From trauma to resilience: A mixed methods study of negative and positive mental health in young Australian refugees from different cultures

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Declaration of authorship

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

Signed:

Winnie Lau

Dated: May 30th 2013
Acknowledgments

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<table>
<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ANOVA</td>
<td>Analysis of Variance</td>
</tr>
<tr>
<td>ARQ</td>
<td>Adolescent Resilience Questionnaire</td>
</tr>
<tr>
<td>ARQ-R</td>
<td>Adolescent Resilience Questionnaire Revised</td>
</tr>
<tr>
<td>BSI</td>
<td>Brief Symptom Inventory</td>
</tr>
<tr>
<td>CMY</td>
<td>Centre for Multicultural Youth (Victoria, Australia)</td>
</tr>
<tr>
<td>DIMIA</td>
<td>Department of Immigration, Multicultural and Indigenous Affairs</td>
</tr>
<tr>
<td>DIMA</td>
<td>Department of Immigration and Multicultural Affairs</td>
</tr>
<tr>
<td>DIAC</td>
<td>Department of Immigration and Citizenship (formerly DIMIA)</td>
</tr>
<tr>
<td>HoA</td>
<td>Horn of Africa or Horn or African</td>
</tr>
<tr>
<td>HTQ</td>
<td>Harvard Trauma Questionnaire</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally Displaced Person</td>
</tr>
<tr>
<td>MANOVA</td>
<td>Multivariate Analysis of Variance</td>
</tr>
<tr>
<td>ANOVA</td>
<td>Analysis of Variance</td>
</tr>
<tr>
<td>PTE(s)</td>
<td>Potentially Traumatic Event(s)</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-traumatic Stress Disorder</td>
</tr>
<tr>
<td>PSS</td>
<td>Post-traumatic stress symptoms</td>
</tr>
<tr>
<td>SHP</td>
<td>Special Humanitarian Program (Offshore program)</td>
</tr>
<tr>
<td>TFPE</td>
<td>Trauma Focused Psychiatric Epidemiology</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WhoEnv</td>
<td>World Health Organisation Environmental Quality of Life</td>
</tr>
<tr>
<td>WhoPhys</td>
<td>World Health Organisation Physical Quality of Life</td>
</tr>
<tr>
<td>WhoPsy</td>
<td>World Health Organisation Psychological Quality of Life</td>
</tr>
<tr>
<td>WhoSoc</td>
<td>World Health Organisation Social Quality of Life</td>
</tr>
<tr>
<td>WHOQoL</td>
<td>World Health Organisation Quality of Life</td>
</tr>
<tr>
<td>QoL</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
</tr>
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</table>
Abstract

Coinciding with varied conflicts and disasters around the world, there are approximately 14 million refugees worldwide. Refugees endure a range of war related traumatic events and subsequent resettlement stressors, prompting concern among health professionals about the emotional impact of these experiences. Youth refugees are particularly vulnerable to negative psychological and psychosocial consequences, often because they straddle child and adult developmental phases, where not only physical, cognitive, social and emotional development are incomplete, but also where expectations and responsibilities are high.

The majority of research into refugee mental health has used a psychiatric epidemiological approach to explore trauma related negative mental health outcomes such as PTSD or depression. The exploration of risk and protective factors in these outcomes are often encompassed under this approach. While the contribution of this literature has enabled a greatly enhanced understanding of the psychological difficulties faced by refugees, with more work to be done in this area still, not all refugees who have experienced trauma go on to develop negative mental health problems. This has led to the exploration of resilience, the capacity to adapt in the face of significant adversity. The dominance of psychiatric epidemiology and associated methodologies however, have meant that resilience, which derives from a strength based paradigm, has not been examined in refugees to the same extent as studies that utilise solely epidemiological and positivist paradigms.

Using a mixed methodology, comprising quantitative and qualitative techniques, the aim of the research described in this thesis was to explore both negative mental health factors (PTSD, anxiety, depression, and somatisation) and strength based psychosocial mental health factors (resilience and quality of life) in culturally diverse youth refugees (aged 12-27) resettled in Australia. This included a cross cultural investigation totalling (N=82) refugees from established populations such as the Horn of Africans and Sudanese, and new less established populations including the Karen (pronounced Kah-ren) and Togolese.

Across four empirical and qualitative chapters, this thesis found that almost all participants in this study endorsed multiple traumatic events, including separation, loss and bereavement. The most commonly experienced and worse endured events
were those surrounding deprivation of basic necessities, and the death of family members and loved ones. Ongoing stressors in the (re)settlement period included difficulties in language, the experience of racism and discrimination and worries about loved ones and family back home. Mental health problems were observed in up to 30% of the sample, though a number of refugees also displayed partial mental health symptomatology, attesting their status as a particularly vulnerable population.

Using multiple regression analyses to investigate the pre-, peri-, and post-migration factors influencing PTSD, anxiety, depression and somatisation, the role of trauma was confirmed as an important factor in the determination of mental health problems, confirming previous work in this area. However, this thesis also found that different factors across the pre-, peri-, and post-migration stages had a unique influence on different disorders. Trauma for instance uniquely predicted PTSD and somatisation, while post-migration factors were prominent in predicting anxiety and depression.

When strength based and psychosocial variables were introduced (i.e., resilience and quality of life), an inverse relationship was observed between these and negative mental health variables, PTSD, anxiety, depression and somatisation. Multiple regression analyses also showed that resilience was an important predictor in PTSD, anxiety, depression and somatisation, where differential effects were observed for different types of resilience domains (i.e., individual, family, peer, school and community). That is, community resilience was important in predicting PTSD, peer resilience was important in predicting anxiety, and individual resilience was important in predicting depression and somatisation. When resilience domains were used to predict quality of life, peer resilience uniquely influenced overall quality of life.

With regard to cultural differences on negative as well as positive mental health constructs described, the Karen and Sudanese cultures scored greater on symptomatology compared with the Horn of Africans and the Togolese. No cultural differences were found with respect to resilience and quality of life overall, although, some cultural differences were observed across separate domains of family and peer resilience and the separate domain of physical quality of life. Explanations provided as to the vulnerability of the Karen and Sudanese groups focused on the ongoing conflicts these cultures experience, the collectivist nature of the Karen particularly, the unique post-migration circumstances among the Sudanese and Karen relative to
other cultures, as well as the relative euphoria experienced by comparison new cultures such as the Togolose.

Qualitative themes from pre-, peri, and post-migration periods also emerged to complement and contextualise the current findings. Refugees in this study expressed narratives across themes which included personal journeys of flight, traumas, deprivation, and loss experiences, hardships endured, and (re)settlement experiences such as environmental contrasts, opportunities for education and employment, cultural and community distance, developmental and intergenerational changes, homesickness and loneliness, and social exclusion and racism. Recurring themes around mental health constructs, and anger and forgiveness were also found as were themes of resilience and personal resource for coping with difficulties. These findings were discussed in terms of the ongoing tensions that young refugees endure throughout the migration journey, as well as the critical nature of navigating and interacting with the host system.

This thesis contends that despite numerous frameworks that can be applied to refugee mental health, which are often not overt, no unifying theoretical framework exits to completely understand refugee mental health and well-being. The findings of the present thesis however are discussed in terms of the support lent to certain theoretical perspectives including psychosocial, ecological and phase based frameworks of refugee mental health, with particular discussion of the ADAPT model proposed by Silove.

The strength of this thesis is that it adds knowledge to the extant literature by using an integrated psychosocial, ecological perspective, framed around stages of pre-, peri- and post-migration to: (i) investigate a youth refugee population which is under-investigated relative to children and adults; (ii) explore cultural differences in mental health and well-being among young refugees, and particularly new cultures (Karen and Togolose) previously unexplored in the refugee literature; and (iii) investigate positive and psychosocial factors and their relationship to traditional mental health constructs, particularly resilience, which has been an elusive and variously operationalised construct in the refugee literature. A further strength of this thesis is the employment of a mixed methodology to contextualise the refugee experience.
It is concluded that refugees in Australia are a diverse population comprised of multiple cultures and complex experiences which encompass a range of negative mental health issues as well as positive strength factors. While this thesis confirms evidence to suggest that refugees are vulnerable to mental health problems, and that psychopathology is relatively high among them, there is now evidence emerging that demonstrates resilience as a salient construct among this vulnerable group. As there is no ‘one refugee experience’ there is similarly no single construct or unitary discipline to explain mental health and well-being in young refugees. An inter-disciplinary approach, comprised of psychiatric epidemiology in addition to ecological approaches are therefore necessary to advance knowledge and practice in this field, to then enable young refugees to move from trauma towards resilience. Ideas for future research and practice, policy and clinical implications are discussed.
CHAPTER 1: INTRODUCTION

Overview

The mental health effects of conflict, trauma experience, displacement and forced migration are as diverse as they are complex. This thesis presents a program of research investigating the psychological well-being of a group of culturally diverse young refugees resettled in Australia. In this opening chapter, an introduction and rationale for the studies incorporated in this research are presented, before an overview of the main aims and research questions are outlined. The chapter also presents the overarching theoretical framework used in determining the variables selected for investigation as well as definitions of terms and variables studied. The chapter concludes with statements about this thesis’ contribution to the literature and its structural organisation.

Thesis rationale

Mass conflict and war have resulted in an overwhelming number of displaced people across the world (Steel, Chey, Silove, Marnane, Bryant, & van Ommeren, 2009). The devastating and debilitating psychological consequences of war and displacement are now well documented with respect to refugees (Ehntholt & Yule, 2006; Lustig, Kia-Keating, Grant-Knight, et al., 2004; Nickerson, Bryant, Steel, Silove, & Brooks, 2010; Silove, 1999; Steel et al., 2009). Indeed, over the past twenty years and since the widely cited papers of Kinzie and colleagues (1988; 1998; 1996) outlining the psychological effects of trauma across time in Cambodian refugees, research in refugee mental health has burgeoned (Black, 2001). Although increasing, considerably less research has been conducted with youth refugees (Higgins, 2008), often classed as aged 12–28 years (Tipping, Bretherton, & Kaplan, 2007).

From an already vulnerable group of individuals, youth refugees represent a particularly susceptible subgroup because of their unique experiences of often being children at the time of conflict, and growing up as young adolescents and adults amidst ongoing conflict and war (Montgomery, 2008). These potentially traumatic
interruptions to critical stages of development are compounded by the forced changes in roles often observed across a young refugee’s lifespan, which add additional sources of vulnerability to young refugees (e.g., obliged into caregiver roles for siblings) (Bronstein & Montgomery, 2011; Fazel & Stein, 2003; Montgomery, 2008; Punamaki, Qouta, El Sarraj, & Montgomery, 2006).

Mental health research into youth refugees has relied heavily on the findings of adult populations to help establish the kinds of mental health problems that might exist for this younger group (Thomas & Lau, 2002). Although such generalisations can be problematic given the unique set of symptoms that young people present with (e.g., play behaviour in PTSD), the adult literature has helped to establish a research base for young people which has looked mainly epidemiologically at the prevalence of mental health disorders, particularly the manifestation of PTSD, depression, and anxiety (Lustig, Kia-Keating, Grant-Knight, et al., 2004).

Prevalence rates for these disorders have varied considerably from study to study (ranging from 17-50%), most likely due to sampling characteristics and methodological differences (Ehntholt & Yule, 2006; Porter & Haslam, 2005). Although prevalence is varied, there has been consistency in findings across psychological measures of PTSD, anxiety, and depression, with the majority of studies now reporting these problems in their young refugee samples (Fazel, Wheeler, & Danesh, 2005). Less focus has been placed on other psychological problems such as loss, grief, anger (Nickerson et al., 2011), or even somatisation. Regarding the latter, although the expression of physical symptoms is considered a manifestation of psychological distress or anxiety in non-western cultures (Westermeyer, 1989), there is less empirical support for this in youth refugees. Moreover, the extent to which somatisation relates to more common outcomes such as PTSD, depression, or general anxiety is under examined.

Although the literature is clear about the psychological disorders that may present in refugees, even children and young refugees, the pathways by which these disorders develop has received little empirical consideration. While it is presumed that trauma plays the most significant role in determining these outcomes, researchers also acknowledge that there are other important factors across the migration phase (i.e., pre-, peri-, and post-migration) that warrant consideration, particularly the role of psychosocial stressors (Silove, 1999). How these risk factors, which present across all
stages of migration (e.g., from displacement to settlement), work together to influence mental health has not been thoroughly explored, much less the degree to which stressors carry more or less significance. Such a knowledge base could be helpful in determining the interplay of risk and protective factors and important in establishing better interventions for young refugees (Fazel, Reed, Panter-Brick, & Stein, 2012).

One issue where there is little convergence of opinion as to its status as a risk or a protective factor is the role of culture in the development of psychological problems. Similarly, the question of how psychological problems vary across different cultures also remains a gap in the literature on young refugees (Sonderegger & Barrett, 2004). Although cultural factors are often cited to influence psychological outcomes, relatively few papers empirically outline these influences. This omission is possibly due to the difficulties associated with participant recruitment within refugee populations. Not only are refugees difficult to access as a research population (Spring et al., 2003), the recruitment of particular subgroups (e.g., different cultural groups, young groups) pose further difficulties for researchers who strive to recruit larger generalisable sample sizes.

Moreover, studies in cultural influences are naturally difficult to compare as samples of different cultures change alongside changing conflicts and forced migration around the world (e.g., Vietnamese and Cambodian refugees in the 1970’s through 1980’s to Former Yugoslavian and the Horn of Africans in the 1990s), as well as the changing migration policies of different host societies. Australia is one example of the changing patterns in host societal migration policies. Beginning with a large intake of Vietnamese refugees shortly after the cessation of the ‘White Australia Policy’ in 1973, Australia’s humanitarian intake over the last few years has predominantly included refugees from Burma/the Karen State, Sudan, the Middle East and most recently, the Togolese. This is contrasted with Europe where humanitarian entrants largely originate from within Europe itself, the Middle East (e.g., Iraq, Syria) and varied parts of Africa (e.g., Somalia, Tunisia).

In this way, the host society itself may play a role in the dynamic interplay of factors that exist to influence mental health in young refugees. Indeed, the impact of the host society and acculturative factors unique to that society make it difficult to isolate the effects of culture per se, making it difficult to tease out ‘culture’ from ‘acculturation’. Nonetheless, the role of culture is viewed as important in determining
how refugees are affected psychologically and socially by trauma and how they adapt to the experiences of a new country (Sonderegger & Barrett, 2004). This in turn may have implications for how interventions are tailored and received from one culture to another.

In understanding the mental health and psychological well-being of refugees, by far the predominant paradigm has been the ‘psychiatric epidemiological’ or, ‘traumatology’ paradigm (Summerfield, 2002). This paradigm focuses on trauma as the main predictor in the onset of psychological disorders. Undoubtedly, this conceptualisation has been useful in giving validity to conditions driven by the consequences of war, political violence, and human rights violations (Lustig, Kia-Keating, Grant-Knight, et al., 2004). Furthermore, this approach has been successful in understanding complex trauma responses which often arise not from single but rather multiple and chronic exposures (Ehntholt & Yule, 2006). Even the most critical voices of this approach recognise its contribution to improving psychological interventions that have helped reduce suffering and distress experienced by refugees (Tipping, et al., 2007).

At the same time however, constructivists and other opponents have remained very critical of the psychiatric epidemiology approach, maintaining that ascribing diagnoses ignores important recognition of the social factors that underpin suffering and distress (Miller, Kulkarni, & Kushner, 2006; Summerfield, 2001). Critics of the psychiatric epidemiology/traumatology approach argue that refugee mental health problems are not located in the individual per se, but rather in the socio-political context for which the individual cannot be ‘blamed’. Traditionally, these approaches (and their methodologies) are viewed as uncomplimentary (Tipping, 2010). Increasingly, proponents of both camps are recognising that there are indeed psychosocial correlates to a range of mental health problems, not just those labelled as disorders. While there is recognition of these psychosocial factors, how they are related to mental health problems is less understood (Silove, 1999).

Although the psychiatric epidemiological/traumatological approach continues to yield promising findings in refugee mental health, the historical focus on traumatic experiences has unfortunately not enabled other psychological variables of interest to be investigated. This has been problematic in two ways. First, the focus on psychopathology has diverted attention away from the investigation of alternative
mental health states such as grief, loss, loneliness, anger, or as mentioned earlier, culturally specific experiences such as somatisation. Second, the investigation of psychosocial and strength based variables such as life satisfaction, quality of life, or resilience have not been fully explored.

It is these latter, arguably more ‘positive’ mental health factors that have unfortunately largely been neglected. Indeed, the neglect of psychosocial or strength based factors in psychology in general has led to the emergence of positive psychology largely informed by the program of research by Seligman (Seligman & Csikszentmihalyi, 2000). With respect to the refugee literature, the work of Summerfield and Miller have been particularly influential in highlighting the importance of psychosocial variables in the mental health experience of refugees (Summerfield, 2001).

Two emerging psychosocial outcomes receiving more recent attention in the refugee literature are quality of life and resilience. Quality of life is seen as important because it represents an attempt to capture the general or more global life satisfaction of refugees, usually in the resettlement/settlement period. The utility of this construct is evident in its incorporation of life quality across psychological, physical, social, and environmental domains.

Likewise, resilience is important as it is a construct often associated with refugees (and trauma survivors generally) but not well understood and empirically under-tested. This may be because the concept of resilience itself has varied from being viewed as a singular trait to more complex understandings of resilience (i.e., viewing it as a capacity to adapt or recover despite adversity) (Olsson, Bond, Burns, Vella-Brodrick, & Sawyer, 2003). The empirical implications of these definitions have meant that resilience has been only indirectly explored through the presence or absence of mental health problems or through other outcomes such as coping or acculturation. Earlier research within an adolescent Australian population demonstrated that resilience might be comprised from a variety of domains within individual, family, peer, and neighbourhood/community areas of individuals’ lives (Gartland, 2008). Thus, as a construct itself, resilience has recently been directly operationalised in young people (Gartland, 2008), but unfortunately not yet in a sample of young refugees.
Moreover, while quality of life or resilience alone might be of interest to investigate within a positive psychology paradigm, of perhaps greater utility is how these concepts can best be understood in relation to traditional conceptualisations of mental health. Such measures are particularly useful to enriching an understanding of refugee mental health as they allow both negative and positive mental health factors to be considered together. Importantly, empirical questions about the inter-relational nature of these factors can be explored. For instance, questions such as whether it is possible to experience symptoms of PTSD or depression but at the same time display resilience or good overall quality of life could be investigated.

Perceiving mental health in young refugees as a constellation of factors that involve negative and positive outcomes as well as locating the individual within a system of processes that interact to influence psychological well-being (e.g., physical health, social, and environmental contexts) is consistent with ecological models of well-being. Ecological models are seen as a departure from traditional traumatology or constructivist models in that they attempt to view mental health not entirely as situated in the individual or socio-political milieu, but in a combination of these ways as part of a system, alongside, familial, peer, and community networks (Harvey, 1996).

Finally, although mental health understanding in young refugees could be enriched with a mixed theoretical or ecological paradigm, the narratives of young refugees themselves are often only featured in qualitative research studies with small sample sizes (Tipping, 2010). Often theme based, these studies have provided a rich and contextualised experience of the refugee journey. The strength of such designs is that responses to research questions can be directly answered through the voices of refugees themselves, instead of what critics deem as potentially culturally inappropriate tools which are conceived with western constructs of mental health (Tipping, 2010). Unfortunately, few studies in youth refugee mental health have utilised a mixed methods paradigm whereby the stories of refugees and empirical components of mental health can be contrasted to test the validity of such tools, but more importantly to enable a more holistic and contextualised view of psychological mental health and well being in young refugees.
Although refugee research continues to grow, a problem that remains within the literature is the failure to make explicit the theoretical framework underpinning the design and findings of particular studies (Lustig, Kia-Keating, Grant-Knight, et al., 2004). The purpose of this section is to make overt the theoretical framework used to guide the methodology utilised in this thesis and in the interpretation of findings. Although several extant frameworks are discussed and critiqued in greater detail in later chapters of this thesis, it is helpful to present the variables of interest in this thesis in a structured manner so that it is clear how they sit together.

The present research utilised an integrated holistic approach that encompasses both an ecological and a phase-based perspective. The approach is ecological to the extent that individuals exist within and are influenced by particular systems (e.g., families, communities, cultures, society); and phased based to the extent that factors relevant to the individual and system can be organised in a comprehensible manner throughout a migration process.

The model summarised in Figure 1 below outlines the variables to be examined in this thesis. The proceeding paragraphs describe the model in greater detail. It should be noted that it is not possible to list all the possible factors implicated in youth refugee mental health in the figure presented. Consequently, only the variables explored in this thesis, either through quantitative or qualitative techniques, are included. The asterisked variables represent those that are tested in this thesis using quantitative or standardised measures.
Figure 1. The pre-, peri-, post-migration model of refugee mental health factors.

The model presented in Figure 1 represents the array of factors that can impact on young refugees’ psychological well-being (Lustig, Kia-Keating, Grant-Knight, et al., 2004). Organising the potentially salient factors and potential correlates of psychological distress and well-being into pre-, peri-, and post-migration categories helps to highlight the factors that may come into play across the refugee journey
(Ehntholt & Yule, 2006; Lustig, Kia-Keating, Grant-Knight, et al., 2004; Montgomery, 2010). Importantly, the model allows not only for measureable outcomes to be assessed but also allows for a more fluid incorporation of those familial, developmental, cultural, and systemic factors that are important to consider. The model combines paradigms of psychiatric epidemiology, ecology, and social constructivism through enabling the assessment of risk and vulnerability as well as negative and positive mental health outcomes. Thus, the model focuses not only on psychiatric elements which have important validity, but also utilises ecological and psychosocial perspectives to explore alternate and strength focused outcomes.

The pre-migration (also known as pre-flight) phase encapsulates factors associated with the migration experience prior to migration. During this phase, refugees will have encountered stressful, traumatic, and probable life threatening events (Porter & Haslam, 2005; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). Although varied according to the context of war and political milieu in the country of origin, in the main part, these events can include witness of harm and murder, disappearance and loss of family members or friends, persecution or torture, rape, deprivation of living conditions, poor health care, difficulties obtaining food and nutrition, lack of education and employment (Kemp & Rasbridge, 2004; Rousseau, Drapeau, & Corin, 1997; Schweitzer, Melville, Steel, & Lacherez, 2006; Silove, Sinnerbrink, et al., 1997); and in the case of young refugees, deprivation of play, socialisation and compromised development (Punamaki, et al., 2006; Pynoos, Steinberg, & Piacentini, 1999). Hardships endured, pre-morbid physical and psychological functioning, family functioning, and demographic factors such as age, gender, and ethnicity are also included in this phase (Heptinstall, Sethna, & Taylor, 2004; Rousseau & Drapeau, 2004; Rousseau, et al., 1997; Silove, Steel, McGorry, & Mohan, 1998). Importantly, factors that appear in the pre-migration phase may also play a role in other phases (e.g., developmental factors) (Davies & Webb, 2000; Fazel, et al., 2012; Montgomery, 2011).

The peri-migration (also known as peri-flight) phase, encapsulates those flight factors which often include the transition from country of origin, to other countries, and refugee camp experiences (Finklestein & Solomon, 2009). Separations and/or losses through the migration journey can be marked in this phase (Loue, 2009). Often under examined in the research, this transitional phase can occur over months to
years, and may involve exile across various countries. Immigration or flight is often borne out of necessity and rarely voluntary (De Vries & Van Heck, 1994). This period can often be overlooked but is important, especially if the journey to the host society is prolonged and contracted.

The *post-migration* (also known as *post-flight*) phase incorporates those factors that occur in the immediate to midterm (resettlement) as well as the longer term post settlement period (Khawaja, White, Schweitzer, & Greenslade, 2008; Lindencrona, Ekblad, & Hauff, 2008). Often exacerbating psychological distress in this period, these factors may include isolation, language difficulties and other resettlement stressors, uncertain migration status, length of residency in the host society, and host societal factors themselves (Silove & Ekblad, 2002; Silove, Sinnerbrink, et al., 1997). Losses such as cultural heritage or values and family functioning can also impact on psychological well-being (Rousseau, et al., 1997). In the case where migration is voluntary, the resettlement period often brings hopes of new beginnings. Where migration is involuntary or forced, this can be a stressful period involving the resumption of life in a new country and family members left back home (Samarasinghe & Arvidsson, 2002).

In forced migration, the country of origin is markedly different to the host country. Not only are there a range of factors around developing language and cultural understandings of the host society, and securing accommodation and employment, there are also tasks around restoring breakages in family links and dealing with loss of loved ones (Silove, 2005). Racial and cultural discrimination from the host society are also prevalent factors contributing to resettlement stress in this phase (Lindencrona, et al., 2008). Whilst there is often overlap with the experience of voluntary migrants in the post-migration period, this phase is often marked with additional losses for those forced into flight/migration.

The model presented in Figure 1 has the potential to be helpful in exploring the relationship and interaction effects between pre-, peri- and post-flight factors. While it is reasonable to expect that a unique and direct relationship exists between each of these factors and mental health, it is also likely that an interaction between pre- and post-factors will result in a more representative outcome of mental health (negative or positive). However, given the time lapse often associated with forced migration and subsequent resettlement (often years), the relationship between pre- and
post-migration factors is often complicated due to the mediating and moderating effects of external factors such as acculturation or system/structural factors (e.g., navigation of new laws).

Nevertheless, the advantage of the model presented is that it allows for the complexity of refugee experiences to be understood in a broad but flexible framework. Organised by phase factors, the model allows for the direct investigation of factors at each time point that influence both positive and negative mental health outcomes. It takes into account the potential accumulation of factors as well as the interaction of factors across times hypothesised to impact on mental health.

It is important to acknowledge though that mental health outcomes do not follow a standard temporal course. That is, different factors may have differing impacts at different times on mental health, and mental health outcomes in themselves are not the end point. That is, individuals may go back and forth psychologically through the phases and back and forth from positive to negative mental health. Although the pre-, peri-, post-migration model does not explain the complexity of inter-relatedness between variables within and across phases, it does offer much utility in being able to discern the risk as well as protective factors in refugee mental health and well-being.

It is also important to acknowledge that the model does not assume that an accumulation of factors will necessarily result in negative outcomes – hence the recognition of positive mental health in the model, and the recognition of family, cultural, community, and other systems in influencing the individual. In the model described, mental health outcomes are linked to a range of factors that have both psychological and social underpinnings. While it is tempting to view mental health problems as the inevitable consequence of trauma, the majority of research actually supports the notion that refugees are relatively free of mental disturbances (Silove, 2005; Summerfield, 2005). The other advantage of the model described is that it allows for strength-based outcomes to be discovered (Summerfield, 2005).

Although presented as a phase/transitional model, it is recognised that the distinction of phases is arbitrary because the occurrence and experience of all factors are interrelated and even though characteristic of one phase, may actually recur in subsequent phases. Nonetheless, the model captures in a holistic yet systematic way, the factors and their relationships to mental health outcome. In the present thesis, the
described model of refugee mental health will be utilised as the overarching framework for investigation. Of course, the implications for such a model in light of the findings that will be presented in this thesis will be discussed in the final chapter. Indeed, the implications of Silove’s model (to be described in greater detail in Chapter 4 on theoretical frameworks) as an addition to this framework of investigation will also be discussed in terms of interpreting the implications of the current model and how it can be augmented.

The work of Silove (1999) and colleagues has been particularly influential in understanding refugee trauma theoretically, not only in a global context but also in an Australian one. Silove (2006) proposes that the extreme effects of trauma and torture, alongside mass human rights violations, work to challenge human adaptive systems. He proposes a ‘survival and adaptation’ model (also known as ADAPT) in which trauma challenges one or more of these fundamental systems that work to maintain a state of equilibrium in individuals as well as the communities around them.

Table 1 below outlines the five major systems proposed by Silove that are thought to both challenge equilibrium and provide a basis for adaptation. These include: (1) the security and safety system, which is challenged by threat, risk and fear and strengthened by strategies that foster security; (2) the attachment system which is challenged by ruptured bonds and strengthened through repairing social bonds; (3) the justice system which is challenged by human rights violations and strengthened through creating successful justice systems; (4) the role/identity system which is challenged by disrupted institutions and structures and strengthened through re-establishing social roles and identities and; (5) and the meaning system which is challenged by undermined values and beliefs and strengthened through building institutions that foster meaning (e.g., religious, spiritual, existential, political, or cultural).

With a high degree of inter-relatedness across these systems, Silove maintains that each challenge is characterised by both adaptive and extreme responses, to which there are a number of social, psychological, and psychiatric interventions. For instance, if an individual’s or culture’s system of justice is challenged, he/she may experience human rights violations and abuses. Consequentially, the adaptive response may be one of anger, mistrust, and a commitment to justice, and in the extreme form, maladaptive anger or violence. Social interventions may therefore
incorporate trust, reconciliation, punitive, and even forgiving process. Psychological interventions may include those that address dysfunction, and psychiatric interventions may aim to address possible paranoia or extreme depression. These types of challenges, processes and interventions for each system are outlined in Silove’s model, displayed in Table 1.
Table 1.
Silove’s (2005) Survival and adaptations (ADAPT) model.

<table>
<thead>
<tr>
<th>System</th>
<th>Challenge</th>
<th>Adaptive Response</th>
<th>Extreme Response</th>
<th>Social Interventions</th>
<th>Psychological Interventions</th>
<th>Psychiatric interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security/ Safety</td>
<td>Real threat (whole group)</td>
<td>Anxiety, security seeking</td>
<td>Terror, panic</td>
<td>Protection, curtailing hostilities</td>
<td>Crisis intervention for extreme reactions</td>
<td>Treat and underlying disorder (psychosis, severe depression, organic disturbances, etc)</td>
</tr>
<tr>
<td>Security/ Safety</td>
<td>Survival risk group (with mental disorders)</td>
<td>Good family and community care and protection</td>
<td>Dangerous or bizarre functioning, under-functioning, extreme/ persistent distress</td>
<td>Special protection and education for family and network</td>
<td>Comprehensive assessment, crisis intervention, community follow-up, collaboration with traditional healers</td>
<td>Adjunct psychiatric treatment for severe cases</td>
</tr>
<tr>
<td>Security/ Safety</td>
<td>Persisting/excessive fear</td>
<td>Social and family support</td>
<td>Severe PTSD and related reactions</td>
<td>Maximize security and opportunities to regain control</td>
<td>Trauma counselling: group or individual for selected few who are disabled</td>
<td>Adjunct psychiatric treatment for minority with persisting/severe dysfunction</td>
</tr>
<tr>
<td>Attachment</td>
<td>Ruptured bonds, multiple losses and separations</td>
<td>Arousal, separation, anxiety, grief</td>
<td>Prolonged or pathological grief, depression</td>
<td>Tracing and reuniting families. Restoring social networks, rituals</td>
<td>Grief counselling for extreme reactions</td>
<td>Treat complications e.g. paranoia, depression in minority</td>
</tr>
<tr>
<td>Justice</td>
<td>Human rights violations and abuses</td>
<td>Anger, frustration, caution in trusting, commitment to justice</td>
<td>Extreme anger</td>
<td>Truth, reconciliation, indictment, punishment, forgiveness</td>
<td>Group anger management in minority with persisting/severe dysfunction</td>
<td>Treat complications such as depression</td>
</tr>
<tr>
<td>Role/ identity</td>
<td>Disrupted institutions and structures</td>
<td>Role uncertainty/new roles and opportunities</td>
<td>Isolation, passivity, deviancy</td>
<td>Training, work, skills development</td>
<td>Elements of counselling/family therapy in severely affected</td>
<td>Adjunctive – for complications such as depression</td>
</tr>
<tr>
<td>Existential Meaning</td>
<td>Undermined values, culture and belief systems</td>
<td>Existential doubts, adoption of new/hybrid identities</td>
<td>Alienation, loss of faith</td>
<td>Religion, political expression, cultural reconstruction</td>
<td>Elements of humanistic and existential therapy in counselling of severely disabled</td>
<td>Treat clinically severe depression</td>
</tr>
</tbody>
</table>
Silove (2006) maintains that an integral part of adaptation, especially relative to post traumatic stress symptoms and the construct of PTSD in traumatised war exposed cultures, is the establishment of peace and security. Consistent with both a psychiatric and ecological approach, Silove’s framework incorporates a contextual and cultural element to the individual refugee experience in addition to accommodating host societal (or western) frameworks for understanding mental health problems. Importantly, it acknowledges the role of both paradigms in building in an interactive and mutually supportive way of understanding how humans adapt to survive and cope in different environments (Silove, 2006).

A discussion of how Silove’s model is useful in understanding the current research findings is presented in the final chapter of this thesis. As noted previously, the summary provided is intended to introduce broader conceptualisation to the factors involved in refugee mental health as well as highlighting a theoretical foundation for this research. The aim is simply to orient the reader to the vast array of variables that can be considered, with an emphasis on those thought to be particularly significant. Moreover, it is the purpose of this chapter to draw linkages between the variables of interest and provide a structure for how they might be related.

**Contribution of thesis to refugee mental health**

By deviating from a traditional psychological approach and adopting an integrative ecological and psychosocial perspective, this thesis offers a fresh way of investigating youth refugee mental health. The strengths and contributions of this thesis include:

1. Being one of only few studies which investigate refugee mental health from a youth (12 – 27 years) perspective. Given their transition from child to adulthood, this group of refugees is developmentally unique and not adequately represented by the literature in child or adult refugee mental health fields. The present thesis contributes an understanding of the unique experiences encountered by this vulnerable sub-group.

2. Being one of few studies using the Australian context to explore cultural differences in young refugees. To date, a comparison of mental health across different as well as older and newer refugee cultures to Australia has been lacking. This thesis contributes to the understanding of the resettlement mental
health and well-being of different, older and newer refugee cultures in one host society, enabling the unique experience of culture as well as the effects of acculturation of different cultures to be examined.

(3) To this author’s knowledge, this is the first study to examine new groups of resettled youth refugees, both in Australia and internationally. Through investigating a young Karen and Togolese population, this thesis offers a chance to develop new insights to the mental health experiences of these “new” refugees. To date, there have been no published empirical mental health studies regarding the refugee youth cultures of the Karen and Togolese. Hence, this thesis contributes new knowledge to the refugee field.

(4) This thesis represents an attempt to add to the empirical knowledge in this field through an examination of the frequency of psychopathology among youth refugees in Australia. It aims to further extend the understanding of psychopathology by examining the pre-, peri-, post-migration risk and protective factors that contribute to these outcomes. Although these endeavours are not novel in this field, the additional exploration of positive and psychosocial mental health factors removes the single focus on psychopathological outcomes, to enable such outcomes to be considered in light of positive or strength variables such as resilience, and quality of life.

(5) This thesis represents an attempt to merge traditionally competing mental health paradigms (quantitative and qualitative; psychiatric epidemiology and ecology/constructivism) to develop a holistic and contextualised representation of mental health and well-being among young refugees. The present thesis contributes an application as well as enhanced understanding of mixed methodologies to the field of refugee mental health which has been lacking given the dominance of psychiatric epidemiology.

**Aims of this thesis**

Applying an integrative ecological perspective and mixed methodology comprising quantitative and qualitative techniques, the purpose of the research reported in this thesis was to explore mental health and well-being in a culturally diverse youth
The refugee population (re)settled in Australia. Within this overarching objective, five research aims were generated. These are listed below:

1) To estimate the frequency of negative mental health problems (i.e., PTSD, depression, anxiety, and somatisation) in a culturally diverse group of young refugees in Australia, and identify the factors that increase (or decrease) vulnerability to these mental health problems.

2) To explore cultural differences in the frequency of negative mental health problems (i.e., PTSD, depression, anxiety and somatisation), across groups of more and less established young refugees, namely from The Horn of Africa, Sudan, Karen State/Burma, and Togo.

3) To extend knowledge from negative mental health factors to explore alternative psychosocial and positive psychological outcomes, namely quality of life and resilience. Further, to examine the relationship between these and negative mental health outcomes (i.e., PTSD, depression, anxiety, and somatisation).

4) To explore cultural differences in the prevalence of psychosocial and positive mental health outcomes, namely quality of life and resilience.

5) To improve the methodological rigor of research with youth refugee populations by utilising qualitative as well as quantitative methods of data collection to examine the refugee journey through pre-, peri- and post-migration phases. A sub aim of this was to explore the influence of culture on mental health problems and constructs as seen by young refugees themselves.

**Research questions addressed by this thesis**

This thesis addressed the following questions:

(1) What is the frequency of negative mental health outcomes such as PTSD, anxiety, depression and somatisation in youth refugees (re)settled in Australia?

(2) What are the correlates of PTSD, anxiety, depression and somatisation in youth refugees (re)settled in Australia?

(3) What factors across the pre-, peri- and post-migration phases predict these negative mental health outcomes in youth refugees?
(4) What if any, cross cultural differences exist in the frequency of and predictive factors in negative mental health outcomes among youth refugees (re)settled in Australia?

(5) What is the role of psychosocial and positive mental health factors, such as quality of life and resilience, in the mental health of youth refugees (re)settled in Australia?

(6) What is the relationship between negative mental health outcomes (described above) and alternative psychosocial and positive mental health outcomes (quality of life and resilience)?

(7) What if any, cross cultural differences exist in quality of life and resilience among youth refugees (re)settled in Australia?

(8) What do the narratives of a group of youth refugees (re)settled in Australia tell us about mental health in youth refugees?

The structure of this thesis

This first chapter has outlined a rationale for the present research as well as a theoretical framework for investigating youth refugee mental health. Chapter 2 introduces the context of this thesis and its incorporated studies through a discussion of the circumstances with which refugees migrate to Australia. It begins with some definitional concepts of a refugee, and moves to a discussion about the global conflicts that give rise to forced flight, before funnelling to a discussion of the current milieu for refugee migration to and settlement in Australia. An overview of relevant statistics for each of the cultural groups investigated in this research is also presented.

Chapter 3 presents a review of the literature in refugee mental health in young people. In this review which has been published (see Lau & Thomas, 2008), an extended rationale in the context of empirical and other studies is developed for investigating a youth sub-group of an already traumatised vulnerable group of refugees. Gaps in the literature are identified and used to further develop the rationale for exploring this vulnerable sub-group of refugees.

In Chapter 4, the theoretical frameworks for looking at refugee mental health are reviewed and critiqued. This chapter will show that a variety of frameworks exist for approaching and explaining refugee findings and an argument will be made for an
integral approach to considering refugee mental health. The chapter will discuss in greater detail the frameworks chosen for this research, as described earlier in this chapter.

In chapter 5, the overall methodology and protocol adopted for this research program will be presented. The approach described in this chapter is a mixed methodology, comprising both quantitative as well as qualitative techniques that enable the psychological experiences of young refugees to be more comprehensively conceptualized. An interesting subsection of this chapter will review the ethical considerations in conducting research with vulnerable young refugees.

Chapter 6 will present the first of four results chapters. In this chapter, sample characteristics are used to describe what might be typical characteristics of young refugees in Australia. The chapter will present information that characterises young refugees in terms of demographic factors such as nationalities and ethnicities, religious affiliation and languages spoken, length of residency and living situations, accompaniment status, educational and occupational status, countries migrated to, family and parental characteristics, and health status. The nature and frequency of trauma exposure in the sample is also summarised in this chapter.

In Chapter 7, negative mental health outcomes including post traumatic stress, anxiety, depression and somatisation are empirically investigated to establish frequency as well risk factors that contribute to these problems. This chapter extends the current knowledge in psychopathological outcomes in refugees not only in terms of looking at the contribution of vulnerability factors including trauma exposure, but also through an investigation of somatisation. As a symptom often attributed to anxiety, somatisation has been less well-investigated among young refugees. Other psychopathological outcomes were opportune to assess, however were not discussed in detail given the constraints of this thesis. A further focus in this chapter was to explore how psychopathological outcomes and their risk factors might differ across different cultures.

In Chapter 8, a transition from looking at negative psychological outcomes to alternative psychological outcomes is made. The chapter particularly focused on two psychosocial outcomes - quality of life and resilience. Implicit in this study was an examination of quality of life and resilience in relation to negative psychological outcomes. The presence or absence of resilience in particular is often talked about as a
dynamic factor in the psychological experience of refugees. To date, little has been
done to empirically examine this construct, alongside quality of life in young
refugees. This chapter therefore aimed to test these factors, and again how they might vary across different cultures.

Chapter 9 like the preceding chapter is viewed as an important extension of the
traumatological paradigm. Using a strength based perspective, this chapter utilised
data collected from a number of focus groups (with separate cultural groups) to
explore the ‘refugee experience’ through pre-, peri- and post-migration phases. The
introduction of this qualitative methodology yielded an enriched response to the
concept of refugee mental health. Although interpreted through the lens of a
researcher, this chapter aimed to capture the psychological experiences of young
refugees through their own voices and stories. Findings from this chapter are the
result of theme based analysis. Cross cultural differences in the overall themes are
also discussed in Chapter 9.

In Chapter 10, the final chapter, a general discussion of the overall findings in
this research is discussed. Findings are discussed with reference to previous literature
and an attempt is made to understand the findings theoretically. In particular, the
theoretical implications for an ecological and phase based model of refugee mental
health will be discussed alongside other important models that may help to explain the
findings. The utility of Silove’s theory in particular will be discussed. Finally, after
some methodological limitations are acknowledged, the implications for future
research and clinical, practical and policy work with refugees is discussed.
Conclusions around the diversity and complexity of refugee mental health among
young people from diverse cultures are also drawn.
CHAPTER 2: SETTING THE REFUGEE CONTEXT ACROSS REGIONS OF CONFLICT AND IN AUSTRALIA

Overview

Although estimates fluctuate year to year, at the end of 2011, the United Nations High Commissioner for Refugees (UNHCR) approximated that the number of displaced persons around the world was roughly 42.5 million. This included 15.2 million refugees, 895,000 asylum seekers, and 26.4 million internally displaced persons (UNHCR, 2011). These figures highlight the plight of many in the world, who through conflict, have been forced to flee their homes and countries. The aim of this chapter is to outline how individuals and families become displaced and subsequently migrate to resettlement countries such as Australia.

Following a discussion of definitional issues around the term ‘refugee’ (and associated terms), this chapter will review the socio-political conflicts that occurred in the past (and currently) that have led to the forced migration of cultural groups to Australia, including countries forming the Horn of Africa (i.e., Ethiopia/Somalia and Eritrea), Sudan, Togo, and the Karen State/Burma. This is followed by a review of the history of, and current climate for, refugee migration to Australia, before a brief overview of the resettlement and settlement context for refugees in Australia is provided. By this chapter’s end, it will be evident that the migration journey from displacement to settlement can be long and characterised by multiple and different challenges that help shape mental health in young refugees.

A definition of ‘refugee’ and associated terms

The UN has a primary and authoritative role in safeguarding the safety and rights of refugees around the world. As the global body responsible for refugee safety, the Office of the United Nations High Commissioner for Refugees (UNHCR) defines a refugee as:

…..“a person who is outside his/her country of nationality or habitual residence who has a well-founded fear of persecution, because of his/her race, religion, nationality,
“membership in a particular social group or political opinion and is unable or unwilling to avail himself/herself of the protection of that country or to return there for fear of persecution.”

(UNHCR, 1951a; Article 1, Convention and Protocol Relating to the Status of Refugees, United Nations High Commissioner for Refugees, 1951, pp. 16-17)

Often misused in a range of contexts, this legal classification of individuals is distinguished from that of migrants who leave their homes consciously and voluntarily, often without a background of political upheaval and significant trauma, and where a safe passage of return exists if the individual chooses to do so (Refugee Council of Australia, 2013.). The term refugee is also distinguished from that of asylum seeker, which although is also a legal term, is by contrast, a person who has left his/her country of origin, has applied for recognition as a refugee in another country, and is awaiting a decision on his/her application (UNHCR, 2000b).

Although an asylum seeker may have endured a series of circumstances and experiences not dissimilar to refugees and thus may fulfil the requisite of need for international protection, an official declaration of refugee status is not made until claims to this effect are substantiated by a host government. Typically, a refugee is classified as such before arrival to a host country and an asylum seeker is classified following arrival (often ‘illegal’ arrival) to a host country (Lustig, Kia-Keating, Grant-Knight, et al., 2004).

It is important to distinguish the terms refugee, asylum seeker, and voluntary migrant again, from the term, ‘illegal immigrant’. Illegal immigrants are people who enter a country without meeting legal requirements for entry, or residence. This term is confused, as asylum seekers can and do, arrive ‘illegally’, and like refugees can arrive with bare necessities, and without personal documents to verify their status as genuine refugees. As outlined in Article 31 of the Convention, because one has arrived ‘illegally’, refugee status and asylum is not precluded if the person has a well-founded fear of persecution or where their life and freedom are/have been threatened (UNHCR, 1951a).

On face value, distinguishing the terms refugee, asylum seeker, voluntary migrant (sometimes also known as economic migrants) and illegal immigrant, offers clarification on the circumstances under which individuals migrate. Unfortunately
however, the definition of a refugee as set by the UNHCR, does not encompass those individuals who are not singled out especially for persecution, but in fact are exposed to warfare or violence nonetheless (De Vries & Van Heck, 1994). It also does not encompass displaced persons within their own countries (internally displaced persons/IDPs), stateless individuals, and returnees (Tipping, 2010). Like asylum seekers, these individuals often share characteristics and traumatic experiences with refugees, but unlike refugees and asylum seekers are not protected due to their remaining in or returning to their home countries.

The UNHCR does, however, acknowledge these individuals (numbered at approximately 26.4 million, UNHCR, 2011) as forced migrants and persons of concern, and does avail them with practical assistance. For the purposes of inclusion, the term refugee in this thesis will encompass asylum seekers as well as those individuals internally displaced and of concern to UNHCR. Throughout this thesis, the term ‘refugee experience’ will also be used. In accordance with the Australian Government’s National Youth Affairs Research Scheme in Australia, this term, will broadly refer to the refugee experience as “exposure to political, religious or intercultural violence, persecution or oppression, armed conflict or civil discord that incorporates the following basic elements: a state of fearfulness for self and family members, leaving the country of origin at short notice, inability to return to the country of origin, and uncertainty about the possibility of maintaining links with family and home” (Coventry, Guerra, Mackenzie, & Pinkney, 2002, p. 16).

**The context of refugee experience and forced migration**

Before the consequences for psychological well-being that can arise from traumatic experiences and forced migration can be discussed, it is important to understand the socio-political contexts that give rise to these experiences. The following sections will describe conflicts across the worlds that have influenced the most current arrival of refugees to Australia. In particular, conflicts in Africa, including Eritrea, Somalia Ethiopia, Sudan, and Togo as well as in Burma/The Karen State. A brief community profile of each of these cultures within Australia is also provided. These profiles are based on information compiled by the Australian Government, Department of Immigration and Citizenship (DIAC, formerly known as DIMA and DIMIA) (see
Conflict in the Horn of Africa-Somalia. Somalia is located in the eastern or ‘Horn’ part of Africa. It is bounded by the Gulf of Aden, the Indian Ocean, Kenya, Ethiopia, and Djibouti. An area of 637,657 square kilometres, Somalia’s population is about 8.8 million, and its capital is Mogadishu. Settlement of Somali people in the Horn of Africa (originally thought to have originated from the Ethiopian highlands) has occurred over 2000 years (Williams, 2003). To date, the Somali people inhabit present day Somalia and Ogaden (eastern Ethiopia). During colonial times however, northern Somalia was annexed by the British, and the southern and central regions were annexed by Italy. In the 19th century, Ogaden, the Somali territory, was occupied by Ethiopia. Resentment arising from this occupation has led to a number of wars between the two countries (Williams, 2003). Following a merger in 1960 of the colonised British and Italian territories, Somalia became independent and known as The Republic of Somalia. The country’s democratic government at the time though was weakened by ruling elite whose governance was founded on clan-based relationships (Williams, 2003).

Following a coup d’état in 1969, Siad Barre was established as the Somali president. Barre’s rule was characterised by continued clan based governance, bribery, widespread abuse of human rights, encouragement of tensions among other clans and nepotism to members of his own clan (Williams, 2003). Opposition to Barre’s regime increased through the 1980’s and it fell in 1991 when Barre was overthrown by opposing clans. General lawlessness and clan warfare resulted from Somalia failing to agree on a replacement (Williams, 2003). In late 1991, northwest Somalia declared itself the independent Republic of Somalia and a Somalia wide government ceased to exist. A civil war ensued causing over 500,000 deaths.

Between 1991 and 1995, more than a million people fled Somalia, seeking refuge in the neighbouring countries of Kenya, Ethiopia, and Djibouti. About two million were internally displaced. Tens of thousands of Somali refugees resettled in third countries, mainly the United States, Canada, Western Europe, Australia, and New Zealand (Adult Migrant English Program Research Centre, 2012).
After a failed UN peacekeeping mission in 1995, Southern Somalia experienced ongoing conflict between militias supporting rival clans, with no central source of authority or power (Williams, 2003). In the late 1990s, anarchy, armed conflict, and food insecurity persisted throughout southern Somalia, wherein 2000, the UN Food and Agriculture Organization rated Somalia as the ‘world’s hungriest country’ (Williams, 2003). In 2000–01, violence and insecurity prevailed in southern, eastern, and western Somalia. Hundreds of civilians lost their lives in gunfights in Mogadishu, and Merca. Factional conflict, drought, floods, and famine displaced about 20,000 people from their homes during 2001, adding to the million Somalis uprooted in previous years (Adult Migrant English Program, 2003).

In August 2000 warring parties cooperated to form a Transitional National Government (TNG), aimed at reconciling the warring militias and creating national government. However, its authority is not recognised by Somaliland, Puntland, or by warlords in the south and sporadic fighting has continued in Mogadishu.

In 2004, the TNG became internationally recognised as The Transitional Federal Government (TNG). More recently, conflict has arisen between the TFG and the Council of Somali Islamic Courts, which had established control in Mogadishu and other parts of the south. With Ethiopian endorsed USA and African Union Peacekeeper efforts, the Courts were routed from power, but to date, security is tense. The TFG administration, the 14th attempt to establish a government since 1991, continues the task of bringing reconciliation to Somalia which is still divided into clan fiefdoms and by civil wars. The absence of the clear and strong central government in Somalia continues to impede efforts to find long term solutions for Somali refugees (Adult Migrant English Program, 2003).

**Somalis in Australia and Somalian culture.** Settlement in Australia by Somali refugees has occurred over the past twenty years, but increased dramatically during the 1990’s when civil order in Somalia collapsed (Adult Migrant English Program, 2003). Somalis are among the largest African communities in Australia, comprising about 19% of the African refugee population (Phillips & Oxley, 2005). The current research focuses on those refugees who arrived in the wave of migration through the mid to late 1990’s/early 2000s, although ensuing and more recent conflict has seen increasing numbers of Somali finding refuge in Australia. There are two main Somali
languages spoken among Somali’s in Australia: Af Maay, mostly spoken in the South; and Af Maxaa, which is spoken in other parts of Somalia and neighbouring countries, including Kenya, where the refugee camps are located. Many Somali refugees have spent several years living in refugee camps, mainly in Kenya.

The Somali, and broader Horn of African, community in Australia is highly urbanised, with the greatest numbers residing in Victoria, and more specifically in the State’s capital, Melbourne. In Melbourne, the majority live in public housing in the municipalities of Melbourne’s inner west, and south east areas. A large proportion of the Somali, like other Horn of African populations, is under 20 years of age, and most Somali and Horn of African families in Australia, are made up of single mothers with large families (Williams, 2003).

Somalis adhere mostly to the religion of Islam, particularly the Sunni sect (Kemp & Rasbridge, 2004). Islamic traditions are maintained whereby women are expected to cover their bodies and hair when in public and facial veiling is common in Australia. Gender roles are also patriarchal with fathers ‘heading’ the family, and female children having roles as helpers of mothers within the home. Birthdays are not particularly celebrated by Somalis; therefore it is not uncommon for Somali’s to not know the exact date of their birth. As a result, birthdates are often cited to the nearest year, for example, 1st January or 31st, making them difficult to establish by immigration authorities in Australia. Death anniversaries of family members’ however are observed and celebrated.

**Conflict in the Horn of Africa- Eritrea.** Eritrea also forms part of the Horn of Africa. It is bordered by Sudan, the Red Sea, Djibouti, and Ethiopia. Eritrea is a small country of about 121, 300 square kilometres, with a coastline spanning 1000 kilometres along the Red Sea. The population of Eritrea is approximately 4.5 million (DIMIA, 2006a).

