consider and attend to the affective filter of the students in the EFL class, reset the negative feelings, as well as help students to self-regulate and manage their emotions while learning the second language.

These studies are important as they justify the claim that teaching stress reduction techniques including breathing and relaxation exercises to adult ESL students may create a low anxiety environment for language acquisition in the classroom as well as provide a

self-soothing tool for students and non-students to use in speaking in the target language in the classroom or in the society.

Positive Impacts of Stress Reduction Techniques Taught in the Classroom

Research demonstrates that learning stress reduction techniques inside or outside of the classroom does help students (Deshpande et al., 2023); Greene et al., 2019; Kerrigan et al., 2017; Tollefson et al., 2018; Yusufov et al., 2019). This includes (a) a study that examined specific stress reduction interventions including relaxation training and MBSR that reduced both perceived stress and symptoms of anxiety of undergraduate and graduate students (Yusofov et al., 2019); (b) a study that demonstrated peer-led teaching of stress reduction techniques in the classroom, as self-reported by students, positively impacted their academic performance, stress levels during class-time, and stress levels outside of class (Tollefson et al., 2018); (c) a study which found an elective class for self-care solely based on MBSR practices reduced symptoms of stress, improved sleep, and improved mindfulness in undergraduate students (Greene et al., 2019); (d) a study that addressed undergraduate and graduate student stress examining the impacts of a Kabat-Zinn MBSR program on undergraduate and graduate student mental health using the four measures of psychological distress, perceived stress, satisfaction with life, and mindfulness (Deshpande et al., 2023); and (e) a study finding positive impacts of a MBSR program on the stress felt by high-performing undergraduate and graduate students at a university with a competitive academic environment (Kerrigan et al., 2017).

This is important because taken together these studies support the claim that given that stress reduction techniques including MBSR, mindfulness, as well as progressive muscle relaxation, along with other relaxation techniques have been taught in the undergraduate and graduate-level classrooms with students' self-reported positive impacts on stress inside and outside of the classroom, and given that adult refugee and immigrant students can suffer

symptoms of anxiety and trauma, as well as from the situation-specific form of anxiety called language anxiety (LA), stress reduction techniques as part of trauma-informed self-care should be taught in the community college adult ESL classroom.

Yusufov et al. (2019) addressed the problem of high stress experienced by undergraduate and graduate students that could lead to negative health, academic, and psychological outcomes, by exploring the efficacy of stress management techniques in a meta-analysis of the literature and by evaluating the usefulness of the techniques for students to practice. The researchers looked at the effectiveness of interventions in the two groups combined to ascertain how each group benefited from the stress reduction techniques, and if the duration of the intervention, anywhere between one day to over 8 weeks, made a difference in the effectiveness.

Yusufov et al. (2019) focused specifically on anxiety, the physiological, emotional, cognitive response to a stressor, and perceived stress, the individual's evaluation of how stressful or not a situation is and decided on six stress intervention techniques that positively impacted student stress reduction in the given context. Forty-three studies were chosen from a period of 35 years, 1980 to 2015, that took place in Australia, Europe, Asia and in the United States. The studies were required to have a control group and a specified standard measure of stress and anxiety before the interventions were performed, as well as mental health measures of the students' stress and anxiety before and after an intervention.

The researchers examined studies of undergraduate students of diverse backgrounds, including older students, single mothers, and people of color, all of whom experienced one or more financial, familial, social, academic, and racially or ethnically oriented stressors. Undergraduates were dealing with additional stressors of a life transition, exploring identities and values, or making decisions to further education or pursue a career all without well-developed coping skills. They additionally noted that graduate students,

especially in the health fields, contend with stressors such as being responsible for patient care without prior training or job experience while, at the same time engaging with demanding training and learning.

Yusufov et al. (2019) found the following six stress reduction interventions were effective in reducing stress in different ways: psychoeducation, cognitive behavioral therapy (CBT), coping skills, social support, relaxation training, and mindfulness-based stress reduction (MBSR). Of the six techniques, three were more effective for lowering perceived stress equally in both groups, the use of cognitive behavioral therapy (CBT), coping skills, and social support. Anxiety, the physiological, emotional, and cognitive response to a stressor, on the other hand, was lowered by the stress reduction techniques of relaxation training, mindfulness-based stress reduction (MBSR), and psychoeducation in both groups of students, with graduate students having more reduction in stress than undergraduates when using relaxation training and psychoeducation. The research also showed the duration for effective stress interventions ranged from a one-day workshop to several weeks, or even longer for a duration of up to 8 weeks or more.

The authors concluded that the duration of interventions 8 weeks or longer appeared to make little difference than those lasting 8 weeks or less in reducing perceived stress and anxiety, but for one exception. Relaxation training appeared more effective in reducing anxiety when practiced long-term. The authors encouraged interventions of a brief duration that can be learned by students and used during the academic term. This research demonstrates that relaxation training and MBSR practiced for a duration of a one-day workshop to 8 weeks or longer have positive impacts on stress reduction for undergraduate and graduate students. This is related to the work of authors Tollefson et al. (2018) that examined the impacts of an assignment to adopt and teach a stress reduction technique for

five minutes to peers in class throughout the semester on the stress of undergraduate students in the health professions.

Similar to the research of Yusufov et al. (2019), Tollefson et al. (2018) also addressed reducing student stress, in their descriptive quantitative study examining undergraduate perceived stress to determine if a required stress reduction assignment with an educational component and an experiential activity engendered any change in students' perceived stress, knowledge of stress, and attitudes towards stress as well as impact their level of stress by the end of the course. The study took place in a large urban university setting in classes within the Health Professions Department where 10 faculty of 14 classes required all their students to complete an assignment to teach peers a stress reduction technique. While all students were required to complete the assignment, they could volunteer to be in the study and complete all pre- and post-assignment surveys.

The study started with a count of 153 student pre-surveys and concluded with a final count of 87 student post-surveys. Pre-surveys indicated that most students believed that they themselves and other students experienced high levels of stress, that stress affected their academic performance, and that most did not know healthful ways to manage stress. On a rating scale from one to 10 where one is the least and 10 is the most, students rated their stress level at five with the impact stress has on their daily life as five or above. They chose from a predetermined list of stress-reduction techniques and taught peers acupressure, affirmations, aromatherapy, coloring, gratitude, grounding, guided visualization, humor, journaling, mantras, mindfulness, music therapy, pet therapy, physical exercise, progressive muscle relaxation, self-massage, tai chi, and yoga.

The results demonstrated students positively rated the impacts that acquiring, practicing, and teaching stress reduction techniques in class had on their stress. For reducing stress outside of the classroom, post-surveys showed, on a scale of 1-10, 1 meaning no impact

and 10 meaning high impact, all students marked 3 and above, with a mean of 7.3+/-1.8. Seventy-eight percent thought the assignment had a positive effect on their academic performance as well as on stress levels during class time with 95% of students marking a 5 or higher, and with 22% of students marking 10 as the highest impact. In short, students felt learning the techniques and teaching them to others in the classroom had daily positive impacts on stress inside and outside of class.

The quantitative results of this study demonstrate teaching stress reduction techniques including progressive muscle relaxation and MBSR in the student classroom decreases student stress. Authors Tollefson, et al. (2018) concluded that the assignment to teach peers a stress reduction technique was effective in increasing undergraduate students' knowledge of stress, ability to cope with stress, as well as their level of perceived stress. Moreover, a stress reduction technique can help any student with any learning objective be more receptive to learning. This is related to the study by Greene et al. (2019) who wanted to address the symptoms of stress experienced by undergraduate social work students owing to the unique impact social work may have on the student stress levels.

Similar to Yusufov et al. (2019) and Tollefson et al. (2018), Greene et al. (2019) also addressed reducing undergraduate student stress. They noted the ANCHA Report (2016) that revealed undergraduates experience academic stress, financial stress, and the multiple demands of being a student, an employee, or a parent, and in addition, have felt hopeless at some time, have felt overwhelming anxiety, or felt a large amount of stress. In this case, however, the authors also observed undergraduate students of social work experience additional unique stressors.

Many social work students, mark the authors, have previous experiences with addiction, mental illness and trauma placing them at a higher risk of compassion fatigue, burn out, secondary traumatization, and vicarious traumatization. In addition, the authors note that

inexperience and being unable to manage the harmful effects of stress may contribute to these negative outcomes. The researchers sought to deflect the harmful effects of stress on student well-being and to teach coping skills in a self-help for helping professionals elective class, (Greene, et al., 2017) using an MBSR curriculum developed by a certified MBSR teacher as the basis for their main assignment which lasted 8 weeks. They chose MBSR as it was a verified evidence-based stress management technique that could help students reduce present and future stress, be used at work as a social work intervention, as well as cultivate the skills of self-reflection and emotional self-regulation necessary for professional and personal self-care.

