

## School Engagement, Acculturation, and Mental Health Among Migrant Adolescents in Israel

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This study aimed to explore the role of school engagement and the mediation effect of acculturation in predicting 1.5 and second-generation migrant adolescents' mental health and risk behaviors. Participants included 448 seventh to tenth grade Israeli students (mean age 14.50, 53% boys): 128 non-Jewish 1.5 generation migrant adolescents (children of migrants living in Israel), 118 second-generation migrants (children of migrants born and living in Israel), and an age-matched sample of 202 native-born Jewish adolescents. All participants completed a battery of questionnaires assessing mental health symptoms, engagement in risk behaviors, social adjustment, and school engagement. Both migrant adolescent groups also completed an acculturation questionnaire. Differences between groups in school engagement, mental health symptoms, and risk behavior were examined, and structural equation modeling (SEM) was used to investigate the hypothesized mediating effect of acculturation. Findings revealed substantially higher levels of mental health symptoms ( $p < .001$ ) and risk behaviors ( $p = .001$ ) among 1.5 and second-generation migrant adolescents compared with native-born adolescents, with no significant differences between 1.5 generation and second-generation migrants. Migrants' age and gender were associated with mental health symptoms and risk behaviors—older participants engaged in more risk behaviors ( $p = .02$ ), and females had elevated mental health symptoms ( $p = .007$ ). Identification with the host country mediated the relationships between school engagement and mental health symptoms ( $ps .006$  and  $.008$ ) and risk behaviors ( $ps .001$  and  $.004$ ) in 1.5 generation and second-generation migrants, respectively. The results are discussed in reference to current theories and research, as well as practical implications for prevention and intervention.

**Keywords:** migration, adolescents, resilience, school, mental health

Schools are one of the most influential developmental contexts that shape adolescents' lives, and can support the development of competencies and skills that allow for successful adaptation (Eccles, 2009). This is particularly relevant for migrant children, since school plays an in-

strumental role in helping them acquire cultural values and norms that are beneficial for their acculturation and immersion into the new "host" country (Motti-Stefanidi & Masten, 2013). Studies of developmental cascades, which refer to the dynamic interplay between the multiple domains of functioning (Masten, Herbers, Cutuli, & Lafavor, 2008), found that school functioning not only indicates how well a student is faring academically and developmentally, but also predicts later outcomes in adulthood. Likewise, poor adjustment in school has been associated with future maladjustment (Masten, Burt, & Coatsworth, 2006).

The available literature on migrant students' school functioning suggests that their school

This article was published Online First November 9, 2015.

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engagement, or the extent to which they are motivated to learn, and feel connected, involved, and committed to school—all play a pivotal role in propelling them onto a positive academic trajectory (Li & Lerner, 2011). Yet, there remains the question of whether or not school engagement among migrant youth is related to their mental health and level of adaptation. Studies have shown that migrant children are at risk for psychological symptomatology such as externalizing behaviors, anxiety, depression, posttraumatic stress disorder (Murad, Joung, van Lenthe, Bengi-Arslan, & Crijnen, 2003), and increased substance abuse, unprotected sex, and delinquency (Shoshani, Nakash, Zubida, & Harper, 2014; Viner et al., 2006). Given the relationship between school engagement and mental health outcomes (Li & Lerner, 2011), there is a need to better understand how school engagement might affect migrant adolescents' involvement in risk behaviors, mental health symptoms, or even their increased resilience despite difficult circumstances.

Research investigating generational differences in mental health status among children of immigrants shows varying levels of vulnerability when comparing 1.5 generation (children of migrants, were born in the native country, and immigrated to host country during preadolescence) and second-generation children of immigrants (youth born in the host country) (Alegría et al., 2008). Identifying individual differences between the varying generations may contribute to our understanding of the unique challenges faced by each generation in adapting to school, acculturation, and psychological health. Therefore, the present study examines the role of school engagement and acculturation in predicting mental health symptoms and risk behaviors by comparing three groups: 1.5 generation migrant adolescents, second-generation migrant adolescents, and Jewish, native-born Israeli adolescents.

### Impact of Acculturation and Generation on Mental Health

Over the past few decades, global socioeconomic and political developments have led to a rapid growth in international migration. Between 1990 and 2014, the number of international migrants grew from 154 million to 232 million (Pitkänen & Carrera, 2014). Israel has

become a favored destination for mass foreign immigration, and the number of guest workers, asylum seekers, and refugees in Israel rose from 65,000 in 1996, to more than a quarter of a million in 2014. This group represents a particularly vulnerable population in society since their legal status is often unstable and access to health care limited (Nakash, Nagar, Shoshani, & Lurie, 2015). Approximately, 2,000 non-Jewish children of labor migrants and 1,000 children of asylum seekers and stateless migrants currently reside in Israel (Central Bureau of Statistics, 2014).

The term “migrants” is used to describe people who immigrate for varying reasons, such as employment opportunities or seeking refuge after escaping political dangers in their native country. “Migrants” are often classified by generation, depending on their time of arrival—first generation (the initial immigrant), 1.5 generation (children who immigrated with their family), and second-generation (those born in the new country with immigrant parents). Each generation faces unique challenges in adapting to the new culture and society, which are shaped by policies, individual experiences, and structure of communities (Rumbaut & Portes, 2001).

Motti-Stefanidi, Berry, Chryssochoou, Sam, and Phinney (2012) recently developed an integrative model for assessing positive adaptation among migrant youth. They proposed a multi-level framework that applies well-established theories of development to migrant adolescents' adaptation. This centralized model encompasses both acculturation and developmental perspectives, and defines levels of adaptation using the following criteria: (a) achievement of stage-appropriate developmental tasks, (b) level of progress in acculturative tasks, and (c) mental health.

In most developed countries, adaptation is measured by a child's successful navigation of developmental tasks, such as academic functioning and social competence (Motti-Stefanidi & Masten, 2013). It has been proposed that children's ability to meet the demands of a developmental stage will set the trajectory for their success in subsequent periods (Masten et al., 2006). Immigrant youth are also challenged with meeting the demands of acculturative tasks in addition to the normative developmental demands. For example, they must exhibit language competence as well as learn the host

country's attitudes, behaviors, and values (Oppedal, 2006), while still maintaining the norms of their culture of origin. Thus, they are faced with the additional challenge of simultaneously navigating both the heritage and receiving cultures.