The autonomy of Eritrea has long been in dispute. Subjected to periods of rule by the Ottomans, the Tigray Kingdom and the Egyptians, it was colonised by Italy in 1890 and then in 1941 by the British. In 1952, the UN formed a Federation of Eritrea and Ethiopia, making Eritrea an autonomous region of Ethiopia. In 1962, Emperor Haile Selassie declared an end to Eritrean autonomy, proclaiming Eritrea as a province of Ethiopia. Conflict developed between the two countries resulting in an
Eritrean revolt (DIMIA, 2006a). The longest war that ensued was the ‘War of Independence’, occurring between 1961 and 1991. An eventual cease-fire ended the War of Independence, but essentially since this time, Eritreans have fought for independence (Winfield, 2000). Indeed, despite formal independence following a UN monitored referendum vote in April 1993, Eritrea has been in continual border dispute with Ethiopia (Winfield, 2000).

War commenced again triggered by Eritrea’s abandonment of Ethiopia’s currency in favour of its own, and the dividing line and the disputed territory of Badme in 1998 through to 2000. Ethiopia agreed to a peace treaty following considerable pressure from the international community but this war caused over 100,000 deaths. Approximately 356,000 Eritreans became refugees, with a further 310,000 displaced within their own country (DIMIA, 2006a). Many of those who fled had only returned recently to Eritrea from the previous war.

In 2003, a UN boundary commission ruled that the disputed town of Badme was to be awarded to Eritrea. Since this time, tensions have flared periodically, though violence has been averted due to UN peacekeeping operations currently monitoring the Eritrean-Ethiopian border. In addition to border conflict, Eritrea has persistently been affected by frequent drought, affecting food growth, and increasing reliance on subsistence agriculture. Since its independence, Eritrea has become one of the poorest countries in the world, and its infrastructure and economy which relies on subsistence agriculture is severely damaged (DIMIA, 2006a).

There are international concerns for the government’s lack of respect for human rights, democracy and political freedom, poor prison conditions, torture of prisoners, limited activity of non-government organisations, violence and social discrimination against women and restrictions of workers’ rights (DIMIA, 2006a). Due to ongoing conflict, drought and famine, about 750,000 people have fled Eritrea, to refugee camps in neighbouring countries of Sudan and Zaire (now the Democratic Republic of Congo), and Kenya. The UN has expressed concern over possible renewed conflict between Eritrea and Ethiopia, the existence of undetected land mines, the increased food crisis, and restrictions in international aid, (DIMIA, 2006a) resulting in the necessary resettlement of refugees.
**Eritreans in Australia and Eritrean Culture.** Most Eritreans resettled in Australia arrived through the Humanitarian Program, after fleeing during the war years and Ethiopian rule. Many Eritreans lived in refugee camps surrounding Eritrea for many years, sometimes for periods of more than twenty years. Many have also moved from camp to camp, or through successive periods of flight from their homes (DIMIA, 2006a). Younger refugees are often born in camps and unfamiliar to other ways of living (CMY, 2005). Most Eritrean refugees arrive in Australia with varied documentation, and like other Horn of African cultures, birth documentation does not exist.

The 2001 Australian Census indicated there were 1620 Eritrean-born persons living in Australia, an increase of 42 per cent from the 1996 Census. According to the DIMIA (now known as the Department of Immigration and Citizenship, DIAC) Settlement Database, 796 new Eritreans arrived between 2000 and 2005. Though reflecting a small community in Australia, these figures may mask a significant number of refugees identifying as “Eritrean born”, who were actually born outside Eritrea, due to the civil war, changing borders, and large refugee movement (DIMIA, 2006a).

The majority of Eritrean refugees have settled in the state of Victoria. Two, languages, Tigrinya and Tigre, are spoken by approximately 80 per cent of the population. Arabic, and Amharic (remnant language of Ethiopian rule) are also spoken. The main religions practiced by Eritreans in Australia are Islam, mostly from Sunni sect (about 38%), and Orthodox Christianity (about 37%) (DIMIA, 2006a). Eritrean-born refugees who arrived in Australia between 1990 and 1999 (i.e., the period of interest for this study), identified mainly as Tigrinyan, followed in percentage order by Tigrean, Eritrean Blen (Eritrean), and Amhara (Ethiopian). Overall, a third of arrivals in this period were aged 24 years or younger. Other arrivals included 25-34 year olds (31%) and 35-44 years (18%). Thus, the majority of Eritreans in Australia arrived whilst in childhood through to early adulthood. Most Eritrean families comprise extended family members of several generations. Family life is extremely valued in Eritrean culture and a high regard exists for the elderly, whose roles are often to settle household conflicts. Eritreans in Australia remain traditional and patriarchal (DIMIA, 2003). As a result of having relied on food aid prior to Australia, many Eritreans are under-skilled for employment. As the Eritrean
diaspora spans many countries, there remains a small Eritrean community in Australia.

**Conflict in the Horn of Africa - Ethiopia.** With Somalia and Eritrea, Ethiopia forms a part of the Horn of Africa. The country covers about 1, 120,000 square kilometres and is land-locked sharing borders with Eritrea, Djibouti, Somalia, Kenya, and Sudan. Its capital is Addis Ababa. Some of the earliest traces of human civilisation are found in Ethiopia. Despite a system of tributaries from the Nile, major droughts over the past forty years have devastated agriculture and created severe food shortages. Ethiopia is among the least developed countries in the world, ranked 170 out of 177 nations in the United Nations Development Program (UNDP). At 2005, its estimated population was about 73 million (DIMA, 2006b).

Unlike other African countries, the ancient Ethiopian monarchy maintained its freedom from colonial rule with the exception of a four year Italian occupation during World War 2 (DIMA, 2006b). In 1941, Italy was expelled with the assistance of British forces and power was returned to The Emperor Haile Selassie. The history of conflict in Ethiopia cannot be separated from that of Eritrea’s. Following World War II, Eritrea was removed from British control through UN resolution, and in September 1951, became an autonomous territory federated with Ethiopia. As described earlier, in 1962, Emperor Selassie dissolved the Eritrean parliament and declared Eritrea a province of Ethiopia. This resulted in a war, led mainly by the Muslim Eritrean Liberation Front, and contributed to Selassie’s ruin (DIMA, 2006b).

Following the overthrow of Selassie in 1974, the military dictatorship under Lt. Col. Mengistu Haile Mariam (known as Mengistu) was created. During the internal conflict that followed the fall and death of Selassie, the Somali government attacked the Ogaden region of Ethiopia (a Somali-inhabited region). The Somali invasion, described earlier as the Ogaden War, began in 1976. Ethiopia sought help from Cuban and Russian forces who helped to bring the invasion to a halt in 1978 (DIMA, 2006b).

By 1987, Mengistu became president of the newly named ‘People’s Democratic Republic of Ethiopia’. During this time, Ethiopia endured extreme famine as a result of extreme droughts and the Eritrean independence movement progressed. Ethnically based opposition groups emerged including the Tigrayan Peoples’
Liberation Front (TPLF), and the Oromo Liberation Front (OLF), and joined to form the Ethiopian ‘People’s Revolutionary Democratic Front’ (EPRDF). In 1991, the EPRDF entered Addis Ababa, and overthrew the 17-year Mengistu regime (DIMA, 2006b).

A democratic Transitional Government of Ethiopia was formed comprising former revolutionary groups, with the TPLF as the majority party and in 1994, a constitution and multi-party democracy were installed. Prime Minister Meles Zenawi was elected and introduced major change, including the division of Ethiopia into ethnic regional divisions. A second general election was held in 2005 and Zenawi was undefeated as the Prime Minister. This prompted protests with claims of voting corruption, and demonstrations and clashes around the country resulted in multiple deaths (DIMIA, 2003). To date, separatist action from opposing political parties and movements continue. The current Ethiopian government is accused of genocide, torture, unlawful imprisonment, and intolerance of any opposition (DIMA, 2006b).

In addition to Ethiopia’s internal disputes, ongoing tensions with Eritrea have contributed to the country’s instability. As described earlier, although Eritrea gained independence by referendum in 1993 after years of struggle and for a few years the countries endured a fractured ‘peace’. The war recommenced in 1998, resulting in mass population displacement and multiple deaths. Natural disaster, political unrest, persistent drought and famine have resulted in millions of IDP’s over the years. Over the course of mass exodus, many refugees have fled to Sudan, Somalia, Djibouti, and Kenya. Ethiopia itself like many of its neighbouring countries has also played host to refugees fleeing their own countries – particularly the Somali and Sudanese. In 2001, a peace agreement (the Algiers Agreement) was signed by Ethiopia and Eritrea. However, border disputes with Eritrea have continued despite the agreement and the presence of UN peacekeeping forces.

**Ethiopians in Australia and Ethiopian culture.** Since 2000, Ethiopia has featured in the top ten countries for humanitarian entrants into Australia, with entrants peaking in 2003. For the period of 2000-05, the DIMIA settlement database identified approximately 3000 Ethiopians settled in Australia, most residing in Victoria (ABS, 2005). Although entrants have slowed to date, Australia is still accepting refugees currently residing in Kenya and Somalia and family stream arrivals also continue.
Most Ethiopian arrivals come through the Humanitarian Program (65%) and others enter through the family stream (33%). The majority of arrivals (42%) identify as single persons and a further 33% arrive as members of two person families. There are also significant numbers who arrive in family memberships of seven or more people (DIMIA, 2006b). Just over half of the Ethiopian entrants are male (52%). The majority of Ethiopian-born arrivals are young adults and children with approximately 52 per cent under the age of 25 (DIMIA, 2006b). However, the 25-34 year old demographic was the most highly represented group in 2000-05. Most Ethiopian refugees are concentrated in the metropolitan areas of state capitals with very few in regional areas (DIMA, 2006b).

Pre arrival experiences are often characterised by refugee camp life over many years in Sudan and Kenya. Many Ethiopian refugees arrived in Australia following the independence of Eritrea in 1993, and the subsequent expulsion of ‘non citizens’. A change in Ethiopian refugees to Australia occurred in late 2004, where about 350 Ethiopians from the Abu Rakham camp in Sudan were resettled; mostly female-headed families at risk due to no male support. Like the broader Horn of African community, most Ethiopians arrive with little documentation, and come from rural backgrounds with little or no experience of urban life (DIMA, 2006b).

Differences in ethnicity, language, and religion among Ethiopians are complex with about 32% of Ethiopians belonging to smaller ethnic and linguistic groups not identified by Australia’s settlement database (DIMIA, 2006b). Of the remaining 68 per cent, the majority embrace a Coptic or alternative form of Christianity (around 50%), followed by Islam (40%). The ethno-linguistic structure of Ethiopia is also diverse, with over 78 ethnic groups and 84 languages. The four main ethnic groups represented in Australia are Oromo (32%), Amhara (30%), Somali (6%), and Tigray (6%). Main languages spoken are Amharic, Oromo, Somali, Tigrinya, Ometo, Sidamo, and Afar.

Similar levels of education and skill to that of the broader Horn of African community are also observed for the Ethiopian and Somali community (DIMIA, 2006b). Young Ethiopian arrivals to Australia also have little school experience; due to socioeconomic disadvantage, only the highest academic students can progress to secondary school. Similarly, in the family, elders are respected and consulted to
resolve disputes and family cohesion is important. Traditional gender roles are maintained among Ethiopians.

**Conflict in Sudan.** Located in the north east, the Republic of Sudan is the largest country in Africa. It is bordered by Chad, the Democratic Republic of Congo, Egypt, Eritrea, Ethiopia, Kenya, Libya, and Uganda (DIAC, 2006). Sudan’s geography is diverse with deserts, mountains, swamps, and rainforests and at its heart, the Nile River system. The north, where its capital Khartoum is located, is desert-like and agricultural while in the oil rich south, swamps, rivers, and flood plains support cultivation activities. Sudan is comprised of states in east, west, north, and south. Darfur, the site of the most well known conflict, is located in the west. The north is traditionally home to Arabic speaking Sunni Muslims while the south comprises a diverse range of indigenous and Christian religions. Sudan’s population of 41 million is comprised of 50-100 ethnic groups. Population estimates are skewed by war but the majority (53%) are children, with the median age of the country being 18.3 years (Tipping, 2010).

The diversity of ethnic origins, languages, lifestyles, and religions have given rise to Sudan’s turbulent political history (Wama, 1997). The conflict is multifaceted, protracted, and driven by racial, cultural, and religious differences predominantly between north and south, or more particularly the Northern government versus Southern rebel forces. Ethnic group conflict has complicated and worsened the conflict, to which north and south have not been united against each other (Tipping, 2010). Despite being potentially the richest country in Africa, internal conflict, civil war, famine, and constant humanitarian crises have plagued Sudan since its independence from British-Egyptian administration in 1956.

The causes of division between north and south are complex, but rooted in the dominance of northern government military regimes. These regimes have attempted to impose Islamic and Arab culture on the non-Muslim black African southern Sudanese, who are primarily influenced by Christian or and Animist (tribal) traditions, and who seek autonomy and an end to their marginalisation (DIAC, 2006). The origin of these internal tensions can be traced to Sudan’s pre-independence history. The northern part of the region (now known as Sudan) has had a long history with its neighbouring country, Egypt. Kingdoms based in northern Sudan were heavily
influenced by Egypt. Although Christianity arrived in the region by the sixth century AD, Islam gradually replaced it as the dominant religion as a result of continuing Arab migration. In the 19th century, Egypt invaded and conquered northern Sudan. This influenced Slave trading where thousands of Southern Sudanese origin were captured and sold, contributing to southern Sudanese hostility towards Arabs and Islam (DIMIA, 2006c).

In 1896 the British, in partnership with Egypt, invaded Sudan, commencing a period of colonial administration referred to as the Anglo-Egyptian condominium (DIAC, 2006). Differences between the north and south were less exacerbated under British colonialism. Despite this, the British administration left the south politically and economically underdeveloped, although Christianity was reintroduced under British rule (Tipping, 2010). British rule ended in 1953, when a three year period of transitional self-rule led to Sudan’s full independence on 1 January 1956.

Not long after independence, Southern fears of northern domination continued and rebellions in the south escalated into the first civil war which persisted through numerous government regimes. In 1969, Colonel Gaafar Muhammad Nimeiri assumed power, resulting in a signed agreement in 1972 to afford South Sudan some autonomy. The eleven years of ‘uneasy peace’ that followed ended in 1983 when Nimeiri rescinded some concessions of the agreement, provoking a rebellion by southern soldiers (DIAC, 2006). Later that year an attempt to impose Sharia law and Arabic on Muslims and non-Muslims was made by Nimeiri. These actions, combined with disputes over ownership of resources (e.g., oil producing regions; a canal project diverting water to the north), contributed to the re-commencement of civil war. About two million deaths resulted from this ‘second’ civil war and its associated famine and more than four million were displaced (Tipping, 2010).

The Sudan People’s Liberation Movement (SPLM) was formed in the south, and its military wing, the Sudan People’s Liberation Army (SPLA), led by of Colonel John Garang became the main rebel faction (DIAC, 2006). The aggressive promotion of Islam by the National Islamic Front, which seized power in 1989, intensified the conflict and war. During the 1990’s, regionalism and support for the SPLA and other rebel groups grew in the east, west, and south of the country, as both Muslim and non-Muslim populations reacted to a perceived escalation of the dominance of the Arabic centre (Tipping, 2010).
A treaty between the Sudanese Government and the SPLM in 2002 led to the signing of The Comprehensive Peace Agreement (CPA) in January 2005, ending the war (DIAC, 2006). Under the agreement, northern troops were withdrawn from southern Sudan, political power and revenue from Southern oil fields were to be shared, and the return and resettlement of refugees and internally displaced Sudanese were to take place. The right for the south to determine its own political future after an interim six year period (which ended in 2011) was also agreed upon (Tipping, 2010).

Sudan’s second civil war resulted in an estimated 1.9 million lives lost and four million displaced. About 500,000 fled to neighbouring countries and two million people relocated to the greater Khartoum area (DIAC, 2006). According to the United Nations, widespread violations of human rights have occurred on both sides, including the enslavement and attack on civilian populations and the conscription of child soldiers (Tipping, et al., 2007). Abuses of physical integrity, rape, malnutrition, health problems, the destruction of villages, and killings of political opponents have been attributed to the government.

The Sudanese diaspora has seen its people scattered widely, many illegally residing outside of refugee camps. Living in exile is characterised by clashes, discrimination, exploitation, and violence from ‘host’ societies (Tipping, 2010). After the signing of the CPA and the subsequent ratification of an interim constitution, power was decentralized, with the National Islamic Front (now called National Congress Party) and SPLM forming the Government of National Unity.

As the second civil war drew to an end, another conflict in 2003 erupted in Sudan’s west region of Darfur (DIAC, 2006). This conflict however, was not driven by the imposition of Islamic rule, but by rebel groups within north and south forces with grievances around political marginalisation of Africans by Arabs; limited access to; and control of; resources; and anger at being left out of the negotiations which led to the CPA (Tipping, 2010). Rebels have been fighting not only government forces but also the pro-government militia known as the Janjaweed.

The various rebel factions are comprised of Africans, while the Janjaweed are Arabs, although these ethnic distinctions are somewhat blurred (Tipping, 2010). In 2004, the African Union (AU) deployed troops to Darfur to monitor a ceasefire, but despite UN peacekeepers, violence continued in the region with militia attacks on people and aid agencies in and around the camps. An estimated 1.8 million people are
internally displaced within Darfur, and 200,000 more have sought refuge in camps across the border in Chad. A peace accord signed in 2006 by the government and one of the rebel factions did little to reduce the violence (Tipping, 2010). Despite the CPA of 2005 and the peace agreement of 2006, conflict in this Sudan has continued and Sudan continues to be subject to a United Nations African Union peace keeping force and humanitarian aid program.

Also marked in Sudan’s history is the well known story of ‘Sudan’s lost boys’ (DIAC, 2006). During the 1980’s, about 17,000 children (some as young as 3-4) fled after parents and families were killed and villages destroyed by northern government’s Arab militia. The majority were from Dinka and Nuer tribes. Not long after finding refuge, in Ethiopia, these children were forced to flee again (due to an unsympathetic new Ethiopian rule). Ten thousand boys survived the journey to Kakuma refugee camp (Kenya) having survived lion attacks, crocodile crossings, bandit attacks, and starvation and thirst (Geltman et al., 2005; Tipping, 2010). The plight of these boys has highlighted the immense suffering of the Sudanese people, particularly those Sudanese, who arrive often unaccompanied in resettlement countries, having experienced the death of their main care givers.

**Sudanese in Australia and Sudanese Culture.** The Australian Bureau of Statistics (ABS) identifies the Sudanese born community as one of the fastest growing groups in Australia (DIAC, 2006), with arrivals increasing by 34% over the past 10 years. Among the developed countries, alongside Canada and the United States, Australia resettles most Sudanese refugees (Westoby, 2009). The peak of this growth was seen in 2002-03, when Sudan became the top source of arrivals entering in the Special Humanitarian Program, accounting for 33% of the humanitarian intake for this period (DIAC, 2006). Currently, the DIAC’s Settlement database indicates approximately 20,000 Sudanese migrants, with 98% entering through the humanitarian program. It reveals that most refugees were in exile in Kakuma (Kenya) and camps in Uganda, Ethiopia, and Cairo with very few of Australia’s intake originating from Darfur. The majority of Sudanese have settled in Victoria and New South Wales (ABS, 2005).

Although Islam is the dominant religion throughout Sudan, Sudanese migrants (approximately 83%) identify with Christian denominations with the remaining made up of Muslims (12%), other indigenous religions, or no stated religion at all (DIAC,
The main languages spoken are Dinka followed by Arabic; however, a large number of entrants record their language as “African-not defined” (due to constraints of DIACs settlement database not having appropriate individual codes for all of Sudan’s ethnicities and tribal languages). Where ethnicity is defined, Sudanese settlers to Australia are mostly Dinka and Nuer from Southern Sudan. Other ethnic groups include Shilluk, Bari, Madi, Murle, or Acholi (DIAC, 2006).

Family plays prominent role among the Sudanese and kinship ties are close often involving extended families (DIAC, 2006). Most Sudanese refugees arrive in a family unit of 3 or more, and most (about 64%) are classed in a young age of 24 or younger at arrival. Males (55%) outnumber females in terms of gender (45%). Having spent many years in exile or refugee camps (up to 10 years), many refugees have disrupted and therefore limited education (DIAC, 2006).

**Conflict in Togo.** Togo is a small country in West Africa. With a long and narrow geography, it stretches 550 kilometres from north to south, and is 160 kilometres in width (DIAC, 2007). Togo shares borders with Ghana, Benin, and Burkina Faso and Lomé, a port, is its capital. Togo has a tropical climate, characterised by rainy seasons, warm temperatures and dusty winds that blow from the Sahara desert. Togo’s population is estimated at 5.5 million, and the median population age is 18.3 years (DIAC, 2007). The UNDP’s Human Development Report (2006) ranked Togo at 147 out of 177 countries based life expectancy, health, sanitation, economic performance, and education factors. Sixty five per cent of Togo’s workforce engages in subsistence and commercial agriculture, with coffee, cocoa and cotton as the main exports.

Some of the earliest identified migrants to Togo were the Ewe people from Ghana (DIAC, 2007). In the 15<sup>th</sup> century, Togo became known as ‘the slave trading coast’, due to trading posts set up by the Portuguese, Dutch, and French. In 1884, a German protectorate organised by a local chief, over coastal Togo (then known as Togoland), allowed Germany to colonise the area, wedging British Ghana (then known as the Gold Coast) and French Benin (then known as French Dahomey). This spread the Ewe people across southern Togo and Ghana, while the Kabye people from North Togo straddled the Togo and Benin border.

Following WW1, British and French colonial troops invaded and occupied Togoland, partitioning the country to two separate British and French territories
(DIAC, 2007). In 1956, British Togoland merged with the Gold Coast, forming Ghana which achieved independence in 1957. French Togoland became a self-governing republic, headed by Nicolas Grunitzky. Elections later removed Grunitzky and installed Sylvanus Olympio as Prime Minister resulting in Togo’s full independence from France in 1960. Olympio’s rule ended in 1963, following his assassination by a military coup. Grunitzky returned from exile to form a new government, but was removed from power in a coup that brought Gnassingbé Eyadéma from the Kabye tribe to power.

Eyadéma’s presidency was confirmed in a 1972 after national referendum (DIAC, 2007). His rule brought family and other Kabye tribe members to key government positions. In 1986, dissidents supporting Gilchrist Olympio (Sylvanus Olympio’s son), unsuccessfully attempted to oust Eyadéma though pressures forced Eyadéma to adopt some democratic reform, including legalisation of political parties, and amnesty to political opponents. In 1993, Eyadéma won the election amidst allegations of political violence and vote rigging. Political violence escalated between 1992 to 1994, and the army, comprised largely of ethnic Kabye, suppressed opposition opponents of Eyadéma, who were predominantly Ewe’s from the south. Demonstrators and security forces clashed in 1993 resulting in military reprisals that forced about 300,000 Togolese to seek refuge within and in neighbouring countries, Ghana and Benin.

Eyadéma was returned to office in 1998 and in 2001, an enquiry by the UN and the Organization of African Unity found systematic violations of human rights (DIAC, 2007). His son, Faure Gnassingbé became president when Eyadéma died in 2005 amidst claims of electoral irregularities. Further violence between opposition supporters and security forces after this resulted in up to 500 deaths and 40,000 people fled to Ghana and Benin.

An accord between the government and opposition groups in 2006 brought electoral reform, the return of refugees, military restructure and the end of political interference by security forces (DIAC, 2007). By the end of 2006, 14,000 Togolese refugees remained in Benin and Ghana. Many Togolese to date remain in exile from the 1993 and 2005 exodus, fearing persecution and citing mistrust of the Togolese Government.
**Togolese in Australia and Togolese culture.** Togolese refugees in Australia derived from two intakes, the 1992-93 arrivals and the 2005 arrivals (DIAC, 2007). Most of Australia’s intake is from the Krison camp in Ghana. Tensions in the Krison camp escalated in 2005 when residents rioted and destroyed buildings and property, driven by frustration over a perceived lack of progress in resettling refugees. This contributed to the UN referrals of many Togolese refugees to Australia (DIAC, 2007). Although there are more than 30 ethnic groups in Togo, most Togolese entrants to Australia are from the largest ethnic group, the Ewe, who are predominantly from South Togo (DIAC, 2007). Ewe is the most common language spoken by South Togolese, and Mina is spoken by most Northern Togolese. Many Togolese refugees also speak Togo’s official language, French, and some also speak English. With most Togolese entrants from the South, the predominant religion among Togolese Australians is Christian, typically, Charismatic or Pentecostal. The remainder are Sunni Muslim (mainly from north) and traditional religions (e.g., Voodoo) (DIAC, 2007). Some Togolese believe in the consultation of traditional healers as well as or instead of modern doctors.

Having lived in camps for numerous years, many Togolese are unskilled (DIAC, 2007). Literacy and education levels are typically low. The majority of Togolese entrants to Australia have rural backgrounds and large families, sometimes polygamous, where the average number of children is five. Traditional gender roles are held alongside family ties and kinship (DIAC, 2007).

**Conflict in Burma and the Karen State.** Burma (also known as Myanmar) is located on the Bay of Bengal in South East Asia. It shares borders with Bangladesh, India, China, Laos, and Thailand. Although locally known as Myanmar, it is internationally recognised as Burma, following British colonisation in 1886 (DIMA, 2006a). Burma’s climate is tropical, and its geography is rugged, with a dry plain at the centre surrounded by mountain ranges, forest, and woodlands. Burma is divided into seven states: Chin, Kachin, Karen (pronounced “Kaa-renn” and also known as Kayin), Kayah (Karenni), Mon, Rakhine (Arakan), and Shan. The population is approximately 50 million, but Burma’s ethnicities are diverse, with up to 135 recognised ethnic groups. The dominant ethnicity is Burman, accounting for approximately 68% of the population (DIMA, 2006a). After the Burman’s, The Karen constitute one of the
largest ethnic groups in Burma. Despite its natural resources such as oil, gas, and gemstones, Burma’s economy has declined under military rule and it is one of the least developed countries in the world (DIMA, 2006a).

Like the countries already described, Burma’s socio-political history has been marked by civil war and a succession of military regimes (DIMA, 2006a). Having been occupied by Japan in World War 2 (1942-1945), it gained its independence in 1948, following expulsion of the Japanese by a British alliance, and the Anti-Fascist People’s Freedom League (AFPFL), led by Aung San (who was later assassinated after his election to presidency). In the 10 years that followed the democratic government at the time struggled with challenges posed by communist and ethnic minority groups, whom although had some independence, were never given autonomy. A military coup in 1962, led by General Ne Win, saw Burma ruled by a military junta (DIMA, 2006a). This regime enforced Myanmar as the country’s official name, but a lack of recognition of the military junta left the official name widely ignored.

Triggered by a worsened economy, student disturbances and demonstrations broke out in 1988 (known as the 8888 Uprising), resulting in military forces killing more than 1000 demonstrators (DIMA, 2006a). Others fled into the hills and border areas. Despite the 1990 election being won by the National League for Democracy (NLD), an organisation presided by military commanders (State Law and Order Restoration Council) imposed martial law and declared itself in power. Members of the NLD, and particularly, Aung San Suu Kyi (awarded the Nobel Peace Prize in 1991), was imprisoned and released numerous times till 2010. In 2003, Khin Nyunt, following his arrest for corruption, was replaced as prime minister of Burma by Lieutenant General Soe Win. A further uprising against the military government in 2007 led by Buddhist monks (referred to as the ‘Saffron Revolution’), resulted in further deaths and imprisonment of protestors (DIMA, 2006a).

Burma has experienced decades of oppression under its continued military regimes (DIMA, 2006a). By 2002, an estimated 600,000 Burmese were internally displaced and more than a half million Burmese have sought refuge in neighbouring countries. International organisations continue to express concerns for human rights in Burma, which have included forced labour practices, displacement of thousands of villagers, landmines planted by the army, political imprisonment, executions and
military censorship and restrictions. To date, arrests and harassment of pro-democracy activists continue (DIMA, 2006a).

The above paragraphs are important in providing a background to the Karen State conflict, which has drawn relatively less attention, but equally given rise to the displacement of many non-Burmese people, predominantly people from the Karen State. The Karen State, which covers about 30,000 square metres, occupies the eastern and south/lower eastern parts of Burma, close to the Thai Border (DIMA, 2006a). As one of the largest ethnic groups in Burma, the Karen people comprise about seven percent of the population in Burma (approximately seven million) (Karen Buddhist Dhamma Dutta Foundation, 2011). Most Karens are subsistence farmers and live in mountainous jungle areas in the Karen State and in the Tenasserim (Mergui-Tavoy) division in eastern Burma. Ethnic diversity within the Karen people is also significant, with subgroups including: Shaw, Pwo, Bwe, Karenni and Pa-o, each with a distinct set of languages and customs. Traditionally, an animistic culture, Karen people are now mostly Buddhist or Christian (Baptist, or Anglican).

The dominance of the Burman majority over Karen, and other ethnic minorities has been the source of considerable ethnic tension and violence in Burma (DIMA, 2006a). During British occupation, ethnic minorities were free from persecution but in the post WW2 period and since independence in 1948, this equality has not been experienced by the Karen (DIMA, 2006a). Since this time, the Karen and other ethnic minority groups have been at war with the Myanmar government.

Since the massacre of Karen villages in 1949 by Burman militias, ‘the Karen revolution’ has continued. Led by the Karen National Union (KNU) and its armed wing the Karen National Liberation Army (KNLA), the Karen have fought for an autonomous state to date. During the 1962 coup d’état that ascended Ne Win to power, widespread systematic human rights violations have occurred against the Karen people (DIMA, 2006a). These have included forced relocations through the burning and demolition of villages, murder and physical assault of villages, arrest and imprisonment of villagers, forced labour (e.g., used as human shields and minesweepers), active restriction of access to food, education and health, abuse of women and rape, and executions of Karen people by Burmese soldiers.

As a result of ongoing conflict and persecution of the Karen people, there are about 140,000 Karen refugees living across nine camps along the Burma Thai border
These camps include Mae Ra Ma Luang, Tham Hin, Nu Po, Mae La Oon, Ban Mai Nai Soi, and Umpium. Approximately 50,000 Karen refugees have been resettled in America, Canada, Australia, and some European countries (DIMA, 2006a).

In January 2012, and at the time of writing this thesis, the Myanmar government announced a ceasefire agreement with the KNU. The agreement mandated open communication between the government and Karen rebels, safe passage for Karen rebels in Burma, amnesty and reduced sentences for many KNU prisoners. The talks between the KNU and the Myanmar government continue to date.

**Karen in Australia and Karen culture.** At the recommendation of priorities by the UNHCR, Asian (particularly Burmese) and Middle Eastern groups have dominated the most recent arrivals to Australia (African refugees were the main entrants over the previous decade). By the end of 2005, there were about 13,000 Burman born people living in Australia, with the peak of arrivals coming in 2007/08 period. In 2009/10, the largest number of offshore visas granted by Australia went to refugees from Burma (DIMA, 2006a). The main ethnic groups of Burmese-born arrivals to Australia over the period 2000-05 were the Burmese (23%) and the Karen (14%) (ABS, 2005).

Almost 40 percent of Karen/Burman refugees reside in Victoria (Victorian Southern Migrant and Refugee Centre, SMRC, 2011). The largest concentration from Burma/Karen State live in the outer southern and south eastern suburbs (about 11%) or outer western suburbs of Melbourne (about 30%), with a few refugees also living in regional areas such as Bendigo. The majority of newly-arrived refugees lived in refugee camps in on the Burma/Thai border (DIMA, 2006a; Refugee Council of Australia, 2013.), primarily the Nu Po, Mae Lae, and Umpiem refugee camps.

Tibeto-Burman is the main language spoken by these latest refugees (approximately 60%) (ABS, 2005), but the diversity of languages and dialects is reflected in the ‘unidentified category’ section of the DIMIA settlement database (DIMA, 2006a). Karen people in Australia identify as speaking several dialects of the Karen language, including Sgaw Karen, Pwo Karen, Karenni, and Pa’o (Abatto, 2011). Despite Buddhism being the main religion in Burma, the majority of refugees from the Karen State are Christian (about 65%), followed by Buddhist (28%), Islamists, and Animists (DIMA, 2006a).
The Karen are characterised by their distinct colourful traditional dress and shoulder bags, which represent Karen sub groups (DIMA, 2006a). Whilst most Karen are uneducated past primary school, enthusiasm and value for education is high. Some Karen possess basic English skills on arrival to Australia, as English is taught in the larger refugee camps. Animist beliefs can often coincide with Buddhist practice, though for the Christian minority, animism and other religions are usually prohibited. Like other cultures described in this chapter, gender roles are prominent and the family and extended family is strongly emphasised over the individual. For instance, first cousins are thought of as brothers and sisters (DIMA, 2006a). Families comprise of 2-3 children and elders are highly respected members of the family and community. The Karen pride themselves in dance and music and have been widely characterised as a ‘peaceful, moral, and unassuming quiet’ people.

_Trauma experience in refugees_

It is well documented that refugees displaced from countries of conflict and war have been exposed to a number of adverse and/or traumatic events, sometimes gross human rights violations. These traumatic events, which can be direct or witnessed, include persecution; war and conflict exposure; bombardments and shelling attacks; extreme losses such as separation(s) from family, disappearance of family members, death of loved ones and loss of home and country; witness of violent killings or massacre; and other human rights abuses such as illegal imprisonment or detainment, beatings and torture; threatened or actual sexual assault, and child-soldier activity (Burnett & Peel, 2001; Davies & Webb, 2000).

Additionally, young refugees have commonly experienced a dangerous escape from their country of origin, travelling long distances, often on foot; living in unsafe and insecure environments for extended periods of time (e.g., refugee camps, immigration detention, or multiple transition countries) with limited or no access to health care, education, housing, income, social connection, food and water; poor nutrition and hygiene, overcrowding in camps, deprivation of livelihood, political oppression, harassment; disruptions in family functioning and roles; and insecurity and extended periods of uncertain future (Burnett & Peel, 2001). It is also widely acknowledged that torture survivors represent a particularly vulnerable subgroup of
refugees (Steel, Mares, Newman, Blick, & Dudley, 2004), not only because of unimaginable violations to physical and psychological integrity, but also enduring suffering and pain that continues if the person has survived. The psychological impact of traumatic events described above is discussed later in Chapter 8.

The Australian milieu: Australia’s Humanitarian Assistance Program

As a signatory to the 1951 UNHCR Convention, the Australia, through its federal government, is obliged to provide protection to those who apply for refugee status as defined by the convention. The Humanitarian Program fulfils some of Australia’s obligations to provide protection under international law and is divided into an onshore and offshore stream (Refugee Council of Australia, 2013.). The ‘Onshore Program’ awards protection to those individuals who arrive on Australian shores, often by plane or by boat, who meet refugee criteria (UNHCR, 1951b). The program is established to process individuals where no other means for applying for refugee status exists in their country of origin. These individuals are often classed as ‘asylum seekers’. They undergo a lengthy application process to determine their eligibility as a refugee and their eligibility to stay in Australia. Applicants in this program can be held in mandatory or community based detention, with the latter usually applied to families with children, unaccompanied minors, or people with special needs.

Prior to 2008, and at the time of recruitment for this thesis, applicants in the onshore program received Temporary Protection Visas (TPVs), which limited the length of time they were able to remain in Australia, their eligibility for certain benefits, and their rights to apply for family re-union visas. The change of government around this time resulted in the current use of Permanent Protection Visas (PPVs) for all refugees (including asylum seekers) who established a claim for protection in Australia. This afforded applicants the same rights and access to benefits and services.

The ‘Offshore Refugee and Special Humanitarian Program (SHP)’ in contrast, is designed to offer resettlement as a means of protection to those subjected to substantial persecution and in need of humanitarian assistance overseas (i.e., where refugee status is affirmed prior to arrival to Australia). Refugees in this program apply for their status whilst living outside their own countries due to persecution. The
UNHCR refers most applicants under this category for resettlement. Applicants in this program often spend many years in a third country and/or in refugee camps.

Within the Offshore program, various visa categories exist to reflect the status and circumstances of the refugee. Detailed information regarding these visa subclasses can be found at: http://www.immi.gov.au/visas/humanitarian/. Generally, the five visa subclasses include: (i) applicants living overseas who are subjected to gross violation and have UNHCR referral (Refugee visa class 200). This category also includes family re-unification where existing residents can apply on families’ behalves; (ii) applicants who are subject to persecution and gross violations, but are unable to leave their home countries to seek refuge elsewhere (In Country Special Humanitarian visa class 201); (iii) applicants who are supported by a ‘proposer’ who is an Australian citizen or organisation (Global Special Humanitarian visa class 202). This category is for people not formerly classed as ‘refugees’, but are subjected to substantial discrimination and human rights abuses in their home country. They must be proposed for entry by an Australian citizen or permanent resident or an organisation operating in Australia; (iv) applicants under immediate threat and requiring emergency rescue and have UNHCR referral (Emergency Rescue visa class 203); and (v) especially vulnerable female applicants such as vulnerable women and their dependents subjected to extreme violence referred by the UNHCR (Women at Risk visa subclass 204).

Applicants in the various visa subclasses are typically subjected to health and character tests. With exception of visa class 202, refugees are also entitled to have their medical and travel expenses paid by the Australian government with full eligibility to settlement services once in Australia. Regarding applicants in visa class 202, entrants receive less government support and entitlements than other visa classes as it is expected their proposers will meet their support needs (e.g., cost of flight to Australia).

Australia has resettled 6.6 million people since World War II ended. Over 675,000 people have settled as humanitarian arrivals. The arrival of refugees to Australia came to prominence in the late 1970s and 1980s with the influx of ‘boat people’ from China, Vietnam, and Cambodia (Kinzie, Sack, Angell, Manson, & Rath, 1986). Through the early 1990s, Australia’s refugee population further diversified with the inclusion of Romanian, Turkish, and Bangladeshi peoples. From 1995,
coinciding with increasing conflicts in the Middle East and Afghanistan, refugee origins have expanded to encompass Afghans, Kurds, and Iraqis (CMY, 2010).

Australia’s intake of refugees and asylum seekers under its humanitarian assistance program is determined annually based on UNHCR assessments of global needs, the number of displaced individuals likely to require assistance, and the views of organisations and individuals in Australia. This factor makes Australia unique in that governments and their public can determine the makeup of refugees accepted to the program (DIAC, 2013). Currently, Australia has 13,500 places for refugees per annum, although according to the Department of Immigration and Multicultural Affairs (DIMA), Australia’s intake reached 14,444 in 2006. Among 44 industrialised countries that UNHCR includes in its trends analysis, in 2010, Australia ranked fourth behind USA, Canada and the UK, and eighth per capita behind Malta, Switzerland, Sweden, Norway, Liechtenstein, Luxembourg and Canada for refugee recognition and resettlement (Refugee Council of Australia, 2012). The majority of humanitarian entrants to Australia over the past five years have been SHP entrants. In 2007-08, the greatest numbers of refugees within the offshore program originated from Burma, Iraq, Afghanistan, Sudan, and Liberia. Although refugees from Africa make up to about 70% of Australia’s humanitarian intake, over the past few years, refugees from Asia (mainly Burma) and the Middle East have dominated intake statistics (DIAC, 2013).

Orientation, (re)settlement and integration to Australia

Australia’s Offshore SHP comprises the Australian Cultural Orientation Program (AUSCO), an orientation for humanitarian visa holders preparing to settle in Australia. This phase marks the beginning of settlement, and is delivered before entrants embark on their journey to Australia (Tipping, 2010). The five day course administered by The International Organization for Migration (IOM) aims to prepare visa holders for travel, enhance settlement prospects, and create a realistic expectation of life in Australia. It orients entrants to Australia’s government and laws, climate, values and gives practical advice around settling in, cultural adjustment, employment, banking, and services available such as welfare, health, or counselling. Separate orientations are offered to refugee youth. Prior to arrival, pre-departure checks are
also conducted with the aim of reducing medical problems and enhancing medical follow up. Upon arrival to Australia, entrants are offered settlement services and language education (DIAC, 2013). A range of non-government services also offer assistance (e.g., through church groups or charities).

Although settlement actually occurs in many developed countries, developing countries host the majority of the world’s refugees. In developing countries, refugees are often in impermanent arrangements, awaiting repatriation or return to homeland (Tipping, 2010). At this point, an important distinction should be made between ‘resettlement’ and ‘settlement’. Resettlement has been defined in many ways and is often operationalised according to the different intake criteria and policies of different settlement countries (Correa-Velez, Gifford, & Barnett, 2010). A commonly cited definition of resettlement refers to it as being “the organized programme involving the selection in a country of first asylum, transportation, and scheduled arrival in the country of settlement” (Valtonen, 2004, p. 70). In this way, refugee resettlement is a negotiated process, although parties are initially unequal. Immigration officials and resettlement bureaucrats make plans for refugees which dictate the migration process, including arrival and resettlement (Simich, Beiser, & Mawani, 2003).

Contrarily, settlement refers to “the activities and processes of becoming established after arrival in the country of settlement” (Valtonen, 2004, p. 70). The other implication is that resettlement may be a process that is time defined whereas settlement may represent an ongoing period where individuals begin to exercise and establish greater self-determination (Simich, et al., 2003), regardless of official planning and personal and social growth within a safe and stable context of possibility (Correa-Velez, et al., 2010). The settlement phase is where the present and much of the refugee research in developed countries occurs.

Often the resettlement stage is a period of adjustment and acculturation (Correa-Velez, et al., 2010). Acculturation involves decisions on integrating values from one’s home culture into life in a new culture (Selvamanickam, Zgryza, & Gorman, 2001). Acculturation is assisted by building links with one’s own cultural group, friendships, resiliency, freedom, and multiculturalism. Difficulties include racism, dealing with trauma, language, and negotiating identity in a new culture (Brough, Gorman, Ramirez, & Westoby, 2003). Similarly, becoming established is facilitated or hindered by both structural and individual factors related to past
experiences and present circumstances. Key structural factors include: the *social climate of the host community* (Ager & Strang, 2008; Pumariega, Rothe, & Pumariega, 2005), including living close to one’s ethnic community (Ager & Strang, 2008; Beiser, 2005); *peace and security* of the local area (Ager & Strang, 2008), with choice in housing (Ager & Strang, 2008; Porter & Haslam, 2005) and resources for achieving cultural and linguistic competency (Ager & Strang, 2008); a *supportive school environment* with opportunities to study and attain income from employment (Valtonen, 2004), being *settled or reunited* with other family members (Bean, Eurelings-Bontekoe, & Spinhoven, 2007) and general socially inclusion (Brough, et al., 2003; O’Sullivan & Olliff, 2006).

For refugee youth, individual factors might relate to dealing with those traumatic experiences described earlier so that acculturation can be better facilitated. Other factors encompass the speed at which they can become competent in the language of the host country (Chapman & Calder, 2002; Olliff, 2005); experiencing educational success (O’Sullivan & Olliff, 2006); living with supportive family members (Chapman & Calder, 2002; CMYI, 2006); feeling of belongingness to one’s ethnic community (Brough, et al., 2003; Lustig, Kia-Keating, Grant-Knight, et al., 2004), and being able to develop positive relationships with the broader host community (Beirens, Hughes, Hek, & Spicer, 2007; Pumariega, et al., 2005). Many young refugees live with long-term uncertainty about their future as they await immigration decisions (Anderson, 2004; Kohli & Mather, 2003). Individuals with refugee status have reported that friendship, employment, and increased proficiency in the host country’s language help to improve well-being (Wallin & Ahlstrom, 2005). Hence, there is increasing acknowledgment that the resettlement and settlement context through acculturative factors can influence psychological well-being (Porter & Haslam, 2005). It is less clear however to what extent these factors influence mental health in either negative or positive ways.

Despite its strict approach to asylum and detention, Australia is regarded as having one of the more progressive approaches to assisting humanitarian migrants in resettlement (Correa-Velez, et al., 2010). Australia’s approach to settlement aims not only to achieve full social, economic, and civic participation among newly-arrived communities, but also to promote their psychosocial health and wellbeing (DIMIA, 2003). Its program therefore is firmly aimed towards the successful integration of
refugees to Australian society. There are various definitions and policies around integration. The UN for example defines integration as “a mutual, dynamic, multifaceted, and an on-going process” while others define it as “the ability to participate fully in economic, social, cultural and political activities without having to relinquish one’s own ethno cultural identity and culture” or “a process by which settling persons become part of the social, institutional, and cultural fabric of a society (Breton, 1992, p. 74, as cited in Valtonen, 2004)”. For the refugee’s part, this necessitates some preparedness to adapt to the lifestyle of the host society without loss of cultural identity. For the host society, it requires a willingness for communities to be welcoming and responsive to meet the needs of a diverse population (Berry, Phinney, Sam, & Vedder, 2006).

Integration frameworks focus on housing, education, and employment (Tipping, 2010). These areas are seen as essential to successful integration but are mediated by (1) social connectedness (having bonds with family, friends, and neighbourhood); (2) social bridges (with other communities); and (3) social links (structures of the host state) (Tipping, 2010). While these are important, the key to successful integration is that barriers that undermine integration are removed. These include barriers around social exclusion, language, racism and discrimination. Australia’s approach to integration has changed historically and with increasingly diverse entrants, its integration programs have had to adapt (Spinks, 2010).

Beginning with ‘assimilative’ driven policies, these progressed to ‘integration’ and eventually ‘multiculturalist’ policies. The subtle changes in policy at different stages of Australia’s’ migration history have slowly acknowledged the need for migrants to retain their cultural identity (Tipping, 2010). From the 1980’s, a shift from what was considered ‘language diversity’ turned to multiculturalism – a melting pot of different cultures. At present, integration policies largely focus on the “the promotion of Australian ideals and values and about fostering tolerance, and cohesion” (Tipping, 2010).

Refugee youths and their resettlement and integration in Australia

According to the UNHCR (2003), almost half the world’s population of displaced persons and refugees are children and adolescents. This proportion though varies
depending on the region of conflict. In Central Africa for example, 57 per cent of refugees are children, whereas in Central and Eastern Europe, about a fifth are under the age of 18 (Lustig, Kia-Keating, Grant-Knight, et al., 2004). A growing proportion of those arriving to Australia as refugees and humanitarian entrants are young people however, with 74 per cent of new entrants over the period of 2005-2009, aged less than 30 years on arrival (Refugee Council of Australia, 2013.). In 2010–11, 51 per cent of Australia’s 12,527 humanitarian arrivals were under the age of 25 and twenty eight per cent were between the ages of 12-24 years. Continuing the recent overall trend of all refugee settlement to Australia, young people from Afghanistan, Iraq, and Burma represent the largest of the Humanitarian Program for the age group 12–24 years. Prior to this, Sudanese youth represented the largest group of youth humanitarian entrants (CMY, 2010). About 59% of these humanitarian arrivals are male, and 41% are female. Most of these youths (about a third) settle in the state of Victoria (DIAC, 2006), particularly around the greater Melbourne area (capital of Victoria). About 15% of refugee youths live in regional areas.

The pre-arrival experiences of humanitarian youth arrivals have diversified in recent years. Most young refugees have spent time in refugee camps, with about a third spending at least 2 years in a camp, a further 19% in camps for up to seven years, and a further 11% in camp for up to 12 years or more. A significant proportion of young refugees arriving to Australia have had little or no previous education. More than a third (34%) aged between 12–24 years arrive with six or fewer years of schooling. Of the 66% that arrive with seven or more years of education, this is usually interrupted, inadequate, or bears little resemblance to the Australian education system. Other young refugees spend significant periods of time, or were even born in third countries (e.g., Burmese born in Thailand or Afghani youths born or spent several years in Pakistan). Growing numbers of humanitarian youth arrivals have spent time in Australian Immigration Detention Centres (CMY, 2010).

Many young refugees come to Australia with their immediate or extended family, and others as unaccompanied minors or with nonparent carers, such as siblings. A small portion arrive through migration programs other than the SPH (e.g., on orphan or last remaining relative visa), but nonetheless are from refugee ‘source countries’, and therefore, likely to have experienced persecution or periods in refugee
camps. All young people who are settled through the SHP are likely to have endured any one or a number of traumatic experiences described earlier in this chapter.

There are many conceptualisations of the age range that determines ‘youth’. By western standards, youths are considered to be between 12 - 26 years of age. By other cultural standards, this could be extended to the age of 30 (Tipping, 2010). Moreover, while the adolescent to early adult transition is seen as a significant and individualised experience, this is not necessarily the case in other cultures, which may not even see adolescence as a significant stage, or marker of maturity (CMY, 2010).

Nonetheless, during the transition from adolescence to young adulthood, multiple transitions occur for young people. Adolescence is the phase of life for young people aged 12 to 19, or in some definitions, up to 25 (CMY, 2010). It is understood as a time where young people experience significant physical (including brain growth), psychological, and intellectual growth. These changes inform the development of a sense of identity, including sexual identity, independence, belongingness in a group or community, religious belief, relationships with peers and family, and the development of life goals (Erikson, 1968). The process of identity formation which is part of adolescence may be particularly complex for young people already affected by the overlay of the refugee experience, trauma experience, cultural adjustment and dislocation, loss of established social networks and the practical demands of resettlement (Refugee Resettlement Advisory Council, 2002). Thus, their vulnerability to psychological problems is higher than for other age groups (McGorry, 2002).

Young refugees often must negotiate education and employment pathways (many with a history of profoundly disrupted or no formal education), a new language and culture, make new friends, and navigate unfamiliar and complex social systems (such as Centrelink, Australian laws, public transport), while also negotiating individual, family and community expectations (CMYI, 2006). On the other hand, refugee youth often learn English and adapt to life in Australia more quickly than members of their parents’ generation. Some studies have highlighted the significant representation of refugee youth who are providing care to family members (e.g., siblings or parents) (Moore & McArthur, 2007), with young males more likely to be ‘hidden’ carers. This additional pressure on young refugees has been linked to a stronger sense of responsibility to care for kin within families of migrant or refugee
backgrounds (Becker et al., 2003), and is identified as a concern because families from ethnic backgrounds are less likely to access services that support people with a mental health problem (Ramanathan & Hickman, 2007).

Moreover, it has been shown that some young refugees experience shame when asking for help due to stigma from their communities for ‘failing’ to adequately fulfil their familial expectations and duties (CMY, 2010). Having grown up in cultural contexts where the wellbeing of the whole family and community is prioritised above individual aspirations, refugees often juggle the expectations of family and their cultural community with those of mainstream Australian society, which places high value on individual choice in terms of study, career and relationships. Young refugees are often the ‘front line’ in the settlement process, having to act as brokers (including interpreters) between services and systems and their parents and community members. This adds to the emotional vulnerability of this subgroup which already includes reduced opportunities to participate in social activities, less money, reduced opportunities to form meaningful intimate relationships, and an inability to fulfil academic requirements (Moore & McArthur, 2007). Finally, young refugees face additional challenges of developing a bi-cultural or multicultural identity, and may find that the general expectations of Western society, where young people move to independence to pursue individual goals, is not always appropriate for them. Those who have experienced trauma or loss may find their capacity to achieve what are considered normal development goals (e.g., positive sense of self) is diminished by their trauma experiences (Silove, 2005).

Young refugees possess a range of resettlement needs that are considered within the context of these traumatic experiences. With significant overlap with general migrant groups, issues confronted by young refugees include: (i) learning English, (ii) restarting schooling through a an unfamiliar mainstream school or finding work, (iii) adjusting to a new and potentially hostile culture, (iv) separation from the extended family, (v) navigating unfamiliar systems and environment, and (vi) forging new social networks. Regarding language and education, in Australia, the States vary on education pathways for refugees. In Victoria, school aged refugees enter the mainstream schooling system (or employment system if old enough) via 6-12 months of English Language School (also known as Intensive English Centres). Young refugees of post-compulsory school age are able to access free English tuition through
Adult Migrant Education Program (AMEP) providers. Young refugees often find it difficult to access appropriate education and training pathways, particularly as their previous education may have been disrupted or even non-existent (CMY, 2010). Pressure to leave school and take up work, or to work part-time, has been found to be high for young people. They often feel responsible for helping to repay family debt and may themselves send money overseas to support family and friends, and assist further family members to migrate (CMY, 2010).

The ecological perspective is useful in understanding the multiple pressures young refugees’ experience. These include individual challenges, as well as those that come from family, school, peers, and the community. Individually, refugees may experience a range of emotions that arise from the effects of torture or trauma (e.g., depression, anger, nightmares, difficulty making meaningful relationships), in addition to coping and adapting to a new life in Australia and searching for their own identity within different cultures. Familial challenges such as inter-generational conflict due to changing expectations and reversal of roles, changes in family composition and dynamics, and guilt about family members left behind and responsibility for them, can significantly impact on attachment and perceived family support. Indeed, are often the most powerful factors in successful integration (CMY, 2010; Weine, 2008).