The educators wanted to know how an MBSR class would impact mindfulness skills of the students, and the purpose of the teaching note was to discuss the empirical results as well as to share student subjective experiences with the MBSR assignment. They used a used a mixed-methods, exploratory study to assess the effects of the MBSR assignment on students' mindfulness by administering the Five Facets of Mindfulness Questionnaire before and after the MBSR assignment as well as the students' subjective experiences written in a journal that was part of the assignment. Green et al. (2017) use the following descriptions of the five facets from Baer et al. (2008):

> Observing includes noticing or attending to internal and external experiences, such as sensations, cognitions, emotions, sights, sounds, and smells. Describing refers to labeling internal experiences with words. Acting with awareness includes attending to one's activities of the moment and can be contrasted with behaving mechanically while attention is focused elsewhere… . Nonjudging of inner experience refers to taking a nonevaluative stance toward thoughts and feelings. Nonreactivity to inner experience is the tendency to allow thoughts and feelings to come and go, without getting caught up in or carried away by them. (p. 330)

This study included 19 participants, 17 female and two male students all of whom chose to volunteer for the study. For the MBSR assignment, the students studied readings and watched videos related to weekly topics, as well as practiced daily yoga, progressive muscle relaxation, visualizations, and journaling. Each day for eight weeks, they performed a practice, noted in a log the time spent, and responded to the prompt, "What came up in your mindfulness practice, how did it feel, and what did you notice in terms of physical sensations, emotions, thoughts, etc.?" (p. 410). The quantitative findings of this study revealed 63% of students felt their stress had been lowered by the end of the school semester. In addition, an increase in aspects of mindfulness between the pre- and post-surveys, along with the qualitative findings of writing in student journals reflected that each participant, all students, had a positive experience with the skills learned during MBSR training.

In short, students reported their new MBSR skills helped them reduce stress, improve their sleep, and increase their mindfulness. This study demonstrates students self-reported positive impacts of learning a stress reduction technique, MBSR, in the classroom. The authors conclude that MBSR is useful for students while in school, and they encourage other teachers to create MBSR activities and assignments for their students. This is related to the work of Deshpande et al. (2023) who looked at the impacts of an MBSR program on psychological distress and perceived stress of undergraduate and graduate students, this time outside of the classroom.

In a study conducted between 2016-2018, again implemented by professionals in the social work, counseling, and health fields, Deshpande et al. (2023) addressed undergraduate and graduate student stress in their mixed-methods study evaluating the impacts of a Kabat-Zinn MBSR program on student mental health using the four measures of psychological distress, perceived stress, satisfaction with life, and mindfulness. Conducted at a large private university in the Northeastern United States, a total of 90 students,

independently or clinician-referred, attended an eight week-long mindfulness class for two and a half hours per week that was given by an MBSR-certified instructor at the college counseling center. For the quantitative measures, the researchers surveyed the 90 students before, at mid-point after week four, and after completion of the program. For the qualitative measures, 115 participants were surveyed, and the researchers asked students the two following open-ended questions: “What did you find most helpful in this group?” and “What are some barriers you experienced to implementing the practices of this program? (Deshpande et al., 2023, p.3).

The authors found three consistent themes in student responses. One, students appreciated having a dedicated time and space that allowed them to practice both mindfulness and meditation. Two, one quarter of the students expressed MBSR as having positive impacts, “positive emotional and cognitive outcomes” (p. 5) on their mental health. One student shared that she liked having tools to manage stress and counter ruminations, not to get “swept away by bad emotions” or “counter-productive stress responses” (Deshpande et al., 2023, p. 5). Third, the students liked the support. They liked having a sense of community, sharing difficulties, and getting ideas from each other, as well as learning new skills together. The researchers also found emotional and cognitive barriers to mindfulness practice at home included lack of time/busy schedules, inability to commit to a regular time or to motivate oneself, and a lack of energy.

Deshpande et al. (2023) concluded MBSR positively impacted the students’ mental health and worked well as a group-based support to student mental health. Students were especially helped by having the consistent scheduled time and space to practice, with the instructor and peers, and learning experientially together in real time in a supportive group. They thought creating a social connection and the opportunity to learn from each other’s experiences were especially valued. The authors also noted that at the four-week survey, they

measured positive impacts in student responses of mindfulness, psychological distress, and perceived stress demonstrating that a shorter length of time practicing MBSR skills had beneficial impacts.

Deshpande et al. (2023) also observed the "lack of energy" to practice suggested some students may not have been able to value mental health hygiene enough to pursue MBSR practices owing to the social stigma. Relatedly, to take the emphasis off "illness." They also suggested calling mental health "stress reduction" or "well-being."

The researchers concluded that the duration of four and eight week-long MBSR program practices produced positive impacts on student mental health, that MBSR practices can be scheduled to meet student time management needs, and MBIs can lessen student stress. Importantly, they also indicated universities can promote student mental health and wellness through faculty and staff, and provide tools, resources, and connections to campus care to support student mental health. This is related to the work of Kerrigan et al. (2017) who studied the impact of a MBSR program on the stress felt by high-performing undergraduate and graduate students at university with a competitive academic environment.

In 2017, Kerrigan et al. noting that two of the most common mental disorders affecting college students are anxiety and depression, addressed the feasibility of implementing an MBSR program at a university by interviewing students in a pilot program for their responses to stress and the impacts of MBSR practices on their stress and pressure coming from external "socially prescribed perfectionism" (Kerrigan et al., 2017, p. 910), and the impacts on stress MBSR practices. Noting mindfulness has had a positive impact on mental health on various populations while also observing most university studies have been conducted on nursing and medical students, the authors sought the response of students with strong academic achievement orientations in the general population of a highly competitive high-ranking university of the Northeastern United States.

They performed an in-depth qualitative study using semi-structured interviews to examine the potential positive benefits, given the rigorous academic environment, that an on-campus MBSR program would offer students. The authors did this by studying the impacts of an MBSR class held in the fall semester with 8 weekly sessions and a retreat on a total of 13 students, 10 of whom completed the program, and three of whom did not finish. The 10 who fully completed the MBSR program were interviewed twice, before the program began and after it ended. Three of the participants who did not finish the program were interviewed to determine reasons for attrition. Of the 13 participants, 11 were undergraduate women, 2 were men, one of whom was a doctoral student and the other an undergraduate.

In addition to student goals and backgrounds, the researchers examined their stressors and stress management practices. They wanted to know the reasons why students wanted to take MBSR training, what prevented attending class and practicing the exercises, and how the students felt after taking the MBSR training, and whether they thought MBSR would be useful to other graduate and undergraduate students. The findings revealed the students felt relentless pressure from campus expectations to excel in schoolwork and in the extracurricular activities with the result that they felt "stressed and overwhelmed" (Kerrigan et al., 2017, p. 911). Some physical symptoms of stress that students indicated included poor sleep, shortness of breath, stomach pain, muscle tightness, migraine headaches, and "fast beating of the heart" (Kerrigan et al., 2017, p. 911) along with an unfocused mind.

The post-training results showed the students found MBSR stress reduction techniques could present a chance to disengage from the constant demand to perform well. One student observed "I thought this was a nice way to kind of force myself to take a step back…and experience something that's very different than what I'm used to" (Kerrigan et al., 2017, pp. 912-913). In addition, MBSR practices gave them skills and the opportunity to reflect on how they related to the pressure, and moreover, how to reframe negative thinking

patterns that lead to anxiety and depression. In short, they learned how to become aware of the pressure and change their relationship to it.

The students also found they could identify symptoms of stress and interrupt anxious feelings, “practicing being aware of the sensations in your body has helped me to identify the physical stress responses better…when I feel tightness in my chest…[I] do what I can to manage that feeling” (Kerrigan et al., 2017, p. 914). Overall positive impacts including better sleep, less headaches and migraines, as well as better pain management. The students concluded stress reduction was urgently needed and that an MBSR program may be useful to other students.