Two independent dimensions underlie the process of acculturation: the extent to which an individual connects to the heritage culture (the origin country) versus an individual's relation to the receiving culture (the new country) (Berry, 1997). This bidimensional model proposes that high involvement in both the heritage and receiving cultures is the most adaptive approach to acculturation and relates to better mental health outcomes (Berry, Phinney, Sam, & Vedder, 2006). Furthermore, success in normative developmental tasks, for example, school performance, is often dependent on success in acculturative tasks, such as language competence (Suarez-Orozco, Suarez-Orozco, & Todorova, 2010). For this reason, school functioning has been used to gauge migrant children's development as well as their progress in the acculturation process (Motti-Stefanidi et al., 2012).

Immigrant generation status has also been suspected to impact immigrants' acculturative success and psychological well-being. While earlier research tended to focus on the mental health risks of 1.5 generation immigrants, recent studies highlight the vulnerability of second-generation migrants (Coll & Marks, 2012; Nakash, Nagar, Shoshani, Zubida, & Harper, 2012). For example, a large-scale study of migrant families in the United States from nine countries, indicated that across most groups, compared with 1.5 generation adolescents, the second-generation adolescents suffered from a higher prevalence of behavioral and health problems (Harris, 1999). Also interesting, is that when compared with their native, U.S.-born counterparts, first- and second-generation groups appeared to fare better on a variety of health indicators (Coll & Marks, 2012). This phenomenon is referred to as the "immigrant paradox," which describes the unexpected, initial advantage many new immigrants may have, and then the decline that occurs with time on many dimensions of adjustment (Coll & Marks, 2012; Suarez-Orozco, Rhodes, & Milburn, 2009). In seeking to explain this paradox, Buriel (2012) suggests that first-generation migrant

parents are self-selected and choose to immigrate with the hope for better opportunities. Therefore, they are motivated to adapt as newcomers and display remarkable resilience. However, these positive and motivational forces dissipate in following generations, who often continue to live in economically deprived areas with limited opportunities for upward mobility.

Nevertheless, recent literature indicates that there are inconsistencies in the immigrant paradox, depending on the child's ethnicity, age, and developmental area. For example, in the study of migrant families in the United States (Harris, 1999), children of Mexican, Cuban, European, and Canadian ethnicities showed fewer declines in health over the generations, compared to other ethnic groups. Another study comparing migrants' health in several European countries identified significant differences in physical health across host populations and migrant groups, without any distinct patterns (Rechel, Mladovsky, Ingleby, Mackenbach, & McKee, 2013).

A review of literature related to migrant children's adaptation indicates that in studies controlling for socioeconomic status (SES) differences in immigrant families, the immigrant paradox is muted or completely disappears. This suggests the role of SES in explaining the variability in adaptation between different immigrant generations and groups (Hernandez, Denton, Macartney, & Blanchard, 2012). The literature also explains that the gradual decline experienced by immigrant families may stem from parents' limited educational attainments and employment opportunities, which are typically the cause of lower wages and persisting poverty (Bleakley & Chin, 2004).

Language proficiency has also been identified as a significant factor that increases the socioeconomic gap and social isolation between migrants and natives (Bleakley & Chin, 2004). In the educational and developmental context, language barriers limit parents' involvement in their children's schooling. Parents' poor language proficiency may also impair their child's language development and communication skills, especially in younger children who often acquire language from their parents (Olivos & Mendoza, 2010).

Extant literature has also examined the effects of gender on migrant children's mental health outcomes (Stevens & Vollebergh, 2008).

Most studies on gender differences have shown that compared with migrant boys, girls experienced more internalizing problems, depression, and anxiety symptoms (Bengi-Arslan, Verhulst, Van der Ende, & Erol, 1997). Although these gender differences have also been seen, at least in part, across nonmigrant adolescents (Nolen-Hoeksema & Girgus, 1994), they have been more pronounced for migrant adolescents, with migrant girls also exhibiting higher mental health problems than their native female counterparts (Carlerby, Viitasara, Knutsson, & Gådin, 2011; Flink et al., 2012).

The explanation for these gender patterns has not been fully explored. Some scholars have proposed that boys' and girls' differential access to power and resources in society in general (Yuval-Davis, 1997), and asymmetric power relationships between boys and girls in different cultures (Carlerby et al., 2011), might partly explain these differences. In addition, scholars have argued that more traditional migrant families place certain socialization demands on girls, and they are faced with the challenge of negotiating the often conflicting gender-based expectations of their culture of origin and those of their new host culture (Dion & Dion, 2001).

For example, one study found that Somali adolescent girls who identified more strongly with their heritage culture than American culture had improved mental health. Better mental health of Somali boys, on the contrary, was associated with greater identification with American culture (Ellis et al., 2010).

Relatively few studies have examined the impact of immigrant children's age on their adaptation. These studies reveal a significant relationship between age and immigrant children's mental health outcomes and how well they adapt to the host country's culture (Stevens & Vollebergh, 2008). Here, too, the findings are inconsistent—some studies reported higher symptomatology and risk behaviors among younger children compared with adolescents (Bengi-Arslan et al., 1997), while other studies show more adjustment problems among immigrant teens compared to younger children (Stevens et al., 2003). These mixed findings indicate the importance of further investigating the intersectionality between SES, gender, and age and its association with adjustment patterns among immigrant children and adolescents.

## School Engagement, Acculturation, and Well-Being

In the last decade, researchers have conceptualized the construct of school engagement, in order to provide a multifaceted perspective on students' adjustment and functioning in a variety of domains within the school context (Fredricks, Blumenfeld, & Paris, 2004). Emotional engagement encompasses students' sentiments toward school, their feelings about teachers, affective reactions to the classroom environment, feelings of connectedness, and identification with school. Behavioral engagement refers to participation in academic activities as well as exhibiting positive conduct, such as following the rules and adhering to classroom expectations. Cognitive engagement highlights psychological investment in learning and students' motivation to master learning tasks (Ladd & Dinella, 2009).

In comparing migrant adolescents to their nonimmigrant peers on academic indices, studies showed that migrant students earned lower scores on aptitude tests, had lower grades, higher dropout rates, and relatively low college enrollment (Ruiz-de-Valesco, Fix, & Clewell, 2001). In addition, consistent with the immigrant paradox, studies showed patterns of decline in academic outcomes such as school engagement, success, and hopes for the future, with longer stays in the host country (Portes & Rumbaut, 2001). However, this seemingly inevitable negative trajectory associated with immigrant status does not hold true for all students. Studies on psychological well-being and school engagement have also reported variability when comparing different ethnic migrant groups as well as members within certain groups (Motti-Stefanidi & Masten, 2013).