Young refugees’ resettlement experiences will also depend on how they negotiate the expectations and value systems of both their cultural community and within the broader host community. Whether young people feel accepted and able to attain a sense of belonging and identity is moderated by such factors as racism and stereotyping, access to culturally appropriate sport and recreation opportunities, positive dialogue between young people and community and opportunities for meaningful participation. Such social capital is a key factor for young refugees becoming established in the new country (Beirens, et al., 2007; Woolcock, 1998). Successful resettlement is underpinned by opportunities to participate and belong in families, peer groups, school, ethnic, and broader communities (Correa-Velez, et al., 2010).

It is likely that diverse experiences exist among young refugees in Australia and resettlement offers refugee youth a realistic opportunity to achieve full human potential (Correa-Velez, et al., 2010). Yet, the tasks of resettlement pose immense
challenges and there is mounting evidence that the resettlement context can have equal if not greater negative impact on wellbeing as the pre-migration context (Montgomery, 2010; Porter & Haslam, 2005a). In sum, refugee youth are at risk of developing psychopathology or maladaptive behaviours in response to both pre-migration traumatic exposure and the demands of resettlement (Pumariega, et al., 2005).

Summary and conclusions

This chapter has provided a context for examining psychological well-being in refugees, particularly younger refugees, who because of their development stage are more vulnerable. The chapter presented a widely accepted definition of a ‘refugee’ and its distinguishable terms and an overview of the current socio-political circumstances that underpin trauma experience, forced migration to Australia and mental health in the (re)settlement period. After identifying a specific group of refugees requiring attention, namely young and newer populations, the next chapter will review the empirical literature on the psychological well-being of this vulnerable subpopulation.
CHAPTER 3: LITERATURE REVIEW ON THE PSYCHOLOGICAL WELL BEING OF YOUNG REFUGEES

Overview

Having provided a context and a description of the processes by which young refugees resettle in Australia, this chapter will review the literature pertaining to the mental health and psychological well-being of young refugees. This review will highlight key themes observed in the literature and identify areas where more empirical investigation is needed, consolidating the rationale for this thesis.

The literature described in this chapter was gathered using the following databases: PsycINFO, Medline, Web of Science, Scopus, CINAHL (EBSCO), and PubMed. Search terms using a combination of single and combined descriptors included: refugee (or asylum seeker); young (or youth or child or adolescent); mental health (or psychopathology or disorder); psychological well-being; trauma; refugee and PTSD (or post traumatic stress or depression or anxiety or somatization or somatisation); stress and refugee; cultural differences (or transcultural); Horn of African (or Ethiopia or Eritrea or Somalia); Sudan (or Sudanese); Karen (or Karen State or Burma); Togo (or Togolese); resilience; and quality of life (or life satisfaction. Database searches were restricted to articles published from 1990-2012 and those published in English.

The chapter will review the mental health literature in young refugees in accordance with the phased based (pre-, peri-, and post-migration) organising framework adopted in this research, and used previously across other refugee studies and reviews (Berman, 2001; Papadopoulos, 2001). The phases will be used to organise the mostly empirical literature across two broad areas – the psychological sequelae of the refugee experience, and the risk and protective factors implicated in mental health outcomes. Due to the limited research specifically focused on a ‘youth’ sample, this review draws from both child and adolescent as well as adult literature where appropriate. A review of the former is deemed suitable for the purposes of
describing youth refugee mental health given that some authors in this literature consider children and adolescents to comprise up to the age of 25 (Bronstein & Montgomery, 2011; Hart, 2008).

The chapter will conclude that a bourgeoning body of research now exists in refugee mental health. It will however, also show that the research is less clear about the mechanisms by which risk and protective factors exacerbate or temper the effects of trauma and migration experience, and the role that culture has in the mental health of refugees. These conclusions will shape the investigations of this thesis by building a rationale for the extension of knowledge beyond PTSD and psychopathologic outcomes, to include risk as well as strength based factors, and a cultural/societal context. A need for a mixed methodological approach will also be identified.

**Existing literature reviews**

The data base search in this thesis yielded several review and meta-analytic papers in both child/adolescent and adult refugee populations. These include those by Lustig, Kia-Keating, and Knight et al. (2004), Fazel, Wheeler, and Danesh (2005), Porter and Haslam (2005), Ehntholt and Yule (2006), Lau and Thomas (2008), Davidson, Murray, and Schweitzer (2008), Steel Chey, Silove, Marnane, Bryant, and Van Ommeren (2009), and the latest, Bronstein and Montgomery (2011). Earlier reviews can be found by referring to Keyes (2000), Rousseau (1995), and Jensen and Shaw (1993). It is important to acknowledge that the literature review reported in this chapter utilises the structure and content of a review published earlier by the author in the course of her candidature (Lau & Thomas, 2008) as its basis, although it has been revised to incorporate literatures to date. The reviews outlined above, which comprise literature reviews, systematic reviews, and meta analyses will be described throughout the chapter, but the present chapter attempts to integrate and extend them by including literature to date, particularly regarding resilience and protective variables, and where possible, literature pertaining to the groups investigated in this thesis (i.e., Horn of African, Sudanese, Karen, and Togolese). It should be noted however, with exception to Sudanese youth refugees, and to a lesser degree, Horn of African youths, the literature search failed to yield any empirical studies examining Karen and Togolese
refugees. The need to explore ‘newer’ populations and an opportunity to compare these groups to more established ones is therefore identified by the current thesis.

*The psychological sequelae of the ‘refugee experience’*

There is considerable literature focused on the mental health of adult refugees (Dybdahl, 2001; Hicks, Lalonde, & Pepler, 1993; Hyman, Vu, & Beiser, 2000). Unfortunately, the quantum of research directed specifically towards the mental health of child, adolescent, and youth refugees has not matched those investigating adult refugee populations (Dybdahl, 2001; Hicks, et al., 1993; Hyman, et al., 2000). This is surprising given that half the world’s refugee population comprises children and adolescents, with a further high proportion comprising young adults (Cole, 1998; UNHCR, 2002; Westermeyer, 1991). The unmatched investigation may be due to difficulties associated with population access and engagement, systematic sampling, cultural and language barriers, limited culturally and age validated assessments, and wariness of parents and participants to trust researchers (Richman, 1993; Silove et al., 1997).

The potentially traumatic events (PTEs) experienced by young refugees were described in the previous chapter. These experiences render them extremely vulnerable to psychological disorders, not only because of traumatic stress exposure itself (Fazel, et al., 2005), but also because of their incomplete biopsychosocial development, dependency, inability to understand certain life events (Kocijan-Hercigonja, Rijavec, Marusic, & Hercigonja, 1998) and underdevelopment of coping skills (Ajdukovic & Ajdukovic, 1993). The majority of research unsurprisingly has therefore focused on psychological symptoms arising from PTEs, with predominant focus on Posttraumatic Stress Disorder (PTSD) and/or its symptomatology (Richman, 1993; Weine & Henderson, 2005). Although PTSD is usually assessed in the resettlement or post-migration stage, the events that occur leading up to displacement and flight and subsequent settlement in the post-migration period, often occur in the pre-migration phase. The pre-migration setting is characterised by social upheaval (Rambaut, 1991), limited access to educational and social opportunities, threats to safety and family’s safety, and the experience of PTE’s (Lustig, Kia-Keating, Grant-Knight, et al., 2004).
The impact of pre-migration trauma: PTSD and symptomatology

Post Traumatic Stress Disorder (PTSD) refers to a configuration of symptoms experienced after a traumatic event, characterised by re-experiencing phenomena (e.g., flashbacks), heightened arousal (e.g., physical arousal, startle response), and avoidance behaviours (e.g., active avoidance of reminders, withdrawal). It is classified as an anxiety disorder, which may be acute or chronic, and of short or long term duration (Cunningham & Cunningham, 1997) (see Diagnostic Statistical Manual IV for PTSD criteria). Young refugees who present with PTSD may exhibit in addition to DSM-IV criteria, symptoms of confused and disordered memory about events, repetitive play themes related to trauma, personality changes, imitation of violent behaviours, pessimistic expectations, complaints of physical discomforts, aggression, conduct problems, and guilt over one’s own survival (Hicks, et al., 1993).

Despite controversy surrounding the application of PTSD to young refugees (e.g., the diagnostic approach ‘medicalises’ and ‘Westernises’ emotional disturbance and ‘pathologises’ perfectly normal reactions to abnormal situations), investigations across various refugee countries of origin have shown that trauma symptomatology is not only common in children, adolescents, and young adults, but also that studies documenting these effects are abundant (Lustig, Kia-Keating, Grant-Knight, et al., 2004).

PTSD symptom and prevalence studies

Though not identified by this literature search, the pioneering work of Kinzie, Sack, Angell, Manson, and Rath (1986) is cited frequently throughout the recent literature. In this classical study, 46 Cambodian refugees resettled in the United States (US) were interviewed following exposure between the ages 14-20 (in 1975-1979), to starvation, forced labour, separation, beatings, and executions arising from the Pol Pot regime. Almost half the participants interviewed exhibited PTSD symptoms alongside less effective adaptation. Over half also experienced significant depression, with family separation a significant factor in reported symptomatology. In a similar but
larger study with 209 Cambodians aged between 13 and 25 resettled in the US, Sack, McSharry, Clarke, Kinney, Seeley, and Lewinsohn (1994) found an 18% prevalence rate of PTSD and an 11% rate of depressive disorder. High rates of psychiatric disorder were also observed in participants’ parents, with 53% of mothers reporting symptoms consistent with PTSD, and 23% consistent with depression. Amongst fathers, 29% indicated PTSD symptomology and 14% indicated depression.

More recently, de Jong, Komproe, Van Ommeren, El Masri, Araya, Khaled et al., (2001) used the Composite International Diagnostic Interview (CIDI), to determine life time prevalence rates of PTSD among Algerian, Cambodian, Ethiopian, and Gaza strip refugees. This study is unique in that it was conducted in non-western resettlement countries. Prevalence rates for PTSD of 37%, 28%, 16%, and 18% among these respective groups of refugees were found. It was concluded that contextual differences in studies of trauma and human rights violations play a crucial role in PTSD rates (de Jong, et al., 2001).

Consistent with the cultural context findings of de Jong et al. (2001), there have been many investigations of single refugee cultures that support the fact that pre-migration trauma plays a damaging role in the determination of mental health disorder. For example, such findings have been established cross culturally in children, youth, and adults from regions including: Afghanistan (Mghir, Freed, Raskin, & Katon, 1995); Bosnia (Geltman, Augustyn, Barnett, Klass, & McAlister Groves, 2000; Papageorgiou et al., 2000; Weine et al., 1995); Cambodia (Sack, Seeley, & Clarke, 1997); Chile (Hjern, Angel, & Hoejer, 1991); Croatia (Ajdukovic & Ajdukovic, 1993); Central America (Arroyo & Eth, 1985; Espino, 1991; Rousseau, et al., 1997); El Salvador and Nicaragua (Arroyo & Eth, 1996); Lebanon (Saigh, Fairbank, & Yasik, 1998); the Gaza Strip (Thabet & Vostanis, 2000); Iraqi-Kurdistan (Ahmad, Mohamed, & Ameen, 1997); Israel (Laor, Wolmer, Mayes, & Gershon, 1997); Iran (Almqvist & Brandell Forsberg, 1997; Almqvist & Broberg, 1999); Rawanda (Dyregrov, Gupta, Gjestad, & Mukanohele, 2000); Kuwait (Nader, Pynoos, Fairbanks, Al-Ajeel, & Al-Asfour, 1993); Somalia (Ellis, MacDonald, Lincoln, & Cabral, 2008); Sudan (Paardekooper, de Jong, & Hermanns, 1999); and Tibet (Servan-Schreiber, Le Lin, & Birmaher, 1998). Newer refugee populations that have emerged from recent global conflicts, such as the Karen and Togolese cultures are yet to be explored, and the search of empirical literature failed to yield any empirical
studies relating to these groups. It is important therefore that the present research should also aim to investigate the mental health needs of these newer refugee populations.

While there is substantive evidence in child and adult literatures of the validity of the PTSD construct in different cultures (Davidson, et al., 2008), the study by de Jong et al. (2001) is representative of only a handful of studies that compare mental health outcomes across different refugee cultures. These include the study by Rousseau, Drapeau, and Corin (1997), which showed that higher levels of trauma exposure in families was more related to family conflict and depression in Central American refugees whereas it was associated with less parental depression in South East Asian refugees. A study by Arroyo and Eth’s (1996) showed that Latin American young refugees displayed more conduct and academic problems than South East Asian refugee children.

In an adult population, Gerritsen, Bramsen, Devillé, Van Willigen, Johannes, Hovens, and Van der Ploeg (2006) investigated the prevalence of physical and mental health problems among older adult Afghan, Iranian, and Somali asylum seekers (n=232) and refugees (n=178) living in the Netherlands. They found asylum seekers rated their physical health more poorly than refugees, though over half experienced at least one chronic physical health problem. Similarly, although psychological symptoms were high across both groups, more asylum seekers experienced PTSD, depression and anxiety (rates were 28% vs 11% for PTSD; 68% and 40% for depression/anxiety). Participants from Afghanistan and Iran displayed higher risks for PTSD and depression/anxiety. Although Gerritsen et al. (2006) did not discuss in any detail the factors attributable to these differences, it was suggested that a selective Iranian population with multiple trauma histories could explain these higher rates (Gerritsen, et al., 2006).

Using a sample young first and second generation adolescents and refugees (aged 11-20) settled in Finland, Liebkind and Jasinskaja-Lahti (2000) compared these migrants with those from the Soviet Union, Turkey, Somalia, and Vietnam. Most indices of psychological well-being were negatively related to perceived discrimination. Although no group differences were found for acculturation stress and psychosomatic symptoms, most cultural groups differed on psychological well being, parental support, family related values, and perceived discrimination. For instance,
anxiety was higher for Russian, Turkish, and Vietnamese migrants than for Somali migrants. Vietnamese migrants also reported higher levels of depression than Somali migrants. In accordance with expectations concerning cultural differences, Turkish and Russian migrants had a higher sense of mastery than Vietnamese and Somali migrants, and Russian migrants displayed more behavioural problems than the Vietnamese. Liebkind and Jasinskaja-Lahti concluded that further research is needed to specify the particular acculturation profiles of different cultural groups to find more culture-sensitive and contextual explanations for group differences.

Given that the studies by Rousseau (1996; 1997) were conducted with children, while the studies by Gerritsen et al. (2006) and Liebkind and Jasinskaja-Lahti (2000), were conducted with older adults, it is unclear whether the mental health profiles of youth refugees living in Australia vary as a function of culture differences. Consistent with the conclusion of Liebkind and Jasinskaja-Lahti, there is great value in determining how post-traumatic symptomatology is influenced by different cultural or contextual influences (Rousseau, 1995) in a youth refugee population in Australia.

Although the studies described so far highlight the direct link between trauma exposure and the development of PTSD symptomatology, there is mixed, and sometimes conflicting evidence regarding the prevalence rates of PTSD (and depression) (Fazel, et al., 2005). Prevalence rates in the literature have ranged between 0-99% for PTSD, while depression rates have ranged between 3-86% (Steel, et al., 2009). At the lower end, these rates suggest that mental health problems could be dangerously rejected, and at the higher end, could suggest inappropriate conclusions about psychiatric morbidity and disability (Fazel, et al., 2005). Reasons attributed to the large variation in prevalence rates include sample differences (e.g., community vs clinical), sample characteristics (e.g., age, culture, sample size, sample bias, variation in trauma exposure), methodological factors (e.g., length of time since political violence ended, length of stay in a host country; different assessment measures and cut off scores), study design (e.g., longitudinal vs cross sectional) and contextual factors (e.g., attitudes of host society, support in the resettlement country) (Fazel, et al., 2005; Lustig, Kia-Keating, Grant-Knight, et al., 2004; Steel, et al., 2009).

To date, there have been two high quality papers published that have attempted to clarify prevalence rates in PTSD and depression. The first, published in
The Lancet by Fazel et al. (2005), systematically examined the prevalence of serious mental disorder in 7000 refugees resettled in Western countries from Asia, Former Yugoslavia, the Middle East, and Central America. Using rigorous criteria to reduce the number of papers reviewed to twenty eight eligible surveys (e.g., excluded self report studies, and clinical samples), substantial differences across sampling and methodologies were found. Separating their papers into those with sample sizes of less and greater than 200, Fazel et al. reported that PTSD prevalence in adult refugees is around 9%, while the depression rate for adults is 5% and 4% for anxiety. Regarding child refugees, the PTSD prevalence rate was estimated to be 11%, with a range of 7-17%. For children, psychological problems were three times higher than in the general population. According to Fazel et al., smaller sample sizes and less rigorous study designs tended to yield higher prevalence rates across both disorders.

Fazel et al. (2005) concluded that refugees resettled in Western countries were about ten per cent more likely to experience PTSD symptoms than the general population of those countries, and that an overlap in depression and anxiety was probable. They did note, however, limitations to epidemiological studies such as their own in that psychiatric disorders are difficult to ensure because there is substantial heterogeneity in refugee experiences and in the settlement countries themselves. In addition, the Western emphasis on interview measures, inclusion of studies carried out over decades, and substantial sampling and methodological variation also limit findings regarding prevalence. Nonetheless, Fazel et al.’s (2005) review represents one of the most accurate studies in prevalence. Unfortunately, although the weighted mean age for adult studies was 27 years, only prevalence rates for child and adult groups were reported, thereby leaving unclear the prevalence rates expected for a youth sample. Moreover, a comparison of rates across cultures was not reported in this study.

The second high quality review, published in The Journal of the American Medical Association (JAMA), was that conducted by Steel and colleagues (2009). This study is the first, and to date the largest, systematic review and meta-analysis based on epidemiologic surveys of refugee and post conflict mental health (Steel, et al., 2009). Again using rigorous criteria to select studies for their review (e.g., studies where \( n > 50 \); studies reporting only PTSD, depression or both; adults only), the study yielded 161 articles reporting on 181 surveys of 81,866 adult refugees across 40
countries. With the aims of addressing the prevalence variation in PTSD and depression and determining the relative influence of methodological factors (e.g., sample characteristics, diagnostic measures) and substantive factors (i.e., torture and other PTEs) accounting for PTSD and depression, it was found that methodological factors, particularly non-random samples, self-report measures and small samples, significantly affected these outcomes (Steel, et al., 2009).

Controlling for the methodological influences, Steel et al. (2009) found that torture which was found to be endemic at 21% across 81 surveys, was the strongest predictor of PTSD ahead of other PTE’s. The cumulative exposure of other PTEs was the strongest predictor of depression. Such ‘dose-effect’ findings in PTSD and depression are discussed in later paragraphs. PTSD prevalence using the more methodologically rigorous surveys yielded a range of 13-25%. This prevalence range was consistent with the 20% prevalence rate for mental disorders reported by WHO in societies exposed to humanitarian emergencies (Steel, et al., 2009). Limitations reported in this study included the lack of assessment of culturally valid measures and the reliance on self-reported torture experience. Again, it is also unclear whether the prevalence statistics cited in Steel et al. (2009) generalise to a youth population in Australia. Nonetheless, the findings of both Fazel et al. (2005) and Steel et al. (2009) add great weight to the deleterious impact of conflict related violence and displacement on mental health (Tipping, 2010).

There have been three recent comprehensive reviews regarding children and adolescents (Bronstein & Montgomery, 2011; Ehntholt & Yule, 2006; Lustig, Kia-Keating, Grant-Knight, et al., 2004). First, in their exploration of stress reactions, interventions, and ethical considerations in child and adolescent refugees, Lustig et al. (2004) reported similar findings to those of adult reviews. That is, conflict-related exposure was found to exert a significant influence on mental health. However, the research evaluated by Lustig et al. pointed to a variety of factors (that are described later) which mediate such stress reactions. Lustig et al. (2004) concluded that multiple socio-ecological levels of research and intervention are needed, particularly for vulnerable refugee groups such as unaccompanied minors (Lustig, Kia-Keating, Grant-Knight, et al., 2004). The issues described in this paper are consolidated in the White Paper from the National Child Traumatic Stress Network Refugee Trauma Task Force in the US and have subsequently formed guidelines related to child and
adolescent refugee trauma. Second, Ehnholt and Yule (2006) reviewed the issues associated with the assessment and treatment of refugee children and adolescents. In summarising the literature, these authors also found that children and adolescents are exposed to multiple traumatic events and severe losses, the difficulties of which continue with ongoing stressors in the host country.

Third, in addressing the limitations of previous reviews (i.e., these authors claimed earlier reviews did not use systematic reviewing processes and did not establish mental health prevalence in children), Bronstein and Montgomery (2011) set out to systematically review the evidence base for psychological distress in refugee children in Western countries. In this review, Bronstein and Montgomery (2011) utilised the standardised Strengthening the Reporting of Observational studies in Epidemiology (STROBE) process to evaluate the empirical literature. Consequently, their review allowed for the inclusion of studies using self-report measures, which they argued are potentially more accurate reporting measures for different cultural groups. In this review, a total of 30,003 children resettled in Canada, Denmark, the Netherlands, UK, Sweden and the USA were examined.

The review incorporated data from different regions of Sub-Saharan and East Africa (58%), the Middle East (21%), Europe (11%), Asia (6%), and a variety of stateless and unidentified countries. Using widely published papers, these authors found prevalence rates for PTSD between 19-54% (beyond norms for other child trauma populations), and between 3-30% for depression. Bronstein and Montgomery concluded that: (i) cumulative adverse pre-migration experiences predict internalising and externalising disorders, PTSD and depression; (ii) pre-migration correlate factors to psychological distress include older age, female gender, separation from parents, and unaccompaniment; (iii) violent death of family members is predictive of PTSD; (iv) post-migration factors have a direct relationship with PTSD and depression; and (v) post-migration correlates of distress include ‘uncertainty’ regarding the granting of refugee status, discrimination, restrictions in living arrangements related to internal displacement, and language difficulties. In their concluding remarks, Bronstein and Montgomery recommended that with a focus on psychological distress dominating the literature, more research relating to resilience and coping factors was needed.
Studies investigating the frequency and type of PTEs

Studies have also investigated the impact of trauma before migration, in relation to its type, frequency, and duration (Athey, 1991; Berman, 2001; Mghir, et al., 1995). These investigations provide evidence that the greater the nature and extent of exposure, the poorer the psychological outcome in terms of onset and severity of PTSD symptoms (Espino, 1991; Papageorgiou, et al., 2000). As described earlier, the systematic review and meta-regression conducted by Steel et al. (2009) showed that a dose dependent relationship exists between PTE’s and PTSD and depression. That is, although more associated with depression, a cumulative effect for exposure events was observed for both PTSD and depression.

In an earlier study by Steel, Silove, Phan, and Bauman (2002), long term effects of trauma were assessed on mental health outcomes in Vietnamese refugees in Australia. Trauma was found to be a significant predictor in PTSD symptoms and reduced functioning, and although symptoms did decline with time, the risk of mental health problems remained in people exposed to four or more traumatic events.

Among the 34% of adolescent and young adult refugees from Afghanistan who met criteria for PTSD, major depression or both, Mghir et al. (1995) similarly demonstrated an association between the total number of events experienced and the presence of these disorders. Drawing from a displaced and war exposed population, Macksoud and Aber (1996) examined the relationship between the number and type of war traumas and psychosocial development among 224 Lebanese youth aged between 10 and 16. These investigators assessed ten categories of war exposure. As predicted, the number and type of traumatic exposure were positively related to PTSD symptoms. Young people exposed to multiple traumas (e.g., shelling, combat) and those who were bereaved, victimised or had witnessed violent acts, showed greater PTSD symptoms than those who had not experienced these events. Moreover, depressive symptoms were more evident in those who had experienced traumatic separation from their parents and displacement than those who remained with their parents (Macksoud & Aber, 1996).
Similarly, Almqvist and Brandell-Forsberg (1997) investigated whether the amount of trauma exposure is related to the prevalence and stability of PTSD over time. Whilst finding it is possible to diagnose PTSD during initial stages of assessment and one year later, these authors also found that a fifth of children directly exposed to organised violence and persecution (e.g., through assault on parents or bomb attacks within 50 metres) were at risk for developing chronic states of PTSD. Heptinstall, Sethna, and Taylor (2004) also found that the number and nature of traumatic events (i.e., death of family members or witnessing someone be killed, tortured or injured) experienced by children in the country of origin predicted higher PTSD. Together, these studies indicate that not only does more frequent exposure increase risk for disorder, but the specific type of trauma and its proximity is also important in predicting the onset and duration of PTSD and other psychopathology.

Further support for studies which show that the type of trauma experienced is important, comes from studies investigating substantive and interpersonal forms of trauma such as rape or torture (Steel, et al., 2009). As seen in Steel et al’s (2009) review of published torture studies, this factor predicted PTSD more strongly than other PTEs. Some authors have stated that the perception of threat, the actual threat to life and the level of personal involvement are crucial components to understanding why such events are associated with higher psychological risk (Ehntholt & Yule, 2006; Momartin, Silove, Manicavasagar, & Steel, 2003).

The experience of direct combat by a child or young refugee can also place them at greater risk for experiencing significant PTE’s such as rape, torture, war injury, thus increasing severity of PTSD, depression, anxiety, and substance abuse (de Silva, 1999; Lustig, Weine, Saxe, & Beardslee, 2004). Among child soldiers, tangible losses such as the loss of home, family and friends, often coincide with a loss of moral perspective. Unfortunately, the length of time engaged as a child soldier exacerbates risks for these young refugees making recovery harder to achieve (Boothby, Upton, & Sultan, 1991).

To investigate how traumatic exposure is understood across pre-, peri-, and post-stages, Sinnerbrink and colleagues (1997) examined the relationship between exposure to violence and mental health outcomes in Khmer adolescents in the USA. A quarter of their sample partially or fully met criteria for PTSD, with the number of violent events experienced predicting PTSD and level of functioning. Not only was
pre-migration exposure predictive of PTSD, the number of violent events exposed to across participants’ lifetime (i.e., time in Cambodia as well as resettlement time US) more strongly predicted PTSD and level of functioning (Sinnerbrink, et al., 1997). Investigating Khmer adolescent refugees exposed to community violence, Berthold (1999) also noted the impact of multiple traumas before and following resettlement in the US on PTSD. These findings are noteworthy as they demonstrate the cumulative effect of trauma into the resettlement period, and its predisposing features to future distress and function (Berthold, 1999; Sinnerbrink, et al., 1997). Finally, the association between severity of exposure in terms of frequency and proximity of experienced events and the presence of PTSD in children and adolescents has been supported in different cultures including Bosnian (Papageorgiou, et al., 2000); Vietnamese (Mollica, Poole, Son, & Murray, 1997); Cambodian (Sack, Clarke, & Seeley, 1996); Palestinian (Garbarino & Kostelny, 1996a; Thabet & Vostanis, 1999), Middle Eastern (Montgomery, 1998) and Central American refugees (Espino, 1991).

**Longitudinal and prospective studies**

Although underrepresented in the literature, longitudinal and prospective studies provide good insight into the course of PTSD and long term mental health effects of trauma, sometimes extending well into the settlement period (Tipping, 2010). The longest of follow up studies have been conducted by Kinzie and colleagues, with their original sample of Cambodian adolescents (Kinzie, 1988; Kinzie, Sack, Angell, Clarke, & Rath, 1989; Kinzie, et al., 1986). In the initial study, 50% of the 40 Cambodian refugees who had been imprisoned for up to two years in concentration camps and exposed to massive trauma during the Pol Pot regime, met criteria for PTSD, just over half also meet criteria for major depression.

Subsequent 3 year follow up of thirty of the original participants by Sack, Clarke, Him, Dickason, Goff, Lanham, and Kinzie (1993) revealed that although depressive symptoms had diminished, 48% of participants still exhibited symptoms meeting the criteria for PTSD. Participants with poorer PTSD outcomes also showed poorer social adjustment. In the subsequent 6 year follow up, 38% still exhibited PTSD criteria, although there was a reduction in the rate of depression (Sack, et al., 1993). Twelve years after the initial study, 35% of subjects still exhibited criteria for
PTSD and 14% had depression (Sack, Him, & Dickason, 1999). Of the whole sample, over twelve years, 56% had endorsed PTSD at some point through follow up, suggesting a variable onset and course of trauma related symptomatology.

These authors add increasing empirical support to the idea that PTSD and poor adjustment in young refugees can persist well into later adulthood. They also noted however, along with the prevalence of depression, the intensity of PTSD symptoms tend to diminish over time. Where depression was initially shown to coexist with PTSD symptoms, depressive symptoms had reduced substantially after six years. Such findings distinguish PTSD as a direct manifestation of trauma, contrary to the result of resettlement stress, which is often attributed to depression (Sack, et al., 1993; Sack, et al., 1999). Despite the persistence of PTSD, participants in Sack et al’s. (1999) study were adaptive, suggesting that time can not only be a powerful healer, but also, the focus on psychopathology can at times be misleading (Tipping, 2010).

In a more recent 3 year follow up of Bosnian adult refugees originally living in a Croatian refugee camp, Mollica, Sarajlic, Chernoff, Lavelle, Vukovic, and Massagli (2001) tracked the influence of migration to another region on the course of depression, PTSD and disability. Forty five per cent of the original respondents who met DSM-IV criteria for depression, PTSD, or both continued to experience these disorders. Sixteen per cent who were asymptomatic later developed one or both disorders. Their analysis revealed co-morbid depression and PTSD and to a lesser extent comorbid disability at initial and follow up time points. Males, older age and isolation from family were associated with increased mortality. Mortality and emigration did not affect PTSD and depression (Mollica, et al., 2001). These findings support those of Kinzie (Kinzie, Sack, Angell, Clarke, & et al., 1989; 1986) and Sack et al., (Sack, et al., 1993; 1999) in that early diagnosis can predict chronic psychopathology and illness. Almqvist and Broberg (1999) assessed the prevalence of PTSD in Iranian children following two and a half years of resettlement in Sweden. For a fifth of children previously exposed to trauma, PTSD diagnoses remained stable. Supporting the argument that PTSD can be enduring, these authors also remarked on the problem of research with minors, which relies heavily on parental interviews for data which can underestimate symptoms in children (Almqvist & Broberg, 1999; Geltman, et al., 2000). Regarding the long-term effects of trauma, age
at the time of traumatic experience does not appear to influence its persistence (Dreman & Cohen, 1990).

Lie (2002) also conducted a 3 year follow up of refugees resettled in Norway. With a large original sample of 462, 240, 52% of these were followed up at three years. These authors found that symptoms of depression and anxiety remained similar over time, whereas PTSD symptoms significantly increased. A background of life threatening pre-trauma, long term exile conditions, and stressors in resettlement were identified as multifactorial risk factors in the determination of psychological disorders (Lie, 2002). Hauff and Vaglum (1995) similarly followed up Vietnamese refugees in Norway but found no decline in psychological distress, with almost one in four of the original \( n=145 \), likely to be experiencing a psychiatric disorder, usually depression. Risk factors identified by these authors included being female, long term separation from family, extreme trauma in Vietnam and negative life events in Norway.

Together, these studies provide evidence that many refugees, even with the passage of time, can continue to endure psychological symptoms (Ehntholt & Yule, 2006). As many of the authors and studies described above note however, there are methodological limitations which restrict the generalisability of findings. These include small sample sizes and large attrition rates, changes in the instruments and diagnostic standards over time (Kinzie, 1988; Kinzie, et al., 1986; Rousseau, Drapeau, & Rahimi, 2003; Sack, et al., 1993), reliability of parent reports, Western and etic (outsider) constructs, reducing cultural suitability (Rousseau, et al., 2003); and potential treatment received over time by respondents (Mollica, et al., 2001). Some of these are indeed also problems related to cross sectional designs.

On the other hand, it is important to note that there are longitudinal studies which have showed contrary effects in mental health over time. Rousseau, Drapeau, and Rahimi (2003) followed up \( n=57 \) early to late adolescent Cambodian refugees, exposed to refugee camps and parental trauma, resettled in Quebec, Canada. Their study explored the relationship between psychiatric symptoms and social adjustment over time, uniquely, with a Canadian non-refugee adolescent control group. Seventy six refugees were initially assessed and re-assessed at two and four years later. Behavioural and emotional symptom profiles were similar across both groups, with slightly less risk taking was observed in the refugee group. These authors concluded that a paradox exists in cross sectional studies between psychiatric symptoms and
level of adjustment to new culture and society (Rousseau, et al., 2003), in that South East Asian refugees functioned well despite experiencing high levels of psychological symptoms. These authors cautioned against the dangers of pathologising the consequences of extreme human experiences, whilst at the same time, not minimising the impact of these collective trauma experiences.

Similarly, the Refugee Resettlement Project by Beiser and Hou (2009; Beiser & Hou, 2006) attests to the need to be cautious in relying on sole outcome studies focused on the trauma-PTSD relationship. This project is a 10 year longitudinal study (1980-1990) examining mental health in South East Asian refugees in Canada. In addition to exploring cultural idioms of distress, this project assessed depression, anxiety and somatisation. At 10 year follow up, although depression at the initial assessment predicted depression ten years later, the rate of depression at the 10 year mark in this refugee group was actually lower than that of the general Canadian population (Beiser & Hou, 2001).

Becker, Weine, Vojvoda, and McGlashan (1999) also investigated the psychiatric sequelae of Bosnian adolescents after a year of resettlement to assess delayed PTSD onset. Of those initially diagnosed with PTSD, none met criteria for diagnosis a year later and only one participant not previously diagnosed, displayed PTSD symptomology. Becker et al. (1999) concluded that the diminution of PTSD over time might reflect the fact that symptoms are transient and not representative of enduring psychopathology. They did nevertheless report that the symptoms shown at one year follow up remained similar to the clusters of symptoms observed in their initial investigation and that their participants had also remained with their parents, potentially offsetting PTSD symptomology. Hence, while there is evidence to support the chronic nature of PTSD in young refugees, there is also evidence to suggest that such long-term effects may be mediated by other factors (Becker, et al., 1999).

One of the most significant studies to provide substantive evidence for mediating factors in the trauma-psychological disorder relationship is a meta-analysis conducted by Porter and Haslam (2005). Their widely cited study explored pre-displacement (pre-migration) factors associated with mental health outcomes for refugees and IDPs. Using fifty six studies that met rigorous inclusion criteria (i.e., refugee sample compared to at least one comparison group on measures of psychopathology), their findings, like studies cited earlier, supported a dose response
to traumatic exposure. The key finding however was that post-displacement conditions moderated mental health outcomes (Porter & Haslam, 2005). Poorer outcomes were found in refugees that were living in institutional housing conditions, those with restricted economic opportunities, those with histories of internal displacement in their own country, and those repatriated to countries they had fled from or which the conflict had not resolved. Being female, older, more educated, having a background of rural residence, and a higher pre-flight socioeconomic status were also associated with greater psychopathology.

The authors concluded that psychopathology is not viewed as an inevitable consequence of acute trauma and war stress, but rather a reflection of contextual factors which could be mitigated by generous material support from governments and agencies (Porter & Haslam, 2005). Unfortunately, the rigorous criteria applied to this meta-analysis excluded meaningful epidemiological and sociological studies. Moreover, only two of the studies reviewed used psychometrically valid measures to assess important social variables (Tipping, 2010). The range of contextual factors which occur across pre-, peri-, and post-migration phases, investigated by single studies, are described in later sections of this chapter; following a discussion of comorbid and alternative psychological outcomes to PTSD.

Studies of symptomology and other comorbidity

Although the studies cited above primarily focus on PTSD (and sometimes depression) as the main outcome, there are numerous studies that have focused on the co-occurrence of different disorders or alternative outcomes to PTSD and other disorders altogether. Simultaneous presence of more than one disorder associated with PTSD is a common finding in the literature, and as seen in the studies cited, it is difficult to disentangle or ignore the presence of other symptoms. Kinzie et al. (1986), for example, noted depression and anxiety as problems most commonly associated with PTSD symptomology. Similarly, Hubbard and colleagues (1995) found the existence of more than one disorder in their sample of refugee adolescents and young adults exposed to trauma as children. Of the 24% of adolescents and young adults that
were diagnosed with PTSD, 57% of these had at least one additional diagnosis, all being affective and anxiety related (Hubbard, et al., 1995).

Using the Child Behavior Checklist (CBCL), Sourander (1998) found that in addition to PTSD, depression and anxiety were most common among their child refugees. When interviewed, most children reported somatic complaints, uncertainty about the future and in some cases expressed suicidal thoughts. Though the presence of anxiety is not surprising given its overlap with PTSD, Clarke et al. (1993) note that depression may commonly occur due to ongoing adversity following resettlement.

Tousignant and colleagues (1999) presented their results of a psychiatric epidemiological survey of 203 refugee adolescents aged between 13-19 years from 35 different countries resettled in Canada. Using the Diagnostic Interview Assessment Scale and global assessments of general functioning, these authors showed a 10% difference against refugee adolescents in rates of psychopathology compared to normative data obtained from a province wide survey of Quebec adolescents. Twenty one per cent of participants displayed psychopathology in forms of simple phobia (25%), overanxious disorder (13%), depression (5%); conduct disorders (6%) and attempted suicide (3%). Elevated rates of phobia and overanxious disorder according to these authors were probably due to their association with PTSD. Females displayed more psychopathology than males in this sample with similar ratios evident in the Quebec survey, but neither age at arrival nor cultural differences were found to be significant factors. Despite the high rates of psychopathology when compared with a normative population, according to global functioning assessments, these adolescents had good social adaptation (Tousignant, et al., 1999).

Kocijan-Hercigonja, Rijavec, and Hercigonja (1998) also investigated the existence of more than one disorder and alternative problems in refugee and displaced children. They compared three groups of children aged between five and fourteen years. The first group comprised of Muslim refugees from Bosnia and Herzegovina; the second of displaced children from Croatia; and the third of non-displaced local children. These authors found significant differences in the prevalence of eating disorders, with displaced children exhibiting more eating disorders than non-displaced and refugee children. Significant differences were also observed in sleeping disorders with more sleep problems found in displaced children followed by refugee and non-displaced children. Refugee children used significantly fewer coping strategies than
displaced and non-displaced children and the effectiveness of these strategies were reported to be greater in displaced and non-displaced children. In terms of adjustment, displaced children were less satisfied with their present situation than other children. They also reported feeling generally worse than other children, and were less optimistic about the future. While displaced children were lower on anxiety than refugee children, no differences across the sample on depression measures were found (Kocijan-Hercigonja, Rijavec, & Hercigonja, 1998).

When Kocijan-Hercigonja et al. (1998) compared parent and child assessments, parents did not report of their child’s fatigue, palpitation, breathing problems, trembling, or crying reinforcing earlier suggestions of the importance of attaining data directly from young people. Kocijan-Hercigonja et al. (1998) attributed sleeping and eating problems in displaced children to the severity of trauma these children experienced. Furthermore, displaced children tended to evaluate their life at present as worse than others because of difficulties associated with camp life. Elevated anxiety in refugees was attributed to trauma, whereas in displaced children, it was attributed to uncertainty in status and the future. Thus, young people can have negative beliefs and expectations about their futures, indicating potential adjustment problems (Kocijan-Hercigonja, Rijavec, & Hercigonja, 1998). Although not widely reported in the literature, elevated rates of substance abuse and aggressive behaviour have also been demonstrated in adolescent victims of war (Arroyo & Eth, 1985). An increased rate of psychosis has also been observed among young adolescent refugees resettled in the UK (Tolmac & Hodes, 2004).

Obradovic, Kanazir, Zalisevskij, Popadic and Simic (1993) investigated 102 young people aged between 8-19 from Bosnia, Herzegovina and Croatia in collective accommodation. Eighty eight per cent reported feeling sadder than before the war, 87% reported being more worried and 62% reported feeling more tense. Satisfaction from play was reduced in 65% of participants. Of the physical symptoms reported, all increased following the war and included lack of appetite, disturbed sleep, excessive perspiration, headaches, respiratory problems, and gastric complaints (Obradovic, et al., 1993).

In their investigation of varied psychological outcomes, Howard and Hodes (2000) noted the distinction between disorders of neuropsychiatric origins (i.e., causes attributable to damage to brain functioning) and those from psychosocial ones (i.e.,
causes attributable to family and social processes). Comparing refugees, immigrants, and British young people, the researchers found that refugees received more diagnoses of a psychosocial nature than the other two groups. They were also more isolated and disadvantaged (Howard & Hodes, 2000). The tendency to manifest disorders of a psychosocial nature is consistent with Rousseau, Drapeau and Corin (1996) who found a positive association between learning difficulties, academic achievement, and emotional problems in South East Asian and Central American refugees.

Furthermore, the tendency of traumatised young refugees to report more psychological problems, diagnostic and otherwise (e.g., guilt, uncertainty) has been found to be associated with the occurrence of more daily stressors and less perceived social support (Paardekooper, et al., 1999). Although the exact rates of disorder and dysfunction tend to vary across studies and frequently reaches 40% to 50% prevalence, there is nevertheless consensus across studies investigating PTSD and other psychological problems, which show these rates to be much higher in refugee than non-refugee populations (Bird, 1996; Tousignant, et al., 1999). The cumulative effects of each disorder were also evident in Momartin et al.’s. (2003) study which showed worse long term outcomes for refugees experiencing both PTSD and depression than those who had one or the other.

Although the focus of this research is on mental health in young refugees, the associated overlap with physical health problems cannot be ignored. The refugee literature consistently cites serious health problems including malnutrition, exposure to unhygienic conditions and associated disease, especially in refugee camps (Correa-Velez, et al., 2010; Lustig, Kia-Keating, Grant-Knight, et al., 2004; McCarthy & Marks, 2010), physical injuries (e.g., fractures), chronic health complaints, meningitis, encephalitis, brain damage (often due to head trauma and lack of nutrition), and problems related to sexual or physical abuse (Lustig, Kia-Keating, Grant-Knight, et al., 2004; Westermeyer, 1991). Lustig et al., (2004) particularly note the physical consequences and increased vulnerability to sexual assault and physical abuse in child-soldiers. Thus, the influence of these potential health problems cannot be overlooked when considering psychological comorbidity in this population (McCloskey & Southwick, 1996; Westermeyer, 1991).
Mental health issues can also manifest in somatic health complaints (Locke, Southwick, McCloskey, & Fernández-Esquer, 1996; Lustig, Kia-Keating, Grant-Knight, et al., 2004; Van Ommeren et al., 2002). Indeed, the higher rates of somatic complaints in young refugees suggest that the overlay of physical and psychological symptoms may be much greater than that presented at face value. One interesting study by Van Ommeren, Sharma, Sharma, de Jong and Cardena (2003) showed that PTSD predicted greater somatic complaints, regardless of symptoms of anxiety or depression. Unfortunately, while it is broadly recognised that somatic complaints can manifest as psychological distress, notwithstanding Van Ommeren et al.’s (2003) study, Schweitzer et al.’s (2006) study (described later) and earlier literature by Westermeyer (1989) reporting somatisation, fewer studies have looked at its relationship with disorders such as PTSD, anxiety and depression.

Thus far, it is clear that much of the research has looked at PTSD, depression, anxiety and other negative outcomes. Positive or psychosocial impacts however are less identified in the refugee literature (Correa-Velez, et al., 2010). These impacts are explored in a few studies which have concentrated on quality of life (Ager, Ager, & Long, 1995), life satisfaction (Van Selm, Sam, & Van Oudenhoven, 1997), well-being and adjustment (Ager, 2002; De Vries & Van Heck, 1994). Ager (2002), for example, examined the concept of quality of life among Mozambican refugees in Malawi. Objective quality of life factors such as food and water, safety, clothing, and shelter as well as subjective factors such as belonging and esteem needs were shown to be important in this refugee group.

Similarly, Van Selm et al. (1997) found life satisfaction among Bosnians resettled in Norway was higher when Norwegians perceived them as positive. Higher internal locus of control was also associated with greater life satisfaction. Such studies looking at these alternative psychological outcomes are reviewed in greater detail later in Chapter 8, which explores quality of life and resilience factors in young refugees. In addition to the small number of studies examining positive or psychosocial impacts, there are few studies which explore mental health from the refugee’s perspective. Research has tended to instead focus on an ‘outsider’ perspective that usually involves psychometric measures to arrive at findings. Qualitative studies on the other hand have the potential to both validate psychometric studies (which are criticised for an over-reliance on Western frameworks, concepts, and measures), and
provide ‘insider’ insights to the context of relationships between variables (Tipping, 2010). Thus, not only have alternative positive outcomes been neglected in the refugee literature alternative methodologies which aim to contextualise psychosocial factors in the refugee experience have also been overlooked.

Despite the numerous studies that have found poorer adaptation in young refugees, good adaptation following multiple traumas has also been reported (Berthold, 1999; Punamaki, Qouta, & El-Sarraj, 2001). Loughry and Flouri (2001) for example, investigated the behavioural and emotional problems of 455 former unaccompanied refugee youth aged between 10 and 22, three to four years after their repatriation to Vietnam from refugee centres in Hong Kong and South East Asia. No differences between age matched controls who never left Vietnam and repatriated children were found on self-efficacy, trauma, and social support. In this study, trauma and living without parents in refugee camps did not lead to increased behavioural and emotional problems in the immediate years after repatriation.

Although a publication bias in the literature may result in the underreporting of positive adaptation, the studies that do show positive adaptation imply that a diagnosis is not always suggestive of severe functional impairment (Sack et al., 1995). The fact that mental health symptoms are shown to reduce over time in addition to the possibility of good functioning despite diagnoses, demands that mechanisms that promote or impede such adjustment be investigated (Beiser, Dion, Gotowiec, Hyman, & Vu, 1995). The next section reviews such studies with regard to those risk and protective factors that occur in the pre-, peri- and post-migration phase.

*Risk and protective factors in youth refugee mental health: Pre-migration factors*

The dynamic interplay between risk and protective factors that impact on refugee mental health is not yet fully understood. However, there is widespread agreement that of those factors posing serious risk in the pre-migration phase, trauma exposure is the single most identified factor (Berman, 2001). While the literature on trauma exposure was discussed in detail earlier in this chapter, a range of other pre-migration factors that mediate the trauma – psychological disorder relationship are now emerging in the literature. These are broadly categorised into individual/demographic, family, and environmental factors.
Regarding individual and demographic factors, female gender is more associated with risk (Hollander, Bruce, Burstrom, & Ekblad, 2011) although the influence of gender is contested in the refugee literature. Dispositional factors such as good temperament, positive self-esteem, ability to respond to new and stressful situations, and coping style (e.g., endorsement of courageous-emotional and active intentional coping such as expression of courage and affirmative emotional coping action) have also been shown to decrease vulnerability to poor psychological outcome and adverse life events (Almqvist & Broberg, 1999; Garmezy, 1991; Lustig, Kia-Keating, Grant-Knight, et al., 2004). When moderated by the impact of trauma however, these coping styles do not appear to protect against mental health problems (Lustig, Kia-Keating, Grant-Knight, et al., 2004). Others however, have argued that different contexts of different migration phases may require the use of different strategies, such that effective strategies in some situations may not be effective in others (Lustig, Kia-Keating, Grant-Knight, et al., 2004). Paardekooper et al. (1999), for example, found that young Sudanese living in camps utilised strategies such as emotion-inhibiting (e.g., keeping quiet), emotion–focused (e.g., spending time with others), wishful thinking, and prayer as coping strategies for camp life. They attributed reliance on these strategies to limited opportunities in camps to use more usual effective styles such as problem focused strategies. Although useful for survival in refugee camps settings, such strategies could be detrimental in a resettlement environment as they might cause hindrance to help seeking behaviours (Paardekooper, et al., 1999).

Other dispositional factors in the pre-migration phase shown to buffer against negative mental health effects include belief and meaning systems. Punamaki (1996) for instance, found that a strong ideological commitment (e.g., defiance towards the enemy, glorification of war) among Jewish Israeli adolescents protected them from anxiety, depression and fear of failure at low levels of political violence. At higher levels of exposure, however, these protective effects diminish (Punamäki, 1996). Basoglu et al. (1997) in their study of tortured versus non tortured activists, also showed that ‘psychological preparedness’ can ‘immunise’ against traumatic stress (Basoglu, et al., 1997). Servan-Schreiber et al. (1998) similarly found that a sense of participation against oppression and Buddhist beliefs among Tibetan refugees were protective in offsetting mental health problems and accelerating recovery (Servan-
Schreiber, Lin, et al., 1998). Though not commonly cited as a pre-migration individual risk factor, pre-existing conduct problems and chronic physical illness have been shown to heighten vulnerability to psychological problems (Ehntholt & Yule, 2006).

Regarding family factors, pre-migratory family functioning has been found to influence psychological outcome in young refugees. Almqvist and Broberg (1999), for instance, suggested that family climate and cohesion before and after migration are the best predictors of mental health in young refugees. These claims are supported by Green et al. (1991), Hicks et al. (1993), Rumbaut (1991), and Thabet and Vostanis (2000) who all argue that family dysfunction, parental incapacity, and qualities of family life prior to exposure are influential in post-traumatic stress reactions and adjustment. Green et al. (1991) and Punamaki (2001) particularly argue that parental capacity and family cohesion in the aftermath of traumatic exposure are of equal or greater importance in the post-traumatic stress reactions of young refugees. Thus, family dysfunction before exposure predisposes PTSD in children and adolescents.

For very young refugees, pre-morbid mental health difficulties experienced by family members can increase the risk of traumatic stress reactions and mental health difficulties. Ajdukovic and Ajdukovic's (1993) study of the influence of maternal mental health on children's stress reactions and stress indexes emphasised the emotional and behavioural state of mothers as major mediators between young people’s traumatic experience and psychological functioning. Rousseau et al. (1997) also argue that while the family enables a young person to rediscover safety and security amidst destruction, parental stress on the other hand is conducive to destroying parent-child relationships due to parent physical and psychological unavailability. Indeed, parents’ own experiences of persecution, war violence, terrorism, powerlessness and exhaustion can compromise their ability to provide adequate physical and emotional care for their children (Fox, Cowell, & Montgomery, 1994; Hicks, et al., 1993; Miller, 1996; Sack, et al., 1996). The provision of family support, especially parental, is emphasised as a factor of resilience during war, so long as they are not pushed beyond stress-absorption capacities (Dybdahl, 2001; Garbarino, Kostelny, & Dubrow, 1991). Regarding environmental factors, the influence of peers is also important in the pre-migration phase. This is unsurprising given that protective factors such as social ability, and prosocial behaviour, allow
young people to access their supports during times of high stress (Garmezy & Rutter, 1983).

*Risk and protective factors in youth refugee mental health: Peri-migration factors*

Despite considerable focus on the stressors that occur in the pre-and post-migration phases (perhaps in the latter because most research is conducted during resettlement), the peri-migration phase has also shown to pose heightened risks for young refugees. This phase is often characterised by direct threats to an individuals’ and families’ safety, displacements, transitions, camp experiences, dangerous experiences associated with flight, and extreme uncertainty about the future (Lustig, Kia-Keating, Grant-Knight, et al., 2004). For young people, development occurs amidst turbulence and the risk of family separation from parents or care-givers is high at this stage (Lustig, Kia-Keating, Grant-Knight, et al., 2004). Often separation occurs by accident or because of safety concerns and chaos that accompany flight. Violence or disaster can also render entire villages without adults. Thus, many young refugees can travel extensively without guardians. Young people who are separated from their families and arrive to countries of asylum unaccompanied experience increased threat to their mental well-being. In fact, there are several studies which have examined the roles of family separation and unaccompaniment (Ajdukovic & Ajdukovic, 1993; Hicks, et al., 1993; McCloskey & Southwick, 1996; Rambaut, 1991; Servan-Schreiber, Lin, et al., 1998; Sourander, 1998).

Unaccompanied minors are usually defined as persons under the age of 18 who have been separated from their parent/s and are not being cared for by an adult who has a responsibility to do so (Sourander, 1998). Among studies focused on this group, Felsman, Leong, Johnson, and Crabtree-Felsman (1990) compared three groups of Vietnamese refugees encamped in the Philippines. These included adolescents, young adults, and unaccompanied minors. Whilst anxiety remained high across all groups, young adults and unaccompanied minors were over represented in clinical ranges on measures of psychological distress. These findings corroborate those of Kinzie et al. (1989; 1986) who demonstrated that it was neither the amount nor type of trauma witnessed, nor age or gender that were critical in determining psychiatric outcomes, but rather a decreased presence of a nuclear family member.
While many Cambodian refugees in their study had lost an average of three family members, those who had been able to re-establish contact with at least one family member reported fewer adjustment problems than those without family contact. The uncertainty and lack of opportunity to appropriately grieve for disappeared or missing family members may help explain a higher psychological risk in separated and/or unaccompanied refugees (Ehntholt & Yule, 2006).