Interestingly, when asked what students would most benefit from MBSR, the response was “anyone who sticks out in a crowd,” and who experiences more stress than the average student, such as pre-med students, science majors, athletes, sorority or fraternity members, students with disabilities. The researchers noted these identified groups of people were students with high pressure majors and “students who may be considered outsiders to the general group norm” (p. 912). Kerrigan et al. (2017) concluded that university campuses should explore stress reduction techniques that shifted the campus environment that pressured students to perform “perfectly” to one that supported student well-being. The results/findings of this study demonstrate that teaching MBSR practices to high-performing general population students may lower symptoms of stress, interrupt or reframe negative thoughts, cultivate self-acceptance, and in short, give the students skills with which to notice their responses to stress and to self-regulate their emotions.

In summary, research demonstrates that stress reduction techniques taught inside and outside of the classroom can lower symptoms of stress anxiety inside and outside of the classroom for graduate and undergraduate students. This includes (a) a meta-analytic review of the literature between 1980 to 2015 by Yusufov et al. (2019) that illustrates both

undergraduate and graduate-level students benefit from specific stress reduction interventions that reduced both perceived stress and anxiety; (b) a study by Tollefson et al. (2018) that demonstrates undergraduate students in the health professions reported reduced stress inside and outside of the classroom by adopting and teaching stress reduction techniques including MBSR and progressive muscle relaxation to peers; (c) a study that claims social work undergraduates who took an elective, Self-Care for Helping Professionals, based on practices of MBSR self-reported improvements in the quality of the sleep, mindfulness, and in overall stress reduction (Greene et al., 2018) (d) a study evaluating the positive impacts of an MBSR program on student student stress by having the consistent scheduled time and space to practice, with the instructor and peers, and learning experientially together in real time in a supportive group (Deshpande et al., 2023); (e) a study on the positive impacts of an MBSR pilot program on undergraduate and graduate student stress experienced on a high-pressure academic campus (Kerrigan et al., 2017).

Taken together, this body of research justifies the claim that teaching stress reduction techniques including MBSR and relaxation training, inside and outside of the classroom has positive impacts on reducing undergraduate and graduate students' perceived stress and anxiety (Deshpande et al., 2023; Greene et al., 2019; Kerrigan et al., 2017; Tollefson et al., 2018; Yusufov et al., 2019) and suggests stress reduction techniques should be taught to another population of college students of diverse ages, backgrounds, and cultures who are in a major life transition, adult ESL community college students. ESL classes offer a consistent place and time (Deshpande et al., 2023; Tollefson et al., 2018) for students to practice and to reduce stress in the classroom (Greene et al., 2019; Tollefson et al., 2018). Talking about the MBSR skills and experience of practices cultivates connections in a supportive group in which students learn from each other's experiences (Deshpande et al., 2023; Tollefson et al., 2018)).

MBSR practices may help some ESL students, who are unaware of the normal expected development of interlanguage as part of becoming bi-lingual speaker, disengage from the notion that "My English is not good," or a similar perfectionistic tendency (Kerrigan et al., 2017) and may be an extra tool for self-regulation when confronted with the extra stress of being non-native English speakers ``who may be considered outsiders to the general group" (Kerrigan et al., 2017, p. 912). In short, students can possess tools to manage symptoms of stress and anxiety as well as skills of self-regulation, take care of themselves and their families, and in the process, learn about mental health, the cultural concepts of health, as well as how to talk about symptoms while acquiring English language skills.

Summary

This literature review claims stress reduction techniques should be taught in the community college adult ESL classroom to reduce symptoms of stress and anxiety during language acquisition, teach self-care, de-stigmatize, normalize and familiarize students with mental health issues, and support their access for mental health care so that they may take care of themselves and their families.

Evidence that supports this claim includes 4 sets of studies that demonstrate that (a) immigrant and refugee adults may suffer from trauma and stressors during stages of migration and contend with barriers to mental health utilization (Potocky & Naseh, 2019; Salami et al., 2019; Sangalang et al., 2019) (b) immigrant and refugee adult community college ESL students may suffer symptoms of stress and anxiety from trauma and stressors and ESL teachers want to mitigate stress (Adkins et al., 1999; Eastman, 2020; Krivitsky, 2017; Medley, 2012); (c) ESL students may also suffer language anxiety (SLA) within and without the classroom in their adopted community with negative impacts on the language acquisition and on acculturation (Garcia de Blakeley et al., 2017; Horwitz et al., 1986;

Pishghadam et al., 2016; Sevinç & Backus, 2019); (d) graduate and undergraduate students suffer from symptoms of anxiety as well as perceived stress and self-report positive impacts of learning stress reduction techniques in and outside of the classroom (Deshpande et al., 2023; Greene et al., 2019; Kerrigan et al., 2017; Tollefson et al., 2018; and Yusufov et al., 2019).

This claim and body of evidence addresses symptoms of trauma and stress as well as language anxiety that adult ESL students may experience in the classroom during language acquisition and in the majority language culture in everyday life situations of working, taking care of families, and of taking care of themselves. As immigrant and refugee ESL students may not access mental health support owing to a lack of resources, documentation of legal status, language proficiency, cultural stigma, or any number of obstacles, these lessons can provide the basics of self-care and positive emotional health.

With my field project, I propose to create a framework for lessons teaching stress reduction techniques that includes MBSR and progressive muscle relaxation recordings, scripts, daily activities, a self-care plan, and a final group project and self-care plan along with basic communication ESL lessons that use vocabulary that express emotions and feelings.

CHAPTER III - THE PROJECT AND ITS DEVELOPMENT

Description of the Project

The project is a set of four lessons each teaching one of the four stress reduction techniques of progressive muscle relaxation (PMR), as well as the mindfulness-based stress reduction (MBSR) practices of mindful breathing, mindful eating, and the loving kindness meditation. The lessons are designed to engage multiple intelligences and learning styles in all four language areas. Thus, each lesson is complete with a script, a recording, a journal page, a weekly record, a space for the visual representation of the experience, an evaluation of the technique, questions for self-reflection and discussions as well as a group presentation assignment, and a self-care plan for reducing personal symptoms of stress and anxiety. The teacher may choose to refer to the Mood Meter by Marc Brackett that presents vocabulary of nuanced emotions and feelings for each lesson to increase English vocabulary.

First, students need to try one stress reduction technique in class, record and discuss their reactions to it. Second, they choose one of the techniques and practice it every day for two weeks, filling out the time in the practice log and choosing a word to describe their feeling after the practice. Third, at the end of two weeks, students can evaluate their experience through writing a full journal entry and creating a visual expression of the experience such as an image, a drawing, a photo, or meme, or anything else of their choosing. The final steps include joining group discussions and creating group presentations, and lastly, designing a personal self-care plan for reduction of stress.

Scripts

The scripts for mindfulness and progressive muscle relaxation are syntheses and distillations of scripts produced for speakers of native English. As many scripts for native English speakers are lengthy using complex syntax, advanced vocabulary, the enunciation of and the meaning of the words in the practice directions may be unclear for adult ESL students

to initially understand and follow. Hence, these scripts are written in shorter sentences with the basic vocabulary pertaining to each practice, while being true to the intention of the practice.

Lastly, some scripts may appear repetitious to the native English speaker or to the person who has not practiced mindfulness before, however, in keeping with mindfulness stress reduction techniques, repetition can be soothing and thus, provide comfort and calm. The repetition may also be enjoyable for the students while learning the language.

Recordings

Pitch, intonation, as well as the pacing of instructions are important to set the conditions for understanding the English words as well as for receiving and performing the instructions. The melodious lilting lullaby voice intonation that is sometimes used in relaxation recordings for native English speakers may distract the ESL listener. The English words may not be clearly perceived. Hence, a low-pitched softer voice and a slower rate of speech is used in the recordings to induce feelings of calm and to be more easily understood. If the rate of speech in the recording is not comfortable for the students, the teacher may produce a recording from the pre-typed script.

Content

These stress reduction techniques have been chosen for their known impact on reducing symptoms of stress (Deshpande et al., 2023; Greene et al., 2019; Kabat-Zinn, 2013; Kravitsky, 2017; Tollefson et al., 2018; Yusufov et al., 2019) . In addition, they are combined with activities designed to appeal to multiple intelligences and learning styles that students can use to express themselves while growing their English skills in all four language areas. For example, the stress reduction technique of mindful eating of a raisin engages the senses of taste, smell, touch, hearing, and vision, all facets of bodily-kinesthetic intelligence. Reading the script, listening to the recording, as well as the act of holding and consuming the

raisin use linguistic intelligence and appeal to the aural, the visual, and the tactile learner while also developing English language listening and reading skills. The journal activity invites use of intra-personal intelligence, cultivates self-reflection, and develops English language writing skills, while the art activity helps visual and spatial learners to express themselves in any medium of choice.