Current research is limited in explaining why some migrant adolescents fare better than others on school outcomes such as engagement and achievement. The inconsistent findings suggest more complex pathways that explain the differences between migrant youth's school functioning and mental health. Motti-Stefanidi et al. (2012) posit that acculturation may play a crucial role in the relationship between immigrant children's developmental and psychological well-being. However, to date, the interrelationship between school engagement, level of ac-



culturation, and mental health have not been examined empirically.

Nguyen, Messé, and Stollak's (1999) study on Vietnamese youth who immigrated to predominantly Anglo American communities indicated that involvement in the American culture predicted positive functioning in personal, interpersonal, and achievement domains, while involvement in the Vietnamese culture only predicted positive family relationships. Another study found that Indian immigrant adolescents (1.5 generation) who identified with the receiving culture had higher GPA scores than adolescent immigrants with low host national identification (Farver, Bhadha, & Narang, 2002). Although these studies provide evidence of the role of acculturation in predicting positive outcomes, they are limited and few have investigated the differences between 1.5 and second-generation children of immigrants.

This study examined three hypotheses. In line with previous literature reporting the influence of migration on adolescents' mental health (Darwish Murad et al., 2003), the first hypothesis predicted that migrant adolescents would have higher levels of mental health symptoms and would have higher reports of risk behaviors, compared to native-born Jewish Israeli youth. Next, based on the multi-level framework for migrant youth adaptation (Motti-Stefanidi et al., 2012), the second hypothesis predicted that school engagement would be positively related to host national

identification (see Figures 1 and 2, Path a), and negatively related to mental health symptoms and engagement in risk behaviors (Path c). The third hypothesis predicted that host national identification would mediate the relationships between school engagement and mental health symptoms, and school engagement and risk behaviors, with negative relationships between acculturation and both risk behaviors and mental health symptoms (Path b).

## Method

### Participants

The sample consisted of 448 seventh- to tenth-grade Israeli students: 128 non-Jewish, 1.5 generation migrant adolescents, 118 non-Jewish second-generation migrants, and an age-matched sample of 202 native-born Jewish adolescents, evenly distributed by gender in each group. Their age ranged from 12 to 16 ( $M = 14.50$ ,  $SD = 1.40$ ). Of the 1.5 generation migrant adolescents, 18.8% ( $n = 24$ ) were born in Asia, 21.1% ( $n = 27$ ) were born in the Philippines, 21.1% ( $n = 27$ ) were born in Eastern Europe, 7.8% ( $n = 10$ ) were born in South America, 23.4% ( $n = 30$ ) were born in Africa, and 7.8% ( $n = 10$ ) were born the Middle East. The families of the 1.5 generation group were in Israel for an average of 7.84 years and their length of stay ranged from four to 13 years.

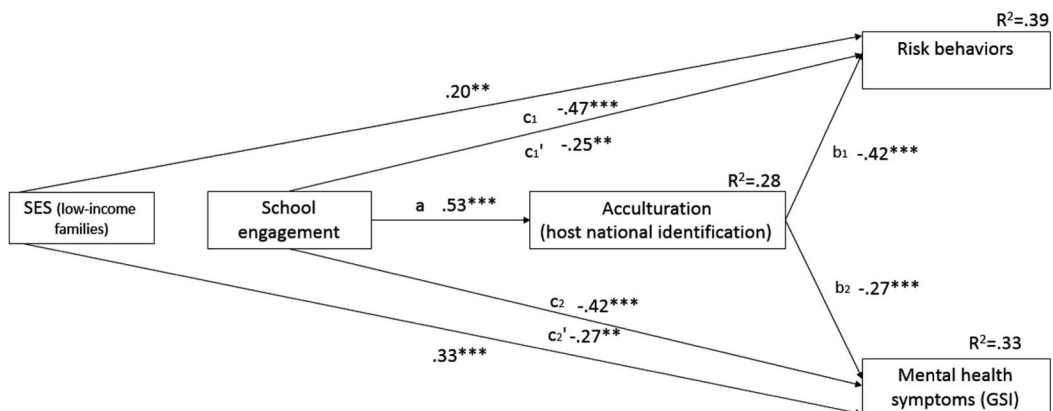


Figure 1. Model 1: 1.5 generation. Indirect effect of host national identification on the relationship between school engagement, mental health symptoms, and risk behaviors among 1.5 generation migrant adolescents. \*\*  $p < .01$ . \*\*\*  $p < .001$ .

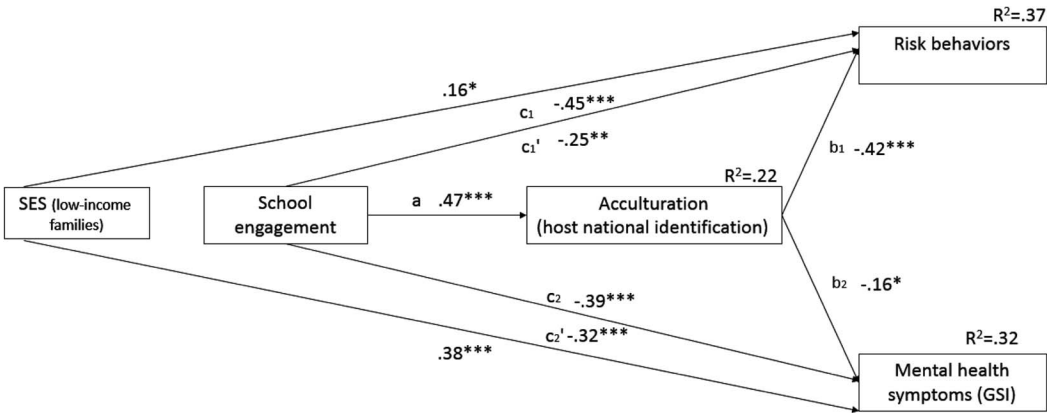


Figure 2. Model 2: second-generation. Indirect effect of host national identification on the association between school engagement, mental health symptoms, and risk behaviors among second-generation migrant adolescents. \*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ .

The second-generation group included 118 adolescents that were born in Israel to migrant parents. Of the second-generation adolescents' parents, 16.1% ( $n = 19$ ) were born in Asia, 15.2% ( $n = 18$ ) were born in the Philippines, 23.7% ( $n = 28$ ) were born in Eastern Europe, 11% ( $n = 13$ ) were born in South America, 27.1% ( $n = 32$ ) were born in Africa, and 6.9% ( $n = 8$ ) were born the Middle East. In terms of SES, 21.1% ( $n = 27$ ) of the 1.5 generation group reported high SES, 43.8% ( $n = 56$ ) reported middle SES, and 35.1% ( $n = 45$ ) reported low SES. In the second-generation group, 31.4% ( $n = 37$ ) reported high SES, 44.1% ( $n = 52$ ) reported middle SES, and 24.5% ( $n = 29$ ) reported low SES. In the native-born Jewish group, 46% ( $n = 93$ ) reported high SES, 30.7% ( $n = 62$ ) reported middle SES, and 23.3% ( $n = 47$ ) reported low SES. The majority of the migrant participants were Christian (71.1% and 75.4% of the 1.5 and second-generation groups, respectively), and most of the remainder were Muslim (20.3% and 19.5% of the 1.5 generation and second-generation group, respectively), whereas the entire sample of native-born Israelis was Jewish. The sociodemographic characteristics of the participants are presented in Table 1.

Procedure

After receiving authorization from the university's ethics committee, the Israeli Ministry

of Education's ethics committee, and consent from the school principals, the research assistants acquired consent from the parents and from the adolescents themselves. Exclusion criteria were special education-only classes and inability to read questionnaires or understand Hebrew. The participation rate was 100%, since all of the 448 students in the participating classrooms consented to participate in the study. Migrant participants were recruited from a school in an ethnically diverse area of central Israel that has a large non-Jewish migrant population—out of the school's 824 students, 382 (46%) came from immigrant families of migrant workers and asylum seekers from Sudan, Darfur, and Eritrea. The remaining students in the school were Jewish Israelis. The native-born Jewish adolescent sample was recruited from another public school with a total of 778 students, the majority of whom were native-born Israeli Jews. The school was in close geographical proximity to the immigrant groups' school and both neighborhoods were characterized by low to medium SES. Data was collected in May, 2014. All participants completed the counter-balanced self-administered questionnaire battery within an average of 30 min, during the regular school hours.

Measures

**Demographic information.** A short sociodemographic measure was administered, including items describing demographic back-

Table 1  
*Socio-Demographic Characteristics of the Adolescents Among Study Groups*

	1.5 generation migrants ( <i>n</i> = 128)	Second-generation migrants ( <i>n</i> = 118)	Native-born Jewish ( <i>n</i> = 202)	Statistic
Age	<i>M</i> = 14.94, <i>SD</i> = 1.95	<i>M</i> = 14.24, <i>SD</i> = 1.20	<i>M</i> = 14.31, <i>SD</i> = 1.07	<i>F</i> (2,445) = 16.40, <i>p</i> < .001
Gender				
Male (%)	53.1, <i>n</i> = 68	51.7, <i>n</i> = 61	52.9, <i>n</i> = 107	$\chi^2$ = .05, n.s.
Female (%)	46.9, <i>n</i> = 60	48.3, <i>n</i> = 57	47.1, <i>n</i> = 98	
Family origin				
Israel (%)			100, <i>n</i> = 202	
Asia (%)	18.8, <i>n</i> = 24	16.1, <i>n</i> = 19		
Philippines (%)	21.1, <i>n</i> = 27	15.2, <i>n</i> = 18		
Eastern Europe (%)	21.1, <i>n</i> = 27	23.7, <i>n</i> = 28		
South America (%)	7.8, <i>n</i> = 10	11, <i>n</i> = 13		
Africa (%)	23.4, <i>n</i> = 30	27.1, <i>n</i> = 32		
Middle East (%)	7.8, <i>n</i> = 10	6.9, <i>n</i> = 8		
SES status				$\chi^2$ = 29.78, <i>p</i> < .001
High above average (%)	10.9, <i>n</i> = 14	15.3, <i>n</i> = 18	17.8, <i>n</i> = 36	
Above average (%)	10.2, <i>n</i> = 13	16.1, <i>n</i> = 19	28.2, <i>n</i> = 57	
Moderate (%)	43.8, <i>n</i> = 56	44.1, <i>n</i> = 52	30.7, <i>n</i> = 62	
Low (%)	18.7, <i>n</i> = 24	16.9, <i>n</i> = 20	16.4, <i>n</i> = 33	
Very low (%)	16.4, <i>n</i> = 21	7.6, <i>n</i> = 9	6.9, <i>n</i> = 14	
Religion				
Jewish (%)			100, <i>n</i> = 202	
Muslim (%)	20.3, <i>n</i> = 26	19.5, <i>n</i> = 23		
Christian (%)	71.1, <i>n</i> = 91	75.4, <i>n</i> = 89		
Other (%)	8.6, <i>n</i> = 11	5.1, <i>n</i> = 6		

ground (gender, age, participant's country of birth, family origin, religion) and SES that were determined by a set of income thresholds (very low, low, average, good, very good).

**Mental health.** The Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982) consists of 53 self-report items rated on a scale from 0 (*not at all*) to 4 (*very much*). The measure provides distress indices and assessment of symptoms across nine dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychotic ideation, and one miscellaneous symptom subscale, which includes four items that factor into the other dimensions but are not unique to any of them. According to Derogatis and Spencer (1982) the miscellaneous symptom items should be included when calculating the total score, but not as a separate dimension. For a single summary measure, Derogatis and Spencer (1982) recommend using the Global Severity Index (GSI), which is the average of ratings assigned to symptoms (higher scores reflect elevated symptomatology). The BSI is designed for adolescents and older populations and has been widely used for assessment of mental health symptoms among diverse samples from a variety of countries, for example, Israeli children and adolescents (Slone & Shoshani, 2014). The scale has shown adequate concurrent validity and internal consistency, with alpha coefficients ranging from .71 to .85. Cronbach's alphas in the present study ranged from .74–.82.

**Risk behavior.** The Middle School Youth Risk Behavior Survey (Centers for Disease Control and Prevention, 2011) is a brief self-report measure that assesses engagement in risk behaviors in the past two years, and has been widely used among ethnically diverse middle school students who are around 10 to 16 years old. The scale employs a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*very much*), with high scores reflecting elevated engagement in risk behaviors. This measure included the following items: "Have you carried a weapon, such as a gun, knife, or club?," "Have you been in a physical fight?," "Have you tried smoking a cigarette?," "Have you used psychoactive drugs?," "Have you had sexual intercourse?," "Were/are you overweight?," "Were/are you underweight?," and "Have you felt that you put yourself in danger when riding a bike, skate-

board etc.?" Two additional items measured hours spent watching TV and surfing the Internet, daily. This scale has shown high test-retest reliability, with studies reporting adequate to high reliability (Centers for Disease Control and Prevention, 2011). In this study, the alpha coefficient was .75.