Sourander (1998) examined traumatic events and emotional and behavioural symptoms in 46 unaccompanied minors awaiting placement in an asylum centre in Finland. Having experienced a number of losses, separations and threats, most of these young people exhibited symptoms of PTSD, depression, and anxiety. Half were found to be functioning within clinical or borderline ranges on the Child Behaviour Checklist (Achenbach & Rescorla, 2001), and those under 15 years of age were particularly vulnerable. Procedures related to awaiting asylum also contributed to elevated stress alongside complaints of physical nature, uncertainty about the future and suicidal thoughts. Sourander (1998) concluded that unaccompanied young people are highly vulnerable towards emotional and behavioural symptoms, which are exacerbated by asylum-seeking stress. McKelvey and Webb (1997) have also reported that high rates of psychopathology among unaccompanied Vietnamese were significantly exacerbated during stays in a processing centre during flight in the Philippines. Rousseau (1995) notes that the majority of unaccompanied young people are boys, reflecting the family or boy's decision, largely to reduce vulnerability to soldier activity and to increase capacity to be able to support the family in the future. Moreover, the impact of multiple separations from family can interact with previous traumatic experiences, further increasing the psychological risk to unaccompanied youth. From a developmental perspective, increasing autonomy in these young refugees can cause them to relive past separations creating further difficulties in adjustment (Derluyn & Broekaert, 2008; Rousseau, 1995). Such realities and burdens for young people underscore the increased risk to psychological health.

Adaptive strategies that are most effective with unaccompanied young people are those that promote continuity with the past and balance the demands of the external reality (Rousseau, 1995). For instance, unaccompanied young people have better mental health outcomes when they are placed with foster families of the same ethnic group (McCloskey & Southwick, 1996; Rousseau, 1995). Hicks et al. (1993),
also noted an exacerbation of problems in unaccompanied children and adolescents when placed with adults of dissimilar cultural backgrounds. Kinzie et al. (1991) further note that irrespective of the ethnicity of the foster or new carer, when natural caregivers are substituted, antisocial and negative emotional behaviour is understandably more likely to be exhibited.

The process of sought asylum has been found to be directly related to increased psychological problems (Silove, Sinnerbrink, et al., 1997; Sinnerbrink, et al., 1997; Sourander, 1998). Sinnerbrink et al. (1997) assessed 40 adult asylum seekers attending English classes at a community welfare centre in Sydney. They found that asylum seekers experienced ongoing sources of severe stress due to separation experiences, fears of being repatriated, barriers to social services, and issues related to processing of refugee claims. More than a third of participants had difficulties attaining adequate health services. Thus, salient aspects of the asylum seeking process may compound the stressors suffered by an already traumatised group (Sinnerbrink, et al., 1997).

Noting the difficulties in accessing asylum seekers who had not been accorded residency status, Silove et al. (1997), assessed trauma, anxiety, depression, and living conditions among forty asylum seekers attending a community resource centre in Sydney. High anxiety scores were associated with female gender, poverty, and problems with immigration officials. Loneliness and boredom were also directly associated with anxiety and depression. Of the 79% who had experienced a traumatic event, 37% obtained a PTSD diagnosis. This diagnosis was significantly associated with greater exposure to pre-migration trauma, delays in application processing, dealing with immigration officials, obstacles to employment, racism, loneliness, and boredom. At the time that Silove et al.’s (1997) study was conducted, Australia enforced a mandatory detention policy for asylum seekers without appropriate documentation – whilst in place, this policy increased risks for hopelessness, despair and self-harm (Fazel & Silove, 2006; Mares & Jureidini, 2004). Dudley estimated that suicidal behaviours among men and women in Australian detention centres were alarmingly 41 and 26 times the national average (Dudley, 2003).

Steel, Mares, Newman, Blick and Dudley (2004) also interviewed parents of children and adolescents detained in Australian immigration detention centres for up to two years. Twenty six disorders were identified among 14 adults; and 52 disorders
were identified 20 children they interviewed. Although Australia is widely recognised for its progressive offshore program, the Human Rights and Equal Opportunity Commission’s enquiry into children into immigration detention, which led subsequently to the abandoned policy of mandatory detention, received alarming submissions about the destructive problems seen in detention centres. These included: self-harm, severe anxiety and depression and other mental health problems, emotional numbing, hopelessness, social isolation, and exacerbation of impacts from other traumas (Davidson, et al., 2008).

Regarding children and adolescents in the process of sought asylum, the study of Ajdukovic and Ajdukovic (1993) stands among few in the published literature. These authors compared two groups of children who were displaced together with their families into two different housing arrangements - those living with host families and those living in communal shelters. Young people in host families showed lower rates of stress, fearfulness, despondency and aggression, and fewer nightmares than those living in sheltered environments. Higher stress indexes among young people in collective shelter were also correlated with mothers adaptive problems, negative perceptions of communal housing and perceptions of worsened relations with children since displacement (Ajdukovic & Ajdukovic, 1993). These findings were attributed to the unfavourable living conditions of shelters impacting on mothers abilities to cope. These findings are consistent with those from McCallin’s (1992) earlier large survey of 600 Vietnamese minors living in a refugee centre in Hong Kong, which showed anxiety and depression was most pronounced among those unaccompanied. More recently, Bean, Eurelings-Bontekoe and Spinhoven (2007) showed that severe internalising complaints and traumatic stress reactions were higher among unaccompanied refugee adolescents when compared with those refugee adolescents living with parental caregivers.

Living in refugee camps poses additional risks for psychological distress in refugees (Davidson, et al., 2008; Ehnholt & Yule, 2006; Loff, Snell, Creati, & Mohan, 2002). Many refugees arrive in host countries through refugee camps on foreign soil. Such camps have been described as ‘institutional’ to the extent that they depersonalise ‘individuals to numbers’ (Harrell-Bond, 2000; Lustig, Kia-Keating, Grant-Knight, et al., 2004) and that traumatic events are common (Lustig, Kia-Keating, Grant-Knight, et al., 2004). For instance, Harrell-Bond (2000) investigated
Sudanese youths in Kenyan refugee camps, and found high incidence of malnutrition, lack of adequate food, water and medical care. Despite these PTE’s, education programs, thought to be protective, attract these young people to remain (Tipping, 2010). Rothe, Lewis, Castillo-Matos, Martinez, Busquets, and Martinez (2002) also found a high incidence of PTE’s among Cuban refugees, with 80% of their sample witnessing acts of violence, 37% witnessing acts of attempted suicide, and 19% experiencing family separation. Although it is difficult to assess mental health status during camp stay, studies that have researched this variable (Duncan, 2000; Sourander, 1998) have consistently found that PTSD symptomatology is high (up to 75%) (Duncan, 2000), particularly the re-experiencing elements of trauma (e.g., nightmares). Further, PTSD symptomology was also found to be disproportionally high in separated or unaccompanied young girls and women (Duncan, 2000).

It was concluded in Steel et al.’s. (2009) meta regression study that displaced populations living within or external to the source country or living in refugee camps had higher rates of PTSD than those that were permanently resettled in another country. On the basis of such findings, it is not surprising that improvement in the environmental conditions of these camps could help mitigate the mental health consequences of conflict and displacement. Among all these risks, the one established protective factor is a hopeful attitude in preparation for resettlement (Lustig, Kia-Keating, Grant-Knight, et al., 2004; Muecke, 1992).

Together these studies offer evidence that within the process of displacement, flight and while awaiting resettlement (i.e., peri-migration), there are a number of factors that can pose additional risk to a young persons’ psychological well-being, including single and multiple separations from family (or as implied separation due to death) (Correa-Velez, et al., 2010) and subsequent unaccompaniment; living in shelters or processing centres, refugee camps and associated hardships; and the process and experience of sought asylum itself. Underscoring these risk factors are the negative mediating factors of supervised and/or communal living with others outside a family/cultural group, the inability or removal of opportunity to maintain traditional parent and family roles, the loss of perceived control and learned helplessness (Garbarino & Kostelny, 1996a). Where traditional roles are maintained and the length of communal living (i.e., in refugee camps) is decreased, less adverse psychological effects have been observed (Markowitz, 1996; McKelvey & Webb, 1997).
Again, although it is evident that separation and sole migration increase risk significantly, there are some studies that report that despite these risks, good adaptation following separation and unaccompanied migration can occur (Krupinski & Burrows, 1986; Rambaut, 1991; Wolff, Bereket, Egasso, & Tesfay, 1995). Krupinski and Burrows (1986), for example, found that although separation contributed to difficulties during the first year of resettlement, psychological problems did not appear to be influenced by separation after this time. Of course, these findings go against most of the reported literature, and may indeed represent a more accurate depiction of the complexity of interplay between risk and protective factors across all phases of refugee migration.

**Risk and protective factors in youth refugee mental health: Post-migration factors**

The post-migration (or resettlement) phase is characterised by a series of adjustments including geographical and cultural relocation; loss of homeland, family, and friends; and challenges of a new language and culture (Berry, 1990; Lustig, Kia-Keating, Grant-Knight, et al., 2004). It is a time when hope initially can offset grief (Keyes, 2000). As with the pre- and peri-migration phases, there are individual, family, cultural, community, and systemic factors that are implicated in the post migration phase that shape young refugees’ mental health. It is perhaps in this phase, however, where the complexity of interaction across these factors, in addition to acculturative experiences, is emphasised.

Regarding individual factors, while there are some that are consistently found to be risky or protective, for other identified factors, the findings are mixed. With respect to age, some studies suggest the cognitive immaturity of younger refugees is protective at post-migration (Dybdahl, 2001; Elbedour, Ten-Bensel, & Bastien, 1993; Garbarino & Kostelny, 1996a; Papageorgiou, et al., 2000), yet others suggest it is the inability to articulate and express distress or the attribution of egocentric explanations in younger children, which constitutes risk (Berman, 2001). Weine et al. (1995), on the other hand argue that PTSD is more common in older age groups (i.e., middle to late adulthood), probably due to ‘fewer’ experiences of (or opportunities for) trauma among younger children and adolescents compared to adults. Similarly regarding
gender, it has been found that boys are more vulnerable than girls (El Habir, Marriage, 1994; Elbedour, Ten, & Maruyama, 1993; Garbarino & Kostelny, 1996b). While in contrast, studies on refugees exposed to the Gulf war have found that females show higher frequencies of stress reactions (Greenbaum, Erlich, & Toubiana, 1993; Klingman, 1994) and greater decreases over time in males relative to females in post-traumatic stress, anxiety, and depression (Stein, Comer, Gardner, & Kelleher, 1999). Porter and Haslam’s (2005) meta-analysis did conclude however that being female poses greater risk, in spite of what appears to be equal vulnerability in males and females. These findings, originally based on adult samples, were corroborated in a young refugee study conducted by Bean, Derluyn, Eurelings-Bonteko, Broekaert, and Spinhoven (2007). These authors found female gender and older age to be negatively associated with mental health outcomes among adolescent refugees. Differences in gender may however reflect cultural expectations for the display of emotion or females being more adept to openly report symptoms (Lau & Thomas, 2008).

Among other individual factors, there is some emerging research that show loss of meaningful social roles and life projects can affect mental health outcomes in the resettlement phase (Colic-Peisker & Walker, 2003). Individual factors that are consistently shown to promote better mental health in the post-migration phase however, relate to a realistic expectation of adjustment (McKelvey & Webb, 1996). Additionally, personal characteristics such as self-esteem, sense of coherence, resiliency and holding future oriented views have also been reported as protective (Beiser & Hyman, 1997; Correa-Velez, et al., 2010; Ehntholt & Yule, 2006; Kohli & Mather, 2003; Lustig, Kia-Keating, Grant-Knight, et al., 2004; Rothe, et al., 2002)

Unsurprisingly, family factors also play a significant role in shaping the mental health of young refugees in the post-migration period. Kinzie et al. (1986) for example, noted the protective effects of re-established parental contact following migration. Arroyo and Eth (1996) similarly found that young refugees who remained in nuclear families were less likely to receive a psychiatric diagnosis than those who lived alone or were fostered. Garbarino, Kostelny, and Dubrow (1991) and Richman (1993) further maintain that PTSD can be evident in multiple family members, particularly when marital relations are strained. Thus, at the very least, the presence of a family member can significantly decrease negative mental health outcomes for
young refugees. Family cohesiveness can heighten this protectiveness (Garmezy, 1991).

Consistent with life prior to resettlement, parental mental health factors are also important risk and protective factors in the determination of young refugees’ mental health (Papageorgiou, et al., 2000; Sack, McSharry, Clarke, Kinney, & et al., 1994). Sack, Clarke, and Seeley (1995) for instance, interviewed 118 Khmer adolescent refugees and one of their parents (usually mother). When environmental factors such as separation/divorce or therapeutic intervention were controlled for, risk for PTSD was found to increase for adolescents with one parent exhibiting PTSD. While psychological problems in the family or parents are significantly related to psychopathology in young refugees, the mental health of mothers in this regard is especially important (Ajdukovic & Ajdukovic, 1993).

Although the role of family and parental mental health could suggest a genetic susceptibility to PTSD (Hodes, 2001; Sack, Clarke, & Seeley, 1995), such findings could also implicate the role of learning factors in the concurrence of PTSD in young refugees and their parents. Lukman and Bach-Mortensen (1995) argue that such is the established link between parent and child disorder that children of torture victims, who seek asylum in resettlement countries, can have high levels of emotional and physical symptoms such as stomachache or headache, even when not exposed to the traumatic events themselves.

The availability of supports outside the family, such as peer support and cultural community support also facilitates successful adaptation even when young refugees have survived extreme trauma (Almqvist & Broberg, 1999; Fox, et al., 1994). Conversely, isolation from support has been found to be a major predictor of poor psychological adaptation (Jupp & Luckey, 1990). Relationships with peers have also been noted to affect school performance in refugees (Driver & Beltran, 1998), while emotional problems such as concentration difficulties, anxiety, or depression can predict learning difficulties at school. Importantly, school, education and employment systems are seen as critical systems for enabling opportunities for socialising with peers and connectedness to the host community.

With regard to cultural community, it has been shown among Kosovo Albanians, that ethnic and group identity can lower anxiety and depression and increase self-efficacy (Kellezi, Reicher, & Cassidy, 2009). The maintenance of close
ethnic community ties has also been shown to be a protective factor to mental health in young as well as older refugees, alongside cultural and religious traditions which assist to restore continuity in the past and present (Berry, 2005; Punamäki, 1996; Rousseau, 1995; Sack, Clarke, Kinney, et al., 1995). However, as resettlement continues over time, the maintenance of close ties can reduce social inclusion with host communities (Colic-Peisker & Tilbury, 2003) and strong attachments to ethnic identities can impact in negative ways (Berry, 2005) through, for example, greater discrimination and unemployment (Beiser & Hou, 2006). Overall though, it seems that positive perceived social support from peers and one’s own community are considered protective, while social isolation can impact negatively on psychological well being (Colic-Peisker, 2005; Lie, 2002; Silove, Sinnerbrink, et al., 1997).

So far it is apparent that similar risk and protective factors around the individual, family, and community exist across all migrating phases. In the post-migration phase however, systemic and broader acculturative factors begin to play an even more significant and compounding role. Of the systemic (or environmental) stressors, poverty, low socio-economic status (Correa-Velez, et al., 2010; Ehntholt & Yule, 2006; Fazel & Stein, 2002), and unemployment, particularly long term paternal unemployment (Lustig, Kia-Keating, Grant-Knight, et al., 2004; Tousignant, et al., 1999) can negative influence the mental health of young people (Howard & Hodes, 2000). Time taken by bureaucracies to decide on immigration applications, isolation and instability (Correa-Velez, et al., 2010; Ehntholt & Yule, 2006; Fazel & Stein, 2002), are also important risk factors. Some authors also cite the lack of comprehensive schooling strategies as obstacles for refugees (Christie & Sidhu, 2002), while, the capped restrictions on free English tuition in Australia and lack of recognition of overseas qualifications pose further barriers for refugee adults (Davidson, et al., 2008).

Colic-Peisker and Walker (2003), in particular, argue that negative social and mental outcomes are related to the compatibility of the host culture and characteristics of the resettlement program. These factors are thought to interact with individual dispositions and circumstances to affect responses to resettlement. An ‘active’ response, whereby individuals take part as ‘achievers’ and ‘consumers’, as opposed to a ‘passive’ response, whereby individuals ‘endure’ or act as ‘victims’, can produce better mental health outcomes. However, these factors are dependent on host
community reactions towards refugees. Colic-Peisker and Tilbury (Colic-Peisker &
Tilbury, 2003) in particular single out the role of the medicalisation of the refugee
experience which encourages refugees to take a potentially unhelpful ‘passive’
response to their resettlement. In a similar way, others argue that the more disparate
the cultural fit between Western systems and refugees themselves, the more
significant the barriers to successful resettlement and mental health (Miller & Rasco,
2004a). This is exemplified by the dissimilarity between Western psychotherapy and
traditional beliefs about mental health in refugee cultures, which is often a main cause
of service under-utilisation (Davidson, et al., 2008).

In their Australian review of mental health and well-being of refugees,
Davidson et al. (2008) reported on studies that showed negative attitudes and
behaviours from members of the Australian community towards refugees. They cited
the studies of Louis, Duck, Terry, Schuller, and Lalonde (2007) which showed a
representative sample of Australians supported harsh, exclusionary treatment of
refugee claimants; and Schweitzer, Perkoulidis, Korne, Ludlow, and Ryan (2005),
which showed up to 60% (especially males) of Australians held attitudes associated
with prejudice towards refugees. Hence, the experiences of systemic difficulties as
well as host community reactions are important risk and protective factors to consider
(Louis, et al., 2007; Schweitzer, et al., 2005).

Of broader acculturative factors, acculturative stress (i.e., stress that arises
from adapting to a new culture), also places young refugees at greater psychological
risk. For example, language acquisition, difficulties at school, bullying, and
discrimination (Ellis, et al., 2008; Hyman, et al., 2000; Montgomery, 2008) have been
shown to predict poor adaptation. Rousseau (1995) also reported that academic
achievement that is mediated by quick language acquisition and stable peer relations
is predictive of good psychological outcomes. Pumariega, Rothe and Pumariega
(2005) also state that acculturative stress or tension by which youths are encouraged
by their families to stay loyal to their ethnic values while at the same time required to
master the host culture in school and social activities can pose additional risks. In
response to this tension, some refugee youth may either over-identify with their own
culture of origin, with the host culture, or become marginalised from both (Berry, et
al., 2006).
The literature has identified three important factors in refugee adaptation to a new culture that either increase or decrease susceptibility to poor mental health. The first is conflict in the development of identity among adolescents/early adults. When adapting to a new society, refugees are often faced with sudden losses in identity and subsequent demands to reconstruct themselves in a new context (Colic-Peisker & Tilbury, 2003). The identity reconstruction process varies in individuals, families, and cultural groups (Sonderegger & Barrett, 2004). Tensions in the creation of this identity have consistently been related to poor psychological adjustment, not only to refugee groups but migrant groups more broadly (Davidson, et al., 2008; Rousseau, 1995). Berry (1991) argues that acculturation and identity can be categorised in four processes. These include (i) integration – the retention of cultural identity while maintaining contact with members of the new culture, (ii) separation – the maintenance of contact with one’s own culture only, (iii) assimilation – the establishment of contacts with new culture without retaining original cultural values, and (iv) marginalisation - the shedding of one’s original identity and culture but not seeking contact with other cultural groups. There is a great deal of research regarding these processes in migrants (Davidson, et al., 2008), though fewer in refugee samples. Those studies with refugees, however, consistently show an ‘integration’ style of identity and acculturation to be more associated with better mental health outcomes (Berry, et al., 2006). Furthermore, for refugee children and adolescents in Australia, those who have positive attitudes towards their own culture of origin and the Australian culture, have higher ratings of self-worth and peer acceptance (Kovacev & Shute, 2004).

The second important factor in contributing to mental health outcomes in young refugees is cultural bereavement. This term connotes a response by refugees of losing touch with attributes of their homelands (Eisenbruch, 1990). Elements of cultural bereavement include survivor guilt, anger, and ambivalence. The extreme of these elements often mirror traumatic grief reactions, which can be typical in situations of massive loss (e.g., excessive clinging to the past, over-idealisation of loved ones). These reactions represent risk factors to mental health, particularly to those of unaccompanied young refugees who are resettled with foster families dissimilar to their culture (Eisenbruch, 1990).
The third factor to influence mental health in the post-migration phase is intergenerational conflict. Intergenerational conflict arises when young refugees adapt much faster than their parents (Lau & Thomas, 2008). As such, parental and child roles change, and the authority of parents is often compromised by their dependence on children for language and cultural access to the host society (e.g., children often become language brokers for parents). Cultural differences in family structure and discipline can sometimes be add odds with Australian norms (Davidson, et al., 2008), creating additional stress and vulnerability. High parental expectations have also been shown to significantly predict intra-personal conflict in refugee children and adolescents, thereby posing further risk to poor adaptation (Hyman, et al., 2000). Fortunately however, positive outcomes are associated with longer stay and time in the country of resettlement (Beiser & Hou, 2006; Davidson, et al., 2008; Lustig, Kia-Keating, Grant-Knight, et al., 2004; Steel, et al., 2009). Although some researchers note higher symptoms initially in the resettlement period, given the demands of psychological and physical resources, followed by a subsequent decrease in symptoms (Davidson, et al., 2008), others note the increase of symptoms over time (Tran, Manalo, & Nguyen, 2007) or curvilinear presentations of symptoms. Others again note different time frames altogether for the increase of symptoms, such as the first one to two years after resettlement (Beiser, 1988). However, as Steel, Silove, Phan, and Bauman (2002) report, although time can be a powerful healer, risks can remain high. Fluctuations in the nature of symptoms therefore imply that the relationship between pre-, peri- and post- risk and protective factors is not straightforward (Davidson, et al., 2008).

Although discussion of treatment issues is beyond the scope of this thesis, early intervention and psychosocial assistance have frequently been reported as crucial protective factors despite low rates of help seeking behaviour in refugee populations (Howard & Hodes, 2000). Indeed, in her assessment of young Chilean adults who experienced childhood war related traumas of parental loss, Punamaki (2001) concluded that both the nature of trauma and the timing and duration of assistance were critical to wellbeing in adulthood. Though there are few documented early intervention studies with young refugees, therapies using cognitive behavioural techniques (Ehntholt, Smith, & Yule, 2005; Vickers, 2005), testimonial therapies (verbal accounts of experiences with aims to assimilate fragmented memories to
reframe the survivor story) (Lustig, Weine, et al., 2004), and narrative exposure therapies, which tackle multiple traumatic events through an autobiographical narrative (Schauer, Neuner, & Elbert, 2005) are among those that are showing effectiveness later in the post-migration period. Support is also gaining for other expressive therapies such as music and art therapies, particularly among refugees with illiteracy (Davidson, et al., 2008). In keeping with the socio-ecological factors described in this chapter, ecological models of treatment, such as school based trauma and grief psychotherapy (Layne et al., 2001) or school based CBT (Barrett, Moore, & Sonderegger, 2000; Barrett, Sonderegger, & Sonderegger, 2001) and family centred interventions (Weine et al., 2006) are protective in offsetting longer term mental health problems. The value of expressive and ecological therapies is thought to reflect the de-identification of refugees as ‘patients’. While the role of traditional healers is not established, the literature does recognise this to be important in protecting young people against psychological disorders (Ehntholt & Yule, 2006).

Finally, although this chapter has grouped the relative risk and protective factors across three the stages, there is some research that explores the relative influences of factors within different stages on the impact of mental health in the resettlement phase. Montgomery (2008), for example, investigated pre-arrival trauma and post-migration social life in Middle Eastern refugees, 8-9 years following arrival to Denmark. Externalising behaviours were associated with the witness of attack on others after arrival and the number of schools attended. Protective factors against these behaviours included work or school stability, maternal education, and increased age. Internalising behaviours were predicted by the number and type of traumatic experiences prior to arrival in Denmark, stressful experiences following Denmark, and experiences of discrimination. Protective influences against internalised behaviours included the number of Danish friends, and social life in Denmark.

Montgomery concluded aspects of Danish life were more predictive of psychological problems than pre-trauma experiences (Montgomery, 2008). These findings offer support for Steel, Silove, Bird, McGorry and Mohan (1999) who found 20% of variance for PTSD was accounted for by pre-migration trauma, 14% by post migrations stress, and 66% unaccounted. Miller and Weine et al. (2002) similarly used regression analyses to determine that pre-migration factors predicted post-trauma stress, contrary to depression, which was predicted by exile related stressors which
included acculturative tasks such as learning a new language and seeking employment. Nicholson (1997), on the other hand, found post-migration stress such as limited social support, unemployment, and language difficulties was more predictive than pre-migration trauma on mental health difficulties generally among south East Asians resettled in the US. These studies highlight contradictions in the literature about the relative influence of pre-versus post-migration factors on mental health. Although it seems both are highly relevant, the relative influence of pre- and post-migration factors on mental health outcomes has not been explored in a diverse youth sample to date of refugees resettled in Australia.

Literature relating to populations investigated in this thesis

The literature search conducted for this thesis yielded several papers concerning mental health factors in Sudanese and Horn of African youth populations, reflecting the growing diasporas of these groups. The search, however, failed to yield any empirical studies relating to Karen and Togolese young refugees, although two papers relating to the acculturative and identity experiences of Christian Karens, and health needs of the Karen, respectively were found (no papers were found reporting on mental health among resettled Togolese populations). It is probable that the dearth of published literature is an outcome of the recency of migration by Karen and Togolese refugees. Other factors, such as access issues to these new communities, might also contribute to the dearth of literature in these newer refugee groups. Nevertheless, these two papers are summarised in this review, alongside key findings relating to the Horn of African and Sudanese refugee communities.

Studies of Karen refugees. With regard to the Karen community, the paper by Worland and Darlington (2010), reported on focus group findings of predominantly young Christian-Karens and older Karen community leaders in Australia. Exploring acculturation, identity and resettlement, these authors found that a strong sense of both Karen and Christian identity influenced resettlement experiences in Australia. Resettlement experiences were strongly attached to values of education, faith, community, and nationalism, the latter enabling the Karen to maintain a protective collective sense of identity.
In a more recent study, Mitschke, Mitschke, and Teboh (2011) interviewed 21 Karen adults between the ages of 20 and 71, resettled in the USA. They found that Karen refugees from Burma experience major obstacles in locating and accessing employment and health care, which were attributed to language and transportation barriers. Interviewees expressed needs for assistance in learning English and help with transportation, job skills, and financial planning. These authors concluded that the basic needs of refugees are not met following the initial relocation period (Mitschke, et al., 2011). Unfortunately, mental health effects of trauma and other issues were not examined by these Karen studies, but do allude to the fact that psychosocial interventions, particularly those that strengthen resources such as language capability, financial security, faith, and community may significantly improve outcomes for Karen refugees. Although mental health was not explored, Mitschke et al. (2011) reported feelings of disillusionment expressed by many of their participants, in addition to exposure to violence and tensions in the resettlement period. They suggested these factors could potentially at their extreme turn to hopelessness, despair, and depression.

Studies of Horn of African refugees. With regard to the Horn of African communities, there are several papers which have examined these communities in a broader group of refugees and some papers which have examined them singularly, either in countries of displacement or resettlement. In semi-structured interviews with 106 Ethiopian refugee claimants in the UK, Papadopoulos, Lees, Lay, and Gebrehiwot (2004) explored experiences of migration, adaptation and health beliefs and practices. Difficulties in dealing with the immigration system, housing and social services, and social isolation were reported and many experienced problems with gaining employment or employment appropriate to their qualifications. Most participants also believed that the stress of adaptation and settlement affected their mental health and led to depression, leading the authors to conclude that migration, adaptation and settlement experiences impact on the health of refugees, which need to be considered in the provision of health and social care.

Contrary to findings described by Papadopoulos et al. (2004), Aptekar, Paardekooper, and Kuebli (2000), using a random sample of displaced Ethiopian youths in the Kaliti camp in Addis Ababa, Ethiopia, assessed 108 traumatised
participants using standardised and non standardised psychological tests. Participants having lived six years in an extremely poor camp for displaced persons, were unexpectedly found to display considerably less psychopathology than had been predicted. This result was attributed to the adolescents’ appraisal of particular circumstances of their lives. That is, these refugees compared their poverty and freedom within their own immediate community with other Ethiopians as well as the freedoms and poverties experienced by their parents when they were adolescents. The openness of the community in allowing adolescents to live outside of traditional norms was particularly salient for females (Aptekar, et al., 2000). The findings related to appraisal of situations relative to others, is important in understanding the cognitive mechanisms underpinning protection to mental health risk. Like Papadopoulos et al. (2004), however, these authors suggest that other factors, More broadly, situational and community factors, are important sources of risk and protection against mental health problems (Aptekar, et al., 2000).

In a population based survey of 338 Somali and Oromo refugee youth aged between 18-25 in the USA, Halcon, Robertson, Savik, Johnson, Spring, Butcher, Westermeyer, and Jaranson (2004) assessed war-related trauma history, immigration factors, problems, and coping. Youth with symptoms of posttraumatic stress syndrome reported more traumatic events (28 vs.16 in the non-traumatised group), and this trauma history was strongly associated with physical, psychological, and social problems. Strategies reported to combat sadness included prayer (55 %), followed by sleeping (40%), reading (32%), and talking to friends (28%). Hence, while many Horn of African young refugees experience life problems associated with war trauma, many utilise age-appropriate coping strategies that promote the health and successful adaptation to adult life.

Using a culturally adapted version of the MINI Neuropsychiatric Interview, Bhui et al. (2006) assessed 143 Somali refugee claimants recruited from primary care and community settings on a range of ICD-10 classified disorders. Comorbidity was high among PTSD sufferers, though common mental disorders such as depression and anxiety were more featured. Risk factors associated with these problems included sought asylum, unemployment or low education involvement, the use of Khat (leafy plant with psychotropic, euphoric, metabolic and cardiovascular effects similar to amphetamine), and primary care attendees relative to recruits from community
settings (Bhui, et al., 2006). The use of Khat may be indicative of the strategies that may be unique to particular cultures surrounding mental health. These findings support that public health interventions for Horn of African refugees more broadly should focus on common mental disorders, not just PTSD, Khat use, and mental health screening on arrival through primary care settings (Bhui, et al., 2006).

These findings supported an earlier study by Bhui and other colleagues (Bhui, Abdi, Abdi, Pereira, Dualeh, Robertson, Sathyamoorthy, & Ismail, 2003), which found that anxiety and depression were incrementally more common with cumulated pre-migration traumatic events. Shortages of food, being lost in a war situation, suffering serious injury, and being close to death were each related to specific psychiatric symptoms. Suicidal thinking was more common among Somalis who were unemployed before migration and in those using khat. Torture did not influence psychiatric symptoms in this study, leading the authors to suggest that resilience factors may be in play and that anxiety and depression among refugees cannot always be explained on the basis of posttraumatic stress states even though they are common in such disorders (Bhui et al., 2003).

Ellis and colleagues (2010) have also published a number of studies attesting to the mental health effects of young Horn of Africans aged 11-20 resettled in the USA. In their 2010 study, they examined the role of social identity (acculturation and gender) in moderating the association between discrimination and mental health among young Somalis. Discrimination was a common experience for most of their 135 participants and was associated with worsening mental health. Contrary to most studies, for girls, greater Somali acculturation was associated with better mental health. Discrimination and PTSD was also less strong for girls who showed higher levels of Somali acculturation. For boys, greater American acculturation was associated with better mental health, and the association between discrimination and depression was less strong for boys with higher levels of American acculturation (Ellis, et al., 2010). Not only does this study suggest within variation in cultural experiences of mental health and acculturation, but also that acculturation and social/community can be a helpful resilience factor, though which community (i.e., original or host) may be important.

In a qualitative study investigating young Somali Muslim female refugees and asylum seekers, Whittaker Hardy, Lewis, and Buchan (2005) revealed interpretative
themes including resilience and protection, identity and beliefs, concealment of secrets, which were all influenced by acculturation and Islamic and Somali cultures. The young women tended to ‘get on’, and cope with life, valuing support from family, services and religion. However, the pressures of navigating conflicting and changing cultural and religious positions, and concealing distress, posed barriers to accessing support. Thus a paradox exists in how refugees value familial support, but also validate concealment and fear of disclosures. Moreover, substantial variations in individual beliefs may require a range of different service provisions. (Whittaker, et al., 2005).

**Studies of Sudanese refugees.** The literature regarding the mental health of Sudanese refugees is growing, particularly with regard to qualitative studies and studies conducted in an Australian context. Schweitzer, Melville, Steel, and Lacherez (2006) explored pre-migration traumatic experiences, post-migration living difficulties, PTSD, anxiety, depression, and importantly somatization in 63 Sudanese resettled in Australia. They found that both traumatic experiences and post-migration living difficulties were significant predictors of poorer outcomes, while higher social support, particularly from family and Sudanese community members, were predictive of higher psychological wellbeing. Post-migration difficulties predicted anxiety and depression while pre-migration trauma experienced by the family predicted all outcomes. Years in transit and family separation were directly associated with depression, while length of residence in resettlement and employment were directly associated with depression, anxiety, and somatisations. Females also displayed greater symptoms than males (Schweitzer, et al., 2006).

In two other studies involving smaller samples and qualitative methods to explore coping strategies in the pre-migration, transit, and post-migration phases amongst Sudanese refugees, religious beliefs and social support were a critical mechanism in enhancing coping (Khawaja, et al., 2008; Schweitzer, Greenslade, & Kagee, 2007). Interestingly, Schweitzer and colleagues (2007) found the strategy of comparing oneself with others who were less fortunate to gain perspective was a commonly used as a strategy by Sudanese refugees (previously observed in Horn of African refugees), while Khawaja and colleagues (2008) highlighted other cognitive strategies, including reframing the situation in terms of the growth in inner strength,
accepting difficulties, and focusing on personal and political future wishes and aspirations. Also using qualitative techniques, Tipping, Bretherton, and Kaplan (2007) interviewed 30 Sudanese youths between 18-30 years of age. Their participants reported negative experiences following traumatic events including fractured meaningfulness in life, disrupted schooling and social networks, long-term mental health problems, distrust in authority, and a reduced sense of belongingness. Some of their participants reported racism, discrimination or feeling disadvantaged. Despite this, experiences of social connectedness during resettlement, multiculturalism, freedom, peace, security, rights, and educational opportunities were all positively experienced. Social support was critical to quality of life, particularly having family present in Australia (Tipping, et al., 2007).

Utilising a large sample of 220 Sudanese refugees in a mixed methods design, Simich, Hamilton, and Baya (2006) found greater psychological distress was associated with economic hardship, and discrepancies between expectations of life in Canada and actual experiences in Canada. Economic hardship was directly related to sleep difficulties, depression and unwanted memories. Comparing this to a US study, qualitative interviews with unaccompanied Dinka males found high levels of resilience were maintained using cultural coping mechanisms such as suppression, distraction, finding comfort in the collective experience of loss, constructing meaning from suffering, and focusing on the hopefulness of resettlement. Body metaphors were also used in descriptions of coping with suffering (Goodman, 2004).

Finally, Tempany (2009) in their review of the literature on Sudanese refugee mental health, reported on the growing internal and global Sudanese diaspora. Of the quantitative studies reviewed, Tempany (2009) found that most studies showed high rates of psychopathology (e.g., Paardekooper, et al., 1999), particularly PTSD and depression. However, in her review of mixed methodologies, Tempany cautioned that despite high symptom rates, functioning in Sudanese was not necessarily reduced. It was noted that Sudanese themselves often report more concern with current stressors, such as family problems, than with past trauma. Tempany (2009) also found strategies such as silence, stoicism, and suppression to be among the most preferred coping strategies. There was some evidence for cultural idioms of distress, though the literature is formed with mixed views about the notion of psychological distress, ranging from those which support the applicability of PTSD constructs, which locate
psychological trauma within the ‘self’ to those that find PSTD notions incompatible with Sudanese cultures which see ‘self’ as inseparable from others (Tempany, 2009).

In summary, the studies relating to Horn of African, Sudanese, and Karen refugees bear much in common with broader migrant groups (particularly in terms of acculturative stress) as well as the broad literature on refugee mental health and wellbeing (e.g., Elntholt & Yule, 2006; Lustig, Kia-Keating, Grant-Knight, et al., 2004). What they also demonstrate however is the need to be more ‘culture-sensitive’ to idioms of distress, differing expressions of distress and varied coping strategies.

Summary and conclusions

The research in the psychological well-being of young refugees has identified key areas of consistency. It is apparent that most research in this area is directed at the prevalence of psychopathology, with particular emphasis on post-traumatic stress symptomology, followed by mood and anxiety problems. This research clearly demonstrates that young refugees are vulnerable to the effects of pre-migration stressors, most notably exposure to trauma. It is also apparent that particular groups in this population constitute higher psychological risk than others, namely those with extended trauma exposures, those with substantive traumas (e.g., torture victims), unaccompanied or separated young refugees and those displaced or in the process of seeking asylum. Research often conducted in the post-migration period, suggests that a range of pre-, peri-, and post-migration factors can significantly affect mental health outcomes, and that certain risk and protective factors exist to temper or aggravate psychological symptoms. These include individual dispositional and demographic factors such as age, gender, self esteem, beliefs, attitudes and coping style, family factors such as cohesion, support, familial/parental psychological health; system and environmental factors such as peer and community support; and acculturative factors such as identity development, cultural bereavement and intergenerational stress. But even with widely reported mental problems and numerous risks, the literature is also clear that good adaptation can occur, even in the presence of psychiatric symptoms. Indeed some studies report good adaptation and no/few mental health problems.

The literature reviewed here has helped to identify particular areas which require further investigation. These include (i) investigations of newer refugees
groups and comparisons of outcomes such as PTSD, or depression across different cultures; (ii) investigations of specific ‘youth’ samples which often fall in the divide between child/adolescent and adult literatures; (iii) investigations of alternate psychological outcomes such as somatisation and positive/psychosocial adaptation, (iv) investigations of risk and protective factors that exacerbate or temper the effects of trauma and migration experience; although risks are fairly well established, more investigations are needed in relation to resilience and adaptation factors; and (v) investigations of psychological well-being from refugee perspectives; while much research has utilised quantitative techniques to gain a very good understanding of mental health issues, qualitative investigations might help to consolidate these findings to address limitations in Western frameworks and provide further ‘insider’ insights to the context of relationships between variables.

Investigations of psychopathology continue to be useful given the applicability of these problems in potentially traumatised refugee populations. Indeed it is generally accepted that the use of mental health constructs bring scientific legitimacy to human suffering (Breslau, 2004), which in turn, can help to mobilise help available to young refugees (Summerfield, 1999). What is required however is an extension to the exclusive focus on trauma and PTSD, where additional psychosocial and ecological factors that occur across all phases of migration are considered in influencing mental health and well-being in the resettlement context. Allowing for an integrated holistic perspective on refugee psychological well-being necessitates an understanding of theoretical perspectives underpinning refugee mental health. Though the literature is well organised by pre-, peri- and post-migration factors that influence mental health, there exists a lack of overt theory to explain how psychological well-being in young refugees is understood. The next chapter will explore theoretical frameworks used, though not always clearly reported in understanding the refugee experience.
CHAPTER 4: THEORETICAL PERSPECTIVES IN YOUTH REFUGEE MENTAL HEALTH

Overview

Despite mounting research in refugee mental health, much of this work has lacked an explicit theoretical framework to guide descriptions and explanations of the refugee experience (Lustig, Kia-Keating, Grant-Knight, et al., 2004; Ryan, Dooley, & Benson, 2008). This has meant that mechanisms underlying mental health responses, and therefore treatment mechanisms, are not clearly understood. This chapter provides an overview of theoretical perspectives in refugee mental health. It draws on phase based understandings as well as perspectives in the trauma, developmental, acculturative, and psychosocial/eco logical spheres to provide a framework for understanding youth refugee mental health. The aim of this chapter is to make explicit the approaches that are available to enhance a theoretical understanding of youth refugee mental health, thereby creating a lens from which to focus the present research. It argues that there is no unifying theory from which to understand refugee mental health; and that rather, the complexity and multifactorial nature of the refugee experience requires a dynamic understanding that draws from a number of relevant perspectives.

The phased based approach to refugee mental health

As outlined in Chapter 1, the present thesis utilises a phased based understanding to organise the numerous and diverse variables considered to be important in refugee mental health. In the absence of overt theories, phase-based models have arisen to address the need to organise factors relevant at different chronological phases in the refugee experience, namely at pre-, peri-, and post-migration (Davidson, et al., 2008). During each phase, distinct stressors and responses to trauma and migratory experiences can vary. During the pre-migration phase, refugees can experience economic hardship, social upheaval, political oppression and rising chaos in their region (Ager & Strang, 2008; Rambaut, 1991). Disruptions to education and social
development can also occur alongside the anticipation of negative and devastating events. Threats to individual/family safety and the witness or participation in violent activities may also be experienced (Papadopoulos, 2001). Experience of PTE’s often occur in this phase (Davidson, et al., 2008). For instance, physical injury or torture, the death of loved ones, the disappearance of family members, witness of violence and death, and at the extreme, exposure to mass killings. Decisions about whether to leave ones home, family, friends, community and belongings are made in this phase (George, 2010).

During the peri-migration phase, the sudden direct experience of war can result in sudden departure (Lustig, Kia-Keating, Grant-Knight, et al., 2004; McCarthy & Marks, 2010). Young refugees may experience displacement from their homes, often resulting in transitional placements, such as refugee camps. During this time, uncertainty about the future may be experienced (Fazel & Stein, 2002), with reliance on external sources to meet basic needs while determining options for asylum. Children born in this phase are vulnerable due to disruptions in care giving and attachment, and for older children, separation from parents can occur. Due to often chaotic departure, few opportunities exist for families to say goodbye (Tipping, 2010). Often called the peri-migration or flight phase, this phase will involve the journey towards the country of first asylum (Ager & Strang, 2008). This journey can be long, arduous and dangerous and throughout the journey, multiple separations can occur. While many refugees arrive in camps, there are many who live on the outskirts, in countries of asylum. During this period of temporary settlement, hardships are often inexperience in the forms of illness and disease, malnutrition, squalor living conditions, and restrictions to health and medical access (Tipping, 2010).

Psychological threats include those that arise from previous trauma, boredom, loss of autonomy and freedom, disempowerment, uncertainty, helplessness and hopelessness. Disruption in education is commonplace and opportunities to practice cultural and family traditions are limited. Often refugees experience hostile attitudes and behaviours from the ‘host’ society (Tipping, 2010). Unfortunately for many refugees, this period is long and protracted, often due to awaiting claims of asylum. Although potentially traumatic experiences resulting directly from war occur often in the pre-migration phase, exposures to PTEs also commonly occur in the peri-
migration stage. These often include dangerous living conditions associated with life in exile and/or camp life (Hjern, Angel, & Jeppson, 1998).

In the third post-migration phase, young refugees experience further challenges around resettlement and acculturation to the host country (Williams & Berry, 1991). Although characterised by hope for a better future, the process of settlement can be stressful. During this time, refugees encounter new belief systems, values, and mores which need to be incorporated into existing belief systems. This can pose challenges to psychological adjustment (Papadopoulos, 2001). Everyday societal systems such as laws, healthcare, transport, education and language need to be learned and navigated. Many refugees endure financial hardship during this settling period, which is underscored by the search for suitable accommodation and employment, particularly when prior employment and education are not recognised (Beiser & Hou, 2001).

Inconsistencies across old and new cultures have to be reconciled and new cultural patterns and family roles can disrupt resettlement. Younger refugees face additional challenges when straddling old and new cultures (Davidson, et al., 2008). Due to educational opportunities and more rapid language acquisition than parents, young refugees may experience pressures as cultural liaisons for older generations (Coll & Magnuson, 1997). With a dominating host culture, opportunities to maintain one’s original culture are diminished. Missing family and friends as well as concerns for those left back home can compound resettlement stress, as can the added responsibilities of supporting those back home (Beiser & Hou, 2001). Correa-Velez (2010) maintains that social isolation can be a harmful factor, particularly when racism and discrimination are experienced. Acculturative factors are often underplayed in terms of their influence on adjustment, but such resettlement stress can maintain, exacerbate or trigger psychological distress in young people. Indeed, they can have a direct and deleterious influence on the experience of depression in young refugees (Sack, et al., 1999).

Although sometimes viewed of as a ‘default’ theoretical framework in the absence of comprehensive models, the utility of phased based understandings is that they neatly draw out identifiable factors that are relevant to the refugee mental health experience. Despite the growing recognition of the influence of different factors across time however (Lustig, Kia-Keating, Grant-Knight, et al., 2004; Silove,
Sinnerbrink, et al., 1997), phase models unfortunately have tended to only summarise factors in an organised manner discretely across time. Fewer studies take the phase based approach further to examine how such factors empirically relate to one another across time to measure their unique and combined impacts on mental health in young people (Silove, Sinnerbrink, et al., 1997). How such relationships between variables explain mental health outcomes is also lacking in the phase based approach. Moreover, phase based models have been criticised for being too discrete in that some experiences occur across several phases. For example, deprivation of basic needs, separations, the inability to practice cultural and religious traditions and/or loss experiences all occur over pre-, peri-, and post-phases. Despite such criticisms, the phase based approach offers a clear way to understand and organise the refugee experience in a systematic way, making it appropriate for empirical study designs (Lustig, Kia-Keating, Grant-Knight, et al., 2004). The implications of the phase based approach in terms of its linearity and how it can be improved to understand refugee mental health are discussed in the final chapter.

**The trauma focused psychiatric epidemiology (TFPE) approach**

Over the past 20 years, a substantial body of literature in refugee mental health has accumulated (Silove, 2005) (see Chapter 3 for review). The underlying theoretical approach of most of this research has been the application of *trauma focused psychiatric epidemiology* or TFPE, also known as *traumatology* or *trauma theory* (herein referred to as TFPE). Based on a positivist philosophy, TPFE merges two fields of study, psychiatric epidemiology and traumatology - the study of psychological trauma (Miller, et al., 2006). The TFPE model focuses primarily on the diagnosis of psychopathological states resulting from trauma, their prevalence, causes, and correlates. It defines the focus for rigorous empirical study and endorses quantitative methods with the aim of generalising findings across different settings (Miller, et al., 2006). As seen in the literature review in Chapter 3, models such as the pre-, peri-, post- phase framework incorporate elements of TFPE, implying that frameworks for thinking about refugee mental health overlap. Historically, the TFPE approach emerged and has been strengthened by the introduction of the diagnostic category for Post-traumatic Stress Disorder (PTSD), in the third edition of the
Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980) or in like manuals such as the International Classification of Diseases (ICD-10) (De Jong & Van Ommeren, 2002; Watters, 2001). Originally, the category for PTSD arose out of a need to acknowledge the large number of veterans from the Vietnam War presenting with symptoms of ‘combat stress’. Since its application to war veterans, PTSD has been applied to various populations of trauma (e.g., sexual assault, physical injury patients), including refugees (Miller, et al., 2006). Given the likelihood that refugees have encountered stressful and traumatic events, it is unsurprising that TFPE has been popularly applied to refugees, as psychopathological outcomes are among the most obvious consequences of such traumatic experiences (Porter & Haslam, 2005).

Within the TFPE paradigm there exist various empirical models for understanding the effects of trauma. These include cognitive behavioural models, which focus on fear cognitions, catastrophic interpretations, and reinforcement principles postulated to develop and maintain PTSD (e.g., Ehlers & Clarke, 2000; Foa & Rothbaum, 1998; Resick & Schnike, 1992) and emotional processing models, which view PTSD symptoms as a function of erroneously processed traumatic memories (Foa & Rothbaum, 1998). The essence of these theories is to help understand or ‘explain’ the occurrence of traumatic stress reactions within the individual that can be used to generalise to other individuals. In the refugee area, the TFPE approach has legitimised the suffering of many individuals around the world affected by trauma, bringing therapeutic assistance to many in distress (Silove, 2005).

While unquestionably beneficial, the TFPE approach has been widely criticised, particularly in non-mainstream literatures such as sociology or anthropology. First, critics argue that implicit in a TFPE understanding is that refugees are ‘unwell’ and in diagnosing emotional disturbance, they are pathologised for what would otherwise be perfectly normal responses to rather abhorrent or abnormal events (George, 2010; Summerfield, 1999). These critics argue that viewing refugees as simply bearers of psychiatric symptoms minimises the incredible fortitude to flee war and persecution. In addition, it has been argued that an overriding focus on trauma has diverted important attention away from other important issues (Silove, 2005; Summerfield, 1999), such as the impact of meaning/identity/values to individuals, moral and social justice implications (Marsella, 2009), and the social
construction of war itself (Summerfield & Hume, 1993). More specifically, critics argue that the TFPE approach relocates phenomena from the social to biological realm, thereby distorting the human cost of war and objectifying misery and suffering, naturally experienced by war. Summerfield notes that because Western approaches locate cause and place onus of responsibility on the individual, the collective experience of war is ignored. As a result of diagnoses, critics claim that treatments are then imposed on survivors of trauma, which are rarely assessed for acceptability (Summerfield, 1999).

Additionally, it is argued that TFPE reduces the historical and political context to individual psychology and that traumatic experiences are actually larger than what can be captured in a sole PTSD construct (Allodi, 1991). By assuming the universality of a unitary and Western derived construct (or other like constructs such as anxiety or depression), critics argue the TFPE model ignores the influence of culture, thereby challenging its applicability cross culturally (Marsella & Christopher, 2004; Marsella, Friedman, Gerrity, & Scurfield, 1996). Such challenges posit that Western frameworks assume global relevance, in the process de-contextualise the individual from context, and ignore non-Western psychologies. Furthermore, it is argued that Western frameworks that use standardised measures to assess standardised constructs focus on similarities and not differences and that because Western frameworks can identify symptoms regularly, this is not to say that they mean the same things in different cultural settings (Summerfield, 1999). Some go as far as to suggest that mainstream trauma research ignores culturally appropriate empirical work and that investigations of idioms of distress for certain cultures are indeed tokenistic because they rely on Western assumptions and translations of Western emotional worlds to non-Western worlds (De Jong & Van Ommeren, 2002; Summerfield, 1999). Others argue that the indiscriminate acceptance and application of Western practices, which are themselves a cultural construct, and therefore scientifically inaccurate, constitutes potential abuse of minorities (Marsella, 2009). These critics favour instead, the study of idioms of distress, which involve cultural specific patterns of help seeking and traditional coping methods, to be explained within socio-cultural paradigms which do not conceal cultural, and historical specificity (Miller, et al., 2006).

A second criticism is that TFPE is too focused on high impact events that occur in the pre-arrival context (Ryan, et al., 2008; Watters, 2001). Thereby resulting
in the neglect of needs in the post-migration period, where the demands of the former
are judged as greater than those in the host environment. In this way, TFPE is
criticised for failing to address migrant adaptation processes and the impact of socio-
environmental factors in the host society. In narrowly focusing on the pre-migration
context, TFPE fails to assess the multiple and sequential stresses that occur in the
whole refugee experience (Friedman & Jaranson, 1994; Ryan, et al., 2008; Silove,
1999). Indeed, Summerfield (1998, 1999) cites examples in which survivors in the
resettlement phase may have other problems on their mind outside of mental health
issues- that is, many survivors when asked, cite socio-economic concerns such as
finding employment or feeding their families as their main concern. Thus, he argues it
is a fallacy to assume trauma weighs on the minds of refugees. Watters similarly
argues that therapies are unlikely to be successful because patients are not asked about
what they believe is the aetiology of their problems and that the concerns of refugees
may be socio-economic or focused on grief and missing family as opposed to
symptom relief (Watters, 2001).

A third criticism directed towards TFPE is that it is too narrowly focused on
classical psychopathological outcomes such as PTSD and anxiety, thereby ignoring
other adverse outcomes that form part of the trauma experience for refugees. Such
outcomes have only recently been explored and include grief/loss experiences,
cultural bereavement, anger, pessimism (Muldoon & Wilson, 2001), meaninglessness
(Jones, 2002) or altered ideologies (Punamäki, 1996).