The additional activities also use multiple intelligences and learning styles and all lessons culminate in activities that produce meaningful communication. The group presentation taps into interpersonal intelligence and allows for the needs of cooperative social learning using communicative English language skills. The evaluation cultivates self-reflection and critical thinking skills while honing written English skills. The self-care plan provides a way to use the knowledge gained from the entirety of the lesson to self-regulate or to take care of one's distressing emotions, in the face of stressful situations including when speaking the native or English language in the classroom, at home, or out in the community, depending on the context. In this way, students may reduce symptoms of stress and learn English in any combination of ways.

Lastly, in addition to taking care of oneself and being able to communicate one's feeling and thoughts in various styles and contexts using English, one desirable result is that these practices encourage communication with and feedback from family, and moreover, serve as the basis for a family discussion for mental health, opening up lines of communication, and supporting family relationships all of which may open the way for reducing family conflict, a major predictor of negative mental health outcomes (Potocky & Naseh, 2019; Sangalang et al., 2018) in current and future generations.

The immediate goal of teaching these stress reduction techniques is to equip adult immigrant and refugee ESL students with tools of self-care to allay the physiological symptoms of anxiety and stress associated with trauma or language anxiety both inside and outside of the ESL classroom as students. Students learn to recognize their symptoms of anxiety, notice the situations in which they arise, and practice their personal stress reduction technique to cope with and reduce the symptoms.

For example, the goal of progressive muscle relaxation is for the student to become aware of where tension lies in the body, to squeeze, then relax the muscles of that particular muscle group, and to repeatedly recognize the tension and then the relaxation that the squeezing of muscle brings. Eventually, if practiced regularly, the student can quickly notice and relax tensing muscles before feeling further tension or discomfort. This, in turn, can break the cycle of returning to a stressful state with its accompanying symptoms.

The long-term goals of teaching stress reduction techniques are to promote mental well-being through education and self-help, to de-stigmatize mental illness, as well as to foster student confidence in seeking help for any mental health issues for themselves or for their families. Cultural stigma of mental illness and the language barrier are two main reasons immigrants and refugees do not seek mental health services after arrival in their new country. Studies have shown that stress and anxiety from past trauma can lead to future mental and physical diseases (APA, 2023; Kabat-Zinn, 2013), in adults and children. Language anxiety can also affect acculturation as it can interfere with acquisition of the second language in the ESL and EFL classroom (Horwitz et al., 1986), and language acquisition, learning, and practice in the majority language community (Garcia de Blakeley et al., 2015; Sevinç & Backus, 2017).

Development of the Project

This project developed from observations as a volunteer assistant in a non-credit California community college adult intermediate ESL classroom of immigrant and refugee students. Health topics were addressed by the teacher through weekly wellness activities. Stress reduction techniques arose as a possible topic for wellness, and I pursued the research. Research showed that health professionals and health educators of American university students were concerned about the current ill effects of stress on students and sought to provide students with ways of reducing stress in the form of stress reduction techniques. Some techniques repeatedly came up such as progressive muscle relaxation and MBSR practices.

MBSR piqued my curiosity as I didn't quite understand the "noticing the moment" concept. I wanted to know why it was so well-received by the students and promoted by the teachers in the studies and promoted. I enrolled in an 8-week session held at the Center for Integrative Medicine at a well-known local teaching hospital with a physician who was a Jon Kabat-Zinn-certified MBSR trainer. She specialized in mindfulness-based interventions, trauma recovery, women's mental health, as well as global mental health and led group practices.

"Noticing the moment," was clarified to me by eating a raisin mindfully. The steps of the exercise slow down the consumption of the tiny piece of fruit. One is asked to look at the raisin, smell its aroma, feel the textures, and even to listen to it--a raisin does make a sound when you roll it close to your ear--before actually placing it in the mouth. Then the next step was putting it on the tongue, but not swallowing right away. That is when "noticing a moment" became clear. Until that point, I was focused on eating the raisin while thinking of the things I had to do the rest of the day, and I was not aware of the food until I started using all my senses. Once I actually chewed and swallowed the raisin, I realized how much I had

been focused on eating it from the very outset of the exercise rather than on using all my senses to enjoy the smell, sight, feel, and taste of the food. My mind was on other things, yet each step of engagement was a way to break the concentration, to notice the external world using my other senses of smell, touch, sight, and hearing. The act of consuming the raisin was a series of moments where I had focused my mind elsewhere instead of being present and aware of each moment until bidden to use my other senses.

Other mindful exercises cultivate noticing one's thoughts, letting go of them, then returning focus to the breath with the effect of interrupting negative or unpleasant feelings or sensations. This ability to disrupt sensations, feelings, thoughts, and reactions can be useful for lessening the hold of painful ones. The variety of practices were soothing, in part perhaps, owing to the sound of the leader's warm voice and the custom of closing one's eyes during practice. There is just the human voice, no special equipment or highly stimulating sounds or visuals. I thought about how the practices would fit the various learning styles and use multiple intelligence skills and that adult ESL students would take to them. Hence, I created the lessons.

For use with adult ESL students, the primary focus was on using simple syntax with specific vocabulary that relayed the concepts while being true to the intention of the practice. I wrote simple scripts and used them with students in the class. As the students were engaged and responded positively to the exercise, I then recorded the words. Thus, I had the basis for the lesson on the technique.

Reviewing vocabulary and reading a script with students repeating took a surprising amount of time to me, 45 minutes or so. I had one hour a week for four weeks to present these lessons. I developed the four stress reduction technique lessons with scripts and recordings. The students were very engaged and responsive, so I could tell they enjoyed the activity. For my field project, I developed more activities to go with the scripts and

recordings, thus creating full lessons. So, while I know the activities of MBSR and progressive muscle relaxation are fun for students, beyond listening and reading together, ESL students haven't tried the other activities I created. Perhaps that is a limitation. However, Tollefson, had students teach a wide variety of techniques with positive reactions, so I think ESL students would enjoy the range of activities I included.

One odd thing, "voice confrontation" surprised me. Voice confrontation refers to the feeling of embarrassment at the sound of one's voice on a recording. Per Wikipedia, "Upon hearing a recording of their own voice, a person may experience disappointment due to cognitive dissonance between their perception and expectation for the sound of their voice." https://en.wikipedia.org/wiki/Voice_confrontation Voice confrontation proved a challenge and took a while for me to work through while making the recordings.

ESL students might enjoy recording themselves reading the scripts in English from time to time to see how their English pronunciation changes. They can also observe if hearing their voice recorded in English feels any different than hearing their voice recorded in their native tongue. Perhaps in hearing their voice speak English, they could hear the beginning of a new identity in their new home.That could be a tangential activity to learning, teaching, and evaluating stress reduction techniques as part of mental health support for refugee and immigrant students in the community college noncredit adult ESL classroom.

The Project

Screenshots of the project may be found in the appendix and on the website.

CHAPTER IV - CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Refugee and immigrant students with or without documented legal status who populate the California community college non-credit ESL program classes may suffer from symptoms of stress and anxiety arising from migration trauma, post-migration stressors, and language anxiety all of which may interfere with language acquisition, while concurrently experiencing barriers to mental health support including cultural stigma, legal status, and lack of language proficiency.

The purpose of this project is to provide ESL lessons in stress reduction techniques that ESL teachers can implement to support the well-being of learners and to reduce the symptoms of anxiety based in trauma and in language use experienced by adult immigrant and refugee community college ESL students while they acquire and use their English language skills within and without the ESL classroom as they socialize, work, and take of their families and themselves.

The significance of the project is that students learn better when they are not stressed or anxious (Krashen, 1982; Pishghadam et al., 2016; Tollefson et al., 2018). Through learning stress reduction techniques, they can become aware of stress, self-soothe, and create positive learning conditions for themselves in class or in any context (DeSena & Schweitzer, 2023; Deshpande et al., 2023). Stress reduction increases student engagement (Krivitsky, 2017; Tollefson et al., 2018). The subject is culturally relevant, while the activities appeal to multiple intelligences and culminate in meaningful exchanges.