**School engagement.** The 42-item School Engagement Survey (National Center for School Engagement [NCSE], 2006) is a self-report scale measuring school engagement in middle- and high-school students. The measure consists of three subscales of engagement: behavioral engagement (e.g., "I follow the rules at school"), cognitive engagement (e.g., "I am interested in the work I get to do in the class"), and emotional engagement (e.g., "I respect most of my teachers"). Students evaluated each item on a 5-point Likert scale from 0 (*not at all true of myself*) to 5 (*very true*). The subscale scores were calculated separately by averaging items for each scale. High scores reflected high levels of school engagement in each domain. This survey has been used to measure engagement among culturally diverse samples (Shoshani & Aviv, 2012) and has demonstrated good reliability in previous studies (alphas ranging from .87 to .99) (NCSE, 2006). Cronbach alphas for the scales in this study ranged from .80 to .92.

**Social engagement.** The Friends subscale of the School Adjustment Report (Conduct Problems Prevention Research Group, 2001) contains six items that assess the student's interactions with peers. For example, "I get along well with other students at school this year" and "I do not have many friends at school." Items are rated on a 5-point Likert scale, from 1 (*strongly disagree*) to 5 (*strongly agree*). After reverse-coding negative responses, high scores reflected high social engagement. This scale has been used among ethnically diverse populations, with sufficient validity and reliability. In previous international samples, the subscale showed good internal reliability ( $\alpha = .83$ ) (Shoshani & Aviv, 2012). In the present sample, the scale's alpha coefficient was .84.

**Acculturation Index.** This measure (Ward & Rana-Deuba, 1999) assesses two dimensions of acculturation: conational identification (maintenance of original cultural identity) and host national identification (identification with the host culture). Each dimension scale includes



21 practices (e.g., language use, recreational activities, friends, food), values, and identification across both receiving and heritage cultures. Respondents rate each item on how much it applies to them, on a scale from 1 (*not at all*) to 7 (*extremely*). In the present study we used the summed score of the 21-item Host National Identification scale; high scores reflected high host national identification. This measure has been used globally to assess patterns of adjustment among immigrants from several European, Asian, and African countries and from a variety of cultural and ethnic backgrounds with high reliability and validity (alpha coefficients ranging from .92 to .95; Ward & Rana-Deuba, 1999). The present study's alpha coefficient was .94.

### Data Analyses

A power analysis was used to ensure that the size of the sample was adequate for detecting significant differences between the study groups. In comparing GSI (global severity index of the BSI) scores of at-risk samples and control groups (e.g., Slone & Shoshani, 2008; Slone, Shoshani, & Lobel, 2013), we found that a minimum of  $n = 25$  in each group was necessary to detect a difference of  $-0.18$  points on the GSI ( $SD = 0.32$ ) with 0.80 power and alpha set at  $p < .05$ . This indicated the sample size in this study was sufficient for analyses.

To examine between-groups differences in GSI, the specific BSI subscales, risk behaviors, and the school engagement subscales, we employed multivariate analyses of variance (MANOVAs). An independent  $t$  test analysis was used to examine differences in acculturation between the 1.5 and second-generation migrants. We also tested for group interactions with background demographic variables (age, gender, and SES) and used the Bonferroni correction to account for multiple comparisons ( $p < .005$ ). To examine the source of significant differences, we used Tukey's HSD Post hoc analyses.

We employed SEM to determine the indirect effect of acculturation on the relationships between school engagement, mental health symptoms, and risk behaviors among 1.5 and second-generation migrants. Direct effects of school engagement on mental health outcome were also examined for the native-born Jewish ado-

lescents. The parameters of these models were examined with maximum likelihood estimation and bootstrapping using AMOS 21.0. We generated 1,000 bootstrap samples in order to derive less biased standard errors and 95% confidence interval (CI) bootstrap percentiles. We reported two types of fit indices: non-normed fit index (NNFI, also known as the Tucker-Lewis index) and comparative fit index (CFI), and two indices of misfit: root mean-square error of approximation (RMSEA) and standardized root mean-square residual (SRMR). NNFI and CFI close to or above 0.95, combined with RMSEA below 0.06 and SRMR below .08, are indicative of acceptable fit. To select the covariate variables for the mediation model, we examined several path models, using different covariate variables (gender, age, religion, and SES); the model using SES as a covariate yielded the highest fit indices.

### Results

#### Groups Differences in Mental Health, Risk Behavior, and School Engagement

MANOVA analyses yielded a significant main effect for group on the GSI,  $F(2, 445) = 10.84$ ,  $p < .001$ , partial  $\eta^2 = .05$ , observed power = 0.99; Somatization scale,  $F(2, 445) = 12.14$ ,  $p < .001$ , partial  $\eta^2 = .05$ , observed power = 0.99; Obsessive-Compulsive scale,  $F(2, 445) = 17.78$ ,  $p < .001$ , partial  $\eta^2 = .07$ , observed power = 0.99; Psychotic Ideation scale,  $F(2, 445) = 6.06$ ;  $p = .003$ , partial  $\eta^2 = .03$ , observed power = 0.94; Anxiety scale,  $F(2, 445) = 6.15$ ;  $p = .002$ ; partial  $\eta^2 = .03$ , observed power = 0.95; and Hostility scale  $F(2, 445) = 8.47$ ;  $p < .001$ ; partial  $\eta^2 = .04$ ; observed power = 0.97. No significant differences were found between groups on interpersonal sensitivity, depression, or paranoid ideation. Migrant adolescents reported significantly higher levels of somatization, anxiety, phobic anxiety, hostility, psychotic ideation, obsessive-compulsive, and general mental health symptoms (GSI) than native-born Jewish Israelis, with no significant differences between 1.5 and second-generation migrants (Table 2). Migrants' gender was associated with mental health outcomes, such that females had elevated mental illness symptoms (GSI) compared to males in both the 1.5 and second-generation

Table 2

*Means and Standard Deviations of Mental Health Symptoms, Risk Behaviors, School Engagement, and Acculturation Among Study Groups*