The fourth criticism extends from the third in that TFPE does not adequately
account for positive outcomes that are associated with trauma exposure. Studies
driven by TFPE methodologies have directly led research to explore negative
psychopathological outcomes, resulting in fewer investigations into the impact of
trauma on internal characteristics such as meaning (Tipping, 2010) or positive well-
being factors (De Vries & Van Heck, 1994). On a deeper level, the tendency to
conflate the terms refugee and war victim into a generalised category of traumatised
associated with psychopathology, ignores capacities of refugees to ‘keep going’
despite hardship (Summerfield, 1999) and the resilience of many refugees (Muecke,
1992). Indeed, Mollica (2009) postulates that trauma survivors have an innate
capacity to heal themselves – ‘a healing force that strives for survival even if depleted
by violence’.
In response to criticisms levelled at TFPE, proponents of the approach contend that while indeed a large proportion of refugees show fortitude and recovery, particularly in a context where human rights are degraded, a small proportion does not exhibit such resilience (Silove, 2005). Thus, there is an element of ‘abnormality’ from the normal recovery from trauma. Hence, it would seem reasonable to understand those who experience difficulties as bearers of distressing, yet abnormal symptoms. Indeed, rates that show prevalence to be higher in refugee versus non refugee populations suggest that these individuals could be as many as one in ten (Fazel, et al., 2005). Moreover, while it is acknowledged that the PTSD construct is a Western derived conceptualisation, it is difficult to refute overwhelming evidence that this construct holds when applied cross culturally (Ehntholt & Yule, 2006; Harvey, 1996; Marsella, et al., 1996). It is also difficult to deny those studies which show that it is possible to validate under rigorous empirical conditions constructs and measures such as PTSD or depression in different cultures (Mollica, Caspi Yavin, Bollini, Truong, & et al., 1992). Even studies into cultural idioms of distress have found similar constructs to those found in Western classification systems (Van Ommeren, et al., 2002).

Furthermore, with respect to the focus on the pre-migration context, TFPE proponents argue that it has been unfairly criticised for its trauma centricity. Having itself been derived by a Western cultural medical context, it is unsurprising that trauma related symptoms be directed at amelioration of symptoms and suffering. Indeed, the therapies that have been developed from these models of trauma (e.g., narrative exposure therapy) attest to the utility of understanding trauma from empirical standpoints. Furthermore, the paradigm does not in itself set out to exclude other factors and acknowledges that traumatology only forms part of the overall picture in refugee psychological well-being (Ryan, et al., 2008). There is now an empirical challenge to discover not only cultural implications to trauma and pre-arrival experiences but also post-arrival factors that are of equal or greater relevance to understanding refugee mental health (Montgomery, 2008; Porter & Haslam, 2005). One of the aims of the present thesis is indeed to address this need. Although the task of understanding wellbeing and positive factors as alternative outcomes to psychopathology is not new (Jahoda, 1958), critics of TFPE argue this research has lagged given the influence of a trauma driven approach. Though it is
ambitious to apportion blame to the TFPE approach for the under investigation of positive outcomes in research, notwithstanding the attempts by the current thesis, research emerging from the trauma paradigm is now attempting to reduce the disparity between psychopathological research and research that focuses on positive and psychosocial outcomes. Thus, even with the trend towards alternative models of understanding the refugee experience, the TFPE remains important in documenting the ways in which exposure to organised violence significantly increases the risk of both acute and enduring psychological distress (Miller, et al., 2006), and the factors that ameliorate this distress.

The controversy around the two seemingly polarised positions continues alongside a nascent trend towards constructivist paradigms. However, as Silove (2005) argues, the continuation of this debate is essential to help shape priorities for planning and implementing health systems. At the same time, it is important not to overlook the advances that have occurred through TFPE. For instance, TFPE has provided important corrections to the mass denial of psychological suffering (Raphael & Wilson, 2000; Silove, 2005), thereby bringing acknowledgment to understandable distress arising from war and conflict and mobilisation of support.

Herman’s framework of complex trauma

Although never applied to a refugee population, the work of Judith Herman has majorly influenced the trauma field, and is therefore noteworthy for its relevance to refugee trauma (Harvey, 1996). Applied mostly to a population of survivors of child sexual trauma and political terror, Herman’s (1992) framework allows for a spectrum of traumatic disorders, ranging from the impact of an overwhelming single event trauma to the more complex effects of repeated and prolonged exposure. Treatment models based around Herman’s model suggest that because trauma syndromes have common features, recovery processes should follow the pathway in which the trauma syndrome was developed. That is, stages of recovery should involve re-establishing safety, where safety has been otherwise shattered, reconstructing the trauma story, and restoring connections between survivors and their community, where previously these have been broken (Herman, 1992).
Herman’s understanding of complex trauma appears applicable to understanding refugee trauma where exposure to traumatic events is not often single but rather, repeated and prolonged, particularly where torture has formed part of the trauma experience. Herman’s work in ‘complex PTSD’ is notable as it has led to the rethinking of PTSD, particularly complex forms of trauma, the application of diagnostic labels, and the aetiology of emotional disorders. Although Herman’s model of complex PTSD has not been utilised for young refugees, it does highlight the strength of theoretical models to be able to inform trauma focused treatments in such a detailed way (Foa, Keane, & Friedman, 2003; Harvey & Tummala-Narra, 2007). Having achieved such success in the treatment of childhood sexual trauma, the challenge for theoretical models in refugee trauma to inform treatment is ever present.

**Berry’s Acculturation framework**

As mentioned earlier, TFPE has been criticised for ignoring the post-migration context (Ryan, et al., 2008). Acculturative models, on the other hand, are directly focused on the post-migration period, namely the migrant adaptation process. This is the process by which individuals reorganise and rebuild their lives after relocating to a new socio-cultural environment (Ryan, et al., 2008). Within the broader acculturative framework, there exist different models, each one focused on differing aspects of the acculturative process. Socio-cultural models, for example, are concerned with the demands of interacting effectively in a new cultural environment (Ward & Kennedy, 1999), whereas social identity models focus on how individuals come to terms with changing perceptions of ethnic identity as a result of intercultural contact (Ward & Leong, 2006). In contrast, economic approaches focus on the individual’s ability to access the host environment’s labour market and regain pre-migration levels of occupational status (Aycan & Berry, 1996).

Despite these different approaches, the focus in research on refugees has not been on culture learning, ethnic identity, or economic integration, but rather on psychological processes (Ryan, et al., 2008). A range of acculturation frameworks exist to understand the psychological processes over time that occur when one culture meets another (Lim, Stormshak, & Falkenstein, 2011; Williams & Berry, 1991; Wilson-Portuondo, 2003). These approaches infer a process by which individuals
experience initial euphoria and excitement in the host culture that progress to culture shock, crises about which cultural identity to adopt and eventually adaptation.

The most popular application of acculturation models has been the ‘acculturation framework’ by Berry (1997). Berry’s model focuses on the psychological impact of intercultural contact following migration and the range of personal and contextual factors that influence acculturation. The term acculturation is derived from the discipline of cultural anthropology and is defined as “those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups (Redfield, Linton, & Herskovits, 1936, p.149). Berry defines acculturation itself as “the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members” (Berry, 2005, p. 698). In this way, refugees are viewed as influential towards and influenced by the host culture (Berry, 1997).

Berry’s (1997) framework incorporates four strategies employed by individuals in acculturating to a new country. Such strategies inform the way in which individuals seek to acculturate, the outcome of which are varied positive or negative states of adaptation. These strategies include: Assimilation, which entails renouncing the culture of origin and one’s own cultural identity in favour of adopting the host culture; Integration, where membership of the culture of origin is retained, at the same time, maintaining contact with the host culture; Separation, where contact with the original culture is maintained and the host culture is rejected or less important; and Marginalisation, where contact with both the original and host cultures are lost, possibly through exclusion or self-withdrawal. Within the Integration strategy, variations of biculturalism exist ranging in those with high biculturalism, low biculturalism, and blended biculturalism (Phinney & Devich-Navarro, 1997). The outcome of Berry’s four strategies is viewed as a key factor in determining settlement success (2006).

Berry (2005) maintains that integration strategies, which allow one to maintain cultural identity but become an integrated in the host society, produce fewer mental health difficulties and achieve better adaptations. On this continuum of adaptation, assimilation and separation strategies predict more stress and less adaptation than integration strategies, whilst marginalisation strategies are associated
with greatest stress and least adaptation. The processes believed to mediate which acculturation style is used include decision making processes about whether one’s cultural identity, heritage and customs are valued, preferred and therefore maintained; and the extent to which a relationship with other groups and the host society is sought. It is important to note then that there is no freedom to ‘choose’ particular strategies, especially integration strategies, because this can only be chosen when the dominant society is inclusive (Berry, 2008; Colic-Peisker, 2005).

Recognising the host society as a contextual factor, Berry (2005) later added to his theory, four strategies employed by the host society. These included (i) melting pot (when assimilation is sought by the dominant group); (ii) segregation (when separation is sought by the dominant group); (iii) exclusion (when marginalisation is imposed by the dominant group); and (iv) multiculturalism (when integration and diversity is sought from the dominant group). Thus, not only does the individual’s cultural identity and attitudes come into play into refugee mental health but also the host society’s attitude towards integration, that individual and his/her culture. Within Berry’s framework lie a variety of stressors that affect acculturation and psychological adaptation (Berry, 1990). Such ‘acculturative stress’ comes from material changes (e.g., type of housing; different geographical space), physical changes (e.g., new foods or illnesses), political and economic changes (e.g., employment or welfare systems), cultural changes (e.g., learning new language and religion), and social changes (e.g., gender equality or interpersonal styles). Alongside these, are individual changes including values and ethnic identity. Within the individual changes, pre-existing factors such as gender, education level, cognitive ability, also affect the degree to which acculturative style one adopts.

The strength of Berry’s (1990) model is its sensitivity to the demands of cross-cultural transitions and challenges within a psychosocial stress model and the different trajectories for adaptation (Ryan, et al., 2008). In spite of this, it is criticised for lacking empirical support and exaggerating the extent to which the demands of migration are rooted in intercultural contact (Ryan, et al., 2008). These critics argue that Berry’s model ‘overculturalises’ views of migrant adaptation and issues not directly related to culture are ignored. These less salient, but equally important, demands include internal tensions associated with cultural world views, religious and ideological differences, identity confusion, loss of social networks, uncertain legal
status, poor living conditions, or separation from family members. Indeed, the latter could be the most challenging of demands in the adaptation process for refugees. Thus, to describe adaptation demands in earlier years of resettlement as acculturative stress might be misleading as the term disguises needs that are common to all humans irrespective of their ethno-cultural background (Ryan, et al., 2008).

While Berry’s (2005) model acknowledges that changes in both the dominant and non-dominant groups occur through inter-cultural contact, it is also criticised for placing emphasis on changes that occur in the non-dominant group as a result of interactions with the dominant group. That is, because Western culture is the point of comparison, there is inadequate attention given towards the power and histories of colonisation and resistance, which may be central to understanding the multiple ways in which communities and individuals respond to new and changing contexts” (Sonn & Lewis, 2009, p.116). Nonetheless, Berry’s (2005) model does highlight the important influence of a host-society context, which has the power to influence acculturation and therefore mental health experiences of refugees, contrary to locating problems with individual responsibility and choice.

Integrative psychosocial and ecological frameworks

Traditionally, TFPE and social frameworks have been polarised, with each field seen as incompatible with the other (Miller, et al., 2006). Recently, the debate across these camps has evolved to highlight the overlap between these seeming contrary perspectives. Miller et al. (2006) for example, attempt to bridge trauma focused approaches with psychosocial ones, resulting in the application of integrative or holistic approaches to understanding the refugee experience. They propose an alternative to an exclusively scientific paradigm that incorporates some constructivist conceptualisation and methodology. First, they suggest that scientific paradigms should be examined and interpreted with some caution, noting that while PTSD can transcend cultures, the approach can potentially exclude the powerful influence that culture has in the way psychopathology is experienced and expressed (Miller, et al., 2006). Indeed some authors make reference to a ‘category fallacy’ that can befall good intentioned cross cultural research in that an erroneous assumption is made that a diagnostic category developed in one context is applicable to another, just because
the ‘symptoms’ are similar (Kleinman, 1987). Rather than propose an adoption of the constructivist approach, Miller et al. (2006) suggest that quantitative techniques can be brought into a constructivist approach itself. They argue that it is a mistaken assumption that quantitative techniques cannot be utilised in a social constructivist approach, which typically emphasises social constructions of reality, the presence of ‘many truths’ in diverse settings, human agency and meaning, and a personal relationship between the researcher and participant (Miller, et al., 2006). The effects of mediating and moderating factors in the trauma-mental health relationship therefore come into play with such a ‘combined’ qualitative and quantitative approach. These ‘mixed-methodologies’ which often include narrative data collected from interviews, highlight that a set of diverse methodologies can help to examine a greater range of research questions and reduce the hazards of a pure etic approach. The present thesis represents one attempt to incorporate mixed methodology into both an empirical and holistic approach.

In terms of particular techniques that can be embedded into a mixed methods approach, de Jong and Van Ommerman (2002) present a model for data collection that attempts to inform what they call ‘a new cross cultural psychiatry’. Important constructs within this approach include a combined emic (e.g., disease model) - etic (explanatory model) approach. That is, TFPE can be strengthened by studying cultural variables and their context. Qualitative data is necessary because it enhances understanding of the context allowing for better validation and interpretation of data. For a specific outline of their suggested methodologies, readers are referred to de Jong and Van Ommerman (2002). In brief however, the combined methods approach incorporates: (i) the identification of problems and issues through multiple focus groups which addresses issues around replication; (ii) the study of individuals through in depth interviews, which address issues around exploring the subjective world and needs/mental health priorities of the participant him/herself; (iii) snowball sampling which allows for an opportunity to explore the social network and marginalised groups for which there may only be small numbers; (iv) preparations and meeting around the study, which enables the research plan to be discussed by researchers, organisations, and representatives of the research population, and translation of measures if necessary; and (v) the epidemiological survey, where surveys can be informed by and take place in the context of qualitative research and culture.
Discussions of mixed methodologies invariably imply theoretical constructs that are holistic, ecological, and psychosocial in nature. The following paragraphs describe two theories relevant to refugees.

Holistic frameworks attempt to capture the psychosocial effects of the refugee experience (e.g., Silove, 1999, 2005), placing trauma experience in context with the individual’s social world. In the refugee experience, in the context of socio-political milieus, human rights abuses, inter-personal relationships and meanings. There are a few holistic frameworks that are relevant to understanding the refugee mental health experience - Silove’s (1999) ADAPT model and ecological theories, such as those posed by Garbarino and Kostelnky (1996a) and Harvey and Tummala-Narra (2007).

**Silove’s ADAPT model**

Informed by extensive clinical and field based work with survivors of torture and trauma, especially in Africa and East Timor, Silove’s (1999, 2005) psychosocial ‘Survival and Adaptation’ model (also known as ADAPT for Adaptation and Development After Persecution and Trauma) conceptualises the experience of extreme trauma and torture as an assault on five adaptive systems that destabilise a state of physical and psychological equilibrium (refer to Figure 1 in Chapter 1 for overview of Silove’s ADAPT model). These systems include: (1) the security-safety system; (2) the attachment system; (3) the justice system; (4) the existential-meaning system; and (5) the identity-role system. Premised on the idea that mental health professionals can play a key role across the acute to longer term post emergency setting, Silove (2005) argues that two key processes are essential to an understanding mental health in post conflict societies – these are survival and adaptation.

Silove’s model is informed by psychosocial, traumatology, and severe mental health models, and attempts to carry through not only explanations of adaptive and maladaptive responses to warfare and humanitarian crises, but also brings together an array of eclectic interventions (consistent with Herman’s approach) to manage these responses (Silove, 2005). Interventions therefore focus around the five systems primarily involving the re-establishment of security (safety-security system), reparation of social bonds (attachment system), creation of effective justice (justice system), promotion of communal coherence and meaning, religious, spiritual,
existential, political or cultural pursuits (existential system), and re-establishment of roles and identities (identity system).

Regarding the safety and security system, Silove (1999, 2005) suggests that the core characteristic of war experience is that it threatens the safety and security of not only an individual, but of a mass population. For the individual, assaults to this system can be represented by PTSD, which are triggered by threat to life exposure. Silove asserts that certain subgroups experience an assault on safety and security in different ways, which in turn direct the level of intervention required. That is, the mass population will experience adaptive responses to traumatic events with anxiety and security seeking behaviour, with extreme adaptations including terror and panic. Interventions directed by the approach therefore include social interventions (i.e., protection, curtailling hostilities) or psychological ones which incorporate crisis interventions for extreme reactions.

Consistent with ideas of resilience in the majority, not everyone in this mass population will require psychiatric intervention. Silove argues however that high risk groups (those with mental disorders) may experience different adaptive responses ranging from adaptive (e.g., care and protection provided by family) to extreme (e.g., bizarre functioning or persistent distress). Likewise, social interventions may include support and education for family, psychological interventions may comprise comprehensive assessment or community follow up, and psychiatric intervention may include treating the underlying disorder (e.g., treat psychosis). Silove (2005) claims this subgroup constitutes a very small proportion of post-conflict populations. Other subpopulations, will include those who are generally under-functioning with challenges around persistent or excessive fear and whose responses will range from adaptive (e.g., require social and family support) to more extreme, such as severe PTSD. Social interventions will include those around maximising security and opportunities to regain control, psychological interventions such as trauma specific counselling and psychiatric interventions that will be adjunctive in more severe cases. Of the five highly evolving and inter-related systems, Silove maintains the establishment of peace and security is paramount.

Regarding the attachment system (and the other remaining systems), the focus becomes more of adaptation rather than on survival as is the case in the safety and security system. One of the major disruptions caused by mass violence and
displacement is the rupture of interpersonal bonds (Silove, 2005). Separation and losses include those that are actual and symbolic. In Silove’s model, social interventions are essential in the reparation of severed bonds – where possible, families should be traced and united, and sought confirmation should be made of the fate of those missing (Silove, 2005). Interventions may be focused here, for example, on re-establishing culture specific morning rituals. Silove’s model maintains that exposure to loss is common in mass violence and while most people adapt, albeit painfully (Silove, 2005), for the minority who experience traumatic grief reactions, individual psychological interventions may be appropriate.

Regarding the justice system, the human rights perspective is fundamental in understanding refugee mental health. Traumatic events, in particular torture experience, can be degrading, de-humanising and humiliating to survivors (Silove, 2005). Survivors can sometimes be forced or obliged to make impossible choices among a set of alternatives that are equally reprehensible (e.g., exploit another). Such events can compound a sense of injustice and it is not uncommon for survivors to live in societies that remain corrupt, devoid of justice, and where perpetrators live with impunity, thereby leaving survivors with unavailable mechanisms for justice. Acute responses may therefore entail individual or group anger intervention resulting in normalising interventions, or counselling for dysfunctional anger. Medium to longer term social responses to mass injustice may include the re-establishments of criminal justice systems, truth and reconciliation commissions, compensation mechanisms, and local rituals that exact punishment or encourage forgiveness (Silove, 2005). For a minority, extreme sense of injustice provoked by ill-treatment, may lead to adaptive difficulties (Silove, 2005).

Regarding the existential-meaning system, warfare, cruelty, and trauma experience can shake an individual’s sense of life and humankind (Silove, 2005). These feelings can shape behaviours and attitudes over the short to long term and individuals and communities may find challenges in trusting authorities or outsiders. The challenge to undermined values and cultures, and belief systems can result in existential doubts, to extreme responses such as alienation or loss of faith. Social interventions are critical to help re-establish and could include measures around religious or political expression, cultural reconstruction activities and common purpose among community and society. The re-establishment of trust according to
Silove is largely determined by the individual’s social environment. For those severely affected, psychological interventions could entail elements of existential therapy with psychiatric adjunctive treatment where required (e.g., in the treatment of severe depression) (Silove, 2005).

Regarding the identity and role system, challenges to this system include the breakdown of physical integrity, identity, sense of agency and control, all of which are affected by oppressive regimes (Silove, 2005). Silove maintains that being divested of identity, social position, role, and possessions, not only represent human rights abuses, but also pose strong threat to feelings of empowerment and efficacy. Key interventions should address social, cultural, and economic needs. The availability of work or restoration in heritage and culture for instance can restore meaning and a sense of collective identity. Responses range from adaptive, such as role uncertainty, or more extreme responses, such as isolation or passivity. Interventions are directed at multidisciplinary modalities including training and skill development, psychological counselling for those severely affected, and adjunctive psychiatric interventions if required for more severe complications, such as severe depression (Silove, 2005).

Silove’s framework provides intentional flexibility for a successful theoretical model in that it allows for specific contexts, cultures, and societies to be considered as important influences in not only individual but cultural recovery from mass conflict (Silove, 2005). Moreover, it attempts to accommodate models of trauma and related diagnostic constructs, which for a significant minority can range from the mild to severe. Rather than focused on the psychiatric disorder as the outcome, however, the survival and adaptation model is based on the assumption that human beings are resilient and indeed, adept at adapting to changing environments and striving toward survival (Mollica, Poole, & Tor, 1998; Silove, 2005).

Ecological models relevant to youth refugee mental health

Originating from biological systems theories, and then later informed by psychodynamic, social, and community systems (Harvey, 1996; Harvey & Tummala-Narra, 2007; Williams, 2010), ecological models of trauma are gaining popularity in understanding the refugee experience. These models are analogous with biological
premises that organisms survive, thrive, and decline. Like other living things, humans also evolve with their communities and environments (Harvey, 1996). The early work of Bronfenbrenner (1979) has influenced much of the work in human developmental psychology. His ‘ecological systems theory’ considers human development as occurring within a milieu of his/her systems. These systems or ‘nested environments’ include the: (1) microsystem; (2) the mesosystem; (3) the exosystem; and (4) the macrosystem (Bonfenbrenner & Morris, 1998).

In this inter-reliant system, the microsystem refers to the immediate surroundings of the individual. These contexts include the connections to family, peers, school/teachers, and general neighbourhood. The majority of direct interactions with social agents take place within this system and the individual is considered to play an active role in interactions, helping to construct his/her own social setting (Bronfenbrenner, 1979). The protective roles of parents (or absence of parent/s), peers and communities seen in the refugee literature would be subsumed in this system. The mesosystem refers to the relationship between different micro-systems or the system that connects the different contexts; for instance between family and school experiences, school to peer experiences, or family to church experiences (Bronfenbrenner, 1979). In terms of traumatic response, young people’s separation from family might result in difficulties establishing friendships or in learning difficulties at school.

The exosystem refers to the connection between a social setting in which the individual does not have an active role (Bronfenbrenner, 1979). For example, an individual’s experience at school may be influenced by government decisions about the number of hours of English classes his/her mother is entitled to receive. Such decisions might impact negatively on the time available to spend with the young person or positively through parental acculturation. The macrosystem describes the culture or cultural context in which individuals live (Bronfenbrenner, 1979). These contexts include developing and industrialised host countries, socioeconomic status, poverty, or ethnicity. Members of cultural groups typically share a common identity, heritage, and values. The macro system evolves over time, because each successive generation may change the macrosystem, leading to individual development in a unique macrosystem. As a result of acculturation in young refugees, for instance, heritage, identity, and values may change. Lastly, the chronosystem refers to the
patterning of environmental events and transitions over a lifetime as well as socio-historical circumstances in the individual’s life (Bronfenbrenner, 1979). Separation from family, for instance, may be considered one such transition. In such situations, emotions can range from being intensely painful initially, to effective adaptation, but the course may be variable. The chronosystem might also encompass socio-historical circumstances such as educational opportunities for women which might impact on the life of female refugees in host countries.

In relation to traumatised cultural populations, Garbarino, Elbedour, and Harvey have extended the work of Bronfenbrenner (1979) and other ecology theorists (e.g., Belsky, 1993). The work of Garbarino and others will be described in the next section in relation to developmental ecological frameworks. A discussion of Harvey’s (Harvey, 1996; 2007) model for adults will also follow.

*Developmental (ecological) frameworks in youth refugee mental health*

The age at which trauma, displacement, and migration occur is seen as an important contextual factor to understanding youth refugee mental health experiences (Lustig, Kia-Keating, Grant-Knight, et al., 2004). As discussed in Chapter 3, although young people are especially vulnerable because of incomplete development, it is unclear the extent to which age and development influence mental health experiences and how trauma, displacement, migration, and acculturation experiences affect development itself. Developmental frameworks are important to consider in youth refugee populations since many youths at resettlement, will have spent their early and formative years growing up in conflict or peri-migration states (CMYI, 2006). In their review, Lustig et al. (2004) concluded that culturally appropriate developmental frameworks that take into account ecological factors are necessary to ensure a comprehensive understanding of refugee youth mental health. Although specific developmental perspectives have been developed more recently for refugees (e.g., Boothby, 2008; Elbedour, Ten-Bensel, et al., 1993; Garbarino, 2001) and will be discussed, it is noteworthy to mention Erikson’s (1968) eight stage theory of psychological development. This theory states that combined with biological maturation, social environments provide individuals with sets of psychological conflicts and crises across infancy to adulthood that require resolution.
These conflicts occur with each developmental milestone. For example, conflicts of trust versus mistrust in occur in infancy, identity versus role confusion in adolescence, or intimacy versus isolation in adulthood. The goal of these crises is to successfully resolve them before new ones present themselves (Erikson, 1968). Whether successful or not, the results of the resolution, are carried forward to the next crisis, providing a foundation for its eventual resolution. Applied to refugees, Erikson’s theory poses that wartime experiences of mistrust, persecution, and powerlessness exacerbate the psychological crises that occur in normal development, producing psychological vulnerability and compromising emotional development. Moreover, children and adolescents are dependent on adult decisions which are often made in upheaval and political violence. This trust in adults’ ability to care for them and the safety of the world become undermined (Lustig, Kia-Keating, Grant-Knight, et al., 2004). Although not tested on a young refugee sample, Erikson’s model is culturally relative and reliant on Western constructions of childhood. The cultural applicability of this theory may therefore be limited as it assumes normal development is not culturally embedded (Kinzie, 2001a; Summerfield, 1999).

The most prominent work in developing culturally sensitive ecological-developmental frameworks have come from Garbarino (2001) and colleagues. Being directly informed by his work in children exposed to community violence, Garbarino (2001) argues from an ecological perspective that risk accumulation occurs in children who are exposed to war trauma. The ‘risk accumulation’ model states that as pathogenic (or negative) influences increase, the likelihood of psychological harm increases. Conversely, where salutogenic (or positive) influences occur, recovery is enhanced (Garbarino & Kostelny, 1993, 1996b). This notion of addressing a balance between risk and protective factors is particularly relevant to what may seem to be an operationalised form of resilience, suggesting there may be a point at which exposure to risk relative to protective factors exceeds the limits of resilience.

Garbarino (2001) argues that there are major pathogenic impacts of war and that the processes associated with disruption to development brought about by war trauma, are both direct and indirect. Directly, trauma stimulates the stress hormone cortisol, impeding brain development and subsequent intellectual development. Consequently, abstract reasoning, impulse control, and moral development are impeded. This biological change is well documented in research studies of trauma in
infants and children (Newman & Steel, 2008). Indirectly, war trauma can disrupt the normal care giving that ordinarily occurs, resulting in emotional neglect (Garbarino, 2001).

Garbarino (2001) also argues that war exposure impacts on the development of ‘social maps’ which children form in the course of normal development. These cognitive representations or pathways are crucial in mediating the experience of risk in later outcomes. Such maps may include ideas that ‘adults are powerless and unreliable’ versus ‘adults are trustworthy because they know’ or that ‘school is a safe place’ versus ‘the only safe place is at home’. Garbarino argues that pathogenic influences can easily disrupt these maps, severely compromising the perception of security and safety. In this way, Garbarino’s (2001) theory is largely informed by not only physical understandings, but also social and cognitive learning models of fear. In this process, the social-cognitive crises that arise for children initiate processes of moral development, including the role of meaning and ideology (Garbarino, et al., 1991). Further, Garbarino (2001) argues that a process that accelerates war into pathogenic experiences is the social disruption of families. Hence, children will cope and display resilience in situations as long as parents or caregivers are managing. The role of mothers as primary caregivers and givers of support is crucial to whether or not risk can be ameliorated in the young person. In the absence of such support, children may rely on their interpretations and ideology as an alternative means to cope (Garbarino & Kostelny, 1996b; Garbarino, et al., 1991).

Garbarino’s (2001) theory also views trauma as pathogenic to the philosophical and ideological world of the child. He argues that war and danger disrupt a sense of meaning in life but can be restored through individual narratives which allow for interpretations of events and a way of segueing into the future. Like Mollica (2009), who believes narratives can be therapeutic, Garbarino argues that story telling is essential to the maintenance of coping and resilience. While ideologies can enhance resilience, Garbarino (2001) argues children may cope with danger by adopting ideologies that are dysfunctional for normal situations.

In sum, Garbarino’s (2001) model states that trauma arises when a child cannot give meaning to dangerous experiences. Pathogenic experiences associated with war result in overwhelming arousal and emotion because the immaturity of the child’s brain cannot modulate arousal. Pathogenic experiences also result in
overwhelming cognition, rendering a child unable to make sense of his/her experiences, resulting in ‘abnormal’ thoughts, feelings and patterns of behaviour. Chronic experiences of war trauma redefine a young person’s social reality and meaning to life. To accommodate and ameliorate pathogenic influences, adult caregivers must play a prominent salutogenic role (Garbarino, 2001).

Similar ecological models have been posed by Boothby (2008) and Elbedour et al. (1993). Boothby, for instance, argues that child development occurs within overlapping systems of the family, community, and society. The framework emphasises stabilisation across these systems, particularly the community, as well as the reduction of risks, and strengthening of resilience. Boothby asserts that armed conflict creates a culture of violence and produces de-stabilisation that damages support across these interacting systems. Risk and protection are viewed at a macro level system, where war destroys peace and trust, institutions and laws, damages infrastructure, including vital developmental systems such as schools, and denies basic needs. A societal norm of violence is also established. The family system is also impacted, as well as community relationships and life (Boothby, 2008).

Similarly, Elbedour and colleagues (1993) argue that suffering in war exposed children results from complex interactions between psychobiological processes around development, family stability, the breakdown of community, and the impact on culture. Elbedour et al.’s (1993) model is based on earlier work by Belsky (1980). Like Bronfenbrenner, Belsky suggested that the four forces of individual development (ontogenic development), the family (micro-system), the community (exo-system), and culture (macro system) determine the level of maltreatment and response to that maltreatment in children. Elbedour et al. (1993) add a fifth dimension in that the sudden impact, intensity, and duration of war-related experiences compound these interactive processes. This view is certainly supported by the empirical literature reviewed in the previous chapter.

Regarding individual development, Elbedour et al. (1993) suggest that the ability of children to integrate their traumatic situations is dependent on their resources and developmental characteristics at the time of the situation. This is perhaps useful in explaining the sometimes inconsistent findings for age and less so, but apparent, by gender (Eth, 2001; Rutter, 2006a). Of course, the family system is critical in the way children manage the stress of war and trauma. Consistent across all
theoretical models reviewed, family acts as a buffer to stress, particularly the role of mothers whose own responses are resilient (Elbedour, Ten-Bensel, et al., 1993). The community and peer system in Elbedour et al.’s (1993) model is drawn from Garbarino’s work and suggests that school is critical as a care-giving environment. It is argued that not only is school the most continuous institution for children after the family, it represents the most important unit of development in modern social systems (Elbedour, Ten-Bensel, et al., 1993). The breakdown and interruption to school can therefore have enormous impact on the life of a young refugee.

Within the culture system, ideologies, religions, beliefs and attitudes towards violence in the culture are thought to mediate children’s responses to trauma. Finally, Elbedour et al. (1993) state that incidents such as bombardments and sudden unexpected attacks are crucial in how children will cope psychologically with trauma. They argue the nature of war itself leaves children scarred. In their model, Elbedour et al. (1993) argue against the idea that children cope with war by assuming it is ‘normal’ (i.e., the idea that war becomes so embedded and pervasive that it becomes the ‘norm’ experience for children). Indeed, that ‘normalisation of war’ could suggest a maladaptation to war itself, becoming more harmful when a world view normalising violence, gets passed onto future generations (Elbedour, Ten-Bensel, et al., 1993).

Harvey’s ecological model of trauma, resilience and recovery

Like Silove (2005) and the ecological theorists mentioned above, Harvey’s (1996) ‘ecological model of resilience’ assumes that human resilience can occur in the experience of trauma. The model understands violent and traumatic events as ecological threats not only to adaptive capabilities of the individual, but also of the community to foster resilience among its members (Harvey, 1996). Harvey proposes that individual differences in trauma response are the result of highly complex interactions between person factors (e.g., pre-trauma coping, age, cognitive flexibility, hopes, and attitudes), event factors (e.g., nature/severity of trauma, degree of violence/humiliation, separation) and environmental factors (e.g., home, school, support system, community attitudes and values). Thus, individuals are not equally vulnerable, and independent and reciprocal interactions among these factors form the basis for less or more resilient responses to trauma (Harvey & Tummala-Narra, 2007).
These interactions also help to determine the availability of social support and underlie access to and comfort with professional care (Harvey, 1996).

Ecological research is driven by attempts to gain a full understanding of psychological trauma, recovery, and resilience in both treated (e.g., clinical) and untreated (e.g., community) populations. Harvey’s model underscores the notion that resilience and recovery are not rare, but common (Bonanno, Galea, Bucciarelli, & Vlahov, 2007). In taking this idea further, the model suggests that there are multiple pathways towards resilient outcomes and that a number of transactional resources can be used to arrive at more positive outcomes (Harvey, 1996). That is, inter-dependent and reciprocal interactions set the stage for greater or lesser resilience. The strengths of such models are that they are attentive to the experience of trauma survivors from diverse contexts and at various points in the recovery process. Central to these models are their emphasis on the applicability of constructs to different cultures. Although ecological models offer great promise in capturing the factors identified, few studies have explicitly tested the interrelationships described by such models. The present thesis attempts to utilise an ecological framework, alongside phase-based psychosocial understandings to capture youth refugee mental health and resilience.

In summary, the holistic ecological and psychosocial models overviewed, have in common the psychological sequelae experienced by individuals, the essential mediating roles of families, and the stabilising role of peers, communities, cultures, and societies. These systems provide individuals a sense of continuity, attachment and contact, a sense of sharedness and commonality (e.g., language, physical appearance), a sense of security, a sense of culture and acceptance, positive regard, and a sense of grounding in lost order (Elbedour, Ten-Bensel, et al., 1993). Importantly, they are able to inform sensitive treatment practices that can address individual needs (trauma response and other) as well as strengthen families and communities within the individual’s system, and culture more broadly (Miller & Rasco, 2004b). The models offer insights into unpacking the individual, allowing attention to be given to values, norms, countries of origin, and decision making processes. They emphasise environmental factors as having major roles in development, allowing variation from culture to culture. That is, they allow for a combination of risk factors associated with trauma and mental health in young refugees to be incorporated. Ironically, it is for these reasons that the models are criticised - for being too complex and unwieldy -
and thus failing to achieve the research goals of identifying manageable, isolatable factors and pathways around understanding mental health. Like all models though, they can only approximate the truth (Williams, 2010).

Importantly, ecological-developmental perspectives have been applied to young people exposed to community violence or maltreatment and (Lynch & Cicchetti, 1998), displacement (Betancourt & Tanveer Khan, 2008), terrorism (Moscardino, Scrimin, Capello, & Altoe, 2010) and victims of violence (Harvey, 1996; Harvey & Tummala-Narra, 2007). In refugee populations, they are beginning to be applied (Correa-Velez, et al., 2010). Whilst sharing overlap, psychosocial models slightly differ from ecological ones in the attention they give to social, cultural, and political contexts. Ecological models emphasise more the immediate family and community in recovery.

**Summary and conclusions**

Unfortunately, explicit theoretical bases have been lacking in refugee mental health studies (Lustig, Kia-Keating, Grant-Knight, et al., 2004). This chapter attempted to broaden the scope of theoretical knowledge in refugee trauma and make explicit the relevant theoretical approaches underpinning much of the research in this area. In doing so, it highlighted the complex and diverse range of inter-related factors across all phases of migration that need to be considered in explorations of refugee mental health. It is no surprise given the range of factors that need to be considered, that no unifying theory currently exists in the refugee mental health area.

Although a variety of approaches exist, theoretical frameworks in this area generally derive from two traditionally competing paradigms, the “biomedical-positivist” and the “socio cultural-constructivist” paradigms. Overlapping with each of these broad perspectives, are other relevant frameworks including developmental and acculturative models, as well as integrated psychosocial and ecological models directed at risk and resilience across a range of factors including the individual, family, culture, community, and broader society (original and host). The frameworks presented the diversity of disciplines and constructs available to understand the refugee experience, which although are sometimes at odds with each other, often show overlapping features and similarities.
This chapter highlighted that while there has been an overemphasis of PTSD (and psychopathologic) centric research, this research has also been invaluable in demonstrating the validity and consistency of this approach. Acknowledging the contribution of psychosocial and ecological frameworks, which emphasise viewing the individual in his/her socio-historical-political- and cultural context, it is apparent that research is needed to refine the exploration of mediating and contextual factors on negative as well positive responses to traumatic exposure.

To conclude, there are merits and disadvantages among all approaches presented. Common themes across the models observed include: (i) there are multiple factors across the individual, family, peer group, community, culture, and broader society to consider, and that organising these factors across pre-, peri- and post-migration categories can be helpful; (2) that resilience and adaptation is presumed in refugee populations, but a significant minority may require trauma focused approaches; (3) mixed methodologies offer a chance to enrich our understanding and research agenda by contextualising war and trauma experience on the basis of individual, culture, social, historical, and political circumstances; and (4) integrated psychosocial and ecological models show promise in that they are also drive treatment priorities. Importantly, the theories reviewed here provide coherence with literature reviewed in the previous chapter. Rather than taking a one approach versus another, the complexity of the refugee experience requires a combination of various approaches. The current thesis will utilise an integrative approach based on the phase based continuum and psychosocial and ecological models to explore the interaction of factors that contribute to mental health outcomes in young refugees resettled in Australia. It will maintain the dominant focus on trauma but try to gain a richer understanding of the inter-relationships between factors described and psychological outcomes for young refugees. The resulting mixed-methodology in applying this framework for understanding and the method itself is presented in the next chapter.
CHAPTER 5: METHODOLOGY AND METHOD OF THIS THESIS

Overview

The previous chapter contended that the utilisation of mixed-methodologies offers a chance to conceptualise the refugee mental health experience through a holistic lens that need not compromise, but rather enhance, empirical rigour (de Jong, et al., 2001; Miller, et al., 2006). This chapter will describe the mixed methodology adopted in the thesis. The method, combing quantitative and qualitative techniques, incorporates the use of psychometric assessments as well as individual and focus group interviews. Before these aspects are described, some ethical considerations that guided this research are discussed, with the aim of underscoring the challenges encountered in cross cultural research with vulnerable populations. These considerations are consistent with those outlined by the RMIT Human Research Ethics Committee, which approved this research (see Appendix A), but are discussed in more detail with respect to how such principles were applied in the current research.

Ethical considerations

Trust, rapport, and engagement. Given their exposure to war trauma and other associated risk factors, young refugees in the transition of childhood/adolescence to adulthood, are particularly vulnerable (Newman & Steel, 2008). Conducting ethical research with such populations therefore poses many ethical challenges (Ellis, Kia-Keating, Yusuf, Lincoln, & Nur, 2007; Miller & Rasco, 2004a). Researchers must not only protect their participants from potentially intrusive or insensitive research, but also balance the possible benefits of participation against the potential risks (Emanuel, Wendler, & Grady, 2000; Leaning, 2001; Newman & Kaloupek, 2004). Implicit in these actions is the establishment of trust and rapport, not only with individuals, but also their ‘microsystem’ (i.e., families and cultural communities), whom often act as gatekeepers to individual members and whose guidance is often relied upon (CMY, 2005). It is well established and understandable that families and/or communities are
reluctant to provide access to their members by ‘outsiders’, who may be perceived as exclusionary to the group or as representations of ‘authority figures’, that perpetuate the persecutory experience (CMY, 2005). Silove (1997) also argues that asylum-seekers (and probably refugees) who have been persecuted by authorities in the past are understandably wary of researchers inquiring into their backgrounds. Even if and when accessed, these communities may engage in superficial manners that afford them protection but precludes the collection of meaningful data (Miller, 2004). For example, social desirability - consenting to participate but providing what are perceived as desirable responses – may be a particular issue when researching within these communities. The establishment of trust and rapport before embarking on recruitment or data collection is therefore a necessary criterion for studies to proceed ethically (Miller, 2004). This, in turn, can facilitate the protection of participants and enable more accurate documentation of mental health concerns for that particular community.

Regarding the current thesis, despite divergence in the degree of privacy and openness across individuals displayed within the communities involved, direct observations (especially at first contact), suggested that a high degree of privacy within the populations existed. To ensure that trust and rapport was established, the researcher and her assistant (a 3rd year psychology student) met with community leaders prior to embarking on recruitment, to talk about the aims and particular aspects of the research. A number of meetings were held across different settings (e.g., churches, organisation venues, and homework clubs), ensuring different community leaders were met at different times. These meetings not only provided the opportunity to discuss the broader reasons for the researchers’ presence, but also served as a vehicle in which to gauge issues confronting those communities from the perspectives of representatives themselves. Leaders also saw the meetings as an opportunity to share aspects of their cultures. These meetings took place alongside the researchers’ participation in community activities and events (e.g., weekend soccer matches, community dances, fundraisers). Occasionally, the researcher was invited to give a community talk about mental health issues to community members or organisations in which leaders belonged. From a trust building perspective, attendance and participation in these activities were critically important.
Such activities served the dual purpose of introducing the researchers to key members of the community and prospective participants (including their parents and families) and eliciting information about current perceptions of the community’s needs and difficulties. Once a greater understanding of community needs and rapport were established, community leaders introduced the researchers to community members and prospective research participants. This process of engagement occurred up to twelve months preceding recruitment and data collection in some cases and was maintained through the duration and after completion of the study. It is important to note, however, that the researcher was aware of the potential for ‘over-engagement’ and the need to not make promises that could not be fulfilled within the research context (e.g., unable to therapeutically address mental health issues or problems in families). Thus, the careful process of ‘disengaging’ with communities was as essential as the process of engagement.

**Consent and coercion.** In research generally, the principles of informed consent are among the most essential ethical considerations (NHMRC, 1999). Potential impediments to attaining voluntary, informed consent, particularly among young refugees, include disparities in language, cultural and social norms, power, education, and familiarity with research paradigms (Leaning, 2001), such as the right to revoke consent. For refugees, this becomes a more sensitive issue given their potential persecutory experiences and experiences around authority (Silove, Sinnerbrink, et al., 1997). That is, researchers may be perceived as representations of authority which may include governments, militia, or police. Given affiliations between researchers and universities, the power relationships perceived between ‘the authority figure of a teacher’ and ‘the learner/student’, may also impact on the giving of full informed consent. Moreover, it is important for researchers to ensure that coercion because of these imbalances does not occur and that measures are taken to ensure that a full understanding of rights around participation is obtained by participants and/or their caregivers if under the age of consent (NHMRC, 1999). Also, researchers should be aware of the conflict that may arise in situations where children want to participate and the caregiver does not and vice versa (Dyregrov, et al., 2000). This factor highlights the need to provide participants and their caregivers equal attention in
explanations of the study, and of course the need to respect caregiver concerns and refusals for their children to participate.

Regarding the current thesis, it was challenging to ensure that enough information was shared with participants (and caregivers where indicated), to allow them to make an informed consent without overwhelming them with pages of ethically sound, but inaccessible statements (Ungar, Liebenberg, & Brown, 2005). Indeed, Ungar et al. (2005) argue there is a tendency for institutions to demand lengthier disclosures by researchers prior to consent which may be unworkable in research settings with cross cultural populations. The current research therefore utilised cultural liaison officers alongside interpreters to assist with the reading of the Plain Language Statement and Consent Form to ensure that a comprehensive understanding of the research was gained, and that questions could be adequately addressed.

Also noteworthy is that even when parental consent was not required for participants over 18, many participants considered it necessary to obtain verbal consent from their caregivers to participate. In these instances, information sheets designed for parents were given to participants to give to caregivers and opportunities to meet the researcher and discuss the research further were offered (e.g., home visit). The researcher emphasised the parameters of the research in her verbal explanations of the study and that this research in no way would impede or influence other processes, such as applications for immigration or employment status. To address the possibility that participants from different cultures may feel compelled to continue with interviews (even when told they can stop at any time) because either it is not perceived as a ‘right’ or ‘wanting to please/comply’ (Ungar, et al., 2005), the right to stop and recommence, or withdraw at any time without consequence was emphasised.

Cultural and language issues. Language and cultural barriers make the collection of accurate data more difficult, especially if sampling includes participants from diverse language groups (Ungar, et al., 2005). The issues of translation and interpretation are therefore essential in order to gain a shared understanding of phenomena being studied. Regarding translation processes, researchers need to consider the validity of their tools. In rigorous studies, translation of measures and back translation, alongside expert consensus among cultural experts are considered gold standard measures for
ensuring that tools used are appropriate for the culture studied (Semege, 2011). Similarly and where the gold standard is not possible, the use of interpreters can be helpful in verbally translating constructs and concepts of interest. A noteworthy consideration here is the importance of avoiding assumptions about the use of interpreters. For instance, it is important to consider that ‘cultural sameness’ may discourage personal disclosure or lead to problems of confidentiality and dual roles in interpreters (e.g., some interpreters act as community leaders themselves; some interpreters may have different tribal affiliations to a participant from a different tribe). It is essential if available therefore, to use appropriately trained and accredited interpreters. Of course, this is not always possible given the diversity of languages and dialects spoken by refugees (CMY, 2005).

In terms of cultural issues, response bias is also sometimes a problem in certain contexts where youth, unfamiliar with standardised questions, may try and give the “correct” answer. In other contexts, the use of open-ended qualitative methods may be inappropriate as some may not feel comfortable disclosing personal information (Ungar, et al., 2005). Such fears have been addressed in flexible designs that allow, for example, different data collection techniques and researchers providing more detailed instructions to participants when completing questionnaires and interviews. Even as they are making the transition to more adult-like status, the formality of the research process can create social expectations for compliance (Ungar, et al., 2005).

With respect to the current research, a decision was made not to have the measures translated, as participants were assumed (and assessed) as having a sufficient degree of English. Although translation and back translation may have improved the validity of Western derived questionnaires, most participants, having lived in Australia for more than three years, were satisfactorily versed in the English language. Plain language statements and consent forms, however, were available in translated versions for both individuals and particularly caregivers. Similarly, the use of accredited interpreters were used where possible, but in some cases, cultural liaisons for communities were used in the absence of an available accredited interpreter (e.g., Ewe [for the Togolese] is a new language in Australia and thus interpreters were not widely available during this study). In many cases, cultural liaisons were appropriate given their insights into cultural issues that might influence
the research. For instance they were helpful in elaborating on constructs and questions presented by the research. All interpreters and liaisons were briefed around issues of confidentiality.

**Confidentiality and safety.** Ungar (2005) highlights that Western research contexts offer a variety of constraints. For example, disclosure around extreme suicidality can result in the breach of confidentiality under national medical and research and university guidelines. Leaning (2001) also maintains that although participating in research can be a positive experience as shown (Dyregrov, et al., 2000), researchers must protect participants from harm (Leaning, 2001). This principle speaks to the potential for upset, distress, and possible re-traumatisation in disclosing one’s personal traumatic experiences. The researcher must therefore be careful in weighing up whether these risks can be balanced and outweighed by benefits in participation. In the event of such threats to safety (physical and psychological), researchers must be able to facilitate appropriate supports. Also, in instances where there is good reason to fear for one’s safety, such as in war or tribal conflict, personal disclosure may compromise neutrality or inadvertently make it appear that one is colluding with outside members of the community (Ungar, et al., 2005). Hence, disclosure from young refugees may not always be forthcoming and the research environment could be seen as threatening. In soliciting individual accounts, researchers need to be aware of these safety and disclosure issues.

Regarding the current thesis, privacy and confidentiality issues were emphasised at the individual level, prior to data collection, and again at a group level. In terms of individual confidentiality, individuals were assured that responses would remain private and any data collected unidentifiable. Interpreters and cultural liaisons were briefed about this issue prior and where possible, accredited trained interpreters were used. Participants were given explanations around how confidentiality might need to be breached in extreme circumstances such as disclosure of active suicidality. In the group setting, a similar process was followed but specific issues and expectations related to group confidentiality were emphasised. Participants were informed that opportunities to discuss in private, issues they were not comfortable to raise in the group, could be explored in subsequent individual interviews.
Prior contact with participants as well as the fact that many participants knew each other through their communities appeared to increase safety and confidentiality. Participants did not feel constrained in situations where a Western population might prefer the confidentiality of someone not close or known to them. Perhaps in a group setting, this had something to do with the ‘depersonalising’ of issues, making it safer to disclose and talk more generally (i.e., about the culture in general) about any mental health concerns they may have had. Regarding safety issues, participants were informed that the potential for distress was present by the obvious nature of the subject topic. Participants were therefore informed that this may occur, but that naturally, such feelings afterwards would dissipate.

All participants, in addition to receiving a verbal explanation, were given a debrief sheet that explained the normalising nature of distress when talking about traumatic experiences, strategies for managing emotions (which were approved by leaders and included such things as talking to someone close and trusted), and contact numbers for organisations for follow up (e.g., refugee counselling services – see Appendix H and I for debriefing sheet, and accompanying support service flyer). Although it was difficult to gauge what might have been going on internally; outwardly, it was observed that most participants reported the experience to be helpful (even if at times teary) and not overly distressing. Indeed, this could be consistent with some authors who state that refugees can get used to ‘telling their stories’ either to migration officials, authorities, and that indeed sometimes get interviewed ‘to death’ (Ungar, et al., 2005). Facilitation to counselling services were offered to every participant, but this need was not identified by the participants in this study.

Benefits to the participant and community. One consideration that gets overlooked in the research process (the agenda of which is to ‘extract data’), is what benefits might exist to individuals and communities participating in the research (CMY, 2005). As described above, not only should researchers clarify potential adverse effects and possible risks that for refugees include socio-political consequences (Dyregrov, et al., 2000), they also need to overtly state the potential upset and further emotional sufferance arising from revisiting traumatic (Rousseau, 1993). Leaning (2001) and Pennebaker (1993) indeed suggest caution with the presumed benefits of participants verbalising their traumatic experiences. Similarly, Ungar (2005) argued that
communities with a history of being “researched to death”, necessitates a clear explanation of how information would be used and interpreted, and who would have ownership of the research results. Thus, not only do researchers need to consider how they will interpret and disseminate information, but also what benefits participants can receive for their consultation, and what can be provided in terms of tangible benefits to individuals and their communities (CMY, 2005). Although the idea of monetary compensation as a direct individual benefit may be considered a form of coercion, the Centre for Multicultural Youth in Victoria, in their guidelines for engaging youth into research recommend ‘paying them’ to participate. Thus, intrinsic rewards, although helpful in themselves, such as sense of ‘helping others’ in like situations, or an ‘opportunity to voice their story’, may not be sufficient in terms of providing benefits to young refugees.

Unger (2005) also argues that research might create expectations in communities that projects will help solve the problems the communities face. Such global goals are not possible, however, and the role of researchers should incorporate results being returned to each community and shared in an appropriate forum to help decision makers address issues in their own communities. Invariably, the extent of the impact of the research will be different for each community (Ungar, et al., 2005). Regarding the current thesis, participants were given relatively small monetary rewards to participate in this research through vouchers that could be used in major supermarkets. This strategy was endorsed by many community leaders and representatives, who stated this, could be one of the most practically helpful of benefits. With respect to information dissemination and benefits to the community, leaders and elders were invited to information sessions that explained the preliminary findings and themes arising from this research. Follow up support agencies were also given to leaders, who expressed a desire to know what services they could offer their communities when the research was complete.

Findings of this thesis were also presented to participants themselves through information sessions. Although participants were tangibly rewarded with gift vouchers to compensate their time and travel, the potential benefits were also framed around providing a forum for young people to articulate their experiences, needs and aspirations, a chance to increase knowledge and awareness of emotional issues, an opportunity to increase confidence in using English (especially for newer refugees),
and in the longer term, from consultation, to improve psychological outcomes for young refugees. One community expressed that an intended and delivered benefit to their community was to help foster ‘leaders’ within the younger people. Feedback from consultations after the research was conducted was positive in this regard.

**Good practice guidelines for refugee youth.** The present thesis was conducted in accordance with good practice guidelines set out by Centre for Multicultural Youth in Victoria (CMY, 2005) (refer to CMY, 2005 for detailed outline of principles). Although the practice principles are directed at service provision for young refugees, the general principles served as appropriate guides for practice in this research. These principles included the core values of understanding, trust, and social justice and access. The value of understanding involved making an active attempt to learn about what was considered important to the young individual and what their life experiences meant for them. This required sensitivity to intellectual and emotional processes as well as an appreciation of the needs of young refugees (CMY, 2005). The value of understanding ensured that the strength and resilience of refugees were acknowledged alongside sensitivity to the diversity of backgrounds, experiences and circumstances that affected their well-being (CMY, 2005).