The project accomplishes the purpose of reducing stress and de-stigmatizing mental health issues through a series of exercises that encourage discussion of feelings, exploration of contexts or circumstances in which those feelings arise while learning English vocabulary, usage, and meanings. The lessons contain the vocabulary, or building blocks, for the expression of feelings and emotions, while the activities provide communication contexts for

using the vocabulary, exploring self-care concepts, and communicating in relationships. The lessons culminate in using Bloom's taxonomy higher order thinking skills to evaluate the stress reduction technique and to create a group project as well as to design a self-care plan using all the learned skills.

At the same time, students learn to destress and to recognize their symptoms of anxiety, notice the situations in which they arise, and practice their personal stress reduction technique to cope with and reduce the symptoms. For example, the goal of progressive muscle relaxation is for the student to become aware of where tension lies in the body, to squeeze then relax the muscles of that particular muscle group, and to repeatedly recognize the tension and then the release of tension that the squeezing of muscle brings. Eventually, if practiced regularly, the student can quickly notice and relax tensing muscles before feeling further tension or discomfort. This, in turn, can break the cycle of returning to a stressful state with its accompanying physiological symptoms.

Recommendations

Exploring cultural concepts of distress, modes of expression, behavior around symptom expression, and cross-cultural practices of communication would be useful for developing understanding of how to talk about mental health issues for the ESL teacher and the current first generation adult ESL students. The students may gain the awareness, confidence, and resources to address any mental health issue they or their children, the second-generation, or the third-generation could face without transmitting the negative impacts of cultural stigma that cause emotional pain and prevent emotional healing.

Hence, I would recommend developing future lessons that delve into and examine the cultural stigmas around mental health, once students have developed their English skills to feel comfortable discussing the issues. Perhaps cultivating self-care and well-being in a new language can create new health behaviors that support mental health for the current and future generations.

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APPENDIX

Adult ESL Stress Reduction Techniques

https://sites.google.com/view/esl-stress-reduction/home

https://sites.google.com/view/esl-stress-reduction/home

Materials - Recording - Script - Vocabulary

More activities

Vocabulary for emotions - Journal for response to first practice

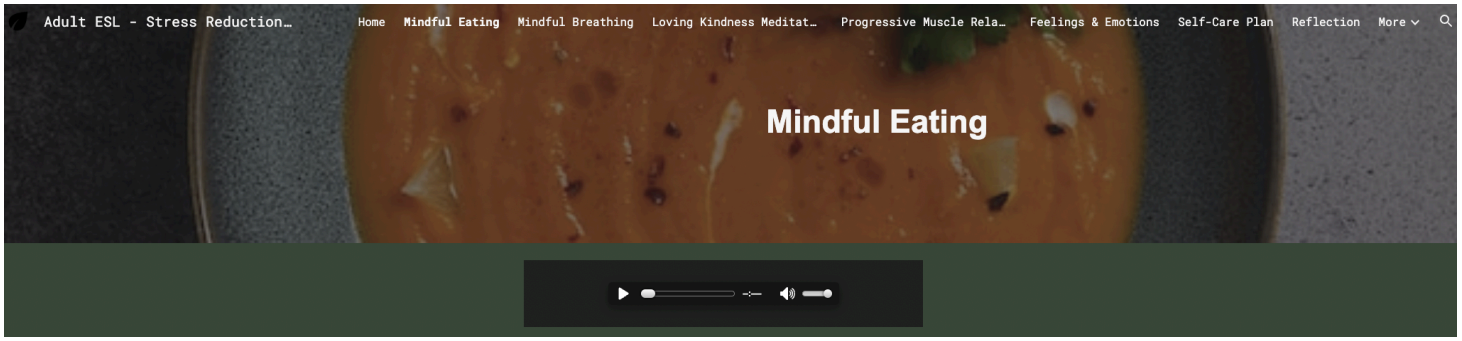
Daily Log for 2 weeks of practice - Visual creation for response to 2-weeks of practice

Group Presentation - Self-care plan to reduce stress

The Home Page

The home page is divided into three sections to facilitate access to the recordings, scripts, vocabularies, and activities. At the very top are the links via words to the individual stress reduction techniques and activities. Next, the individual stress reduction techniques are visually represented by images, and the buttons below them immediately access the recordings, scripts, and vocabulary. The bottom third of the home page lists the additional activities to evaluate if, after two weeks of practice, practicing a stress reduction technique has reduced feelings of stress.

Definitions are from the Cambridge Dictionary



Explore the raisin with all your senses.

1. Focus on this raisin. Turn it in your fingers. Look at its dark and light colors.

2. Explore the texture. Feel how the raisin is soft, firm, rough, or smooth.

   Notice your thoughts. Let them be. Focus back on the raisin.

3. Place the raisin under your nose. Smell it.

4. Hold the raisin to your ear. Roll it. Squeeze it. Listen for a sound.

   Slowly bring the raisin to your mouth. Notice how your mouth waters.

   Gently put the raisin on your tongue. Roll it in your mouth. Feel the sensations.

5. Chew the raisin. Notice the side of your mouth where you bite it.

   Taste the flavors.

   Slowly chew the raisin. Notice your saliva increases and its texture changes.

6. Notice when you want to swallow the raisin. Notice your intention.

Feel the sensations of swallowing the raisin as it goes down your throat to your stomach. This is mindful eating, noticing each moment and becoming aware of each of your senses.

Vocabulary

Focus pay particular attention to

Focus on your breath means pay attention to your breath.

Intention something that you want to and plan to do; an aim

His **intention** is to walk for 30 minutes every day.

Mindful giving

to someone or something

Be **mindful** of the baby. She is sleeping and the loud TV wakes her up.

Mindful deliberately **aware** of your body, mind, and feelings in the present moment, in order to create a feeling of calm

Being **mindful** of your emotions and your body can help you relax.

Rough not smooth

The bark on a tree is **rough**. It can scratch your skin.

Saliva the liquid that is made in your mouth

Chewing gum makes **saliva** in your mouth.

Sensation a physical feeling or perception in your body

Pain is a **sensation**. Itchiness is a **sensation**. Hunger is a **sensation**.

Texture the quality of something that you can touch, for example whether it is rough or smooth, or soft or hard

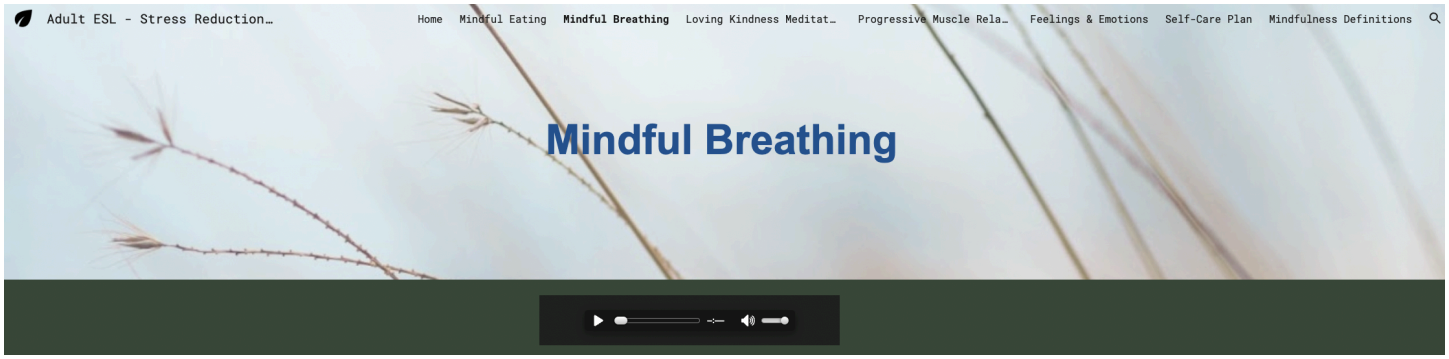
Glass has a smooth **texture**.

—

Verb form

let it be, let them be
to allow something to happen

Let your thoughts be means don't focus on your thoughts, allow them to come and go.
Let them be.



Mindful Breathing

1. Sit comfortably in a chair with both feet on the ground.

   Notice where your body feels the chair and your feet touch the floor.

   Notice where your body feels tension and relax.

   Let your shoulders drop down.

2. Breathe normally. Breathe naturally.

   Inhale and exhale.

   Notice your breath in your nose and throat.

   Watch your chest move up and down.

   Imagine your stomach is like a balloon.

   Inhale. Fill the balloon with air.

   Exhale. Let the air out.

   See how your stomach moves out and in with each breath.

   Note any sensations or feelings.

   Focus on your breath.

   Inhale and exhale.