	1.5 generation migrant ( <i>n</i> = 128)	Second-generation migrant ( <i>n</i> = 118)	Native-born Jewish ( <i>n</i> = 202)
Mental health symptoms			
General Severity Index <sup>****</sup>	1.33 (.67)	1.21 (.80)	.95 (.81)
Somatization <sup>****</sup>	1.25 (.95)	1.24 (.87)	.83 (.86)
Anxiety <sup>**</sup>	1.41 (.77)	1.27 (.94)	.95 (.82)
Phobic anxiety	.94 (.82)	.83 (.75)	.64 (.82)
Hostility <sup>***</sup>	1.42 (.98)	1.39 (.96)	1.01 (.99)
Psychotic ideation <sup>**</sup>	1.40 (.93)	1.28 (1.03)	1.15 (.98)
Obsession-compulsion <sup>****</sup>	1.70 (.85)	1.48 (.92)	1.11 (.93)
Depression	1.22 (.82)	1.15 (.95)	.99 (.97)
Interpersonal sensitivity	1.19 (.98)	1.06 (.99)	.89 (.99)
Paranoid ideation	1.41 (.93)	1.28 (1.04)	1.15 (.98)
Engagement in risk behaviors			
Risk behavior total <sup>****</sup>	20.27 (6.65)	17.47 (4.01)	16.77 (5.41)
Involvement in physical fight <sup>**</sup>	2.25 (1.24)	1.98 (1.21)	1.76 (1.17)
Carrying weapon <sup>**</sup>	1.53 (1.12)	1.28 (.86)	1.20 (.67)
Cigarette smoking <sup>**</sup>	2.02 (1.59)	1.45 (1.15)	1.66 (1.21)
Psychoactive drugs <sup>**</sup>	1.31 (.89)	1 (.67)	1.16 (.64)
Sexual intercourse	1.58 (1.22)	1.15 (.63)	1.69 (1.24)
Underweight <sup>****</sup>	1.85 (1.22)	1.21 (.52)	1.34 (.89)
Overweight	1.76 (1.18)	1.62 (1.07)	1.50 (1.05)
Television-watching <sup>****</sup>	2.97 (1.54)	3.13 (1.53)	2.26 (1.17)
Internet use <sup>****</sup>	3.29 (1.62)	3.43 (1.58)	2.82 (1.40)
School engagement			
Emotional engagement <sup>****</sup>	3.39 (.78)	3.30 (.67)	2.19 (.65)
Cognitive engagement <sup>****</sup>	3.47 (.53)	3.49 (.71)	2.76 (.58)
Behavioral engagement	3.73 (.79)	3.81 (.74)	3.91 (.70)
Social engagement <sup>****</sup>	3.52 (1.01)	3.93 (.75)	3.96 (.79)
Host national identification	73.38 (27.64)	82.32 (27.01)	

<sup>\*\*</sup>  $p < .01$ . <sup>\*\*\*</sup>  $p < .001$  for main effect of group.

groups,  $F(2, 445) = 3.6$ ;  $p = .007$ ; partial  $\eta^2 = .05$ ; observed power = 0.81.

In addition, migrant adolescents reported significantly higher engagement in risk behaviors compared to native-born Jewish adolescents,  $F(2, 445) = 15.54$ ;  $p = .001$ ; partial  $\eta^2 = .07$ , observed power = 1. The 1.5 generation migrant group reported more involvement in physical fights, carrying a weapon, cigarette smoking, and drug use and had a higher prevalence of being underweight compared with native-born Jewish Israelis. However, second-generation migrants reported less drug use compared with native-born Israelis. Both migrant groups (1.5/second-generation) reported spending more hours a day watching TV or surfing the Internet. In addition, migrants' age was associated with risk behaviors—in the 1.5 and second-generation groups, older participants reported more risk behaviors,  $F(2, 445) = 2.1$ ;  $p = .02$ ; partial

$\eta^2 = .06$ ; observed power = 0.93. Analysis of acculturation in the two migrant groups revealed higher levels of identification with the host country in the second-generation adolescents ( $M = 82.32$ ,  $SD = 27.01$ ), than in the 1.5 generation migrants ( $M = 73.38$ ,  $SD = 27.64$ ),  $t(244) = 2.56$ ,  $p = .01$ , Cohen's  $d = 0.32$ .

For school engagement, there was a significant main effect for group on school engagement,  $F(2, 445) = 37.36$ ,  $p < .001$ , partial  $\eta^2 = .14$ , observed power = 1; emotional engagement,  $F(2, 445) = 157.23$ ,  $p < .001$ , partial  $\eta^2 = .41$ , observed power = 1; cognitive engagement,  $F(2, 445) = 29.49$ ,  $p < .001$ , partial  $\eta^2 = .26$ , observed power = 1; and social engagement,  $F(2, 445) = 11.50$ ,  $p < .001$ , partial  $\eta^2 = .05$ , observed power = 0.99. Post hoc comparisons revealed that the native-born Jewish group scored significantly higher on social engagement. Both 1.5 and second-genera-

tion groups reported higher levels of emotional engagement and cognitive engagement in school and there were no significant between-groups differences in behavioral engagement. Means and standard deviations of the study variables are presented in Table 2.

SES had a significant main effect on risk behaviors,  $F(1, 446) = 6.79, p = .009$ , partial  $\eta^2 = .02$ , observed power = 0.74, and on the GSI,  $F(1, 446) = 6.52, p = .01$ , partial  $\eta^2 = .02$ , observed power = 0.72, with significantly lower levels of mental health symptoms and risk behaviors in children from families that were at or above the average income, compared to children from low-income families. There were no significant main effects of SES on school engagement or acculturation. However, there was a significant interaction between SES and group on school engagement,  $F(2, 445) = 6.79, p = .009$ , partial  $\eta^2 = .02$ , observed power = 0.74, such that in the native-born Jewish group, participants with low SES reported significantly lower levels of school engagement ( $M = 3.08, SD = 0.74$ ) than participants with high SES ( $M = 3.31, SD = 0.66, p < .001$ ). However, in both 1.5 and second-generation migrant groups there were no significant differences in school engagement between participants with high and low SES.

### Indirect Effects on Mental Health Through Acculturation

We used an SEM to test the mediating effect of acculturation on the relationships between school engagement, mental health symptoms (GSI), and risk behaviors, with SES as a covariate. The first model examined the direct and indirect paths between all variables in the 1.5 generation migrant group (see Figure 1). The second model examined the same paths among second-generation migrants (see Figure 2). We predicted that school engagement would be positively related to level of acculturation, reflected by host national identification (Path a), and that host national identification would be negatively related to risk behaviors (Path b1) and GSI (Path b2). In addition, we expected that school engagement would be negatively related to risk behaviors (Path c1) and GSI (Path c2).

The standardized coefficients,  $p$  values, and multiple squared correlations in the 1.5 generation model are presented in Figure 1. All path

coefficients in the model were significant in the expected direction although the effect sizes for these relations were in the small to medium range. Chi-square was significant,  $\chi^2(1) = 13.61, p = .003$ , but because other fit indices indicated acceptable fit (NNFI = .956, CFI = .973, SRMR = .042, RMSEA = .058) we examined the structural components of the model.