The value of trust was engendered from the first point of contact, particularly in recognition of traumatic life circumstances and loss prior to settlement in Australia. Importantly this required a recognition of the young person belonging to a persecuted minority and an understanding that when using an interpreter it could not be assumed that a climate of trust existed (CMY, 2005). Although it was difficult to adhere specifically to social justice principles (e.g., it was not in the scope of this research to provide support or counselling or to ensure equity in information received about refugee rights and entitlements), the notions of access were incorporated in the present approach to participant recruitment and data collection. That is, young refugee’s rights around receiving information about further support services available was communicated in a way that was accessible and sensitive to their needs (e.g., referral to a person within the community designated to assist with welfare needs, or provision of information regarding available mental health services).
Methodological design of this thesis

This study utilised a mixed methods approach for investigating the psychological well-being of young refugees. As described in Chapter 4, this allows for the use of quantitative methods that identify associations between specific relevant variables, and for the use of qualitative methods to provide a cultural and subjective context to understanding these relationships (Ahearn, 2000; Miller, et al., 2006). Hence, quantitative and qualitative techniques were employed to holistically examine psychological outcomes for young refugees living in Australia. The quantitative phase utilised a range of standardised questionnaires to assess psychiatric morbidity, well-being, and resilience while the qualitative phase utilised in depth individual and focus group interviews that focused on the experiences encountered by individuals and groups before and after arrival to Australia. Within the qualitative component, narrative accounts were relied upon to provide detailed elaborations on the mental health factors relevant to young refugees (Rousseau, Mekki-Berrada, & Moreau, 2001). This study also represents a quasi-experimental design where homogeneous groups of participants from various cultures are compared on measures of psychological wellbeing.

Sampling strategy and participants

Recruitment. Recruitment of participants in this thesis occurred via two methods. First, they were recruited from a range of migrant and community organisations providing support to refugees and asylum seekers around the Melbourne metropolitan as well regional parts of Victoria. Organisations with specific emphases on the communities of interest in this thesis or where there were large refugee settlements were targeted (e.g., inner western metro area of Melbourne, regional towns of Shepparton and Ballarat). An introductory letter was sent to organisations inviting them to be involved in the study.

Follow up telephone calls were made to arrange a face to face introduction and meeting times to discuss the aims and purposes of the research. Consenting organisations assisted in the recruitment of young refugees by helping to distribute information about the study, helping to identify prospective participants, providing
consulting rooms, and other general administrative tasks. However, organisational support did not always lead to community member participation (e.g., no prospective participants identified, time constraints). Moreover, some participants were recruited independent of the organisations that agreed to participate. Of the fifteen organisations formally approached, nine (60%) agreed to offer assistance in recruiting participants.

In the second method of recruitment, participants were enrolled on an individual basis through the researcher’s own contacts and via a ‘snowballing’ approach. This well established sampling strategy allows for consented individuals to ‘nominate’ other potential participants, who would be followed up and assessed for inclusion. As mentioned in Chapter 4, snowballing is particularly useful for communities that are marginalised or small (De Jong & Van Ommeren, 2002).

**Inclusion criteria.** Inclusion criteria for the study included all of the following: (1) a person between the age of 12-25 with refugee or asylum (protection visa) status; (2) a refugee or asylum seeker residing in Australia for at least one year; (3) sufficient English language competency as assessed by general ability to hold a conversation, read basic English, and conduct everyday tasks in English (e.g., banking, shopping); (4) individuals from either a Horn of African, Karen State, Middle Eastern, Sudanese or Togolese cultural background; and (5) individuals not currently receiving treatment or counselling for emotional issues.

**Exclusion criteria.** Exclusion criteria included any of the following: (1) person not aged between 12-25; (2) person not of refugee or asylum seeker status; (3) refugee or asylum seeker living in Australia for less than one year; (4) limited English skills as assessed by researcher and cultural liaison personnel with respect to conversational skills; (5) refugees or asylum seekers from cultural backgrounds other than those cited in inclusion criteria (e.g., Vietnamese); and (6) individuals receiving counselling or treatment for emotional issues. It should be noted, however, that two participants identified as having ‘uncertain’ age status and over the age of 25 (i.e., 27), were included. It was thought important to include these participants, not only to acknowledge their participation and experiences, but also in keeping with the concept that ‘youth’ in different cultural contexts can be considered up to the age of 30 (Tipping, 2010).
**Participant sample.** A total of $N=82$ of young refugees participated in this study. Participants were aged between 12 and 27 years ($M=17.82; SD=3.30$). There were $n=32$ males and $n=50$ females. Participants came from a range of cultural backgrounds. Of the 82 who reported their ethnicity ($n=77$), these included participants from The Horn of Africa (i.e., Eritrea, Ethiopia, and Somalia, mean age=$17.25; sd=2.49; n=10$ males, $n=10$ females), The Karen State (i.e., Karen and Chin Ethnic minority groups, mean age=$20.30; sd=3.18; n=11$ males, $n=9$ females), The Middle East (i.e., Iraq and Iran, mean age=$15.40; sd= .55; n=1$ males, $n=4$ females), Sudan (mean age=$18.59; sd=2.58; n=5$ males, $n=12$ females) and Togo (mean age=$16.13; sd=3.60; n=5$ males, $n=10$ females). The age of arrival ranged from 1 to 24 years of age ($M=12.55, SD=5.51$), with length of residency in Australia ranging from 11 months to 17 years ($M=5.28, SD=4.10$). No asylum seekers were recruited, despite their permitted inclusion in the study.

Most participants were fluent in conversational English, with 96% reporting being able to attend to daily tasks requiring English, such as shopping or communicating with a doctor. Cultural liaisons and interpreters were used where the researcher in collaboration with the participant, decided that this might be useful (e.g., during times participants found it difficult to communicate freely or understand particular concepts being conveyed). Where requested by the participant, an interpreter was used. Although all participants were offered the use of an interpreter, for the majority, this was not required. About 10% ($n=8$) of participants were interviewed with the assistance of an interpreter/cultural liaison. Where possible, attempts were made to utilise accredited interpreters, however for newly arrived groups such as the Togolese, this was not always possible. It is likely that interpreters were not required for the majority of participants given their younger age, and potential ability to acquire English language skills more readily than older adults.

Written consent was obtained for all participants in the study. For participants under 18, written consent was provided by a parent or caregiver (see Appendix B-D for plain language statements and consent forms).

The number and proportion of the sample with respect to characteristics of country of origin/nationality, ethnicity, religion and languages spoken are presented in Tables 2-5.
Table 2
*Countries of origin/nationality of participants in sample (N=82).*

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Frequency</th>
<th>% of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Burma/Thailand</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td>2. Sudan</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>3. Togo</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>4. Somalia</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>5. Eritrea</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>6. Ethiopia</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>7. Iraq</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>8. Iran</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>9. Ghana</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 3.
*Ethnicity of participants in sample (N=82).*

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Frequency</th>
<th>% of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Karen</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td>2. Sudanese (includes tribal identities)</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td>3. Togolese</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>4. Somali</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>5. Eritrean</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. ‘Other’/Not reported</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>7. Ethiopian</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>8. Persian</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>9. Iraqi</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 4.
*Religion of participants in sample (N=77).*

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Frequency</th>
<th>% of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Traditional Christian (i.e., Anglican, Protestant, Orthodox, Presbyterian)</td>
<td>42</td>
<td>54</td>
</tr>
<tr>
<td>2. Islam</td>
<td>25</td>
<td>33</td>
</tr>
<tr>
<td>3. Modern Christian (i.e., Jehovah Witness’, Pentecostal, Church of Christ)</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>4. Catholic</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5. Buddhist</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 5.  
*Main language spoken by participants in sample (N=78).*

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Frequency</th>
<th>% of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Karen</td>
<td>19</td>
<td>25</td>
</tr>
<tr>
<td>2. Ewe</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>3. Arabic</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>4. Somali</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>5. Tigre</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>6. Nuer</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>7. Persian</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>8. Oromo</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>9. Swahili</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>10. Dinka</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>11. Shilluk</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>12. Amharic</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>13. Mondang</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*Country of origin/nationality.* Participants originated from nine different nations/regions.

*Ethnicity.* In the majority of cases, reported participant ethnicity was consistent with countries or regions of origin. Table 3 presents the number and percentage of ethnicities comprised in the sample. Notable is that while five per cent of participants identified with being Sudanese \((n=4)\), an additional 16% \((n=13)\) who reported their nationality/country of origin to be Sudan, categorised their ethnicity in the ‘other’ category, in line with their tribal affiliations. These tribal ethnicities including: Afar \((n=1)\); Dinka \((n=5)\); Mondang \((n=1)\); Nuer \((n=4)\); Oromo \((n=1)\); and Shilluk \((n=1)\). For the purposes of reporting the general sample and analyses however, these tribal ethnicities were subsumed in the Sudanese category.

*Religion.* Participants reported a range of religions practiced. Table 4 presents the frequency and percentage of religions practiced among this sample. None of the participants reported practising atheism or no religion at all. Thus, the sample predominantly comprised of traditional Christian faiths, and Islam.
Languages spoken. The main language spoken by participants in this sample was also varied. The main languages spoken by participants in this sample are presented in Table 5. Main languages spoken in this sample paralleled nationalities and ethnicities. The sample mostly comprised main spoken languages of Arabic, Karen, Ewe, Tigre and Somali with the many of the remainder speaking Sudanese tribal languages. Many participants in this sample spoke an additional second or third language. Of those seventy eight participants who responded to the language question, almost 91% were fluent in a second language \(n=70\). Almost fifty percent of those who responded to the language question, were also fluent in a third language \(n=38\). That is, outside their main language, at least a half to 91% spoke second and third languages of English, French, Arabic, Burmese, Thai, Amharic, Tigre, Nuer, and Dinka, Persian, and German.

Quantitative measures

In addition to the collection of demographic information, this research is concerned with the measurement of: trauma exposure and experience; psychopathology, including PTSD, anxiety, depression, and somatisation; and positive psychosocial variables, including quality of life and resilience. Post-migratory difficulties and experiences are also measured to address the impact of phase based factors on psychological well-being. The specific instruments used to assess these factors are now described.

Demographics questionnaire. Participants completed a demographics questionnaire designed by the researcher to examine demographic characteristics of young refugees in Australia. The demographic questionnaire measures gender, age, nationality and ethnicity, religion, languages spoken, age at arrival to Australia, length of residence in Australia, education level (before and after arrival to Australia), occupational status, family living situation (before and after arrival to Australia), history of psychological and physical problems, arrival status (accompanied or unaccompanied), and transition/places of stay (e.g., migration to other countries; refugee camps). Parental factors such as illness before and after arrival to Australia are also measured by the questionnaire. The demographics questionnaire formed the first section of the overall
study questionnaire booklet, which alongside all the psychometric measures in this thesis can be seen in Appendix G – Questionnaire Booklet.

**Harvard Trauma Questionnaire (HTQ).** The present study employed The Harvard Trauma Questionnaire (HTQ) developed by Mollica and colleagues (1992) to measure trauma event exposure and experience (Mollica, Caspi, Bollini, Truong, & et al., 1992). The HTQ was specifically developed for self-report use with adult refugee populations, and is comprised of 17 items which describe a range of trauma experiences that are relevant to war trauma exposed and displaced populations (e.g., “combat situation”, “lack of food or water”, “ill health without access to medical care”, “rape”, “imprisonment”) (Mollica, Caspi, et al., 1992). Respondents choose from four categories of response options for each item including 1=“this happened to me”, 2=“I witnessed it”, 3=“I heard about”, or 4=“not at all”. A second part of the HTQ assesses an additional 16 trauma symptom items, based on the DSM-IV PTSD criteria (e.g., “recurrent thoughts or memories of the hurtful or terrifying events”, “recurrent nightmares”, “unable to feel emotions”, “difficulty concentrating”). Response options are based on Likert scales including 1=“not at all” to 4=“very often”.

Although no official scoring method for Part 1 of the HTQ is described, scoring this part consists of reversing items scores and calculating items to derive a total score, ranged between 0-49, with higher scores indicative of higher frequency and more directly experienced trauma. In the present study, it was of interest to also ‘weight’ trauma in terms of direct and indirect experiences (e.g., this happened to me versus I heard about it”). The resulting higher total scores are indicative of more direct trauma exposure. This is described in more detail in Chapter 9. In scoring Part 2 of the HTQ, total scores are calculated and mean item scores are derived. A cut off recommended by the authors of 2.5 (mean item value) or more are indicative of problematic post-traumatic stress symptoms (Mollica, Caspi, et al., 1992).

Excellent psychometric properties have been demonstrated for the HTQ (Mollica, Caspi, et al., 1992). Inter-rater reliability for all events is reported at ($r=.93-.98$); test-retest reliability at ($r=.89-.92$); internal scale consistency at (Cronbach $\alpha=.90-.96$) and convergent validity with other trauma measures ($r=.84-.93$) (Mollica et al., 1992). Although originally developed for Vietnamese, Lao, and Cambodian refugees, the HTQ has now been translated, adapted, and widely used across a variety
of refugee populations (Hollifield, Warner, Krakow, Jenkins, & Westermeyer, 2009). Similarly, originally developed with adult refugees, the HTQ has been validated successfully for use with adolescent refugee populations (Goldin, Levin, Persson, & Hagglo, 2003) as young as 14 and more recently with children as young as 12-13 (Friedman & Mikus-Kos, 2005). A major advantage of the HTQ, unlike other standardised measures of trauma is that this scale is culturally validated (Shoeb, Weinstein, & Mollica, 2007). Importantly, the HTQ correlates highly with gold standard measures of PTSD such as the Clinician Administered Posttraumatic Stress Disorder Scale (CAPS) (Blake et al., 1995) and the Composite Interview Diagnostic Interview Schedule (CIDI) (World Health Organization, 1997).

**Brief Symptom Inventory (BSI).** Derived from the Symptom Checklist – Revised – 90 (SC-R-90), the Brief Symptom Inventory (BSI) (Derogatis, 1993) was employed to measure psychological symptoms and complaints. This 53-item self-report measure designed for adolescents and adults, assesses symptoms along nine symptom dimensions including: somatisation (e.g., “how bothered are you by “stomach ache or being sick in stomach”); obsession-compulsion (e.g., “having to check and double check what you do”); interpersonal sensitivity (e.g., “feeling very self-conscious with others”); depression (e.g., “feeling lonely”); anxiety (e.g., “nervousness or shakiness inside”); hostility (e.g., “temper outbursts that you cannot control”); phobic anxiety (e.g., “feeling afraid to travel on buses, subways or trains”); paranoid ideation (e.g., “feeling that you are watched or talked about by others”); and psychoticism (e.g., “the idea that someone else can control your thoughts”).

Respondents are asked to rate the severity of such symptoms experienced over a two week period using a 5-point Likert response scale, ranging from 0-4, where 0=“not at all”; and 4=“extremely”. The nine dimension scores are calculated by summing the values for the items included in that dimension and dividing by the number of items endorsed in that dimension. Global indices including a: (i) Global Severity Index; (ii) Positive Symptom Total; and (iii) Positive Symptom Distress Index (PSDI) can also be derived using the BSI, with the GSI being the most sensitive indicator of respondent distress.

The BSI has well established reliability for all nine dimensions ranging from .71 to .85 (Derogatis, 1993). Good internal consistency has also been demonstrated
and test-retest reliability for the nine symptom dimensions has been reported to range from .68-.91 and .87-.90 for the three Global Indices (Derogatis, 1993). The BSI has also been shown to be a valid cross-cultural measure of psychological distress (Aroian, Patsdaughter, Levin, & Gianan, 1995) and has been successfully used on refugee populations (Young & Evans, 1997).

**Post-Migratory Living Problem Checklist (PMLPC).** The Post-migratory Living Problem Checklist developed by Silove and colleagues (Silove, Sinnerbrink, et al., 1997) was used to assess the extent of daily problems encountered by young refugees. The PMLPC is an ad hoc but useful checklist of typical problems reported by refugees and asylum seekers. Items include difficulties associated with immigration processes, and resettlement problems, such as “difficulties finding work” or “gaining access to health care”. Respondents are asked to indicate whether any of the items on the checklist have been a problem over the previous few months.

Responses are rated on a five point ordinal scale which range from 1=“no problem at all” to 5=“very serious problem”. To date, no reliability or validity data is available for this measure, however, the scale has been found to distinguish between asylum seekers and refugees with secure and insure residency status and consistently been identified as a predictor of mental health amongst displaced populations (Silove, Manicavasagar, et al., 1997; Silove & Steel, 1998; Steel et al., 2006). Its use in the present study is to gain a better understanding of the post-migration problems that might be important to understanding psychological well being in young refugees in the post-migration settlement period.

**World Health Organization Quality of Life Questionnaire (WHO-QOL-Bref).** The World Health Organization-Quality of Life Scale-Brief version (WHO-QOL-Bref) developed by The World Health Organization (WHOQOL Group, 1996), was employed in this study as the quality of life measure. It consists of 26-items that measure overall quality of life and quality of life among four domains including: (i) physical health (e.g., “how satisfied are you with your health?”; “do you have enough energy for the day?”); (ii) psychological health (e.g., “how much do you enjoy life?”; “do you feel your life is meaningful?”); (iii) social relationships (e.g., “are you satisfied with your relationship with family and relatives?”; “are you satisfied with
your friends?”); and (iv) the environment (e.g., “are you satisfied with your transport?”, “are you satisfied with your living place?”). The WHO-QoL-Bref has a 5-point Likert response scale (1-5) for each item. As an abbreviated version of the WHO-QOL-100 (WHOQoL Group, 1993), the WHO-QOL-Bref demonstrates good discriminant and content validity, internal consistency and test-retest reliability (Harper & Power, 1998).

A scoring algorithm can be used to transform raw score from the WHO-QOL-Bref to scores onto a 0-100 scale, with higher scores indicative of higher levels of quality of life (WHOQOL Group, 1996). In this thesis, participants were asked to rate their quality of life across a “past month” period. The WHO-QOL is steadily increasing its status as a reliable and valid measure for both adult and refugee populations (Gifford, Bakopanos, Kaplan, & Correa-Velez, 2008).

Adolescent Resilience Questionnaire Revised (ARQ-R). To examine the concept of resilience, the Australian developed Adolescent Resilience Questionnaire (ARQ-R) (Gartland, 2008) was employed. The ARQ-R assesses resilience as measured by five key domains including: (i) individual domain; (ii) family domain; (iii) school domain; (iv) peer domain and; (v) community domain. It comprises 88-items that require respondents to rate how true each statement is across the four key resilience domains. For example, respondents rate statements such as “I find it hard to make important decisions” (individual domain); “My family listens to me” (family domain); “Getting good marks is important to me” (school domain); “I find it hard to stay friends with people” (peer domain); or “The people in my community look after me” (community domain). A 5-point Likert response scale is employed by this measure, ranging from 1=“almost never” to 5=“almost always”.

Currently, a dearth of measures exists to measure the construct of resilience (Windle, Bennett, & Noyes, 2011). Like other emergent tools for measuring resilience more psychometric studies utilising the ARQ measure are needed (Gartland, Bond, Olsson, Buzwell, & Sawyer, 2011). To date however, studies have indicated good reliability for the different subscales on the ARQ ranging from 0.87 in the community to 0.66 in the school domains (Gartland, 2008). Scoring the ARQ is performed by tallying the five separate domain scores. A total score for overall resilience is also yielded, with high scores on this measure indicating higher levels of resilience (range:
88 to 440). This measure has not been validated using a refugee population and this study represents a first attempt to apply this construct to a population of young refugees. However, the ARQ has been used successfully in a sample of young adolescents in Australia which included varied cultural backgrounds (Gartland, 2008).

**Qualitative measures**

**Focus group interviews.** As part of the mixed methodology employed in this thesis, focus group interviews were conducted to gain a deeper understanding of the refugee mental health experience. Individual interviews were also employed to enable participants to express more personal narratives of their experiences. The overarching goals of the focus group and individual interviews were to examine the following broad questions: (a) “What is the psychological experience of young refugees in Australia?”; (b) “What are the conceptualisations of mental health beyond western conceptions?”; (c) “What are the strengths and difficulties encountered by young refugees in Australia?”; and (d) “What are the needs of young refugees in Australia?”

To examine these questions, focus groups were set up for all refugee sub-cultures in this study, with exception to the Middle Eastern participants and the Togolese participants. Regarding the first group’s exception, unfortunately too few Middle Eastern participants were recruited into this study to enable a focus group to be conducted. Regarding the Togolese participants, community leaders recommended the use of individual interviews rather than group ones, largely because of the difficulties for participants, who are dispersed across regional areas, to travel to one venue (e.g., many having resettled recently did not have drivers licences or transportation or were unfamiliar with settings described).

Focus groups conducted with the Karen, Horn of African, and Sudanese groups took place in venues organised by community leaders and representatives (e.g., church halls, public housing spaces, and in one instance a cultural liaison’s home). Food and refreshments were provided during these sessions which generally took place over a morning, afternoon, or evening session. Aside from some community leaders who also took part in the study, focus groups were attended unobtrusively by community leaders and representatives who left the room during question times. Interpreters and/or cultural liaisons were used during the focus groups,
however, given the language competencies of the young refugees, were not often required, unless to explain difficult concepts such as “depression” or “trauma”, or to assist with more minor clarifications.

All focus groups were conducted in a similar format. That is, potential focus group participants (from the original pool of N=82) were recommended and approached by community representatives, who coordinated the available session times for the focus groups. Each focus group comprised a minimum of four and a maximum of six participants. There were seven focus groups run in total. Four of these were facilitated by the researcher. The remaining three focus groups were facilitated one of two research assistants, who were trained before facilitating the groups and who had opportunity to observe a focus group conducted by the researchers. Although the change of facilitator may have introduced some difference across the groups, these differences were minimised by having the research assistants involved from the beginning of the engagement process with communities involved. Moreover, as the process of qualitative research relies on the process being transactional between the ‘researcher and participant(s)’, each group, regardless of whether the facilitator was the same or different, is likely to have produced a different ‘dynamic’ and potential outcome. The thematic findings of focus group data described in Chapter 9 may shed some light on whether similar themes were borne out as a result of potential differences across groups. Nonetheless, focus groups were intentionally categorised by cultural group to enhance the potential to detect cultural differences in responses. In this way, such groupings may address the limitations of western symptoms that are seen to ‘medicalise’ what elsewhere may be viewed as religious or social issues (Kleinman, 1995). Additionally, it may help identify different cultural understandings of what particular cultural groups might deem as mental illness (Mghir & Raskin, 1999).

Although focus groups were organised around structured questions, the intention of these questions was to prompt discussion and promote a rather unstructured flow to participants’ responses. This is considered a hallmark and strength of qualitative research as such a dynamic allows for more accurate representations of priorities and needs directed by the respondent as opposed to an engendered one which might be more characteristic of a systematic empirical framework and therefore unrepresented view of the participant (Miller et al., 2006).
The focus groups were facilitated by questions designed to elicit information on mental health in the particular selected refugee sub-groups. These questions are presented in the method section of Chapter 9 in Table 28.

Questions from the interview schedule were approved by community leaders and representatives prior to their administration. Suggestions were provided by the liaisons to enhance understandings. Such recommendations included statements such as: “try to avoid the word depression, as we cannot explain in our culture…instead, use the word sad and happy”.

Individual interviews. All focus group participants were invited to be interviewed individually face to face with the researcher (or assistant who conducted the focus group). The purpose of these interviews was for participants to elaborate on issues raised in the focus groups or raise new issues they were not comfortable in raising or had not raised for any other reason in the focus group. In particular, this was an opportunity to focus on the personal journeys and stories with the participant and to explore issues around safety and support services in necessary. The two semi-structured questions asked during the individual interviews are presented in the method section of Chapter 9 in Table 28.

Although the intention was again to elicit flow and unprompted narrative, a script was used to prompt participants’ narratives. For example, one of the two questions asked was: “This part of the interview is a chance for me to know more about your personal story. It may include things that you did not feel comfortable talking about with the group or it may be things you’d just like to tell me about your life. Could you tell me about your story?” Example prompters included: What brought you to Australia?, What are your experiences as a refugee/asylum seeker?, What was involved in your journey to Australia?, What things do you worry about? What things do you feel confident with?; What things would you change if you could?; What things do you enjoy doing? What are your hopes for your future?.

Finally, interview data collected from the focus groups and individual interviews were subsumed and categorised by culture in the analysis of themes. This is described later in Chapter 9, which explores the qualitative themes drawn out by the interviews.
General procedure

Approval for this study was gained through the Royal Melbourne Institute of Technology (RMIT) University, Human Research and Ethics Committee (see Appendix A for initial approval letter). At commencement of this study, a list was comprised of all organisations in Victoria, Australia, providing services or support to refugees, particularly young refugees. Initially, letters were sent out to some of these organisations inviting them to be involved with the study. Unfortunately the response to these introductory letters was poor, requiring the researcher to modify her initial contact from letters to directly emailing and phone calling specific members of organisations requesting a meeting to introduce and discuss the research. Sometimes, a number of meetings were held so that relevant staff members could be available to provide feedback.

The percentage of organisations that declined a meeting or involvement with the study is described above. Reasons cited for declining the invitation included: (i) did not have the staff or resources available to meet requests; (ii) already being committed to other current research projects; (iii) concerns that the research may be cumbersome on an already busy youth population; and (iv) concerns that the nature of psychological enquiring (e.g., trauma) may be too distressing for participants (thereby leaving the organisations to cope with the demands for support in the aftermath of the research).

These valid concerns were also held among organisations that were agreeable but after negotiation around the specific issues of concern, incorporation of feedback regarding study aspects (e.g., removal of wording deemed inappropriate) and the development of clear pathways for support, more than half of the organisations agreed to be involved with this research. Thus, the engagement of organisations occurred across a number of meetings, across different settings and with numerous stakeholders (e.g., leaders, managers, community representatives). Trust and rapport was established slowly over time. Meetings held with community organisations entailed an introduction to the background of the researchers, an overview of the study and its aims, and a discussion of areas of concerns from the community’s perspective. On occasion, presentations of the research to staff at organisations were required before consent was obtained.
Once community organisations agreed to assist with the study, processes were put into place to facilitate identification and recruitment of participants to the study. With the assistance of organisation and community representatives, a variety of methods were used to recruit participants. These included direct contact with the designated community members, who would refer interested potential participants, the use of flyers within organisations (see Appendix E and F for Information sheet provided to organisations and recruitment flyer), and word of mouth by participants who had already consented to the study. This occurred alongside recruitment of individuals via the researchers' own contacts and snowballing. Recruitment and data collection occurred over a three year period at various community settings and in some cases home settings.

Using the mixed methods approach to collecting data, two phases of data collection were employed. The first phase involved the completion of focus groups and individual interviews (described above) and the second phase involved the completion of questionnaire booklets. Within the first phase, participants were invited to attend a focus group (or individual interview) at a designated appropriate setting (e.g., church venue, homework club classroom, public housing space, home visit). During this phase, a detailed explanation of the study was provided and informed consent obtained. During the first phase, participants were provided a plain language statement and consent form and where indicated, translated versions of these forms were provided (see Appendix B, C, and D for plain language statements for participants, parents, and consent form). Translations of plain language statements and consent forms were available for the following languages: Arabic, Amharic, Tigrinya, and Karen. For languages less commonly requested, such as Farsi or Dari, the research utilised an interpreter to help explain the project. On most occasions, a translated version of the plain language statement and consent form and interpreter were not needed given the adequate level of English proficiency observed in the young refugees. For participants under 18, parental consent was obtained prior to their invitation to attend the focus group/individual interview. Samples of questions were provided to caregivers, so they were informed of the questions that were being asked of their children in this study.

After consent was obtained, participants began the focus group interview. Privacy and confidentiality were explained and parameters around safety and respect
for other group members were also established. Participants then completed the focus group interview (approximately 1 hour), which was followed by a shorter individual interview (i.e., 15 minutes to 40 minutes depending on the nature of responses). In the case of individual face to face interviews, focus group questions were administered as individual interview questions, which took about an hour to complete, alongside the designated individual questions. The focus group questions were intentionally placed as the first data collection activity as this was seen as an opportunity to build rapport and ask some initial non-threatening questions directed at a ‘group’ or ‘cultural’ level. The individual interviews that followed allowed for appropriate follow up of issues raised in the focus group by individuals as well as an opportunity to follow up any distress or upset experienced by participants. Generally, participants reported the focus group and individual interviews as enjoyable and useful and many talked about them as opportunities to share something about their experience and culture.

Following a break in which refreshments and light food were provided, phase two was implemented.

Phase 2 involved the administration and completion of the questionnaire booklet containing the psychometric measures described above (see Appendix G for the study questionnaire booklet). Sitting independently within groups, participants were instructed to complete the questionnaire booklet and if preferred, were assisted by the researcher or her assistant who read the questions out loud. This allowed participants to stop and clarify meanings and request the assistance of interpreters if necessary. Two assistants were present also during the completion of the questionnaire so that questions about the questionnaire booklet could be clarified, and interpreter called if necessary. Participants were instructed to take their time in completing the questionnaire and were encouraged to be as honest as possible in responding. They were informed that the questionnaire was not a test and that incorrect responses could not be made. Participants were also instructed to begin in accordance with the sections of the questionnaire, which purposely placed the HTQ and BSI questions (i.e., trauma and psychopathology questions) towards the end. The placement of these questions allowed as much time as possible to build trust through earlier aspects of the data collection phases. Given the lengthy nature of the questionnaire, frequent breaks occurred between sections. Together, questionnaires
took between one to two hours to complete (included break times, explanations etcetera).

At the completion of both phases, a debriefing sheet was introduced, explained and provided to all participants (see Appendix H and I for debriefing sheet and accompanying support service pamphlet). Participants were informed that the debriefing sheet was part of standard research protocols and in no way suggested that they needed ‘psychological help’. Follow up contact numbers for support services were provided and assistance to facilitate further support was offered, however this was not utilised by participants. Participants were offered $20 gift vouchers for their participation in either the questionnaire or interviews ($40 vouchers were offered for those who participated in both). Participants were invited to stay back if they desired for refreshments and social conversation.

Among Togolese participants, focus group questions and individual questions were conducted one on one with individuals, mostly in the natural habitat of their homes. On occasions where sib-ships were interviewed, focus group questions were administered in the group setting in the family’s home. Again, participants completed the questionnaire on their own, with the assistance of the researcher and/or cultural liaison person. Importantly, for the younger refugees, parents were often present but situated in another room when the individual interview took place. Closing and debriefing procedures with Togolese and other individual participants occurred as described above.

*Overarching approach to data analyses*

This subsection describes how data were handled across all studies in this program of research. With the assistance of a research assistant to provide quality assurance checks, questionnaire data were entered, screened, cleaned and analysed using the Statistical Package for the Social Sciences (SPSS), version 18.

*Data handling and missing value analyses.* A total of 89 participants consented to the overall study. Seven individuals did not satisfy criteria for being retained in the study sample, which required at minimum, three quarters of parts 1 and 2 of the questionnaire (demographic section and trauma experiences section) to be completed.
As a result, these cases were deleted from the data file. Eighty two participants satisfied requirements for being retained in the study sample. As most participants in this sample were recruited with the assistance of organisations that arranged ‘sittings’ with participants (where the researcher could go through questions in a group and individually with participants and with the assistance of interpreters) most participants completed the questionnaire in full. Questionnaires were checked prior to participants leaving the ‘sitting’ to ensure a minimum member of questions were missed. Hence, there was less than ten percent of missing data, enabling a missing data procedure to be carried out in SPSS (Tabachnick & Fidell, 2001).

Missing data were mostly found to be randomly distributed within the data set except across one questionnaire item (WhoQoL item 21), where the data missing was systematic. For randomly distributed missing data, the Expectation Maximisation (EM) method was utilised to replace missing values. The EM method is considered the “simplest and most reasonable approach to imputation of missing data” (Tabachnick & Fidell, 2001, p. 66) and is preferred to alternate approaches such as mean substitution, provided missing data are distributed randomly (Tabachnick & Fidell, 2001). Another strength of the EM approach is that data analytic procedures such as regression (used in forthcoming analyses) are not compromised (Tabachnick & Fidell, 2001). With exception to missing data from the demographics questionnaire, all randomly distributed missing data points were evaluated and replaced prior to commencement of data analysis.

Systematic missing data identified in WhoQoL item 21 (“how satisfied are you with your sex life?”) was systematic because item 21 was purposely omitted from the questionnaire, due to cultural constraints around its inclusion. As community advisors considered this question inappropriate, the item was left out. According to WhoQoL protocols, subscale total scores do not require all items in that subscale to be completed. Rather, subscale totals are considered valid so long as criteria for that particular subscale are met. In this instance, item 21 is embedded in the social support subscale. The social support subscale requires only two out of the three items to be completed before being considered valid. Consequently, item 21 was not included in the calculation when the social support subscale total score was derived, resulting still in a valid total subscale score for social support within the WhoQoL measure.
Along with missing data analysis and imputation procedures, items on questionnaires were reverse coded where indicated. Subscale scores and global total scores were calculated for all questionnaires and transformed to T-scores where indicated. T-scores were used in analyses where it was of interest to determine clinical ranges and cut off scores for psychopathology (i.e., with BSI data to determine ‘caseness’).

Assumption testing. Exploratory data analysis was conducted on all main variables to ensure that statistical assumptions underlying the parametric procedures to be conducted were met. This incorporated examination of stem-and-leaf and normality plots, as well as statistical analysis of skewness and kurtosis using the Shapiro-Wilk test of Normality. Box plot analysis revealed no major outliers or extreme cases for main variables of interest. Examination of the Harvard Trauma Questionnaire (HTQ) and Total Score Resilience variables revealed no major violations in the normality assumption that would impinge on the validity of data analytic procedures. Therefore these variables were not transformed. All other main variables however showed violations in the assumption of normality. As these variables mostly included the clinical outcome measures such as PTSD or depression, a decision was made not to correct the skew due to the expectation that these distributions are often skewed in the positive direction (i.e., most cases would fall in the lower end of the scale). Also, these distributions are more clinically comprehensible when scores are not transformed (Norris & Aroian, 2004; Tabachnick & Fidell, 2001). A conservative approach was nonetheless taken in the data analysis where for every parametric test conducted, a non-parametric equivalent was also conducted. This revealed little or no change in outcomes across parametric and non-parametric tests. Hence, parametric tests were used across data analytic procedures.

Data analysis and significance testing. Frequency analysis and descriptive data analyses using SPSS version 18 were performed on all questionnaire data to ensure the accuracy of the dataset. Prevalence of mental health problems were examined using frequency analyses; predictors of mental health outcomes were analysed using a series of multiple regression techniques; and group-based analyses to explore cross cultural differences were based on a combination of Multivariate Analysis of Variance
(MANOVA) and Analysis of Variance (ANOVA) techniques, with corresponding post-hoc tests.

Summary and conclusions

This chapter provided a description of the mixed methodological approach employed by the current thesis. Important ethical considerations in this research were also discussed. Having described the method and data analytic techniques employed in this thesis, the next chapter marks the first of four results based chapters that focus on negative and positive factors in refugee mental health. The next chapter will present an overview of the demography of young refugees in Australia. That is, it will describe the characteristics associated with being a ‘young refugee in Australia.
CHAPTER 6: PRE- AND POST-MIGRATION CHARACTERISTICS, TRAUMA, AND RESETTLEMENT EXPERIENCES IN YOUNG AUSTRALIAN REFUGEES

Overview

So far, young refugees have been portrayed as having a variety of diverse cultures, backgrounds, and experiences. Alongside the process of displacement to resettlement in a Western country, multiple transitions also occur. The present chapter attempts to capture some of this diversity and change across time in an Australian sample of young refugees. This contextual understanding is important as not all refugees resettled in Western countries share the same characteristics. By exploring the features of this sample, a picture of who ‘young Australian refugees’ are and what their backgrounds are, may be informed. In this chapter, data collected from the demographics, trauma and post-migration difficulties questionnaires will be examined to describe and contrast the pre- and post-migratory characteristics of young refugees in Australia. It will be concluded that young refugees settled in Australia do so with a background of changing circumstances and challenges that add risk to mental health problems. An appreciation of these transitions across time provides an important foundation to understanding how youth refugee mental health is understood.

How questionnaire data were used and examined

Data from the demographics questionnaire was used to derive information about the sample characteristics, and young refugees in Australia more generally (see Appendix G for questionnaire and Chapter 5 for description of demographics questionnaire). The different characteristics of gender, age, nationality, ethnicity, religion, languages spoken, age at arrival, and length of residency were described in the participant section of the General Method. With exception to age, age at arrival, and length of residency, these characteristics were mostly stable across the pre-and post-migration periods. The more changeable characteristics of places of exile (e.g., migration to other asylum countries, refugee camps), arrival status (accompanied versus
unaccompanied), parental presence, education and occupational status, family living situation, and individual and familial physical and emotional health are described in this chapter. To explore the transition or change across pre- and post-migration periods, frequency and descriptive statistics were obtained for these variables using SPSS (version 18).

The experience of traumatic events as reported through the HTQ (see Chapter 5) (Mollica, Caspi-Yavin, et al., 1992) and the experience of post-migration difficulties as reported through the PMLC (see Chapter 5) (Silove, Sinnerbrink, et al., 1997) were also explored using frequency and descriptive data. In depth procedures related to the screening and cleaning of all data are described in the next main results chapter. Of the 82 participants in this sample, up to seven (8%) did not complete the demographics questionnaire in entirety. Sample sizes in particular analyses in this chapter therefore range from \( n=75 \) and \( n=82 \).

**Residence in exile countries and refugee camps**

One important aspect of the refugee journey is the displacement from one’s home to various other places of exile or asylum. Participants in this study travelled to Australia via a range of exile countries which ranged from none (i.e., direct entry to Australia from home country) to three countries of asylum. The mean number of countries through which participants travelled to in their plights to gain residency in Australia was 1.11 \( (SD=.56) \), with the 77% majority reporting having travelled through one country only. Examining means across each culture, the Togolese travelled to more countries before arriving in Australia \( (M=1.50, SD=.52) \), followed by The Horn of Africans \( (M=1.25, SD=.68) \), Sudanese \( (M=1.13, SD=.52) \), and the Karen \( (M=1.00, SD=0.00) \). These countries included Kenya and Egypt for the young Sudanese; Thailand (Thai/Burma border) for the Karen; Kenya, Ghana, and Benin for Togolese refugees; and countries within the Horn of Africa and Kenya for refugees from Ethiopia, Eritrea, and Somalia. The few Middle Eastern refugees in this sample reported direct travel to Australia \( (M=0.00, SD=0.00) \). Eighty six percent of participants reported residence in refugee camps prior to arrival to Australia, with time spent in camps ranging from six months to more than ten years.
**Parental presence**

Perhaps the most devastating characteristic of war experience among young refugees is the loss of a parent or care-giver. The majority of participants reported that both parents were alive and present in their lives prior to migrating to Australia \( (n=58, 72\%) \). Twenty three percent reported a deceased or ‘missing’ father due to war and conflict \( (n=19) \). One participant reported a deceased or missing mother and three participants reported that both parents had deceased \( (n=5\%) \). Within the subgroup of participants who reported a missing or deceased parent, six percent \( (n=5) \) of these participants were members of an intact sibling group.

**Arrival accompaniment status**

Accompaniment status plays a major role in the mental health outcomes of young refugees (Bean, et al., 2007). The accompaniment status, with respect to those who arrived with immediate family, with extended family or unaccompanied on their own is summarised in Table 6.

<table>
<thead>
<tr>
<th>Accompaniment Status</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accompanied by at least one immediate family member</td>
<td>67</td>
<td>85</td>
</tr>
<tr>
<td>2. Accompanied by at least one extended family member</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>3. Unaccompanied</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

From inspection of Table 6, the majority of participants arrived with at least one immediate family member. A small minority arrived with an extended family member, but without any immediate family. An even smaller minority arrived unaccompanied. Of the 79 participants who responded to this question, 72% \( (n=57) \) travelled to Australia with their mothers, 46% \( (n=37) \) travelled with their fathers, 51% \( (n=41) \) travelled with their sibling(s), 10% \( (n=8) \) travelled with their aunts/uncles, and 4% \( (n=3) \) travelled with at least one grandparent. That is, many participants arrived
with more than one family member (e.g., with their mother and father; with their mother and sibling; or with their father and grandmother). Thirty three percent ($n=29$) reported having travelled with their families, but separated from them along their journey. These same participants were reunited with their family members. In sum, the majority of participants arrived accompanied by an immediate family member, usually their mother. Close to half of the sample was additionally or solely accompanied by their father and/or a sibling(s).

*Pre- and post-migration family and living situation*

The family and living situation is perhaps one characteristic that can change markedly from the pre- to post-migration period. Table 7 presents the number and percentage of participants in various family living arrangements pre- and post-migration to Australia.

<table>
<thead>
<tr>
<th>Family Living Situation</th>
<th>Pre-migration</th>
<th>Post-migration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>%</td>
</tr>
<tr>
<td>1. Lived with at least one immediate family member</td>
<td>72</td>
<td>87</td>
</tr>
<tr>
<td>2. Lived with additional or extended family member(s)</td>
<td>34</td>
<td>41</td>
</tr>
<tr>
<td>3. Lived alone or with person outside their family</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

In the pre- to post-migration contrast of family and living situation, most participants were living with at least one family member both prior to and after arrival to Australia. The pre- to post-migration contrast in living with at least one family member remained relatively stable, reducing by only two family members ($< 2\%$). Similarly, for individuals living alone, only two participants changed their living arrangement during the pre- to post period (albeit, given the small sample, this represents a 50\% variation). In terms of individuals, the change from pre-migration
living with additional or extended families was more pronounced, involving 26 participants (23%). The mean number of immediate and extended family members lived with prior to arrival in Australia was $M=2.41$ ($SD=1.22$). The mean number of immediate and extended family members lived with after migration to Australia was $2.13$ ($SD=0.76$).

The proportion of participants living with their mother prior to and after arrival to Australia was 77% ($n=63$) in the pre-migration period, and 75% ($n=62$) in the post-period. The contrast in pre- and post-migration living situations with fathers was more evident, with 66% ($n=54$) living with their fathers in the pre-period and 51% ($n=42$) living with their fathers in the post period. Eight per cent of participants lived in a house owned by themselves and their families ($n=6$), while the majority of participants (87%), lived in a house or flat rented privately or through the government ($n=67$). Five percent of participants lived in a share house situation with another person ($n=4$).

**Pre- and post-migration education and occupational status**

Participants were asked about their educational and occupational status in the period leading up to conflict, displacement and forced migration, and again in the period shortly after resettlement. The number and percentage of participants attending school or employment are presented in Table 8.
Table 8.
*Pre- and post-migration education and occupational status of participants in the sample (N=76).*

<table>
<thead>
<tr>
<th>Education/Occupation Status</th>
<th>Pre-migration</th>
<th>Post-migration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>1. Enrolled in school/tertiary education</td>
<td>66</td>
<td>87</td>
</tr>
<tr>
<td>2. Employed</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3. Not employed, searching for work</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Not applicable (e.g., too young, not looking for school or work)</td>
<td>7</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 8 shows that the number of participants enrolled in school in the post-migration period was more than those pre-arrival to Australia. This questionnaire data was followed up in the focus group questioning which revealed that of those reporting some attendance at school, 78% of participants reported a disruption to their education at least once (range =1 to 5). Reasons cited for disruption to schooling included: (i) war conditions; (ii) conflict/persecution of self or family resulting in displacement and forced migration; (iii) education was unavailable due to no schooling in refugee camps; (iv) education not being available due to the unavailability of classes beyond late primary to early secondary year levels; and (v) not having money to be able to enrol in school or attend regularly in school.

In contrast, in the post migration period, a majority of participants reported studying full time either at school, university, or TAFE. More participants reported being in paid employment on a full or part time basis than in the pre-migration period; and in the post-migration period, more participants were also searching for employment. Of those in paid employment, categories of occupations included those in: (i) unskilled/labour professions (e.g., factory, nursery hand) (n=7); (ii) semi-skilled professions (e.g., teacher’s aide) (n=2); and (iii) skilled professions (e.g., teacher) (n=1). The change of educational attendance and occupational status from pre- to post-migration periods is discussed later in this chapter.
Pre- and post-migration parental employment status

Participants were also asked about their parents’ educational and occupational status in the period leading up to conflict, displacement and forced migration, and again in the period shortly after resettlement. The number and percentage of participants’ parents attending school or employment are presented in Table 9. The “not applicable” category was directly applied when a participant had expressed a parent had died or was missing (and therefore the surviving parent undertook full time care responsibilities) or where participants could not recall or report their parental employment status, due to their young age at the time. In the post-migration period, the “not applicable” category was applied where a parent had deceased, where parent(s) were not searching for work (e.g., due to illness), were enrolled in English language classes, or had remained in refugee camps or returned to homelands.

Table 9. Pre- and post-migration education and occupational status of participants’ parents in the sample.

<table>
<thead>
<tr>
<th>Education/Occupation Status of Parents</th>
<th>Pre-migration (n =77)</th>
<th>Post-migration (n = 78)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>1. Mother employed only</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2. Father employed only</td>
<td>19</td>
<td>25</td>
</tr>
<tr>
<td>3. Both parents worked</td>
<td>19</td>
<td>25</td>
</tr>
<tr>
<td>4. One or both parents searching for work</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>5. Not applicable</td>
<td>28</td>
<td>36</td>
</tr>
</tbody>
</table>

In the pre-migration period, the majority of participants’ mothers did not undertake paid work but assumed full-time care-giving responsibilities. Under circumstances where mothers did work, this was mostly unskilled irregular work such farming or selling wares or produce in markets (n=8). Under other circumstances where mothers
worked, occupations were reported in semi-skilled (e.g., women’s health workers) \((n=4)\), and skilled categories (e.g., nurse, educators) \((n=2)\). Where fathers worked in the pre-migration period, occupations included those in: (i) unskilled professions (e.g., markets, factory) \((n=14)\); (ii) semi-skilled (e.g., army, mechanic) \((n=2)\), and (iii) skilled professions (e.g., teacher, engineer, parliamentary clerk) \((n=3)\). All participants reported that war and conflict had disrupted parental employment, leading to subsequent displacement and migration. In some cases, occupations directly held by participants’ parents resulted in their forced migration.

In contrast, in the post-migration period, there was a reduction in fathers’ only employment, whilst mothers’ only employment remained at similar levels. While participants’ whose both parents worked reduced slightly in the post-migration period, the number of one or both parents searching for work increased. The fifty two percent who reported responses did not apply to them did so due to either a deceased or absent parent, parent(s) still living in refugee camps or having returned to their homeland, parents whose illnesses and disabilities excluded them from work, and parents who were studying English/other courses.

Occupations of mothers as reported by participants in the post-migration period included the following categories: (i) unskilled/labour (e.g., cleaner, factory) \((n=6)\); (ii) semi-skilled (e.g., teachers aids, child care workers) \((n=4)\); and (iii) skilled/professions (e.g., nurse) \((n=1)\). Occupations worked by fathers as reported by participants in the post migration period included the following categories: (i) unskilled/labour \((n=10)\); (ii) semi-skilled \((n=3)\); and (iii) skilled/professional \((n=1)\). For most participants and/or their parents, the major source of income was through government welfare assistance (Centrelink). The remaining participants reported income generated from employment as well as community members. Other sources of assistance cited by participants included community organisations and the church.

Pre- and post-migration physical and emotional health status

Pre-morbid physical health and psychological functioning have been shown to be indicators of later mental health outcomes (Hollifield et al., 2002). Participants in this study were asked to report serious physical illnesses and emotional difficulties prior to their migration. They were also asked to report difficulties experienced by their
parents. The number and percentage of self-reported physical illnesses and emotional difficulties in participants and parents (as reported by participants) are shown in Table 10.

Table 10.
*Pre- and post-migration self-reported physical and emotional illnesses in participants and parents* *(N=77).*

<table>
<thead>
<tr>
<th>Physical and Emotional Health Status</th>
<th>Pre-migration</th>
<th>Post-migration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( n )</td>
<td>%%</td>
</tr>
<tr>
<td><strong>Participant physical health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Serious health problems</td>
<td>24</td>
<td>31</td>
</tr>
<tr>
<td>2. No serious health problems</td>
<td>53</td>
<td>69</td>
</tr>
<tr>
<td><strong>Participant emotional health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Serious emotional problems</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>2. No serious emotional problems</td>
<td>66</td>
<td>86</td>
</tr>
<tr>
<td><strong>Parental physical health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Serious health problems</td>
<td>33</td>
<td>43</td>
</tr>
<tr>
<td>2. No serious health problems</td>
<td>44</td>
<td>57</td>
</tr>
<tr>
<td><strong>Parental emotional health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Serious emotional problems</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>2. No serious emotional problems</td>
<td>69</td>
<td>90</td>
</tr>
</tbody>
</table>
Of the 31% who reported physical illnesses in the pre-migration period, these illnesses included: (i) serious fever or malaria; (ii) starvation and malnutrition causing serious threat to life; (iii) infectious diseases, such as measles; and (iv) severe migraines. Only three participants reported having these illnesses treated. In the contrasting post-migration period, there was a decrease in the number of reported physical health problems. Of the 8% who reported post-migration health problems, health issues included: (i) arthritis, (ii) persistent headaches, (iii) general pains in the body and feelings of unwellness, and (iv) psoriasis. All reported receiving medical treatment for these problems.

Of the 14% who reported serious emotional problems in the pre-migration period, health issues included: (i) “intense sadness”; (ii) “grief” related to the death of a parent(s); and (iii) “extreme stress” reactions, anxiety and worries about living in war zones. None of these participants reported receiving treatment for their emotional problems.

In the contrasting post-migration period, a similar number reported serious emotional problems, which included: (i) diagnosed depression or sadness; (ii) intense loneliness (missing parents or family back home); (iii) trauma related thoughts and feelings; and (iv) general worries. Of those who reported a serious emotional problem, only one person reported receiving counselling for that problem.

Regarding physical illness among participants’ parents prior to migrating to Australia (reported by participants), 43% of participants indicated that at least one family member had experienced a serious physical illness prior to migrating to Australia. Illness reported included: (i) fever and malaria, (ii) extreme starvation and malnutrition, (iii) diabetes, (iv) infectious diseases, and (v) pain and injuries inflicted by political violence. In 7 of these 33 cases, treatment was received. In the contrasting post-migration period, the number of reported physical problems decreased by about thirty percent. These illnesses included: (i) diabetes, (ii) meningitis, (iii) cancer, (iv) chronic pain from injury, and (v) general or unspecified pains. Of the 17 participants who reported physical family illnesses in the post-migration period, only one third reported that their parents received medical treatment.

Although the majority of participants reported no serious parental emotional problems in the pre-migration period, 10% reported their occurrence. The reported
emotional problems of parent(s) included: (i) war related sadness; (ii) trauma and worries; and (iii) grief from the death of loved ones. All participants who reported a serious emotional problem among parents reported that help for these problems was not sought. Contrasting the post-migration period, there was a two fold increase in participants’ reports of their parents’ emotional health problems. Emotional problems reported in these 17 of participants’ included: (i) depression/extreme sadness; (ii) extreme stress related to integration; (iii) general stress, worries, or nervousness; (iv) trauma related thoughts and feelings; and (v) loss and grief. Participants reported that treatment or counselling was not sought nor received by their parent(s).

Trauma experience of youth refugees in this sample

The HTQ (Mollica, Caspi-Yavin, et al., 1992) was used to record participants’ experience of traumatic events. The number and percentage of participants who endorsed traumatic events on the HTQ ranked by mean score is shown in Table 11. Participants were also asked to describe in an “other” category, events experienced but not otherwise listed on the HTQ (item 12 in Table 11). Categories of events listed as “other” included: (i) environmental dangers (e.g., “dangerous camp conditions”; “harsh jungle conditions”); (ii) neighbourhood attacks (e.g., “targeted attacks on villages”); (iii) casualties of war (e.g., “constant injuries to self and others”); and (iv) general living situations (e.g., “uncertainty/fear of attacks”, “poverty”, “watching others in constant fear”). The most commonly endorsed, “directly experienced” traumatic events were reported to include: (i) a lack of food or water; (ii) a lack of shelter; (iii) ill health without access to medical care; and (iv) unnatural death of a family member or friend. Similarly, the traumatic events commonly reported as being “witnessed” included: (i) serious injury; (ii) murder of a family or friend; and (iii) rape or sexual abuse.
Table 11.

Means, standard deviations, and number and percentage of participants that endorsed traumatic events assessed by HTQ (N = 82).