3. Your mind may wander.

   Notice your thoughts.

   You may hear a sound in the room.

   You may feel a sensation in your body.

   Bring your attention back to your breath.

   Focus on your breath.

   Inhale and exhale.

4. Your mind may hold onto thoughts.

   This is ok.

   Notice your thoughts.

   Let them go.

   Then, focus on your breath.

   Inhale and exhale.

5. Repeat breathing and noticing for five minutes.

   Your body will relax.

When you are ready, open your eyes.

Vocabulary - Breathing

breathe in - breathe out to take air into and out of your lungs

The doctor says, “**Breathe in**, **breathe out”** when he listens to your lungs.

inhale - exhale to breathe in and to breathe out

The doctor also says,**”inhale, exhale”** when he listens to your lungs.

tension a feeling that you are nervous, worried, and not relaxed

Do you feel **tension** when you take a test?

wander you need to pay attention to one thing, but your mind thinks about other things

This book is boring! My mind **wanders** every time I read it.

Loving Kindness Meditation

Begin with yourself. Say these words silently. Focus with your heart and mind.

May I be safe
May I be happy
May I be healthy
May I live with ease

If you are uncomfortable the first time, try again a second time.

May I be safe
May I be happy
May I be healthy
May I live with ease

Think of a special person in your life and hold them in your mind. Say these words to them.

May you be safe
May you be happy
May you be healthy
May you live with ease

Give loving kindness to a person you feel neutrally towards. You do not dislike or like them, they are “ok.”

May you be safe
May you be happy
May you be healthy
May you live with ease

Give loving kindness to a person you do not like or someone who is hard to have a relationship with.

You can use these words or use your own words for your meditation.

May you be safe
May you be happy
May you be healthy
May you live with ease

Give loving kindness to you with your family, neighborhood, or religious community, or any community that is important to you.

May we be safe
May we be happy
May we be healthy
May we live with ease

Now give loving kindness to all living beings in your world and repeat silently to yourself again:

May we be safe
May we be happy
May we be healthy
May we live with ease

Send loving kindness to anyone. Use your own words.

Vocabulary - Loving Kindness Meditation

Loving showing love

Loving kindness the quality of feeling love and being kind toward yourself and other people

The grandmother feels **loving** towards the child.

The grandma shows **loving kindness** when she hugs the little girl.

Phrase

With ease comfortably, untroubled

To **live with ease** is to live comfortably.

The young man is poor, but he is happy. He lives **with ease**.

Verb Form

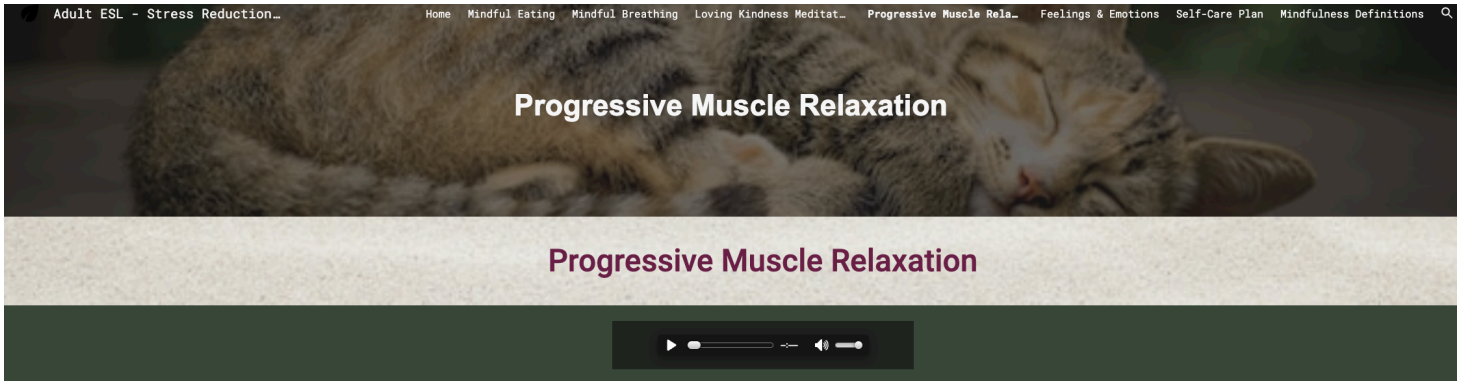
May + _____ + VERB to express a wish or hope for someone

Happy Birthday!

May	**all your wishes**	**come**	true!
May	**we**	**be**	safe.

May	**we**	**be**	safe happy healthy live with ease

May we live comfortably without worry, fear, sadness, disease.



Progressive Muscle Relaxation

Notice how your muscles feel when they are tense, then notice how your muscles feel when they are relaxed. Remember how to relax them. If you feel pain, please stop this exercise.

Preparation

Sit in a comfortable chair with both feet on the ground.
Take a long deep breath and slowly exhale.
Take 4 more long breaths and slowly exhale.

Right hand

Make a fist.
Tense the muscles in your right hand & arm.
Count to 10.
Open your hand.
Relax - let the tension flow out of your hand.
Feel your warm heavy relaxed muscles.

Left hand

Squeeze the muscles in your left hand & arm.
Count to 10.
Relax and let go.
Feel your warm heavy relaxed muscles.

Biceps

Put your palms together.
Push them together as hard as you can.
Count to 10.
Relax, let go.
Notice the difference between tension and relaxation.

Shoulders

Clasp your fingers together in front of you.
Pull your hands apart until you feel tired.
Feel the tension.
Let go.
Notice the heaviness.
Remember how it feels to relax.

Arms &
Shoulders

Stretch your arms out to the sides.
Tense your muscles.
Count to 10.
Rest your arms.
Relax.

Shoulders

Point your shoulders together in front of you.

Tense your muscles.
Count to 10.
Relax.
Pull your shoulders back.
Make your shoulder blades touch.
Count to 10.
Let go & relax.

Head

Push your head back against the chair.
Feel the muscles tense down the back of your neck.
Move your neck forward & backward and left & right.
Now hold your neck stiffly.
Study the tension.
All of your neck muscles are tense.
Count to 10.
Let them relax now.
Let the chair support your head.

Back

Arch your back up and out.
Tense the 2 sets of muscles down your back.
Count to 10.
Relax.
Sink into the chair.
Your muscles feel warm, heavy and smooth.

Glutes

Tighten your muscles.
Count to 10.
Then relax.

Upper Legs

Push your thighs together and apart at the same time as hard as you can.

Count to 10.
The muscles are rock hard.
Then relax.
The muscles are warm, heavy, and smooth.

Toes

Point your toes down.
Point your toes to your head.
Make a fist with your toes.
Curl your toes under your feet.
Let go and relax.

Stomach

Harden your stomach muscles.
Try to sit up.
Tighten your muscles again.
Push your hard stomach muscles in and out.
Relax.

Chest

Take a deep breath in.
Hold it
Feel the tension
Exhale and relax.

Head

Rest your head against the chair

Forehead

Raise your forehead muscles
Try to touch the top of your head
Keep the muscles tense until they are tired.
Let go. Relax.

Face

Let your eyelids, tongue, and cheeks relax.
Now relax your whole body.

Vocabulary - Progressive Muscle Relaxation

Relax

to loosen your muscles;
to become happy and comfortable because nothing is worrying you;

Relax your sore muscles with a massage.
Stop working and let's **relax** outside for lunch.

Tense

to stiffen muscles; to squeeze muscles;
nervous, worried, and not able to relax

Tense your muscles means squeeze your muscles. verb

Tense muscles are uncomfortable. adjective

He is afraid of flying. He becomes **tense** and worried when he is on the airplane.

English Vocabulary for Basic Emotions

To feel means to experience an emotion or a physical feeling. Human beings feel many emotions, and some basic emotions include anger, fear, disgust, contempt, sadness, enjoyment, and surprise. Feelings are related to each other. *Sad*, for example, is feeling *unhappy* usually because something bad has happened. *The teenager is sad that he lost his cell phone*. *He can't talk to friends. Depressed* is feeling *sad* combined with a second emotion, feeling *hopeless. The father is depressed. He lost his job and can't get a new one. Now, he can't feed his family. Depressed is one feeling, sadness, related to another feeling, hopelessness.*

Feelings also have strength. Feeling ***happy*** is feeling pleasure. *The musician feels happy playing the guitar.* He can feel happy every day. Feeling *elated* is the feeling of being very *happy*. *The mother and father feel elated—their daughter is getting married!* Feeling *elated* is a feeling of intense happiness from something special.