Findings revealed that school engagement was positively associated with host national identification ( $\beta = .53, p < .001$ ). In addition, there was a significant negative relationship between host national identification and risk behaviors, and a negative correlation between host national identification and GSI ( $\beta_s = -.42$  and  $-.27$ , respectively, both  $p_s < .001$ ). Low SES was positively associated with the total risk behavior score ( $\beta = .20, p = .003$ ) and with the GSI ( $\beta = .33, p < .001$ ). As seen in Figure 1, the direct effects of school engagement on both risk behaviors and GSI were statistically significant ( $\beta_s = -.47$  and  $-.42$ , respectively, both  $p < .001$ ). Indirect effects were calculated and bootstrapping provided estimated  $p$  values for each of these effects. The indirect effect of acculturation was significant for risk behaviors,  $p = .003$  (95% CI =  $-5.22, -1.25$ ), and for GSI,  $p = .002$  (95% CI =  $-0.41, -0.06$ ). The model reflected partial mediation, where the direct effect of school engagement on risk behaviors and GSI remained, even after accounting for host national identification.

Model 2 tested the same direct and indirect paths among second-generation migrants. The model reflected partial mediation with direct paths from school engagement to mental health and risk behaviors, and with indirect paths from school engagement to acculturation, mental health, and risk behaviors, using SES as covariate (see Figure 2). This model also fit the data well:  $\chi^2(1) = 11.05, p = .01$ , NNFI = .960, CFI = .972, SRMR = .048, RMSEA = .06.

Bootstrap estimation of the indirect effect of acculturation was significant for risk behaviors,  $p = .003$  (95% CI =  $-2.81, -0.97$ ), and for GSI,  $p = .007$  (95% CI =  $-0.37, -0.02$ ).

Analyses reflected partial mediation, with significant small to medium correlations between school engagement, risk behaviors, and GSI, which were weakened but remained significant with the presence of the mediator variable ( $c'$  path for risk behavior;  $\beta = -.25, p = .002$ ;  $c'$  path for GSI,  $\beta = -.32, p < .001$ ).

A third path analysis was performed to test the relationships between SES, school engagement, risk behaviors, and GSI among the native-born Israeli youth (Figure 3).

Unlike previous models, this model did not include the acculturation measure, which was only administered to the immigrant children groups. In this model, analyses revealed a significant path that was not shown in the previous models, between low SES and school engagement ( $\beta = -.28, p < .001$ ), indicating lower school engagement among the Israel-born Jewish adolescents from families with low SES, compared with children from families with medium-high SES. The model yielded high fit indices,  $\chi^2(1) = 0.07, p = .79$ ; NNFI = .999, CFI = 1.00, SRMR = .003, RMSEA = .001.

Like prior models, here too, a significant negative correlation was found between school engagement and risk behaviors, and between low SES and psychological symptomatology. However, unlike previous models, no significant correlations were found between school engagement and GSI, and between SES and reported involvement in risk behaviors.

### Discussion

Previous studies have indicated that migration may be a risk factor for psychological maladjustment and engagement in risk behaviors among youth from immigrant families. However, studies indicate that human development is full of situations in which there are “forks in

the road,” which afford people the opportunity to change trajectories from risk to resilience and from negative to positive developmental outcomes (Dodge, Greenberg, Malone, & the Conduct Problems Prevention Research Group, 2008). From this perspective, the following question guided the present study: which aspects of migrant youth’s lives should be enhanced in the school context to reverse potential trends of decline in academic engagement or mental health to a trajectory of positive adjustment and well-being? This study proposed two interrelated variables, school engagement and acculturation, which were expected to relate to better mental health among 1.5 and second generations of migrant children.

Consistent with previous studies, our findings indicate that migrant adolescents are particularly susceptible to higher rates of mental health problems. In support of our first hypothesis, results showed that both 1.5 and second generation migrant adolescents had higher levels of psychological symptomatology compared with their native-born Jewish peers. Immigrant groups had high levels of mental health symptoms, such as phobic anxiety, hostility, somatization, and obsessive-compulsive symptoms. While there were no significant differences in psychological symptomatology between immigrant groups, second-generation migrants did reported less risk behaviors. In addition, the findings of the study replicate those of previous research, showing that migrant adolescents engage in more risk behaviors as they become

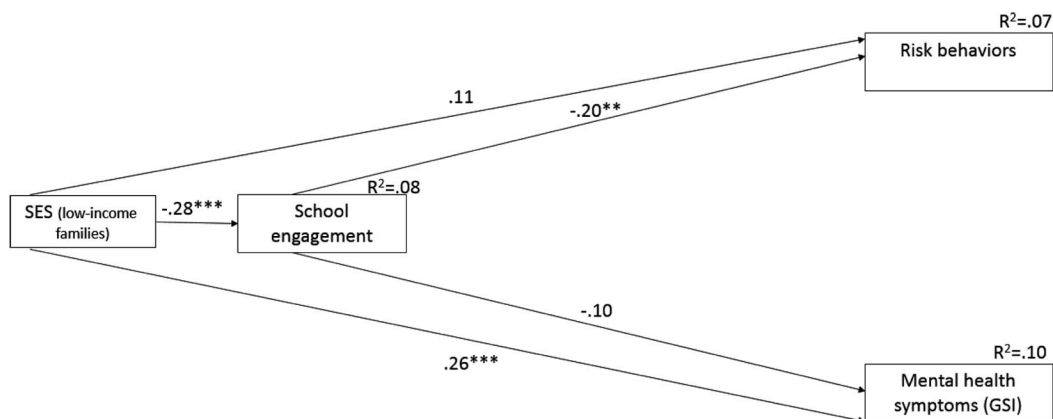


Figure 3. Model 3: native-born Jewish adolescents. SES, school engagement, mental health symptoms, and risk behaviors among native-born Jewish adolescents.  $^{**}p < .01$ .  $^{***}p < .001$ .

older teens (Stevens et al., 2003), and migrant girls may be more vulnerable to developing mental health issues (Dion & Dion, 2001). However, it is not clear if this reflects real gender differences or is the merely the consequence of a known phenomenon of gender differences in willingness to report symptoms and distress (Gilligan, 1982).