<table>
<thead>
<tr>
<th>Traumatic Event</th>
<th>M</th>
<th>SD</th>
<th>Directly experienced</th>
<th>Witnessed</th>
<th>Heard about</th>
<th>Not experienced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of food or water</td>
<td>3.58</td>
<td>0.86</td>
<td>63 77</td>
<td>9 11</td>
<td>5 6</td>
<td>5 6</td>
</tr>
<tr>
<td>Lack of shelter</td>
<td>3.30</td>
<td>1.06</td>
<td>52 63</td>
<td>13 16</td>
<td>7 9</td>
<td>10 12</td>
</tr>
<tr>
<td>Ill health without access to medical care</td>
<td>3.25</td>
<td>1.06</td>
<td>50 61</td>
<td>12 15</td>
<td>11 13</td>
<td>9 11</td>
</tr>
<tr>
<td>Unnatural death of family member or friend</td>
<td>2.96</td>
<td>1.14</td>
<td>39 47</td>
<td>13 16</td>
<td>18 22</td>
<td>12 15</td>
</tr>
<tr>
<td>Forced separation from family members</td>
<td>2.53</td>
<td>1.30</td>
<td>30 36</td>
<td>12 15</td>
<td>12 15</td>
<td>28 34</td>
</tr>
<tr>
<td>Being close to death</td>
<td>2.50</td>
<td>1.29</td>
<td>29 35</td>
<td>12 15</td>
<td>12 15</td>
<td>29 35</td>
</tr>
<tr>
<td>Murder of family member or friend</td>
<td>2.75</td>
<td>1.10</td>
<td>28 34</td>
<td>20 24</td>
<td>20 25</td>
<td>14 17</td>
</tr>
<tr>
<td>Combat situation</td>
<td>2.51</td>
<td>1.22</td>
<td>26 32</td>
<td>14 17</td>
<td>18 22</td>
<td>24 29</td>
</tr>
<tr>
<td>Serious injury</td>
<td>2.47</td>
<td>1.14</td>
<td>19 23</td>
<td>25 31</td>
<td>14 17</td>
<td>24 29</td>
</tr>
<tr>
<td>Unnatural death of stranger</td>
<td>2.32</td>
<td>0.99</td>
<td>14 17</td>
<td>16 19</td>
<td>35 43</td>
<td>17 21</td>
</tr>
<tr>
<td>Forced isolation from others</td>
<td>2.09</td>
<td>1.11</td>
<td>13 16</td>
<td>16 19</td>
<td>19 23</td>
<td>34 42</td>
</tr>
<tr>
<td>Other traumatic event not listed in HTQ</td>
<td>n/a</td>
<td>n/a</td>
<td>11 13</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Lost or kidnapped</td>
<td>1.74</td>
<td>0.97</td>
<td>8 10</td>
<td>7 8</td>
<td>23 28</td>
<td>44 54</td>
</tr>
<tr>
<td>Brainwashing</td>
<td>1.73</td>
<td>0.95</td>
<td>7 9</td>
<td>7 9</td>
<td>25 30</td>
<td>43 52</td>
</tr>
<tr>
<td>Imprisonment</td>
<td>1.81</td>
<td>0.93</td>
<td>5 6</td>
<td>14 17</td>
<td>24 29</td>
<td>39 48</td>
</tr>
<tr>
<td>Torture</td>
<td>1.68</td>
<td>0.92</td>
<td>5 6</td>
<td>11 14</td>
<td>19 23</td>
<td>47 57</td>
</tr>
<tr>
<td>Rape or sexual abuse</td>
<td>1.91</td>
<td>0.91</td>
<td>4 5</td>
<td>19 23</td>
<td>25 31</td>
<td>34 41</td>
</tr>
<tr>
<td>Murder of stranger</td>
<td>1.76</td>
<td>0.59</td>
<td>1 1</td>
<td>4 5</td>
<td>52 63</td>
<td>25 31</td>
</tr>
</tbody>
</table>

*n/a represents non-HTQ item that was added as an ‘other’ category and therefore only reported as directly experienced by participants.
Of all the traumatic events experienced (items 1-18 from Table 11), participants were also asked to rate their worst experience. Table 12 presents the rank ordered number of participants that endorsed each item as their “worst experience”.

Table 12.

*Number and percentage of participants ‘worst’ rated traumatic experience (N=74).*

<table>
<thead>
<tr>
<th>Traumatic Event</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murder of family member or friend</td>
<td>22</td>
<td>(30%)</td>
</tr>
<tr>
<td>Lack of food or water</td>
<td>18</td>
<td>(24%)</td>
</tr>
<tr>
<td>Unnatural death of family member or friend</td>
<td>9</td>
<td>(12%)</td>
</tr>
<tr>
<td>Combat or war situation</td>
<td>8</td>
<td>(11%)</td>
</tr>
<tr>
<td>Being close to death</td>
<td>4</td>
<td>(6%)</td>
</tr>
<tr>
<td>Ill health without access to medical care</td>
<td>3</td>
<td>(4%)</td>
</tr>
<tr>
<td>Other traumatic event not listed by HTQ</td>
<td>3</td>
<td>(4%)</td>
</tr>
<tr>
<td>Rape or sexual abuse</td>
<td>2</td>
<td>(3%)</td>
</tr>
<tr>
<td>Serious injury</td>
<td>2</td>
<td>(3%)</td>
</tr>
<tr>
<td>Forced separation from family members</td>
<td>1</td>
<td>(1%)</td>
</tr>
<tr>
<td>Witnessed murder of stranger</td>
<td>1</td>
<td>(1%)</td>
</tr>
<tr>
<td>Witnessed unnatural death of stranger</td>
<td>1</td>
<td>(1%)</td>
</tr>
<tr>
<td>Lack of shelter</td>
<td>0</td>
<td>(0%)</td>
</tr>
<tr>
<td>Imprisonment</td>
<td>0</td>
<td>(0%)</td>
</tr>
<tr>
<td>Brainwashing</td>
<td>0</td>
<td>(0%)</td>
</tr>
<tr>
<td>Forced isolation from others</td>
<td>0</td>
<td>(0%)</td>
</tr>
<tr>
<td>Lost or kidnapped</td>
<td>0</td>
<td>(0%)</td>
</tr>
<tr>
<td>Torture</td>
<td>0</td>
<td>(0%)</td>
</tr>
</tbody>
</table>

As inspection of Table 12 shows, the events most commonly endorsed as participants’ worst experiences (i.e., with 10% or more of participants endorsing the event as their worst) were: (i) the murder of a family member or friend; (ii) the lack of food or water; (iii) the unnatural death of a family member or friend; and (iv) being in a combat (or war) situation. These events all have an underlying theme of death or serious threat to life. The reported experience of traumatic events and those rated as the ‘worst’ events for participants is discussed later in this chapter.
Post-migration daily living problems

Keeping within a phased based model of contextual factors, participants were also asked to complete the PMLC (Silove, Sinnerbrink, et al., 1997) to identify difficulties experienced in the resettlement period. Table 13 presents the number and percentage of participants who endorsed each of the 21 difficulties listed in the PMLC (Silove, Sinnerbrink, et al., 1997). Items are presented in ranked order (by mean score), from the “most serious worries” to “least serious worries”.
Table 13.

Means, standard deviation and frequency of daily living problems reported by young refugee participants (N=75).

<table>
<thead>
<tr>
<th>Post-migration difficulty</th>
<th>M</th>
<th>SD</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worries about family back home</td>
<td>3.07</td>
<td>1.50</td>
<td>20</td>
<td>(24%)</td>
<td>5</td>
<td>(6%)</td>
<td>14</td>
<td>(17%)</td>
<td>20</td>
<td>(24%)</td>
<td>15</td>
<td>(18%)</td>
</tr>
<tr>
<td>Racism, prejudice and discrimination</td>
<td>2.73</td>
<td>1.39</td>
<td>19</td>
<td>(23%)</td>
<td>16</td>
<td>(21.5%)</td>
<td>15</td>
<td>(18%)</td>
<td>14</td>
<td>(17%)</td>
<td>10</td>
<td>(12%)</td>
</tr>
<tr>
<td>Problems communicating in Australia</td>
<td>2.54</td>
<td>1.40</td>
<td>25</td>
<td>(31%)</td>
<td>14</td>
<td>(17%)</td>
<td>12</td>
<td>(15%)</td>
<td>16</td>
<td>(20%)</td>
<td>7</td>
<td>(9%)</td>
</tr>
<tr>
<td>Problems with language</td>
<td>2.31</td>
<td>1.37</td>
<td>32</td>
<td>(39%)</td>
<td>10</td>
<td>(12%)</td>
<td>15</td>
<td>(18%)</td>
<td>11</td>
<td>(13%)</td>
<td>6</td>
<td>(7%)</td>
</tr>
<tr>
<td>Problems getting things available in home country</td>
<td>2.27</td>
<td>1.40</td>
<td>32</td>
<td>(39%)</td>
<td>14</td>
<td>(17%)</td>
<td>12</td>
<td>(15%)</td>
<td>8</td>
<td>(9%)</td>
<td>8</td>
<td>(9%)</td>
</tr>
<tr>
<td>Problems finding a job</td>
<td>2.08</td>
<td>1.41</td>
<td>42</td>
<td>(51%)</td>
<td>6</td>
<td>(7%)</td>
<td>10</td>
<td>(12%)</td>
<td>10</td>
<td>(12%)</td>
<td>6</td>
<td>(7%)</td>
</tr>
<tr>
<td>Problems with accommodation</td>
<td>1.92</td>
<td>1.18</td>
<td>38</td>
<td>(46%)</td>
<td>16</td>
<td>(20%)</td>
<td>12</td>
<td>(15%)</td>
<td>4</td>
<td>(5%)</td>
<td>4</td>
<td>(5%)</td>
</tr>
<tr>
<td>Problems with work/uni/school</td>
<td>1.89</td>
<td>1.18</td>
<td>40</td>
<td>(49%)</td>
<td>14</td>
<td>(17%)</td>
<td>11</td>
<td>(13%)</td>
<td>7</td>
<td>(9%)</td>
<td>3</td>
<td>(4%)</td>
</tr>
<tr>
<td>Problems with being poor</td>
<td>1.87</td>
<td>1.16</td>
<td>41</td>
<td>(50%)</td>
<td>12</td>
<td>(15%)</td>
<td>15</td>
<td>(18%)</td>
<td>2</td>
<td>(2%)</td>
<td>4</td>
<td>(5%)</td>
</tr>
<tr>
<td>Problems getting government welfare</td>
<td>1.72</td>
<td>0.92</td>
<td>39</td>
<td>(48%)</td>
<td>21</td>
<td>(26%)</td>
<td>11</td>
<td>(13%)</td>
<td>2</td>
<td>(2%)</td>
<td>1</td>
<td>(1%)</td>
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<tr>
<td>Problems getting help from welfare family</td>
<td>1.57</td>
<td>1.06</td>
<td>52</td>
<td>(63%)</td>
<td>10</td>
<td>(12%)</td>
<td>8</td>
<td>(9%)</td>
<td>0</td>
<td>(0%)</td>
<td>4</td>
<td>(5%)</td>
</tr>
<tr>
<td>Feeling lonely or bored</td>
<td>1.57</td>
<td>0.95</td>
<td>47</td>
<td>(57%)</td>
<td>18</td>
<td>(22%)</td>
<td>6</td>
<td>(7%)</td>
<td>0</td>
<td>(0%)</td>
<td>3</td>
<td>(4%)</td>
</tr>
<tr>
<td>Problems with permission to work</td>
<td>1.55</td>
<td>1.12</td>
<td>25</td>
<td>(31%)</td>
<td>14</td>
<td>(17%)</td>
<td>12</td>
<td>(15%)</td>
<td>16</td>
<td>(20%)</td>
<td>7</td>
<td>(9%)</td>
</tr>
<tr>
<td>Worries about being sent home</td>
<td>1.55</td>
<td>0.90</td>
<td>50</td>
<td>(61%)</td>
<td>11</td>
<td>(13%)</td>
<td>9</td>
<td>(11%)</td>
<td>0</td>
<td>(0%)</td>
<td>4</td>
<td>(5%)</td>
</tr>
<tr>
<td>Problems accessing health care</td>
<td>1.53</td>
<td>0.83</td>
<td>47</td>
<td>(57%)</td>
<td>18</td>
<td>(22%)</td>
<td>7</td>
<td>(9%)</td>
<td>0</td>
<td>(0%)</td>
<td>1</td>
<td>(1%)</td>
</tr>
<tr>
<td>Worries about being sent back home</td>
<td>1.51</td>
<td>0.98</td>
<td>53</td>
<td>(64%)</td>
<td>11</td>
<td>(13%)</td>
<td>5</td>
<td>(6%)</td>
<td>3</td>
<td>(4%)</td>
<td>2</td>
<td>(2%)</td>
</tr>
<tr>
<td>Feeling isolated</td>
<td>1.50</td>
<td>0.94</td>
<td>51</td>
<td>(62%)</td>
<td>15</td>
<td>(18%)</td>
<td>5</td>
<td>(6%)</td>
<td>0</td>
<td>(0%)</td>
<td>3</td>
<td>(4%)</td>
</tr>
<tr>
<td>Problems with immigration</td>
<td>1.30</td>
<td>0.93</td>
<td>64</td>
<td>(77%)</td>
<td>6</td>
<td>(7%)</td>
<td>0</td>
<td>(0%)</td>
<td>0</td>
<td>(0%)</td>
<td>4</td>
<td>(5%)</td>
</tr>
<tr>
<td>Conflict with immigration</td>
<td>1.23</td>
<td>0.84</td>
<td>67</td>
<td>(80%)</td>
<td>3</td>
<td>(4%)</td>
<td>1</td>
<td>(1%)</td>
<td>0</td>
<td>(0%)</td>
<td>3</td>
<td>(4%)</td>
</tr>
<tr>
<td>Problems accessing counselling or emotional support</td>
<td>1.19</td>
<td>0.59</td>
<td>64</td>
<td>(78%)</td>
<td>8</td>
<td>(9%)</td>
<td>1</td>
<td>(1%)</td>
<td>0</td>
<td>(0%)</td>
<td>1</td>
<td>(1%)</td>
</tr>
<tr>
<td>Delays in processing application</td>
<td>1.56</td>
<td>1.11</td>
<td>55</td>
<td>(67%)</td>
<td>9</td>
<td>(11%)</td>
<td>4</td>
<td>(5%)</td>
<td>3</td>
<td>(4%)</td>
<td>4</td>
<td>(5%)</td>
</tr>
</tbody>
</table>
The most common difficulties as ranked by mean score above 2 (i.e., above a mild worry) were: (i) worries about family back home; (ii) racism, prejudice, and discrimination; (iii) problems with communicating in Australia; (iv) problems with language; (iv) problems getting things available in one’s home country; and (vi) problems finding a job. These post-migration difficulties are discussed later in this chapter.

Discussion

By describing the sample characteristics of participants in this thesis and their pre- and post-migration contrasts across important demographic personal experience characteristics, this chapter aimed to describe the ‘make up’ of a young refugee population in Australia. It showed that young refugees in Australia are diverse with respect to their demographic and psychosocial backgrounds as well as their trauma and resettlement experiences (Fazel, et al., 2012; Fazel, et al., 2005; Porter & Haslam, 2005). It also showed that are commonalities and overlap in young refugees’ experiences. As seen in the previous chapter, this sample comprised a diverse set of nationalities and ethnicities, mostly from the Horn of Africa and The Karen State, with others from Sudan and Togo making up the majority. Many of these young refugees were in the transitory stages between adolescence to young adulthood with respect to age (aged 18 years on average), but through pre- to post-migration periods, had transitioned from later child to early adulthood.

Although well represented across gender, the young refugees were predominantly female. These factors affirm WHO and UNHCR data that shows the majority of refugees are young and female (UNHCR, 2007). Participants mostly followed Christian and Islamic faiths, and the diversity of nationalities was also reflected in the languages spoken, with more than one and up to three languages spoken across nine different ethnicities. Following the main languages spoken for each cultural group, Arabic, English, and French were the most commonly spoken second and third languages, alongside tribal languages among the Sudanese. Such strengths are not often reported in sample characteristics of other studies (Hutchinson...
The described characteristics are also reflective of data collected from the Australian government in that nationalities included in the current sample are represented in the top six countries that received Australia protection visas in 2010 (CMY, 2010; Department of Immigration and Citizenship, 2010). Thus, with exception to a Middle Eastern representation (for which this study only had a few participants) and a new intake of Togolese, the sample mirrors the primary intake of Australia’s refugee program.

Continuing from the characteristics outlined in the previous chapter, the present chapter summarised characteristics with respect to places of exile, parental presence, and accompaniment status. Family and living situation, education and employment status, and individual and family health status were also explored in a pre-post-migratory comparison. Carrying the pre- peri- post-migration themes across the sample, the present chapter also explored trauma experiences and post migration difficulties. Although these explorations were not, nor intended to be exhaustive, particularly since the pre-, peri-, and post-migration experience encompasses so many transitions that cannot be captured in a broad questionnaire, they do provide a snapshot of young refugees in Australia. The following paragraphs discuss the pre- post-migration contrasts observed in the current study.

Regarding places of exile, it was common for refugees to have exile experiences in a neighbouring country, with some cultural differences observed. Togolese refugees, for example, on average travelled to more exile countries in their journeys to Australia than other refugees in this sample. This cultural difference may represent the more ‘hidden’ plight of Togolese refugees in that more distant travel may have been necessary in order to reach asylum countries where refugee claims can be lodged (e.g., to larger established refugee camps with greater UNHCR presence). Although the exile experiences of these young refugees, particularly in refugee camps, are further explored in Chapter 9, they do suggest that young refugees must travel afar, exposing them to a range of new countries and environments which force them to constantly adapt (Fazel, et al., 2005). Because the journey from displacement to resettlement can be long, for some more than 10 years (Tribe, 2002), it is reasonable to deduce these refugees are exposed to multiple situations and potential dangers along their journey (e.g., hardships of geographical travel, vulnerability to exploitation given language and cultural differences, etcetera).
Regarding parental presence, while most of the sample had the presence of at least one parent prior to forced migration, up to a quarter of participants, had lost a parent (through either death or considered ‘missing’), usually a father. It is unclear whether these estimates reflect more global estimates of parental death, particularly as the current thesis included multiple sibships. These findings do suggest though that a high degree of loss and potential traumatic bereavement may be present in young refugees who migrate to Australia. The added difficulty of not having both parents present to regulate one’s life may compound the potential for psychological distress (Blair, 2000). Notwithstanding, most young refugees appear to arrive in Australia with both parents, and a sibling, which may afford at the least some degree of psychological protection (Fazel & Stein, 2002).

Regarding accompaniment status, most participants migrated with family members, and in some cases, were accompanied by extended family. Although separation did occur among this group, all participants reported re-unification with certain members of their families. Only a small minority arrived in Australia unaccompanied. The relative intactness of families, at least in this sample, suggests that young refugees may experience the protective support of family presence (Weine, 2008). It is important to note here though that qualitative themes revealed that although many participants arrived with siblings or at least one parent, many had also left other siblings and family members behind in their home countries or in refugee camps.

Regarding family and living situation, most participants lived with their mothers in both the pre- and post-migration period. While the mother-child relationship appears to remain intact at least physically, the contrast in the pre-post period for fathers living in the family unit was noticeably different. While the majority of participants that reported travelling with their fathers was consistent with the number of participants living with their fathers in the post-migration period, there may be a number of factors as to why only two-thirds of participants resided with their fathers prior to migration. This outcome may reflect the number of participants’ fathers who died, as well as separation processes between young refugees and their fathers, due to reasons such as fears for safety of the father (or family with the presence of father) or fathers leaving the family unit in order to procure paid work (Macksoud, 1992).
The other notable finding with respect to family and living situation is that the number of participants who lived with extended families in the pre-migration period reduced in the post-migration period. Thus, the family make-up can be very different following settlement (Momartin, Silove, Manicavasagar, & Steel, 2002). Such residential changes or transitions in young refugees lives could imply that family support (e.g., from extended family members such as cousins, or aunties) might not be available in the post-migration period. For cultures that are more collective in nature, this change may have a significant impact on mental health, particularly in the absence of other supports (Schweitzer, et al., 2006).

Regarding education and occupational status, data showed that fewer participants were enrolled in school in the post-migration period than in the pre-migration period, and that enrolment in school in the pre-migration period was relatively high. There are a number of reasons for this outcome. Prima facie this data could be interpreted as evidence for a high rate of school participation. However, it is more likely that the data is reflecting enrolment per se, rather than regular, fulltime, uninterrupted schooling (Sidhu, Taylor, & Christie, 2011). This explanation is corroborated by the qualitative follow up to these questions, which highlighted the array of reasons that school attendance was low and/or was often interrupted (e.g., war, school not available beyond primary level, unable to afford education). Thus, the quality of education received in the pre-migration period may have been quite different to that offered in the post-migration period (Sidhu, et al., 2011).

Alternatively, this data could also reflect the time lapse across pre- and post-migration periods - the actuality that ‘the young’ are ‘getting older’. At the time of testing, many participants were older than the minimum compulsory age for school, and most were beyond the traditional ages of schooling. This could have contributed to the fewer participants enrolled in schooling, although it is important to note, many were enrolled in tertiary and TAFE education. The idea that the time lapse between pre- and post-migration periods can be long is corroborated by the increase in employment and occupational status in the young refugees in this sample. As many had reached an age of employment, occupational levels had increased in the post-migration period. Alternatively again, these findings could suggest that participants had finished high school and like the majority of young people in Australia, did not continue into higher education. Although these interpretations are speculative, the pre-
and post-migration contrasts with respect to education and occupation, do reflect that major transitions occur in the life of a young refugee. Unlike ‘ordinary’ youths, young refugees not only make transitions from early schooling through to adult employment, they must do so amidst a backdrop of instability, war, threat to life, interrupted education, and disrupted family life (Weine et al., 2005).

Regarding parental employment status, only a small portion of the young refugees’ parents in this study worked prior to their migration, probably due to the economic and conflictual circumstances of war (Beiser & Hou, 2001). Most participants in this sample reported being unable to report on parental work status pre-migration due to either the death of a parent, a missing parent, or camp life restricting opportunities to earn income. A similar finding was also made in the post-migration period, with most parents of participants, not undertaking or searching for work (i.e., not applicable category). This speaks to the multiple social issues that are confronted by refugees in the post-migration period. For example, opportunities for employment in Australia may not be accessed due to either the need to consolidate English language, to perform caregiver duties, not being eligible for work, or not being able to work due to pain, illness or disability. Unlike the traditional routes of voluntary migration, employment for forced migrants may be intersected with a range of other social or psychological issues (Beiser & Hou, 2001). The obstacles to a meaningful life through employment opportunities are therefore potentially diminished. Of parents who did work, most had semi-skilled to unskilled positions prior to conflict in their countries and following their subsequent migration. The protracted experience of war and the length of time spent in exile may also prohibit the maintenance of skills and opportunities to learn new skills, which could also impact on employment and occupational status in the resettlement period (Pumariega, et al., 2005). As indicated by the qualitative findings, most participants found it difficult to recall parent work status due to the lengthy time spent in refugee camps.

Regarding physical health among participants and their reports of parental physical health, there appeared to be fewer reported serious health issues in the post-migration period. This may reflect the obvious limited access to health and medical care in the pre-migration period, and better access and utilisation of physical health care in the post- migration period (Fazel, et al., 2012). Regarding emotional experiences though, this change was less evident for participants. There were a similar
small percentage of participants that reported emotional problems across both the pre-
and post-migration period. Participants’ reports of their parents’ emotional status on
the other hand differed significantly in the post-migration period. That is, a 13%
increase of parental emotional difficulty was reported by participants.

Although it is recognised that participant reports were relied upon to gauge
parental emotional health, and therefore interpretation of this data are limited, it was
not within the scope of this project to assess parental mental health directly. What is
interesting to note instead is that irrespective of the presence of emotional health
problems among parents, the children of these parents perceive more emotional
problems in their parents in the post-migration period. The psychological difficulties
experienced by parents cannot be explored by this study, but may suggest that
additional sources of stress in the post-migration period could play a role in parental
mental health, or this period may represent a time in which emotional problems
present following a more ‘acute’ period of flight, where the focus may be on survival,
safety and protection of children (Pumariega, et al., 2005). Nonetheless, a small but
significant minority of participants perceived emotional stress among their parents,
which in turn could affect participants’ mental health, especially if parents are
psychologically unavailable.

Amidst the psychosocial risk factors mentioned so far, perhaps the
characteristic that poses most threat to young refugees is the experience of pre-
migration trauma. Regarding the traumatic events experienced by this sample,
inspection of data revealed that the most commonly experienced events were a lack of
food or water, lack of shelter, ill health without access to medical care, the unnatural
death of family members or friends, the forced separation from family, and being
close to death. Across these events, 35% to 77% of the sample endorsed directly
experiencing these PTEs. At a deeper level, the first three of these events appear to
indicate that the most basic of human needs were not met in the pre- and peri-
migration stage. Such experiences highlight the deprivation of basic necessities for
life which arise from the chaos of war (Husain et al., 1998; Silove, 1999). The fourth
to seventh most endorsed events appeared to cluster around traumas associated with
immediate threat to life and the immediate threat to families’ lives. Not only do young
refugees contend with the deprivation of basic needs, but also the direct and real threat
to their own life and the actual death of loved ones (Momartin, et al., 2002; Silove,
1999). In other words, they survive with constant fear and likelihood, that if they do not die, someone close to them will.

The remaining traumatic events less commonly endorsed between 1-32% included events that appeared to cluster around more gross personal physical violations towards self or others more unfamiliar. Table 11 showed that about 21-54% of participants did not endorse or “directly experience” these more personal gross violations. Although these items were not directly experienced by up to half the participants, it is important to note a large portion did “witness” or “hear about” these events. In other words, extreme violations, although only directly experienced by some, for all, they appeared to be the ‘norm’ in young peoples’ lives. In the event that trauma was not directly experienced, the threat was enduring. Although the fear cognitions were not explored in the present study, these findings do parallel what is outlined in the trauma literature around the loss of control and helplessness in capability to protect oneself and family (Basoglu & Salcioglu, 2011; Prorokovic, Cavka, & Cubela Adoric, 2005; van den Heuvel, 1998). Such chronic threat to life underscores the considerable vulnerability in this group of young survivors.

In this thesis, participants were asked to rate their “worst experience” among the list of traumatic events. Half of the participants in this thesis endorsed the murder of a family member or friend and the lack of food or water as their worst experiences. Regarding the latter, this was a more unexpected finding. Perhaps a more difficult concept for developed countries to grasp, for young refugees in underdeveloped countries severely affected by war, the lack of food or water appeared to be a profound factor in individual’s trauma experiences. One way to understand this finding may be that the deprivation of food and water is seen as a constant, chronic but very real direct threat to life (Drury & Williams, 2012; Silove, 1999).

Maslow’s (1943) humanistic theory of hierarchical needs offers an important foundation theory for understanding these findings related to trauma experience. He suggested that humans are motivated by the satisfying basic needs which occur sequentially in the order of physiological needs, safety needs, belongingness/love needs, esteem needs and the need for self-actualisation (Maslow, 1943). The fulfilment of these needs is often thwarted during war and subsequent displacement. Extending this understanding, Staub (2006) identified some additional psychological and social needs (Tipping, 2010). These included the need for security, positive
identity, effectiveness and control, connection to others, and meaningful comprehension of reality and one’s place in this reality. Like Maslow’s self-actualisation need, Staub argued the need for transcendence (a spiritual need to move beyond material and self needs), which emerges after the other needs are reasonably satisfied (Staub, 2003).

The human needs theories are relevant to the current findings as war and violence are considered to profoundly disrupt the attainment of needs through challenging physical survival capacities, individuals’ understandings of the world and their spirituality, individuals’ capacity to regulate emotions, and their capacity to trust others (Staub, 2006; Tipping, 2010). Survival becomes threatened in war and emergency settings through a lack of food, shelter and water, and security. The violation of rights to have opportunities to attain these needs produce additional challenges for refugees, which in turn may give rise to psychological maladaptation (Joop & De Jong, 2002; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004; Silove, 1999). These issues are further discussed in the implications for theory section in the final chapter of this thesis.

Finally, in keeping with a phase based model of experiences, in this chapter frequency data derived from the post-migration daily living checklist (Silove, Sinnerbrink, et al., 1997) were examined. Participants reported most difficulties in the areas of communication and language, racism, prejudice and discrimination and worries about loved ones and family back home. While the post-migration difficulties checklist was designed to tap problems directly relating to the asylum-seeking process (Silove, Sinnerbrink, et al., 1997), it is unsurprising that items directly related to this process (e.g., delays in processing application, conflict with immigration) were underendorsed by the current young refugee population. This may be attributed to greater certainty about their residency and settlement over time. The difficulties highlighted nonetheless, parallel those reported previously in the post-migration period (Fazel, et al., 2012; Khawaja, et al., 2008; Warfa et al., 2006), and are consistent with psychosocial and acculturative stress factors, which may exacerbate existing vulnerability from pre- and peri- migration experiences (Montgomery & Foldspang, 2008). The next chapter will explore the impact of demographic factors, pre-, and peri-migration trauma experience and post-migration difficulties on mental health.
outcomes in young refugees resettled in Australia as well as psychological outcomes for this group more broadly.
CHAPTER 7: NEGATIVE MENTAL HEALTH FACTORS AND CULTURAL DIFFERENCES IN YOUNG AUSTRALIAN REFUGEES

Overview

Following an exploration of the demographic characteristics of this sample of young refugees, the present chapter focuses on one of the main enquiries in this thesis. That is, the study of negative mental health factors or psychopathology in young culturally diverse Australian refugees. The chapter begins with an overview of aims, research questions and hypotheses for the study, and proceeds to an examination of the prevalence of mental health problems. From an estimation of the prevalence of PTSD, anxiety, depression, and somatisation, the chapter will then examine the pre-, peri-, and post-migration factors which predict these outcomes. Cultural differences across these disorders are then examined.

The findings of this study will show that mental health problems are indeed a concern for this group of young refugees, and that some cultural differences exist. It will conclude that while a high proportion of young refugees do not exhibit PTSD, anxiety, depression, and somatisation, a small but significant number do experience these problems, and that these problems are reliably predicted by identified pre-, peri-, and post-migration factors. Further, whilst a small but significant number exhibit symptoms consistent with a diagnosis, almost a quarter exhibit partial symptoms. This finding is discussed both in terms of the potential vulnerability of these young refugees to mental health problems as well as their resilience – factors that protect them from the development of further or more adverse symptomatology. The general methodology employed in this study is described fully in Chapter 5. Hence, this chapter focuses mainly on the findings regarding negative mental health factors in youth refugees.
Aims and research questions

Consistent with the thesis rationale presented in Chapter 1, the present study had two main aims. The first was to broadly examine the psychological well being of culturally diverse young refugees living in Australia. Although the investigation of mental health problems is not new, this chapter does attempt to investigate mental health in a youth population and in newer groups in Australia, namely, young refugees from the Karen State/Burma, and Togo. This will allow a contrast of mental health difficulties among more established populations such as the Sudanese or the Horn of Africans and less established groups such as the Karen or Togolese. Psychological well being in this young group of Australian refugees will be investigated through (a) an exploration of the frequency of mental health problems; (b) an examination of the correlates of mental health problems; and (c) an exploration of the pre-, peri-, and post-migration predictive factors in these problems.

The second aim of this chapter was to explore cultural differences in the psychological well being of newer and more established cultures of young refugees living in Australia. Surprisingly, despite widespread acknowledgment of the influence of culture on symptoms, there have been few studies which focus on the variation between cultures in manifestations of distress (Westermeyer, 1995). An analysis of differences between cultural groups is therefore helpful in understanding how disorders present or differ culturally, which may in turn allow for more culturally tailored interventions. To achieve these two aims, the present study sets out to answer the following questions:

1. What proportion of young Australian refugees experience negative mental health problems such as PTSD, anxiety, depression, and somatisation?
2. How does somatisation relate to traditional disorders of PTSD, anxiety, or depression?
3. What are the psychological correlates of PTSD, anxiety, depression, and somatisation in young refugees living in Australia?
4. What factors across the transitory phases of pre-, peri-, and post-migration predict PTSD, anxiety, depression, and somatisation, and
particularly, what is the impact of trauma exposure in the development of these problems?

(5) What if any, cultural differences exist in the occurrence of psychological problems among young refugees living in Australia?

Hypotheses

Based on what is known and inferred from the literature, the following hypotheses were tested:

(1) Young refugees in this sample will exhibit rates of PTSD, anxiety, depression, and somatisation higher than that observed in a general community of non-refugees.

(2) A high rate of comorbidity will exist across disorders of PTSD, anxiety, depression, and somatisation among young refugees in this sample.

(3) The experience of trauma will be a significant predictor in the outcomes of PTSD, depression, anxiety, and somatisation.

(4) There will be a range of factors across pre-, peri, and post-migration phases that contribute to the prediction of PTSD, anxiety, depression, and somatisation.

(5) There will be cultural differences in the prevalence of PTSD, anxiety, depression, and somatisation.

Method

The method outlining a description of the participants in this study, the measures used procedure undertaken, and the data analyses in the current investigation are described in Chapter 5.

Results

Frequency of posttraumatic stress disorder. In order to examine the frequency of Post-traumatic Stress Disorder and its symptoms (see DSM-IV for criteria relating to PTSD), this study firstly established a cut-off point at which a diagnosable case for
PTSD could be made. The present study utilised the HTQ authors’ (Mollica, Caspi-Yavin, et al., 1992), suggestion of a ≥ 2.5 cut-off score (mean total item score) to determine PTSD caseness. In this sample, the mean PTSD item score was 1.93 (SD = 0.75). The proportion of the sample with symptoms consistent with diagnostic criteria for PTSD is seen in Figure 2 (disorders of anxiety, depression, and somatisation are also shown in Figure 2). These percentages for ‘caseness’ based on the cut-off score are contrasted with the percentages for those that were considered ‘partial’ PTSD cases (i.e., moderate to high symptoms without meeting DSM - IV criteria, HTQ score of ≥ 2 – 2.4) and with the percentages for those in the sample who did not meet criteria for PTSD (i.e., no or mild symptoms of PTSD) (see Figure 2).

Figure 2. Percentage of sample classified as diagnosable, partial and low/no symptoms of PTSD, anxiety, depression and somatisation.

Figure 2 displays the proportion of the sample meeting diagnostic criteria for PTSD, anxiety, depression and somatisation (high symptoms), against the proportion of the
sample meeting partial criteria (moderate symptoms but not meeting criteria) and the proportion not meeting criteria at all (mild/no symptoms). With regard to PTSD, 22% participants \((n=18)\) met diagnostic criteria for PTSD. A further 24% \((n=20)\) had moderate partial symptoms of PTSD (sub-clinical), and 54% of participants \((n = 44)\) experienced no or mild symptoms of PTSD.

**Breakdown of PTSD symptom clusters.** As PTSD symptoms incorporate a range of physical (arousal) symptoms, it was of interest to examine the breakdown of PTSD symptomatology in an effort to explore the relationship between somatisation and PTSD. PTSD symptoms arranged by cluster criterion that were reported as bothersome “quite a bit” (moderate) or “extremely” (severe) are displayed in Table 14.

<table>
<thead>
<tr>
<th>PTSD Symptom</th>
<th>Number and % of sample endorsing symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Re-experiencing symptoms</strong> (endorsed by 31.5% of sample)</td>
<td></td>
</tr>
<tr>
<td>Recurrent thoughts or memories</td>
<td>42 (42%)</td>
</tr>
<tr>
<td>Recurrent nightmares</td>
<td>26 (32%)</td>
</tr>
<tr>
<td>Emotional or physical reaction at reminders</td>
<td>25 (31%)</td>
</tr>
<tr>
<td>Flashbacks</td>
<td>17 (21%)</td>
</tr>
<tr>
<td><strong>Avoidance symptoms</strong> (endorsed by 26.4% of sample)</td>
<td></td>
</tr>
<tr>
<td>Avoidance of thoughts/ feelings associated with event/s</td>
<td>30 (37%)</td>
</tr>
<tr>
<td>Less interest in daily activities</td>
<td>24 (29%)</td>
</tr>
<tr>
<td>Foreshortened future</td>
<td>24 (29%)</td>
</tr>
<tr>
<td>Detached or withdrawn</td>
<td>21 (26%)</td>
</tr>
<tr>
<td>Unable to feel emotions</td>
<td>19 (23%)</td>
</tr>
<tr>
<td>Avoidance of activities that remind of event/s</td>
<td>17 (21%)</td>
</tr>
<tr>
<td>Inability to remember parts of the event/s</td>
<td>16 (20%)</td>
</tr>
<tr>
<td><strong>Hyperarousal symptoms</strong> (endorsed by 35.4% of sample)</td>
<td></td>
</tr>
<tr>
<td>Trouble sleeping</td>
<td>34 (41%)</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>30 (37%)</td>
</tr>
<tr>
<td>Feeling irritable or having outbursts of anger</td>
<td>29 (35%)</td>
</tr>
<tr>
<td>Feeling jumpy, easily startled</td>
<td>27 (33%)</td>
</tr>
<tr>
<td>Feeling on guard</td>
<td>25 (31%)</td>
</tr>
</tbody>
</table>
As seen in Table 14, within the *re-experiencing symptom cluster*, intrusive memories were the most prominent symptom, followed by nightmares, and emotional or physiological reactions when reminded of the traumatic event(s). Within the *avoidance symptom cluster*, avoidance of event related thoughts or feelings featured most prominently with over a third of the sample endorsing avoidance of thoughts and feelings related to the event, followed by almost one third of respondents endorsing high symptoms for loss of interest in activities, lost sense of future, and feeling detached and withdrawn. Symptoms within the *hyperarousal cluster* were experienced, on average, at a higher frequency than those within the re-experiencing and avoidance symptom clusters. That is, almost half (41%) endorsed sleeping difficulties, followed by a quarter to over a third who experienced difficulty concentrating, feeling irritable or angry, and feeling startled and on guard. The implications of these findings are discussed later in this chapter.

**Traumatic event exposure and PTSD.** To explore the impact of participants’ exposure to traumatic events on PTSD symptoms, three different approaches were used for examining data collected from Part 1 of the HTQ (traumatic event exposure). The first approach was highlighted in the previous chapter where the experience of trauma events were reported in percentage terms for the sample. This approach also incorporated a “weighting” of traumatic events experienced, where direct experiences were given greater weight than witnessed events or events only heard about.

Combining these weights enabled a participant’s total score to reflect their weighted trauma experience, with higher scores reflecting higher weighted trauma experiences (e.g., direct experiences of trauma events contributed greater to the total experience of trauma than events witnessed or heard about; or events witnessed carried greater weight than events heard about, and so on). Within the range of 17-65, the mean total score for this weighted combination of events was 40.98 (*SD*=10.26). The analysis in the previous chapter using item mean scores revealed greatest endorsements or experiences across the sample for deprivation of necessities including food and water, shelter, and good health followed by the murder or unnatural death of loved ones, separation from family, being close to death, and combat situations.
The second approach was to use the HTQ Part 1 data to determine the mean number of traumatic events *directly experienced only* (as opposed to those witnessed or heard about). This analysis revealed the mean total of traumatic events “directly experienced” was 4.80 ($SD=3.38$). The range of traumatic events directly experienced by participants was 0-15. The third approach was to use the HTQ Part 1 data to examine a combination of *directly experienced and witnessed events* (i.e., “experienced it” and well “witnessed it”). The mean total of traumatic events both directly and indirectly experienced was 7.52 ($SD=3.84$). The range of traumatic events both directly and indirectly experienced by participants was 0-17.

Using the total scores of each of these approaches in a correlational analysis with PTSD symptoms, no major differences were revealed in the strength of relationship between trauma experiences coded in each of the three ways and PTSD. That is, there was a moderate positive correlation between weighted trauma and PTSD ($r=.51, p<.001$), a moderate positive correlation between directly experienced trauma only and PTSD ($r=.40, p<.001$), and a moderate positive correlation between equally weighted direct and witnessed trauma experience and PTSD ($r=.48, p<.001$).

Although the correlation using direct trauma was slightly weaker than the other two methods, this difference did not significantly change the strength of the relationship between trauma experienced and PTSD symptoms. Thus, the “directly experienced combined with witnessed” approach, was used in all subsequent analyses involving trauma exposure. This approach was chosen to reduce any controversy surrounding events that were only “heard about” (e.g., potential vicarious trauma), and because it represents a more definitive measure of trauma exposure, consistent with Criterion A1 from DSM-IV diagnostic criteria for PTSD. This does not mean to say though that events “heard about” are not considered traumatic in the refugee experience, as it is argued these events can indeed serve as actual, real, and chronic threats to physical integrity in a war situation. Moreover, some authors argue investigations around the number of traumatic events experienced may not be relevant given the numerous and chronic exposures that occur in refugee experiences and the idea that multiple events happening six or seven times does not necessarily outweigh an event that has happened once (Summerfield, 1998, 1999, 2001; Summerfield & Hume, 1993). The introduction of the DSM-5 scheduled for 2013 will also redefine trauma to reflect such experiences (American Psychiatric Association, 2012).
When type of trauma event experienced was assessed, several event types were more associated with PTSD than others. The significant correlations between trauma event type and PTSD symptomatology are seen in Table 15.

Table 15.
*Significant correlations between traumatic event and PTSD symptoms (N=82).*

<table>
<thead>
<tr>
<th>Traumatic Event</th>
<th>$R$</th>
<th>Number of participants endorsing event as witnessed/experienced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ill health without access to medical care</td>
<td>.27*</td>
<td>62</td>
</tr>
<tr>
<td>Lack of shelter</td>
<td>.37**</td>
<td>65</td>
</tr>
<tr>
<td>Serious injury</td>
<td>.42**</td>
<td>44</td>
</tr>
<tr>
<td>Brain washing</td>
<td>.24*</td>
<td>14</td>
</tr>
<tr>
<td>Rape or sexual assault</td>
<td>.34**</td>
<td>23</td>
</tr>
<tr>
<td>Forced isolation from others</td>
<td>.26*</td>
<td>29</td>
</tr>
<tr>
<td>Being close to death</td>
<td>.40**</td>
<td>41</td>
</tr>
<tr>
<td>Forced separation from family</td>
<td>.44**</td>
<td>42</td>
</tr>
<tr>
<td>Unnatural death of family member/friend</td>
<td>.29**</td>
<td>52</td>
</tr>
<tr>
<td>Lost or kidnapped</td>
<td>.23*</td>
<td>15</td>
</tr>
</tbody>
</table>

*$p<.05, **p<.001$*

Table 15 shows that of the traumatic events that were significantly related to PTSD symptoms, the strongest events were forced separation from family, serious injury, being close to death, which had strong relationships to PTSD. These events together with lack of shelter, rape or sexual assault, and death of a family member or friend were highly significant ($p<.001$).

**Establishing frequency for anxiety, depression, and somatisation.** With exception to PTSD, all measures of psychopathology were measured using the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982). Raw scores on the BSI were converted to T-scores to determine clinical cut offs for each of the disorders measured by the BSI (e.g., anxiety, depression, somatisation). T-scores were preferred over raw scores or means in determining ‘caseness’ as they are clinically considered more interpretable (Schembri, 2011). That is, as a standard score, the T-score can indicate where an individual's score may stand in comparison to a normative sample of peers.
As with other T-score distributions, such as the MMPI or Achenbach Child Behaviour Checklist, the mean is typically represented as a T-score of 50 with a standard deviation of 10 (Schembri, 2011).

In the present study, by convention, scores that were considered at or above 1.3 standard deviations from the mean were considered as warranting clinical attention. That is, T-scores at or above 63 (90\textsuperscript{th} percentile) were used as the criterion for a clinically diagnosable disorder (Derogatis & Spencer, 1982; Shalev, Tuval, Frenkel-Fishman, Hadar, & Eth, 2006). Scores that were considered .5 of a standard deviation from the mean in this study (i.e., had a T score of 55–62) were considered as partial symptomatic cases (moderately symptomatic, but not diagnosable). However, in analyses not requiring a clinical cut-off for anxiety, depression, or somatisation, the raw scores totals were used (e.g., in subsequent correlational and multiple regression analyses).

**Frequency of anxiety.** Using the T-score criteria described above, frequency statistics were derived for the proportion of the sample that met criteria for anxiety disorder. These percentages, separated by diagnostic cases, partial cases, and no/mild cases are shown in Figure 3. As seen in the second column of Figure 3, 21% of participants in the sample \((n=17)\) experienced high anxiety, 28% experienced partial anxiety \((n=23)\), while the majority (51%, \(n=42\)) of the sample experienced mild or no symptoms of anxiety. The mean item score for anxiety was 0.90 \((SD=.84)\). The mean T-score for anxiety was 53.18 \((SD=13.55)\).

**Frequency of depression.** Using the T-score criteria described above, frequency statistics were derived for the proportion of the sample that met criteria for depressive disorder. These percentages, separated by diagnostic cases, partial cases, and no/mild cases are shown in Figure 3. As seen in the third column of Figure 3, 24% of participants in the sample \((n=20)\) experienced high symptoms of depression, 26% experienced partial depression \((n=21)\), while the majority (50%, \(n=41\)) of the sample experienced mild or no symptoms of depression. The mean symptom score for depression was 0.95 \((SD=.91)\). The mean T-score for depression was 53.01 \((SD=13.50)\).
**Frequency of somatisation.** Using the T-score criteria described above, frequency statistics were derived for the proportion of the sample that demonstrated symptoms of somatisation. These percentages, separated by diagnostic cases, partial cases (moderate to high symptoms) and no/mild cases are shown in Figure 3. As seen in the last column of Figure 3, 29% of participants in the sample (n=24) experienced high somatisation, 26% experienced partial somatisation (n=21), while 45%, (n=37) of the sample experienced mild or no symptoms of somatisation. The mean symptom score for somatisation was 0.76 (SD=.79). The mean T-score for somatisation was 53.58 (SD=12.72).

**Comorbidity across PTSD, anxiety, depression, and somatisation.** Person product moment correlations were calculated between each of the PTSD, anxiety, depression, and somatisation measures. Table 16 presents the correlation matrix for these variables. As shown, PTSD, anxiety, depression, and somatisation were significantly interrelated, with the relationships between anxiety and depression, anxiety and somatisation, and depression and somatisation the strongest.

<table>
<thead>
<tr>
<th>Mental health problem</th>
<th>PTSD</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Somatisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>1</td>
<td>.57**</td>
<td>.53**</td>
<td>.51**</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1</td>
<td>.79**</td>
<td>.73**</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td>.71**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatisation</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

**p= < 0.01

**Correlates of PTSD, anxiety, depression, and somatisation.** The pre-, peri-, and post-migration correlates of PTSD, anxiety, depression, and somatisation were examined using correlational analyses. Variables selected for these analyses were chosen on the basis of those identified by the literature and this study to have relevance to young
refugee populations. These potential correlates of distress were categorised into five categories:

i) **Demographic variables** – including, gender, age, age at arrival, and years lived in Australia.

ii) **Pre-migration variables** – including, direct trauma exposure, direct and witnessed trauma exposure, combined weighted trauma exposure, parental status (both parents alive versus at least one parent missing or deceased), pre-migratory physical health, pre-migratory emotional health, pre-migratory parental physical health, and pre-migratory parental emotional health.

iii) **Peri-migration variables** – including, accompaniment status (accompanied by at least one family member versus accompanied by extended family/friend or unaccompanied), separation from family status (yes/no), and number of asylum countries travelled.

iv) **Post migration variables** – including, post-migratory physical health, post-migratory emotional health, post-migratory family physical health, post-migratory family emotional health, daily post-migration living problems, and particular daily problems in communication, racism, accommodation, language, job seeking, poverty, getting things available back home, and worries about family back home.

v) **Psychological health outcome variables** – including, post-traumatic stress, anxiety, depression, and somatisation.

Due to the combination of continuous and categorical variables in some instances, Pearson’s Product Moment correlations were interchanged for point biserial correlations where appropriate. Significant relationships among these variables are shown in Table 17.
Table 17.

Correlation table for demographic, pre-migratory, peri-migratory, post-migratory and negative mental health variables in this study (N=82).

<table>
<thead>
<tr>
<th>Study Variables</th>
<th>PTSD</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Somatisation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.04</td>
<td>.10</td>
<td>-.02</td>
<td>.11</td>
</tr>
<tr>
<td>Age</td>
<td>.21</td>
<td>.24*</td>
<td>.32**</td>
<td>.20</td>
</tr>
<tr>
<td>Age at arrival</td>
<td>.34**</td>
<td>.19</td>
<td>.28*</td>
<td>.24*</td>
</tr>
<tr>
<td>Years lived in Australia</td>
<td>-.19</td>
<td>-.07</td>
<td>-.12</td>
<td>-.13</td>
</tr>
</tbody>
</table>

| **Pre-migration** |       |         |            |              |
| Number of weighted combined trauma events experienced | .51** | .43** | .42** | .44** |
| Number of experienced/witnessed events versus heard about/not experienced at all | .49** | .38** | .35** | .40** |
| Number of trauma events directly experienced | .40** | .32** | .31** | .33** |
| Pre-migratory physical health problems | -.15 | -.14 | -.04 | -.01 |
| Pre-migratory emotional health problems | .11 | -.21 | -.14 | -.28* |
| Pre-migratory parental physical health problems | -.05 | -.22 | -.14 | -.15 |
| Pre-migratory parental emotional mental health | .19 | -.11 | .02 | -.16 |

<p>| <strong>Peri-migration</strong> |       |         |            |              |
| Accompaniment status | .22 | .17 | .42** | .06 |
| Parental status | .27* | .23* | .36** | .26* |
| Separation from family status | .06 | .18 | .15 | -.04 |
| Number of countries travelled | .10 | -.08 | .03 | .01 |</p>
<table>
<thead>
<tr>
<th>Study Variables</th>
<th>PTSD</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Somatisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-migration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-migratory physical health problems</td>
<td>.17</td>
<td>.05</td>
<td>.08</td>
<td>.16</td>
</tr>
<tr>
<td>Post-migratory emotional health problems</td>
<td>.23*</td>
<td>.22</td>
<td>.24*</td>
<td>.29*</td>
</tr>
<tr>
<td>Post-migratory parental physical health problems</td>
<td>-.11</td>
<td>.02</td>
<td>-.07</td>
<td>-.07</td>
</tr>
<tr>
<td>Post-migratory parental emotional health problems</td>
<td>.02</td>
<td>.01</td>
<td>.09</td>
<td>.01</td>
</tr>
<tr>
<td>Post-migratory daily living problems</td>
<td>.42**</td>
<td>.42**</td>
<td>.57**</td>
<td>.38**</td>
</tr>
<tr>
<td>Communication problems</td>
<td>.09</td>
<td>.12</td>
<td>.19</td>
<td>.15</td>
</tr>
<tr>
<td>Racism</td>
<td>.25*</td>
<td>.36**</td>
<td>.37**</td>
<td>.31**</td>
</tr>
<tr>
<td>Problems with accommodation</td>
<td>.18</td>
<td>.37**</td>
<td>.51**</td>
<td>.38**</td>
</tr>
<tr>
<td>Problems with language</td>
<td>.32**</td>
<td>.21</td>
<td>.36**</td>
<td>.26*</td>
</tr>
<tr>
<td>Problems finding a job</td>
<td>.34**</td>
<td>.40**</td>
<td>.50**</td>
<td>.35**</td>
</tr>
<tr>
<td>Problems at school/university</td>
<td>.33**</td>
<td>.33**</td>
<td>.35**</td>
<td>.29*</td>
</tr>
<tr>
<td>Problems being poor</td>
<td>.25*</td>
<td>.23</td>
<td>.40**</td>
<td>.14</td>
</tr>
<tr>
<td>Problems getting things available back home</td>
<td>.15</td>
<td>.10</td>
<td>.15</td>
<td>.11</td>
</tr>
<tr>
<td>Worries about family back home</td>
<td>.26*</td>
<td>.22</td>
<td>.31**</td>
<td>.19</td>
</tr>
</tbody>
</table>

*p = < 0.05, **p = < 0.01
As seen in Table 17, of the demographic factors, there was a weak to moderate significant relationship between age and anxiety and depression. PTSD and somatisation were not significantly associated with age. Age at arrival was also weakly to moderately associated with all disorders, except anxiety. Of the pre-migratory factors, the experience of trauma, irrespective of how it was measured in terms of direct or weighted experience, was moderately significantly related to all disorders, though weighted trauma experience was strongly associated with PTSD. There was also a negative weak relationship between pre-migratory emotional stress and somatisation, though this relationship is inconclusive given the small number of the sample who reported pre-migration emotional illnesses.

Among the peri-migratory factors, being accompanied by an immediate family member (or rather not) was significantly related to depression, but not to PTSD, anxiety, or somatisation. The relationship between accompaniment status and depression was moderate, compared to its relationship to anxiety. Having a parent alive and present (or rather not) was also significantly associated with all disorders at weak to moderate levels. Relative to PTSD, anxiety, and somatisation, parental status was more strongly related to depression.