Stress reduction vocabulary can include four basic kinds of emotions for describing how you feel such as sad, calm, happy, and other unpleasant stronger emotions such as mad, anxious, afraid, shocked, or disgusted.

Feeling calm is feeling peaceful. Stress reduction techniques help bring calm.

The photos of people reveal some common feelings, and the photos of the ocean waves show the power of some emotions.x

** Definitions are from the Cambridge Dictionary.*

Irregular Verb

to feel - to experience an emotion or a physical feeling

Present		Past
I, you, we, they	**feel**	**felt**
She, he, it	**feels**	

_____

He **feels** energetic when he lifts weights.

She **feels** happy when she runs.

Past

He **felt** tired after lifting weights.

She **felt** tranquil after exercise.

How do you feel now in class?

I feel_____ in class.

Yesterday, I **felt** _____ in class

Overwhelmed - when something, is too much, or almost too much, for a person to manage

Stressed out - worried and nervous

Cope - dealing successfully with problems or difficult situations

Regular Verb - to cope

Present		**Past**
I, you, we, they	cope	coped
She, he, it	copes	

We *feel* **overwhelmed** living in a new country.

We use stress reduction techniques, and we **cope** with stress.

Some mothers *feel* **stressed out** working and caring for children.

They talk to friends, meditate, or exercise, and they **cope** with stress.

The family *felt* **overwhelmed** and **stressed out** moving to a new city.

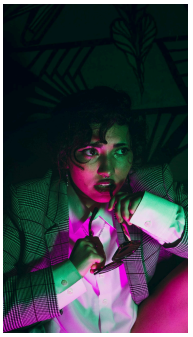
They *coped* by learning stress reduction techniques.

angry

joyful

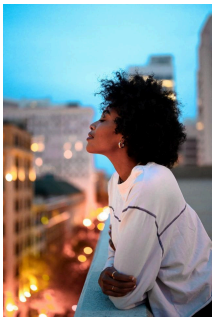
shocked

happy

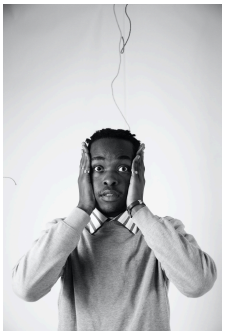


afraid

annoyed



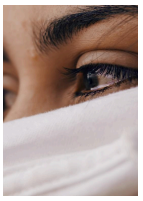
relaxed



panicked

upset

comfortable

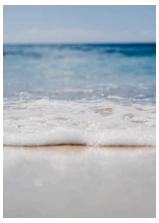


sad

Vocabulary of Feelings in for Stress Reduction

sad	calm	happy	mad
blue	tranquil	energetic	stressed
down	relaxed	upbeat	shocked
depressed	peaceful	cheerful	panicked
unhappy	content	thrilled	anxious
tired	satisfied	excited	troubled
disappointed	fulfilled	focused	frustrated
drained	comfortable	pleased	disgusted
bored	loving	elated	fearful

low energy



calm

more energy

high energy

Basic Emotions

Afraid
fearful; worried that something bad might happen
The nurse is afraid of oversleeping and missing her work shift.

Angry
mad
The little boy feels **angry.** His friend took his toy.

Disgusted
feeling extreme dislike of something
I feel **disgusted** when I smell bad eggs. Don't you?

Happy
pleased and in a good mood
The students are **happy** after a restful 3-day weekend.

Sad
unhappy
The parents feel **sad** their son is moving to a new city.

Surprised
when something happens that you did not expect
The wife feels **surprised** when her husband brings her flowers.

Unpleasant Emotions

Annoyed
slightly angry, a little angry

The shoppers feel **annoyed** when milk prices go up.

Anxious
worried and nervous

Do you feel **anxious** in small spaces?

Panicked
a sudden, strong feeling of worry or fear that makes you unable to think or behave calmly

I feel **panicked** when I see a snake.

Shocked
a big unpleasant surprise:

The workers feel **shocked** by the lay-off. They are losing their jobs.

Stressed worried and unhappy because you have too much work or too many problems to deal with

We feel **stressed** when our family member is very ill.

Upset
unhappy or worried because something unpleasant has happened

The passengers feel **upset** the airplane is late.

Worried
Anxious because you are thinking about problems or unpleasant things that might happen

Some parents feel **worried** about their child on the first day of school.

Sad emotions

Bored
feeling tired and unhappy because something is not interesting or because you have nothing to do

He feels **bored** watching football. He enjoys tennis more.

Disappointed
unhappy because someone or something was not as good as you hoped or expected, or because something did not happen

We feel **disappointed** in the new movie. It isn't very good.

Down
sad

Bad news from home brings the families **down**.

Drained
extremely tired

The student feels **drained** after working all day and studying until midnight.

Tired
feeling that you want to rest or sleep;

They planted six trees yesterday. Now, they feel tired!

Happy emotions

Cheerful
happy

Everyone feels **cheerful** at a party with good food and good friends.

Energetic
having energy

Today, I feel **energetic**. I'm riding my bike for 10 miles.

Excited
feeling very happy and enthusiastic

My friends are **excited** they are going to Canada for vacation.

Thrilled
very excited and pleased

The parents are t**hrilled** their daughter and son-in-law are having a baby.

Calm emotions

Comfortable
you are relaxed and have no pain:

She likes to walk bare-footed. She feels **comfortable** without shoes.

Content
happy or satisfied

I feel **content** when I work hard and spend time with my family.

Peaceful
calm and tranquil

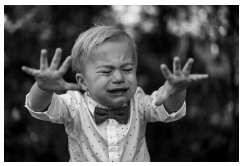
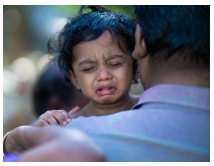
Meditation helps you feel **peaceful**. Playing video games does not help you feel calm.

Satisfied
pleased because you have got what you wanted, or because something has happened in the way that you wanted:

Are you **satisfied** with the quality of T-shirts these days? I'm not. Many T-shirts shrink after one washing.

Tranquil
calm and quiet

I feel **tranquil** at sunrise.


worst | worse | okay
good
fine | better | best

Better or Worse

How do you feel after exercise?

I feel **better**. I feel good.

Sometimes, I feel **worse** after exercise. My muscles ache.

How do you feel when you _____?

I feel _____ when I _____.

I feel _____ when I _____.

Sometimes, I feel _____ when I _____.

Other times, I feel _____ when I _____.

How do you feel after this stress reduction practice?

I feel _____.

Before, I felt _____.

Now, I feel _____.

“How are you?” and “How are you feeling?”

When do you say “How are you” and when do you say “How are you feeling?”

Where are you?

What is the situation?

Who are the speakers?

What is the purpose of the conversation?

What is the reason for the conversation?

			How	**are**	**you?**			
you	child	Sibling	parent	friend	neighbor	student	teacher	doctor

Who	**Where**	**Situation**	**Speakers**	**Purpose**	**Reason**	**Other**
Child						
Sibling						
Parent						
Friend						
Neighbor						
Student						
Teacher						
Doctor						
Other						

		How	**are**	**you**	**feeling?**			
You	Child	Sibling	Parent	Friend	Neighbor	Student	Teacher	Doctor