The present study's findings are somewhat contrary to those that support the immigrant paradox and the presumed advantage of 1.5 generation immigrants. First, in our study, the adolescents in the 1.5 generation and second-generation groups did not show greater resilience compared with their native-born counterparts, as shown in previous literature (Coll & Marks, 2012). Second, compared to the 1.5 generation group, the second-generation group reported better functioning as reflected in their higher levels of acculturation and less self-reported engagement in risk behavior. In contrast, previous literature supporting the immigrant paradox reported poor adjustment among second-generation immigrants, and higher engagement in risk behavior, compared with 1.5 generation youth (Harris, 1999). It may be that certain migration policies in Israel explain these differences, as well as the inability of immigrant families to fully realize the opportunities to improve their lives, as other immigrants around the world experience when moving to a new country. About two thirds of current migrants in Israel have unstable legal status (asylum seekers, former contract workers who have overstayed their visa period, and those who entered without permission to work) and have limited access to health and work opportunities. Large portions of them are integrated into labor industries illegally and remain hidden from the Department of Immigration and law enforcement agents, for fear of being deported from Israel (Schneider, 2008). This is likely to be detrimental to their economic advancement, since their wages are considerably lower than legal workers, and they do not receive social services, or medical and mental health care benefits. Beyond these material and practical constraints, the hardship these families must endure can severely impact family members' psychological well-being. Living in a state of uncertainty about what the future holds, fear of deportation, and persisting difficulty in establishing long-

term aspirations can be a heavy burden, especially for children and adolescents.

Our findings also suggest sources of resilience among this vulnerable population. Children of immigrants showed higher levels of school engagement compared to native-born youth, regardless of their family's SES. Migrant children in both groups (1.5 and second-generation) from families with medium to high SES as well as those with low SES, reported a higher level of engagement in school, both academically and emotionally. In contrast, native-born adolescents from families with low SES reported significantly lower school engagement, investment in learning, as well as lower sense of belonging to and connecting with school, compared to immigrant youth. In conjunction with immigrant youth's advantage in engagement, second-generation immigrants also reported high levels of acculturation and a sense of identification with the local culture. These findings allow for a shift in the current discussion, from dealing with symptoms and risk factors, to an examination of possible pathways for the positive development of immigrant youth. It is also seemingly relevant to consider the pivotal role of the school as a potential place that supports this turning point from a trajectory of maladaptive functioning to one of positive development.

The migration process can hamper family protective factors by causing dramatic changes in family routine, family status, and sources of support. Family resilience factors such as confidence in family members, mutual commitment, cohesion, and perceived support may be diminished during a time when adolescents are especially in need of immense support and assistance. In such circumstances, environmental support factors outside of the family play a critical role in youth's positive development (Shoshani et al., 2014).

The present study's findings support this notion; we observed a negative relationship between migrant adolescents' school engagement, mental health symptoms, and risk behaviors across generations. Moreover, the findings revealed that acculturation mediated the relationship between school engagement and mental health symptoms and risk behaviors. School engagement was related to identification with the receiving culture, and this relationship was associated with lower levels of psychological symptoms and engagement in risk behaviors in



both 1.5 and second generation migrant adolescents.

There are several plausible explanations for these findings. Schools may offer migrant youth refuge from intergenerational gaps and family conflicts that develop from bicultural stress and the pressure to maintain the culture of origin. In this respect, schools can serve as a nonjudgmental environment where youth are exposed to social norms and codes and can embrace new patterns of behavior that are in accordance with the host nation's culture, thus promoting the acculturation process (Motti-Stefanidi & Masten, 2013). Schools can also provide many opportunities for social mobility, social support, and connection with a confidante—someone with whom the child can share their feelings and difficulties (Shoshani & Slone, 2013). This can be a significant figure from the educational staff or even another migrant peer with whom the adolescent has something in common. In school, migrant adolescents can also benefit from befriending a native peer, someone who might encourage the adolescent's acculturation, while providing him with a sense of belonging in his new environment.

The partial support of acculturation in the relationship between school engagement and mental health outcomes suggests that there may be several other processes occurring at school beyond socialization to the new culture that contribute to the psychological well-being of adolescents. Certain factors, such as social support, a sense of belonging, and feelings of success and achievement (Shoshani et al., 2014) can promote resilience and serve the universal needs of children and adolescents, regardless of their background and experience.

## Research Limitations and Conclusions

The present study has several limitations. First, the study relied on self-report measures, which are subject to bias. Limited language fluency may have also been a barrier for migrants' ability to accurately complete the self-report measures. Second, in the present study we compared native participants to a mixture of migrant youth (labor migrants, asylum seekers, and refugees). Although these groups are likely to share some similar postmigration stressors, our analyses may have masked important differences between these groups in terms of pre-

migration stressors, reasons for migration, and ensuing trajectories. However, given the high incidence of irregular migration to Israel and lack of sufficient documentation, we could not access this sensitive information.

In addition, although the schools were in adjacent neighborhoods with similar SESs, the data reflected between-groups differences in SES. Also, the migrant samples' school had a diverse student population, while the native sample's school was relatively homogenous. These group differences in SES and demographic makeup of the schools may limit the generalizability of the study, especially the ability to generalize the findings to immigrants who experience urban segregation and attend schools where the vast majority of students are immigrants. Future studies would benefit from including larger samples from schools with varying characteristics (e.g., a school whose student population is mostly immigrants), while assessing the effects of school characteristics on the adaptation and mental health of migrant youth.

The general classification of participants' family origin in this study, such that it did not differentiate between countries and regions, along with the large variance in countries of origin among the immigrant samples, posed as another limitation in the study. This precluded our ability to examine the differing relationships between mental health and school outcomes, depending on country of origin. Investigating ethnic differences could provide more insight into immigrants' varying acculturation patterns, since the existing literature has indicated that country of origin plays is likely to affect immigrant children's adaptation (see Harris, 1999).

Finally, the cross-sectional nature of the study prohibited causal inference and did not reflect changes in mental health and engagement in risk behavior over time—information that a longitudinal study could potentially provide. Future research should track the long-term effects of migration and school engagement on developmental vulnerabilities, acculturation, and resilience.

This study serves to promote and facilitate further discussion and research on resilience among migrant youth. It reflects the multidimensional role of schools and educators in migrant youth's adjustment, both in nurturing

competence in age-salient developmental tasks and in contributing to their acculturation process. The findings of the study point to the potential benefits of schools prioritizing efforts to strengthen migrant students' sense of belonging to the school and the wider society. This can be achieved through afterschool programs, tutoring and homework services, community activities, social gatherings, and individual or group counseling. By engaging and empowering migrant youth through meaningful activities that cultivate their knowledge and sense of belonging, the school can become a central, encouraging place that fosters resilience and supports the needs of migrant youth and their families.

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Received April 2, 2015

Revision received September 25, 2015

Accepted September 29, 2015 ■