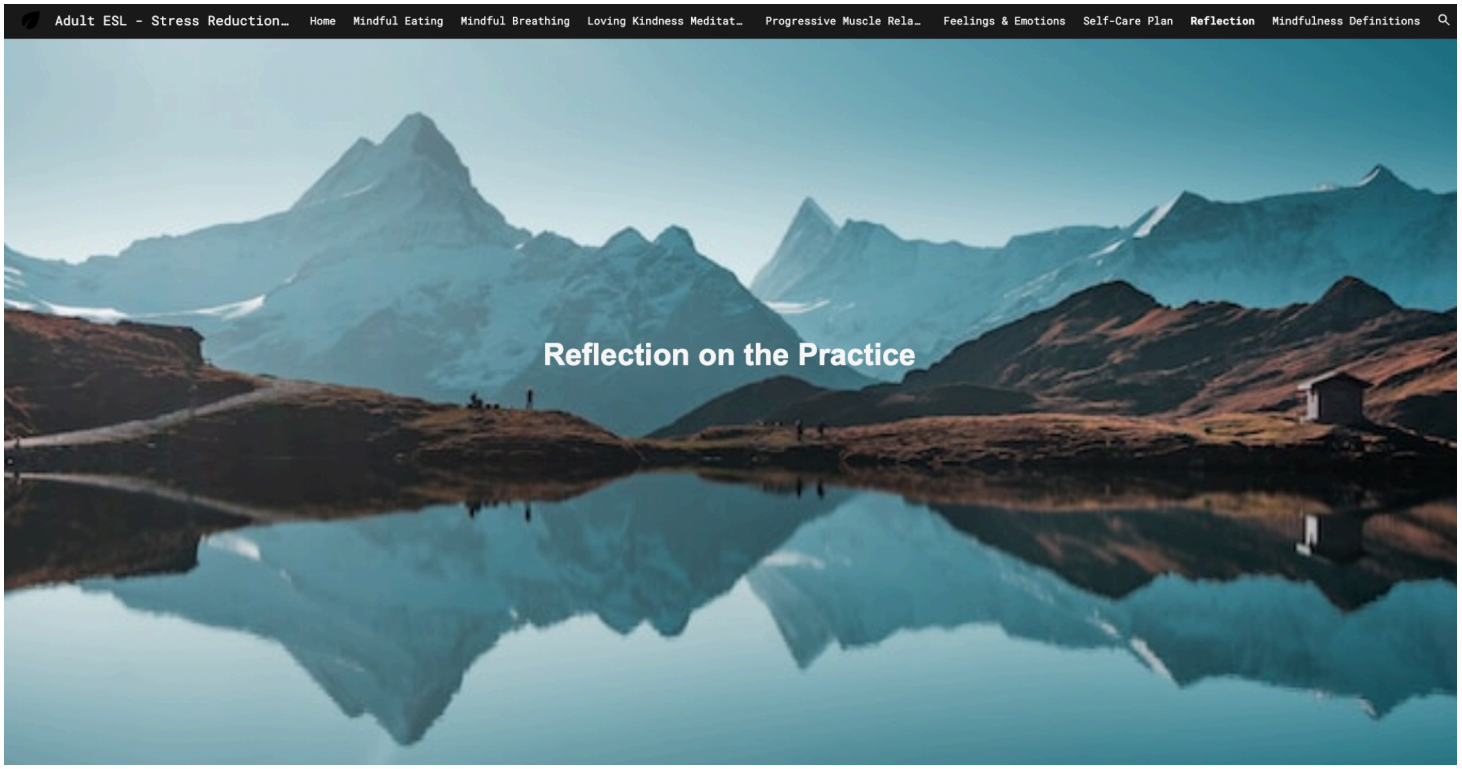
Who	**Where**	**Situation**	**Speakers**	**Purpose**	**Reason**	**Other**
Child	At home	Child is crying	You and child	Is child sick, hurt, angry	Take care of, fix problem, show love	
Sibling						
Parent						
Friend						
Neighbor						
Student						
Teacher						
Doctor						

What pattern do you notice?

We say _____ and _____ for people close to us.

We use _____ for people who are not close to us.

“How are you feeling” begins a personal conversation you have with family and friends.



First Day of Practice and Reflection

First day of the new stress reduction technique

How do you feel after doing the stress reduction technique today?

1a. Circle any words or use your own words to describe how you feel today after the practice.

peaceful good calm less anxious better

the same okay more anxious worse_____ _____ _____

I feel _____

_____

How are the feelings related?

_____

_____

b. Circle any words or use your own words to describe how you felt before the practice today.

tired bored tense relaxed good fine

_____ _____ _____

2. How was doing the stress reduction technique for you?

It felt

_____.

easy challenging difficult rewarding

_____ not bad frustrating _____

_____

Journal

First Day of Practice in Class

Write about any thoughts, feelings, sensations, or any reactions you experienced while focusing on your mindful practice or other stress reduction techniques.

_____

_____

_____

_____

_____

Weekly Record

How do you feel after the practice each time?

Choose one feeling word.

`

	Time of Day	Word
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

Last Day of Practice

Show how you felt before and after you learned this stress reduction technique. Draw a picture, take a photo, or make a video, a meme, or anything you want to.

After I practiced _____

Before I learned _____

Evaluation of the Stress Reduction Technique

Has your practice helped you reduce symptoms of stress and anxiety? How?

_____

_____

_____

Have you noticed any changes in yourself?

_____

_____

_____

How do you cope with anxiety in your culture?

_____

_____

_____

What do you do in your own culture to reduce stress? How does it compare to this technique?

_____

_____

_____

Does your culture see stress or anxiety as a physical feeling, a spiritual ailment, or another kind of condition?

_____

_____

_____

Has this stress reduction technique affected your family?

_____

_____

_____

What does your family think about the practice?

_____

_____

_____

Have they noticed any changes in you?

_____

_____

_____

Would you recommend this technique to another person?

Why or why not?

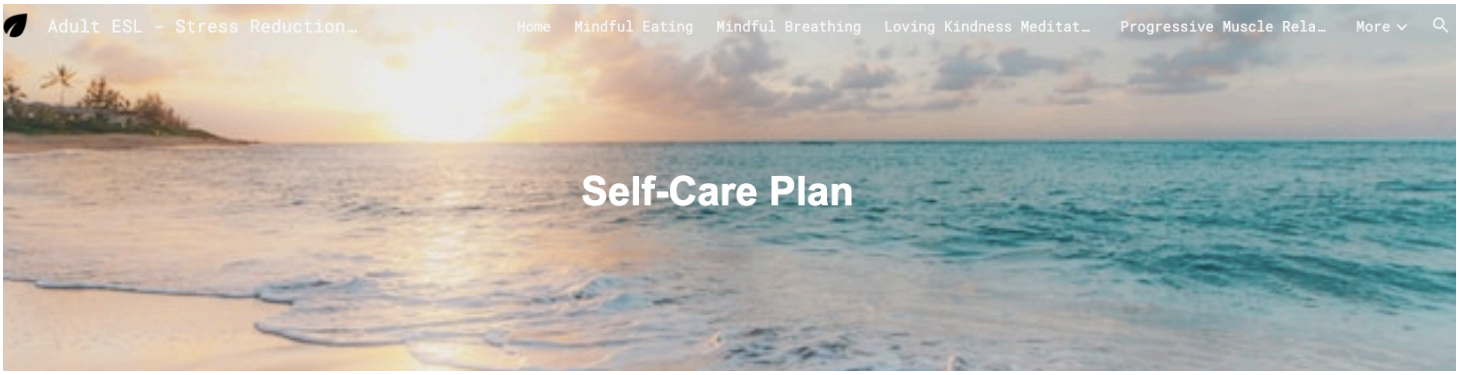
_____

_____

_____

Group Presentation

Discuss your experience with your group and use your answers to prepare a group presentation of your technique to the class. Feel free to use your own photos, artwork, videos, or memes to illustrate your experiences.



Self-Care Plan

Use the following questions to notice your feelings and symptoms and to help yourself when you feel angry, anxious, afraid or any uncomfortable feeling.

What situations make you anxious?

_____

_____

_____

What is one specific situation?

_____

_____

_____

Where are you?

_____

_____

_____

Who are you talking to?

_____

_____

_____

What is the topic?

_____

_____

_____

What are you feeling?

_____

_____

_____

When do you have this feeling?

_____

_____

_____

What makes you feel this way?

_____

_____

_____

What do you notice about your face, your muscles, your body, and your voice when you have this feeling?

_____

_____

_____

Can you put your self-observations into words?

_____

_____

_____

What can you do to change an uncomfortable emotion into feeling better?

_____

_____

_____

How can you help yourself, in general, to feel better?

_____

_____

_____

What is one thing you can do today that helps you towards your goal?

_____

_____

_____

What do you do to take care of yourself?

_____

_____

With friends

_____

_____

At school

_____

_____

At work

_____

_____

In the community

_____

_____

When does speaking English make you anxious?

At home

_____

_____

With friends

_____

_____

At school

_____

_____

On the phone

_____

_____

At work

_____

_____

In the community

_____

_____

_____

When does speaking your native language make you anxious?

_____

_____

With friends

_____

_____

At school

_____

_____

On the phone

_____

_____

At work

_____

_____

In the community

_____

_____

How can you get support from your family?

_____

_____

How do you know what your family member is feeling?

_____

_____

How can you help your family member?

_____

_____

How can you get support for your family from the community?

_____

_____

How can these new stress reduction techniques help you and your family in the future?

_____

_____

Contacts and Important Telephone Numbers

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