Among the post-migration factors, self-reported emotional difficulties in the post-migration period were also small, but significantly positively related to PTSD, depression, and somatisation but not anxiety. The strongest and most highly significant correlates of psychological distress were found in the post-migration variables with total daily post-migration difficulties sharing a moderate to strong positive relationship to all disorders. The relationship between post-migration difficulties and depression was the strongest relative to the other psychological health variables. When examined separately, post migration experiences of racism, difficulties finding a job, and problems at school or university were moderately correlated with all disorders. Problems in finding a job had a particularly strong relationship with depression.

Problems finding accommodation was significantly associated with anxiety, depression and somatisation, though the strongest relationship was evident in the relationship between finding accommodation difficulties and depression. Problems with language were generally moderately associated with PTSD, depression, and somatisation but not anxiety. Problems in being poor were weakly but significantly associated with PTSD, while its relationship with depression was relatively strong.
Problems getting things available in their home country were not significantly related to any disorder, though worries about family back home was significantly related to PTSD and depression, but not to anxiety and somatisation.

**Predictive factors in PTSD, anxiety, depression and somatisation.** Using the literature regarding risk factors and the demographic, pre-, peri-, and post-migration factors identified as significant in the correlational analyses, a model of pre-, peri-, and post-migration factors was developed to predict PTSD, anxiety, depression, and somatisation. To test this model, a series of hierarchical regressions were performed to separately predict PTSD, anxiety, depression, and somatisation.

In predicting PTSD, each predictor was entered in a theoretical hierarchical process with demographic factors entered at the first step (age and age at arrival); pre- and peri-migration factors entered at the second step (parental status, accompaniment status, separation status, trauma experience); and post-migration factors entered at the third step (post-migration daily problems). This method controlled for the impact of all variables previously entered. Table 18 presents the results of the hierarchical regression model for PTSD.
Overall, 23% of the variance in PTSD was accounted for by the included predictors, Adjusted $R^2$ (1, 62) = 0.23, $p < 0.01$. Although the overall model was significant, $F(7, 62) = 3.99, p < 0.01$, the addition of the third step in the model (i.e., post-migration living difficulties) did not produce any significant additional improvement in the model’s predictive power ($p = 0.096$). Considered individually, at step 1, age and age at arrival predicted approximately 7% of the total variance of PTSD ($p < 0.05$). The inclusion of the pre-/peri-migration factors at step 2 (i.e., parental status, accompaniment status, separation status, and trauma experience) added a further 14% and this improvement to the model was also significant ($p < 0.01$). The inclusion of daily post-migration problems at step 3, added a further 2% to the variance of PTSD, although this did not significantly improve the model ($p = 0.096$). The variable that emerged as the strongest and only significant unique predictor of PTSD was trauma experience ($\beta = 0.38, t = 3.39$,
The beta score for post-migration daily living problems suggested a strong contribution, but this was not significant ($\beta=0.24$, $t=1.69$, $p=0.09$).

In predicting anxiety, a similar model to that described above for PTSD was used. Table 19 presents the results of the hierarchical regression model for anxiety.

Table 19.
Summary of hierarchical regression for demographic, pre-, peri-, and post-migration factors predicting anxiety (N=70).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$B$</td>
<td>$SE$</td>
<td>$\beta$</td>
</tr>
<tr>
<td>Age</td>
<td>0.31</td>
<td>0.22</td>
<td>0.07</td>
</tr>
<tr>
<td>Age at arrival</td>
<td>0.07</td>
<td>0.13</td>
<td>0.07</td>
</tr>
<tr>
<td>Parental Status</td>
<td>1.14</td>
<td>1.36</td>
<td>0.11</td>
</tr>
<tr>
<td>Accompaniment status</td>
<td>0.65</td>
<td>2.49</td>
<td>0.03</td>
</tr>
<tr>
<td>Separation status</td>
<td>0.92</td>
<td>1.32</td>
<td>0.09</td>
</tr>
<tr>
<td>Trauma experience</td>
<td>0.35</td>
<td>0.16</td>
<td>0.27</td>
</tr>
<tr>
<td>Post-migration problems</td>
<td>0.13</td>
<td>0.06</td>
<td>0.35*</td>
</tr>
<tr>
<td>$R^2$</td>
<td></td>
<td>.06</td>
<td>.16</td>
</tr>
<tr>
<td>Adjusted $R^2$</td>
<td></td>
<td>.04</td>
<td>.08</td>
</tr>
<tr>
<td>$F$ for change in $R^2$</td>
<td>2.30</td>
<td>1.80</td>
<td>5.38*</td>
</tr>
</tbody>
</table>

* $p<.05$, ** $p<.001$

Overall, 14% of the variance in anxiety was accounted for by the predictor set (Adjusted $R^2$ (1, 62)=0.14 $p<.05$). The overall model was significant, $F(7, 62)=2.60$, $p<0.05$. Considered individually, at step 1, the demographic factors including age and age at arrival predicted approximately 4% of the total variance of anxiety; however, this contribution was not significant ($p=.108$). The inclusion at step 2, of the pre- and peri-migration factors (i.e., parental status, accompaniment status, separation status,
and trauma experience) added a further 4%, though this did not significantly improve the model ($p=.141$). The inclusion at step 3 of daily post-migration living difficulties added a further 6% to the variance of PTSD, and this improvement was significant ($p<.05$). The variables that emerged among significant unique predictors of anxiety were post-migration daily hassles ($\beta=0.35$, $t=2.32$, $p<0.05$), followed by trauma ($\beta=.25$, $t=2.11$, $p<0.05$).

In predicting depression, a similar model to that described for PTSD and anxiety was used. Table 20 presents the results of the hierarchical regression model for predicting depression.

Table 20.

*Summary of hierarchical regression analyses for demographic, pre-, peri-, and post-migration factors predicting depression (N=70).*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$B$</td>
<td>$SE$ $B$</td>
<td>$\beta$</td>
</tr>
<tr>
<td>Age</td>
<td>.36</td>
<td>.23</td>
<td>.23</td>
</tr>
<tr>
<td>Age at arrival</td>
<td>.08</td>
<td>.13</td>
<td>.09</td>
</tr>
<tr>
<td>Parental Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accompaniment status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separation status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-migration problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$R^2$</td>
<td>.09</td>
<td>.26</td>
<td>.37</td>
</tr>
<tr>
<td>Adjusted $R^2$</td>
<td>.06</td>
<td>.19</td>
<td>.30</td>
</tr>
<tr>
<td>$F$ for change in $R^2$</td>
<td>5.08*</td>
<td>4.72*</td>
<td>4.37**</td>
</tr>
</tbody>
</table>

*p<.05, **p<.01, ***p<.001
Overall, 30% of the variance in depression was accounted for by the included predictors (Adjusted $R^2(1, 62)=0.30, p < .01$). The final model as a whole was significant, $F(7, 62)=5.26, p<0.001$. On their own at step 1, age and age at arrival predicted approximately 6% of the total variance of depression, and this contribution was significant ($p<0.05$). The inclusion of the pre- and peri-migration factors at step 2, parental status, accompaniment status, separation status and trauma experience added a further 13% and this improvement was significant ($p<.05$). The inclusion of post-migration living problems at step 3, added a further 11% to the depression variance, and this was statistically significant ($p<.01$). The variables that emerged as the strongest predictor of depression was post-migration daily living problems ($\beta=0.45, t=3.37, p<.001$), followed by trauma experience ($\beta=0.23, t=2.13, p<.05$).

In predicting somatisation, a similar model to that described for the other outcome variables was used. Table 21 presents the results of the regression model for predicting somatisation.
Table 2.
**Summary of hierarchical regression analyses for demographic, pre-, peri-, and post-migration factors predicting somatisation (N=70).**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th></th>
<th></th>
<th>Model 2</th>
<th></th>
<th></th>
<th>Model 3</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$B$</td>
<td>$SE$</td>
<td>$\beta$</td>
<td>$B$</td>
<td>$SE$</td>
<td>$\beta$</td>
<td>$B$</td>
<td>$SE$</td>
<td>$\beta$</td>
</tr>
<tr>
<td>Age</td>
<td>.24</td>
<td>.23</td>
<td>.16</td>
<td>.30</td>
<td>.22</td>
<td>.19</td>
<td>.23</td>
<td>.22</td>
<td>.15</td>
</tr>
<tr>
<td>Age at arrival</td>
<td>.14</td>
<td>.13</td>
<td>.15</td>
<td>.02</td>
<td>.13</td>
<td>.02</td>
<td>-.003</td>
<td>.12</td>
<td>-.004</td>
</tr>
<tr>
<td>Parental Status</td>
<td></td>
<td></td>
<td></td>
<td>2.50</td>
<td>1.30</td>
<td>.23</td>
<td>1.84</td>
<td>1.31</td>
<td>.17</td>
</tr>
<tr>
<td>Accompaniment status</td>
<td></td>
<td></td>
<td></td>
<td>-2.01</td>
<td>2.37</td>
<td>-.10</td>
<td>-3.98</td>
<td>2.55</td>
<td>-.20</td>
</tr>
<tr>
<td>Separation status</td>
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<td></td>
<td></td>
<td>-1.49</td>
<td>1.25</td>
<td>-.14</td>
<td>-1.65</td>
<td>1.23</td>
<td>-.15</td>
</tr>
<tr>
<td>Trauma experience</td>
<td></td>
<td></td>
<td></td>
<td>.48</td>
<td>.15</td>
<td>.36</td>
<td>.46</td>
<td>.15</td>
<td>.35*</td>
</tr>
<tr>
<td>Post-migration problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.10</td>
<td>.05</td>
<td>.26</td>
</tr>
</tbody>
</table>

$R^2$ | .08 | .27 | .31 |

Adjusted $R^2$ | .05 | .19 | .22 |

$F$ for change in $R^2$ | 5.0 | 4.60** | 4.52 |

*p<.05, **p < .01, ***p<.001

Overall, 22% of the variance in somatisation was accounted for by the included predictors (Adjusted $R^2$ (1, 62)=0.22 $p<.001$). The final model as a whole was significant, $F$(7,62)=3.89, $p<.001$. On their own at step 1, age and age at arrival predicted approximately 5% of the total variance of somatisation, though this contribution was not significant ($p=.072$). The inclusion of the pre- and peri-migration factors at step 2, parental status, accompaniment status, separation status and trauma experience, added a further 14% and this was significant ($p<.01$). The inclusion of post-migration daily living problems at step 3, added a further 2% to the variance of somatisation, and though approaching, was not statistically significant ($p=.067$). The only variable that emerged as the strongest unique predictor of somatisation was trauma experience ($\beta=0.35$, $t=3.07$, $p<0.01$).
Cultural differences in negative mental health outcomes. To explore differences in PTSD, anxiety, depression, and somatisation across cultural groups, cross tabulations were performed. Figures 3a and 3b present the results of these analyses showing the proportion of diagnostic and partial cases respectively for mental health problems within each cultural group. As seen in Figure 3a, a consistent pattern emerged for the prevalence of high PTSD, anxiety, depression, and somatisation. That is, relative to Middle Eastern, Horn of African and Togolese groups, the Sudanese and Karen groups exhibited greater symptomatology across all disorders. The Middle Eastern and Togolese groups exhibited the least symptomatology across disorders. Although prevalence did not reach beyond 15% for any of the disorders, depression and somatisation featured as the two most prominent disorders among the Sudanese and Karen cultural groups, with over 10% of the sample experiencing these disorders. The Horn of African group, however, exhibited similar rates of anxiety to the Sudanese and Karen groups. Caution should be exercised in analysing data from the Middle Eastern group given the small representation of this group in the sample (n=5).

*Figure 3a.* Percentage of diagnostic cases of PTSD, anxiety, depression, and somatisation categorised by cultural group (N =77).
Figure 3b. Percentage of partial symptom cases of PTSD, anxiety, depression, and somatisation categorised by cultural group (N=77).

When partial or moderate symptomatology was observed (see Figure 3b), there appeared little difference (i.e., difference of 2%) across cultures for PTSD symptoms, with the exception of the Middle Eastern group who displayed almost no partial symptomatology. This again reflects the few Middle Eastern participants in the sample. For anxiety, the Sudanese and Karen groups again exhibited relatively higher subsyndromal presentations than other groups. For depression, the Horn of African and Karen group appeared to display greater levels of moderate symptomatology than other groups. For somatisation, the Horn of African, Sudanese and Karen groups exhibited similar levels of subsyndromal somatisation relative to the Togolese group.

Significance of cultural group differences in PTSD, anxiety, depression, and somatisation. To determine whether cultural differences observed above were significant, a one-way multivariate analysis of variance (MANOVA’s) was conducted using culture as the independent factor (i.e., Horn of African, Sudanese, Togolese, and Karen) and disorder as the dependent factors (i.e., PTSD, anxiety, depression, and
somatisation). The MANOVA was selected over a series of ANOVA’s given the multicolinearity across dependent variables. Due to the small number of Middle Eastern participants, the MANOVA was run twice, first, with the inclusion of this group and second, with its exclusion. Although no notable differences were observed between the two analyses, a decision was nonetheless made to exclude the Middle Eastern group from the MANOVA. Mean and standard deviation scores from this analysis are seen in Table 22.

Table 22.  
Mean item and standard deviation scores for PTSD, depression, anxiety and somatisation across cultural group.

<table>
<thead>
<tr>
<th>Cultural group</th>
<th>n</th>
<th>PTSD</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Somatisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Horn of African</td>
<td>20</td>
<td>1.74</td>
<td>0.77</td>
<td>0.78</td>
<td>0.87</td>
</tr>
<tr>
<td>Sudanese</td>
<td>17</td>
<td>2.05</td>
<td>0.85</td>
<td>1.41</td>
<td>0.99</td>
</tr>
<tr>
<td>Togolese</td>
<td>15</td>
<td>2.01</td>
<td>0.57</td>
<td>0.45</td>
<td>0.57</td>
</tr>
<tr>
<td>Karen/Burmese</td>
<td>20</td>
<td>2.06</td>
<td>0.82</td>
<td>0.93</td>
<td>0.74</td>
</tr>
</tbody>
</table>

A nonsignificant Box’s M indicated that the homogeneity of variance was not violated, $F(30, 11312)=1.60, p>.001$. The MANOVA revealed statistically significant differences among the cultural groups on the combination of dependent measures (PTSD, anxiety, depression, and somatisation), Wilks’$\Delta=0.61$, $F(12,172)=2.44$, $p<.01$. The multivariate $\eta^2$ based on Wilks’$\Delta$, was small but significant at .13.

Follow up between subject analyses for each dependent variable (i.e., PTSD, anxiety, depression, and somatisation) were performed using the Bonferroni method for adjusting Type I error for multiple comparisons (0.05/4). Each ANOVA was therefore tested at the .01 level. Levene’s test of Equality of Error Variances revealed no significant violation in the assumption of homogeneity of variance for PTSD.
The ANOVA’s revealed no significant effect for culture on PTSD, $F(3, 68)=0.74$, $p=0.53$, $\eta^2=0.03$; a significant effect for culture on anxiety, $F(4,68)=3.90$, $p=0.01$, $\eta^2=0.15$; a significant effect for culture on depression, $F(4,68)=6.03$, $p<0.01$, $\eta^2=0.21$; and a significant effect for culture on somatisation, $F(4,68)=4.77$, $p<0.01$, $\eta^2=0.17$.

Post-hoc comparisons were conducted to assess for group differences in anxiety, depression, and somatisation scores. These analyses revealed significant differences between the Sudanese and Togolese on anxiety ($p<0.01$), the Sudanese and both Horn of African and Togolese groups on depression ($p<0.01$) and again, the Sudanese and both Horn of African and Togolese groups on somatisation ($p<0.01$).

**Discussion**

This chapter aimed to explore negative mental health factors in young refugees (re)settled in Australia through the exploration of PTSD, anxiety, depression, and somatisation. It aimed to estimate the prevalence of these problems, identify their correlates, and pre-, peri- and post-migration predictors. Cultural differences across these disorders were also examined.

**Frequency and comorbidity of negative mental health problems – Hypothesis 1 & 2.**

In estimating mental health problems in this group of young refugees, a similar pattern of psychopathology was observed across disorders of PTSD, anxiety, and depression. That is, between 21-24% experienced high symptoms suggestive of PTSD, anxiety, or depression, whilst a majority of 50-54% experienced no or low symptoms. About 25-28% experienced partial symptomatology across these disorders. Similar findings were observed with somatisation, although, a higher trend for prevalence (29%) was observed for somatisation compared to other disorders. Correlational analyses revealed probable comorbidity across the sample for these disorders, suggesting the likelihood of more than one diagnosis in young refugees who experience higher symptomatology.

It is difficult to compare how these rates for mental health problems contrast with other studies since prevalence for disorder, especially PTSD, has ranged from 7% to 86% according to some estimates (Fawzi et al., 1997). On one hand, these findings
are comparable to the higher rates for PTSD and depression shown by some researchers (Fazel & Stein, 2003; Leavey et al., 2004). But on the other hand, they contradict the lower rates found by studies which compare refugee rates to rates in host societies (Beiser & Hou, 2001; Steel, Silove, Chey, Bauman, & Phan, 2005). This inconsistency could be explained by variations in measures used, diagnostic cut-offs, research designs, and varied methodologies (Davidson, et al., 2008). Or they could be explained by non-methodological factors such as trauma experience, country of origin or dislocation, or cultural expressions of distress.

Nonetheless, when compared to more rigorous or systematic reviews regarding prevalence, the rates observed in this study are higher than those found in Fazel et al.’s (2005) review of studies looking at prevalence of PTSD in adults and children. Whereas these authors found 9-11% prevalence for adults and children, respectively, the current study found rates above these estimates. Similarly, where Fazel et al. found 5% and 4% prevalence rates in depression and anxiety, higher estimates of depression and anxiety were found in the present study. Similarly, higher estimates of mental health problems were found in this study than those reported in Porter and Haslam’s (2005) meta-analysis, which attempted to address the prevalence variation across studies. Porter and Haslam (2005) reported that refugees scored .41 standard deviations lower in indices of mental health than ‘non-refugees’.

Findings regarding estimates of PTSD and depression in this study are more comparable to the meta-analysis conducted by Steel et al. (2009), which attempted to control the methodological influences across prevalence studies in post-conflict and refugee settings. Whereas Steel et al. (2009) found a higher overall weighted PTSD prevalence estimate of about 31% from 145 surveys, this study found a comparably high rate for PTSD and depression of up to 24%. Again, differing methodological criteria and a higher proportion of torture in Steel et al’s. (2009) study might explain the lower rate observed in this study. In addition to the issues already described to explain these inconsistencies in prevalence data, the present sample also straddled adult as well as child populations, which may contribute to differences between Steel et al’s. (2009) and Fazel et al’s. (2005) studies.

In spite of important efforts across the literature, including the current study, to elucidate an accurate frequency estimate for PTSD, depression, and anxiety, in refugee populations, all estimates are nonetheless invariably high. That is, when compared to
12-month prevalence rates for PTSD across western civilian populations, estimates cited in the meta-analytic and systematic reviews as well as the present study all show greater rates for PTSD among refugees. For example, the 12-month PTSD prevalence rate in Australia is estimated at 1.3% (Creamer, Burgess, & McFarlane, 2001) and in Europe, this estimate is 1.1% (Darves-Bornoz et al., 2008). Also, when compared to large epidemiological surveys in young Australians of comparable adolescent to young adult age groups (e.g., The National Health and Well Being Survey Sawyer et al., 2001), the PTSD rates for refugees in the current sample and those reported in other Australian studies (Sawyer, et al., 2001; Slade et al., 2009) are inevitably higher. Thus, the first hypothesis that greater estimates of psychopathology would be observed in the present sample of young refugees when compared to general sample was supported.

Noteworthy in the present findings is that disorders examined showed a high degree of inter-relatedness. High correlations were observed across all disorders, with particularly strong relationships observed between anxiety and depression, anxiety and somatisation, and depression and somatisation. PTSD shared less overlap with anxiety, depression, and somatisation, but was nonetheless still inter-related. Thus, the second hypothesis that PTSD would not be the only mental health outcome and that a variety of psychological problems among young refugees would exist was supported. This finding is particularly salient from a clinical perspective in terms of assessing for comorbidity – in young refugees having one diagnosis appears to add risk to having another diagnosis, compounding the vulnerability and distress that already comes with one disorder.

Although the rate of comorbidity might be explained by the use of the same measure (BSI) to calculate anxiety, depression, and somatisation, this is unlikely since subscales for anxiety, depression, and somatisation were different in item make-up. It is also unlikely because of previous evidence from studies which have found having more than one diagnosis at the same time confers a significant risk to another and one’s ability to function in day to day activities. Mollica et al. (1999), for instance, reported that refugees with co-morbid psychiatric diagnoses were five times more likely to be functionally impaired than those diagnosed with PTSD alone. More research is required to explore co-morbidity between other psychiatric diagnoses, but clinically, these findings are important in highlighting the need to assess a range of disorders and in determining which disorder may be driving distress and therefore which disorder is
to be treated first. These findings suggest those suffering from co-morbid conditions may stand out because of their substantial level of psychosocial impairment (Momartin, Silove, Manicavasagar, & Steel, 2004).

While comparative norms are unfortunately not available for somatising symptomatology, it is interesting to note that up to a third of the sample had high levels of somatisation. This finding could be suggestive of an alternate manifestation of problems or, as sometimes shown in the literature, as a by-product of anxiety and depression (Elklit & Cristiansen, 2009). As all these disorders share common physical and/or arousal symptoms, it is possible the overlap may have resulted in slightly higher somatisation prevalence rates. Although still related to somatisation, PTSD remained more distinct from somatisation than anxiety and depression. That is, somatisation was more highly associated with anxiety and depression than PTSD. This could be attributed to the fact that anxiety and depression share more similar physical symptoms than PTSD, which given its emphasis on re-experiencing phenomena may be less represented by a somatising response. Again, while more research is required to explore potential overlap, the high association between anxiety, depression, and somatisation is consistent with other findings that somatisation, could represent a physical representation of anxiety or depression (Elklit & Cristiansen, 2009). As will be seen later however, these inter-relationships between disorders are complex and require further research.

It is important to note at this stage that about a half of participants did not experience major psychopathology – that is, they reported mild or no symptomatology across each disorder. This observed ‘resilience’ is discussed in the next chapter. When symptoms were classified into partial criteria, however, a further 25-28% met partial criteria for PTSD, anxiety, depression, and somatisation. This finding is important as it highlights that many young refugees might straddle the area between partial and full diagnoses. There are two ways this might be interpreted. First, it suggests that such is the vulnerability in refugees that additional stressors could easily result in tipping over into psychological ‘disorder’. And second, that there may be resilient or protective factors which are keeping them from developing full disabling symptomatology.

Post traumatic stress symptoms and traumatic event exposure. The most commonly endorsed PTSD symptom within the re-experiencing phenomena of PTSD was the experience of intrusive thoughts and memories. This was endorsed by almost half the
sample. Within avoidance phenomena, the avoidance of thoughts and feelings related to traumas were experienced most prominently with over a third reporting these experiences. Within hyperarousal phenomena, sleeping difficulties were also endorsed by about 40% of participants. On average across these symptoms, hyperarousal experiences were most endorsed. Although diagnostic rates of PTSD reached about a quarter, the endorsements of these difficulties, suggest that even in the longer term aftermath of traumatic exposure, ongoing anxiety and perception of threat is high. This is in contrast to studies of other traumatised populations which often see re-experiencing and hyperarousal symptoms subside, and avoidance increase over time (O’Donnell, Elliott, Lau, & Creamer, 2007). Moreover, although considered a maladaptive symptom by Western diagnostic standards, the high rate of avoidance of thoughts and feelings related to the trauma relative to other symptoms found in this study, is consistent with previous research, particularly with Sudanese refugees, that shows avoidance or ‘suppression of thoughts’ as a reported helpful coping mechanism (Tempany, 2009). This strategy of coping is discussed in Chapter 9, when coping and avoidance are examined from a qualitative perspective.

In terms of the number of traumatic events experienced, this young group of refugees directly experienced or witnessed an average of 7.5 traumatic event types. When this data were correlated with PTSD, some support for a cumulative effect for trauma was found, where the more trauma event types experienced resulted in higher PTSD levels. Moreover, the strength of the relationship between traumatic event exposure to PTSD symptoms did not vary as a function of whether the traumatic events were directly experienced or weighted. This suggests that traumatisation exists at many levels and can have an equally devastating effect on psychological health. Importantly, this study did not measure the number of times each traumatic event was experienced, nor did it allow multiple responses to each traumatic event (e.g., did not allow participants to tick witnessed as well as heard about it for the one event). As a consequence, it is argued that traumatic event exposure in this study was measured conservatively.

With regard to the impact of traumatic event type, the items that were found previously (see Chapter 6) to be most commonly endorsed were also significantly related to PTSD symptoms. That is, of the range of traumatic events that were significantly related to PTSD symptoms, the strongest events were forced separation.
from family, serious injury, and being close to death, which all had strong relationships to PTSD. Alongside the lack of shelter, rape or sexual assault, and death of a family member or friend, these relationships were highly significant \( (p < .001) \). Interestingly, lack of food, which was one of the most commonly endorsed traumatic events and one of the most common events rated as participants’ “worst” events, was not significantly related to PTSD symptoms. Therefore, it is possible that the most commonly endorsed or events rated as “worst” are not necessarily the events that trigger PTSD. This supports the idea of that refugee trauma experience and response is complex, such that single event trauma theories may not adequately capture these experiences. Indeed, the increasing awareness of repeated and chronic trauma exposure that may result in a more complex understanding of trauma in refugees is reflected in the upcoming DSM V, which redefines the experience of traumatic event to incorporate repeated and chronic exposure (American Psychiatric Association, 2012). Notably, unlike Steel et al.’s (2009) study, torture was not significantly related to PTSD symptoms, though this relationship was approaching significance, in the present study.

**Correlates of negative mental health disorders.** This study’s findings showed that a range of correlates exist for psychological disorders. The pre- and peri-migration variables of trauma experience and parental status were significant across all psychopathology, though parental status was particularly correlated with depression. Age and age at arrival were seen as important demographic variables to anxiety, depression, and somatisation and accompaniment status as a peri-migration variable was related only to depression. This may be because of its close association with parental status, which was also found to have a relatively stronger relationship to depression. The post-migration factor of living difficulties was related to all disorders, though again, it held a stronger relationship with depression. The particular experiences of racism, difficulties finding a job, and problems at school or university were moderately correlated with all disorders.

Problems finding accommodation was significantly associated with anxiety, depression, and somatisation, though again these difficulties were more strongly related to depression. Language problems and being poor were associated with PTSD, and depression, with the former also related to somatisation. Reported poverty again seemed to have stronger relationships with depression. Concerns about family were
significantly related to PTSD and depression, but not anxiety and somatisation. Thus, in sum, one or some of these correlates were related to particular disorders, whilst one or some were related to all disorders. The disentangled effects of these correlates are discussed below.

**The predictive effects of a pre-, peri-, post-migration model on PTSD, anxiety, depression, and somatisation – Hypotheses 3 & 4.** Notwithstanding the current research, previous literature has demonstrated a range of psychological correlates and risk factors in the determination of mental health problems (Ehntholt & Yule, 2006; Lustig, Weine, et al., 2004; Schweitzer, et al., 2006). Fewer studies however have tested the combination and influence of pre-, peri-, and post-migration factors on disorders. This study used predictive analysis to investigate a risk factor model that incorporated not only traditionally associated factors such as trauma but also a range of other demographic, pre-, peri-, and post-migration stressors, also thought to drive mental health problems in young refugees.

The third hypothesis that the experience of trauma will be a significant predictor in the outcomes of PTSD, depression, anxiety, and somatisation was supported, in that trauma experience influenced all disorders. The fourth related hypothesis that other factors would play a predictive role in psychological disorders was partially supported, in that post-migration factors such as daily living problems uniquely influenced two disorders only – anxiety and depression.

With regard to predicting PTSD, the model was shown to be moderately powerful in predicting PTSD, with just over 20% of variance captured in PTSD attributed to it. Not surprisingly, the single most powerful predictor in the PTSD model was trauma experience. Given that trauma experience is a necessary element in the diagnosis of PTSD this relatedness is expected. This is consistent with previous literature directly linking trauma exposure to PTSD (Fazel, et al., 2005; Kinzie, 1988; Mollica, et al., 1998; Steel, et al., 2002; Watters, 2001). The influence of post-migration stressors was not a unique predictor in PTSD, validating trauma experience as the unique stressor in the development of PTSD. On the other hand, these findings are interesting given their incongruence with findings which suggest that PTSD is influenced significantly by subsequent migration stressors (Heptinstall, et al., 2004).
Although PTSD increases vulnerability to subsequent stressors, trauma exposure constitutes most risk.

In predicting anxiety, the model was significant, though not as strong as the other models. That is, only 14% of the variance in anxiety could be accounted for by the model. Post-migration factors more uniquely predicted anxiety, though the experience of trauma, consistent with expectation, was to a lesser extent also predictive of anxiety. Given that PTSD is an anxiety disorder, sharing some symptom characteristics with other anxiety disorders, it is unsurprising that trauma would also impact on anxiety symptoms. Unlike the anxiety model, however, post-migration problems did not uniquely predict PTSD. This suggests that post-migration difficulties play an important role in driving general anxiety and additional vulnerability in young refugees.

A similar finding was observed for depression in that post-migration difficulties and trauma respectively accounted for most of the unique variance in depression; with post-migration difficulties exerting the greater influence. The variance accounted for in depression, however, was greater than that of anxiety using the same predictors. These findings offer empirical support to arguments made in the literature that difficulties in the settlement period are more associated with depression rather than PTSD or anxiety (Kinzie & Sack, 2002; Sack, et al., 1999). An explanation for this association may be that post-migration difficulties such as racism, loneliness, securing employment, or communicating with others may reflect deeper cognitive or social processes that activate depressed mood and low motivation over time. For instance, racism experiences may trigger alienation and a sense of thwarted belongingness. Similarly, employment expectations that initially come with the optimism of early resettlement might diminish over time with the realisation that language skills limit opportunities for employment. Over time, these ongoing day to day stressors are more likely to entrench depression, offsetting any initial or general anxiety that might come with acculturative stress (Sack, et al., 1996). Also, given that anxiety is an anticipatory response to fear and the future, the responses borne out of resettlement and post-migration difficulties over time are more likely to result in a depressed rather than aroused mood. Moreover, although the pre- and peri-migration traumatic experiences of parental death or unaccompaniment were not uniquely predictive of depression, these traumatic reactions may be more likely to elicit a depressive response based
around grief and bereavement. That is, anxiety is a response to present and future whereas depression is a response to the past.

In predicting somatisation, a moderately strong model emerged with over 20% of the variance in somatisation accounted for by the predictor set, most uniquely the experience of trauma. Like PTSD, the impact of post-migration factors while approaching significance, was not uniquely predictive of somatisation. Despite, the comparatively lower relationship seen in the correlation between PTSD and somatisation ($r = .51$), than seen with depression and somatisation or anxiety and somatisation, these findings suggest a strong link between traumatic event exposure and the physical manifestation of psychological symptoms (i.e., somatisation). The association between trauma and somatisation might in part be explained by the proportion of physical traumas experienced by participants in this sample, which comprised physical injuries, sexual assault and torture. Indices of pain, disability and arousal associated with these traumatic events may have resulted in an increase in somatic complaints. This explanation is supported by studies which directly link torture experience to physical or pain related conditions (Van Ommeren, et al., 2002). It is often suggested that neurobiological changes, increased physiological arousal and poorer health are the mechanisms underpinning this relationship (Elklit & Cristiansen, 2009).

A second interpretation for the link between trauma exposure and somatisation may be that PTSD could be mediating the relationship between trauma experience and somatisation. It has been found that somatic complaints are reported more often in survivors with PTSD compared to those without PTSD (Andreski, Chilcoat, & Breslau, 1998; Elklit & Cristiansen, 2009; van der Kolk, Pelcovitz, Roth, & Mandel, 1996; Van Ommeren, et al., 2002). Indeed, the present findings lend support to Van Ommeren et al.’s study (2003) described in Chapter 3 with Bhutanese adult refugees, which showed PTSD predicted greater somatic complaints, regardless of symptoms of anxiety or depression. This explanation is worthy of further research to explore whether, in the presence or absence of PTSD, the relationship between trauma exposure and somatisation continues to exist. The present study provides some preliminary evidence consistent with the argument that PTSD could mediate the somatising response in that hyperarousal PTSD symptoms were the most commonly endorsed of PTSD symptoms. Given the emphasis on physical arousal in PTSD presentations in this study, it is
possible this physiological factor could have mediated the relationship between trauma exposure and somatisation.

Irrespective of whether mediating disorders or clusters of disorders play a role in the presentation of somatizing disorders, this study shows that somatisation may contribute considerably to the burden of health problems in young refugees. Given this and its influence on help seeking behaviour (i.e., more refugees are likely to present to a primary care setting with a GP for somatic complaints) (Laban, Komproe, Gernaat, & de Jong, 2008), more attention to somatising symptoms than is currently afforded to refugee populations is warranted.

The link between trauma experience and somatisation is important from a clinical perspective as it indicates that somatisation can be a form of expressing distress arising from trauma experience (rather than the typical association with anxiety and depression), irrespective of whether PTSD is presenting or not. The implications for treatment may be different for refugees presenting with either PTSD or somatisation, despite that the aetiology may be the same. For instance, PTSD treatments might focus on re-experiencing symptoms with either prolonged/imaginal exposure or narrative exposure. In somatisation, the use of biofeedback in the mind-body relationship might be indicated to address chronic pain. Thus, it may be important for clinicians to assess for trauma experience in the presentation of somatoform or somatising complaints, for which there is no physical cause, much the same way it is assessed in PTSD presentations. More attention and research is required to explore somatisation as a unique reaction to traumatic event exposure itself or indeed mediated, and to what extent by other disorders including PTSD, anxiety and depression.

Finally, although this study has shown that a model of predictive risk factors can adequately explain some of the variance across disorders, and that two important predictors in trauma experience and post-migration difficulties, contribute to much of the variance in mental disorder, it is important to note that high inter-relatedness existed across disorders. Thus, in trying to uncover the risk factors to somatisation, PTSD, anxiety, and depression, comorbidity across these disorders needs to be taken into account. This comorbidity may reflect the inter-relatedness of subscales on the measure used for these mental health outcomes (i.e., BSI, Derogatis, 1993), but more likely, it is suggestive of a high comorbidity rate existing among young refugees who have experienced trauma, which is also demonstrated in the literature (Halcón, et al.,
Unfortunately, the sample size constricted the addition of comorbid psychopathology in the predictive model, but future studies with larger sample sizes might be able to address causality by controlling for the presence and overlap of other disorders.

Generally, the findings of this study support much of the existing literature that shows post-migration stressors largely contribute to mental health problems in refugees (Daud, af-Klinteberg, & Rydelius, 2008; Heptinstall, et al., 2004; Hodes, Jagdev, Chandra, & Cunnif, 2008; Montgomery, 2011; Silove, Sinnerbrink, et al., 1997; Silove, et al., 1998). This study also underscores the role of trauma as a driving force which creates the vulnerability in the first place. Post-migration factors are important in the sense that they compound or exacerbate this standing vulnerability.

The role of culture and acculturation in mental health problems - Hypothesis 5.
Lastly, the research reported in this chapter explored cultural differences in the prevalence of mental health problems. The fifth non-directional hypothesis that cultural differences would be observed in the prevalence of PTSD, depression, anxiety, and somatisation was partially supported. In general, frequency statistics suggested that the Sudanese and Karen groups displayed greater symptomatology across all disorders than other cultural groups, particularly compared with the Togolese group who reported little psychological disorder. When subjected to mean score comparisons, however, only the Sudanese showed significantly higher symptomology than other cultural groups across all three problem domains (i.e., anxiety, depression, and somatisation). Although the Karen also displayed relatively high mean symptom scores across most disorders, these differences only approached significance. Thus, findings in relation to the Karen need to be interpreted cautiously. No cultural differences were observed in PTSD, increasing the body of literature (Hinton & Lewis-Fernández, 2011; Lustig, Kia-Keating, Grant-Knight, et al., 2004; Mollica & Caspi Yavin, 1991) supporting PTSD as a fairly stable construct across cultures.

The finding of cross cultural differences in symptoms of anxiety, depression, and somatisation can be interpreted in a number of ways. First, it is possible that the relatively low symptom scores of Togolese refugees compared with Sudanese refugees is attributable to their experience of being newly arrived in Australia. That is, an underreporting of symptoms among the Togolese group may have occurred. This
phenomenon has been described in the literature (see Jacobsen & Landau, 2003; Tempany, 2009) where for example, unfamiliarity with ‘research work’, might lead to a perception of threat. Such mistrust could be based on previous and experiences of persecution, fear, and threat. Observations from the qualitative study described in Chapter 9 support the potential for an elevated response to positive emotional well being. In other words, social desirability may have also influenced these findings (Tempany, 2009).

Second, it is also plausible that the Togolese did not report psychological symptoms simply because such symptoms were not experienced. That is, feelings of well being were overall genuinely positive. This explanation is consistent with the findings of Barrett, Sonderegger, and Sonderegger (2001) and Keyes (2000) who argue that refugees are likely to initially experience euphoria in resettlement because immediate threats of danger are removed. However, as losses are realised and foreign cultural norms are confronted, mental health status may start to decline (Barrett, et al., 2001; Keyes, 2000). The mental health experience may therefore be mediated by an increase in hardship, for example, the need to gain employment, or the need to support families in Australia and in home countries. This explanation is also supported by Berry’s work in acculturative stages (Berry, 1990; Berry, et al., 2006) where it is suggested in early stages, hope and optimism may have been triggered resulting in the absence of psychopathology among the Togolese young refugees.

While it is tempting within this explanation to suggest that mental health problems arise as a function of time, this study found that length of time in Australia was not associated with mental health difficulties. Moreover, the Horn of African group, which was the more established cultural group, did not have greater mental health difficulties. Indeed, they were among the groups reporting lower rates of mental health problems. Instead, the present study’s findings suggest that over the course of resettlement, initial mental health problems may not be evident, followed by a development of psychological problems over time, and again followed by a decrease in symptomatology over time. That is, rather than following a linear pattern of course, patterns of mental health problems for newer to more established communities may fluctuate over time. The finding that PTSD did not change across groups, also suggests that anxiety, depression, and perhaps somatization are more affected by resettlement.
and post-migration factors, supporting the previous research in these areas (Sack, et al., 1999).

Further research is therefore needed to map the trajectory of mental health over time for different cultural groups, particularly the Togolese group and whether this cultural group follows a similar mental health trajectory than that of more established ones. Similarly, further research is necessary to investigate whether the mental health of moderately established refugee groups (e.g., the Sudanese and the Karen) improve over time. These findings have important implications to how treatment interventions might be timed.

A third explanation for the finding of greater mental health symptomology within the Sudanese and Karen refugee groups acknowledges the fact that conflicts in Sudan and Burma are ongoing. At the time of data collection, South Sudan had not gained its formal independence and the Karen National Liberation Army had not reached its peace agreement, and war and conflict ensued both states till only recently in 2011 when South Sudan became independent and the KNLA signed its peace agreement. Though arguably these states still enjoy a ‘fractured’ peace, the ongoing conflict around the time of data collection may have provided an ongoing source of distress to these cultures. This explanation is consistent Porter and Haslam’s findings described in Chapter 3, which identified among other factors, poorer outcomes in those for which war conflicts in native countries had not been resolved (Porter & Haslam, 2005). Interestingly, evidence in support of this argument is also found in the qualitative themes reported in the next chapter. That is, many of the Sudanese and Karen participants expressed sadness and guilt at not being able to support their countrymen and families who were still involved in the conflicts. The nature of the collectivist cultures of Sudan (e.g., tribe identity) and the Karen State (strong Karen ethnicity) suggest that greater symptomatology expressed in these groups may be directly related to ongoing conflict and suffering in their own countries.

Moreover, the greater difficulty among young Sudanese and Karen refugees relative to other cultures could be attributed to their post-migration set up. That is, qualitative themes discussed in Chapter 9, revealed the Togolese and Horn of Africans settled in Australia where their communities lived in nearby spaces (e.g., public housing closely located for the Horn of African or small regional town for the Togolese). This was contrary to the Sudanese and Karen whose communities appeared
to be more dispersed. For the Sudanese in particular, tribal differences may have influenced less integration within the Sudanese community. Thus, it is possible fewer opportunities to utilise resources and supports within the community and indeed family (e.g., many Sudanese migrated with only one parent) may be contributing to their vulnerability to problems in anxiety, depression and somatisation.

It is noteworthy that many of the Sudanese and Karen participants arrived to Australia as older adolescents and young adults whereas the Middle Eastern, Horn of Africans, and Togolese arrived as young children or early adolescents. As seen, earlier age at arrival was related to PTSD, depression, and somatisation. Given that age at arrival itself were not uniquely predictive of disorders, it is possible that the present findings reflect an age-culture interaction, where indeed culture may have been driving the relationship between age at arrival and depression and somatisation. Unsurprisingly, older age at arrival appears to increase opportunities for trauma experience as well as create greater difficulties in the resettlement period. It is possible then the Karen and Sudanese were more vulnerable to psychological problems by virtue of being older at arrival, increasing their vulnerability in the post-migration period.

With respect to other salient sample characteristics, accompaniment status was similar across all groups and therefore not a likely explanation for the present cultural differences. Parental presence, however, did differ across the groups with the Sudanese and Karen reporting more parental deaths (or missing status) than the other groups. Alongside age at arrival, these appear to be important mediators in the relationship between culture and mental health problems.

**Summary and conclusions**

The psychological well-being of refugees from a quantitative negative mental health outcome perspective was explored in this chapter. It was found that while most refugees do not experience significant mental health concerns, a concerning proportion are vulnerable to mental health problems (primarily, PTSD, anxiety, depression, and somatisation). An equally significant portion, however, also displayed partial symptomatology reflecting the vulnerability to mental distress in this young group of refugees. Important and consistent correlates and predictors of negative mental health
outcomes were also identified in this chapter. Using these correlates to consolidate a theoretical model of predictive factors for PTSD, anxiety, depression, and somatisation, there emerged a range of demographic, pre-, peri- and post-migration factors which are important in these mental health outcomes. Factors central to this model included trauma experience as well as post-migration daily living problems. The trauma exacerbating effects of post-migration factors in particular, suggests a range of clinical and social interventions could be helpful in reducing negative mental health responses.

Cross cultural differences in negative mental health outcomes were also examined, highlighting particularly the vulnerability of young Sudanese and Karen refugees. While it was important to highlight cultural differences in the presentation of mental health difficulties, the impacts of acculturation and other salient pre--peri- and post-migration factors versus ‘culture per se’ are important in understanding cultural differences. The present findings are consistent with quantitative studies exploring mental health.

While it is important to understand mental health phenomenology, a significant portion of the sample did not report diagnosable symptomatology or reported partial symptomatology. Moreover, while factors within the predictive model of negative mental health revealed important ideas for identifying risk and ideas for intervention, the variance accounted for in disorders suggests a range of other factors which might also exist to explain the remaining variance in mental health problems. One implication of these findings is that positive mental health factors such as resilience could hold the key to a more comprehensive understanding of youth refugee psychological well being. The following study and chapter will therefore explore positive mental health factors and resilience factors in the understanding of psychological well being in refugees.
In the previous chapter negative mental health outcomes in more and less established young refugee groups in Australia was examined. About a quarter of these refugees displayed mental health difficulties consistent with diagnoses of PTSD, anxiety, depression, and somatisation, with some influence of culture in the prevalence of these problems noted. The role of trauma was consolidated as a major determinant in mental health outcomes. In predicting anxiety and depression however, post-migration problems were comparable risk factors to trauma exposure itself. Despite these prominent risks, up to half of the young refugees in this sample expressed low or no symptomatology. This ‘absence’ of disorder raises queries about what factors prevent individuals from developing mental health problems, or, what might prevent them from developing more severe symptomatology. Furthermore, the absence of high symptomatology raises questions about whether alternative outcomes to disorder can be useful in understanding mental health in refugees.

In this chapter, the ‘positive’ and psychosocial aspects of psychological well-being are explored through the investigation of quality of life (QoL) and resilience outcomes. To extend current knowledge around psychopathology, the relationship between these factors and negative mental health is also explored. The chapter begins with a rationale for looking at both psychosocial and positive mental health factors before discussing the utility of constructs such as quality of life and resilience. The empirical study of resilience and quality of life and their relationship with each of the negative mental health outcomes is then explored, alongside the cultural influences in these outcomes.
Introduction

A rationale for studying resilience and quality of life. Psychological approaches to refugee mental health have traditionally focused on the investigation of negative mental health outcomes (Summerfield, 1997). As a consequence, disorders such as PTSD, anxiety, and depression are now common place in the refugee literature (Daud, Skoglund, & Rydelius, 2005; Heptinstall, et al., 2004; Lustig, Kia-Keating, Grant-Knight, et al., 2004; Thabet, Abed, & Vostanis, 2004). This thesis has extended previous work in this area through the investigation of predictive models of vulnerability to mental health disorder. It showed that the relationship between trauma exposure and mental health problems is complicated by a range of risk factors that occur across different stages of the migration process for refugees.

Although the focus on these risk factors addresses important questions of which individuals develop mental health issues and why, it is less frequently asked which individuals do not develop such problems and why (Gartland, 2008). Moreover, it is commonly assumed that if an individual does not develop a psychological disorder, he/she is ‘psychologically well’. Though it is certainly true that young refugees are more vulnerable to developing psychological problems (Fazel & Stein, 2002), many also adapt and function well in their new environments (Mollica, et al., 1997). Unfortunately, notions of ‘adaptation’ and ‘wellness’ have been conceptualised (overtly or covertly) as the absence of mental health problems. That individuals can demonstrate competence and strength despite adversity is often neglected when searching for mental health problems (Garmezy, 1993).

The absence of high symptomatology has often implied that refugees are ‘resilient’, but although the term is commonly used, there is great disparity in how resilience is defined and operationalised, if at all (Gartland, 2008). Paradoxically, resilience, well-being and other positive mental health constructs have been inferred by the absence of psychopathology, rather than by direct operationalisation of the constructs themselves (Nicholson & Walters, 1997).

While it may be true that an absence of psychopathology is representative of resilience, the question of who does not ‘get sick’ and why is only rarely explored (Gartland, 2008). This aspect of resilience is important to understand as it addresses why some are more vulnerable to adversity/trauma and others are not. Identifying such
protective mechanisms has implications for improving prevention and intervention efforts. Surprisingly, in mainstream psychology it has only been recent that other dimensions of the refugee experience have been explored (Porter & Haslam, 2005; Silove, 1999).

Like resilience, which to date has not been empirically well tested, the quality of life (QoL) construct is often posed as a positive or more meaningful mental health outcome for refugees (Tipping, 2010). This construct is also important in testing the assumption that an absence of mental illness is akin to good psychological well-being. One way to operationalise this level of adaptation or well-being is through the examination of QoL which is broadly defined as the extent to which an individual feels satisfied with his/her life overall. The measurement of QoL and resilience are important as they allow departure from conceptualising mental health in pure psychiatric terms to more holistic psychosocial understandings. These constructs are consistent with an ecological approach to understanding refugee mental health. The next sections will discuss the construct and studies related to resilience in greater detail, after which, the construct and studies of quality of life will be discussed.

**The concept and definition of resilience.**

“We all know perfectly well what resilience means until we listen to someone else try to define it.” (George Vaillant, 1993)

In the broader mental health literature, the term ‘resilience’ is used variously to describe a series of flexible qualities (Olsson, Bond, Burns, et al., 2003). Traditionally, it has been conceptualised as an individual trait or characteristic of hardiness or invulnerability that helps one to achieve positive social and emotional functioning despite exposure to considerable stress, adversity, or trauma (Kobasa, 1979; Ramanaiah, Sharpe, & Byravan, 1999). Leading resilience proponents now caution against viewing it as an static immovable trait, favouring instead the notion of resilient trajectories and outcomes (Olsson, Bond, Burns, et al., 2003).

Modern conceptualisations of resilience have therefore defined it as ‘the capacity for successful adaptation to a changing environment’ (Cicchetti & Cohen, 1995); ‘the capacity to thrive, mature, and develop competence despite adverse circumstances’ (Gordon, 1995); ‘the manifestation of competence despite exposure to
stressful or adverse events’ (Garmezy, 1991); the ‘dynamic process involving an interaction between both risk and protective processes, internal and external to the individual, that act to modify the effects of a stressful life event’ (Rutter, 2006b); the ‘process linking a set of adaptive capacities to a positive trajectory of functioning and adaptation after a disturbance (Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008); the ‘ability to establish a pattern of stable and healthy adjustment following an aversive event’ (Bonanno, 2012); and a ‘process of drawing on personal characteristics as well as resources in the environment that encourages resistance to psychosocial risk experiences and successful adaptation’ (Gartland, 2008; Gartland, et al., 2011).

Common to all definitions is the experience of stress/trauma and the achievement of positive outcome (Gartland, et al., 2011). Importantly, these definitions imply resilience is a moveable process of mastering stress and overcoming trauma. Understood in this way, resilience enables individuals to bolster their capabilities for recovery.

Although much reference is made to the idea of resilience in the mental health and refugee literature (Chase, 2005; Ehntholt & Yule, 2006; Fazel & Stein, 2002; Kohli & Mather, 2003; Lustig, Kia-Keating, Grant-Knight, et al., 2004), there is a paucity of research that examines resilience, particularly in the context of refugee adolescents and early adults. Where there is examination, the variability in operational definitions used to guide this research is profuse. Consequently, resilience has been investigated across a broad range of populations who have experienced vastly different adversities, which emphasise different risk and protective factors, and look at different outcomes (Olsson, Bond, Burns, et al., 2003). Indeed, the biggest criticism levelled at the resilience field has been the perceived lack of a unified understanding in the definition of the construct (Gartland, 2008).

Luthar and colleagues argue that the lack of unity in definitions reflect a much deeper problem within the field, which is, the lack of a unifying theory of resilience (Luthar, Cicchetti, & Becker, 2000). However, one commonality between, and within, conceptualisations of resilience is that resilience does not so much imply an immunity or invulnerability to stress, but rather an ability to recover or function well (or well enough) in negative circumstances (Garmezy, 1991). That is, the ability to ‘bounce back’.
Much of the forging work in resilience in Australia has been conducted by Olson and his colleagues (Olsson, Bond, Burns, et al., 2003; Olsson et al., 2003; Olsson, Boyce, Toumbourou, & Sawyer, 2005; Olsson, McGee, Nada-Raja, & Williams, 2012). Their 2003 review of the adolescent resilience literature identified two foci within the field: (i) studies of psychosocial outcomes defined by a particular risk setting and; (ii) studies of protective mechanisms important in successful adaptation (Olsson, Bond, Burns, et al., 2003). They argued that each focus gives a perspective that emphasizes different elements of the construct as well as different approaches to its measurement. Olson et al. further noted that confusion arises when the process of adaptation and the outcome of adaptation are used interchangeably to define resilience. Thus, resilience can be described as an outcome characterized by particular patterns of functional behavior despite risk, and, as the dynamic process of adaptation to a risk setting that involves the interaction between individual and social risk and protective factors. Theoretical accounts or frameworks for resilience should therefore discriminate between processes and outcomes to avoid complexity in the concept, measurement and investigation of resilience (Olsson, Bond, Burns, et al., 2003).

Olsson’s work can be usefully applied to the refugee experience in that not only can outcomes, such as mental health disorder (or absence thereof) or quality of life (reasonable to good), be conceptualized as resilient outcomes despite trauma exposure, the processes around the interaction between risk (in any of the pre-, peri-, or post-migration stages) and protective factors that range from individual to the social to predict adaptation, can also be examined through such an integrative framework.

**Resilience as an outcome.** Outcome resilience research emphasizes functionality, typically in the form of competent behavior or effective functioning despite risk exposure (Olsson, Bond, Burns, et al., 2003). Such outcomes of resilience include good mental health, functional capacity and social competence. Within the refugee literature, outcomes of resilience (although not overtly termed resilience) generally include the measurement of emotional distress, indicated by clinical diagnosis. According to Luthar (2000), the idea that distressing emotion acts in some way as an index of resilience (or lack thereof) is confusing, since it is possible that a resilient individual will display successful coping in the presence of high emotion. Thus, a resilient
individual may not necessarily be devoid of distressing emotion (Luthar, et al., 2000; Rutter, 2012). Moreover, although an individual may survive trauma, they may succumb in other areas. Even resilient individuals therefore need support and may continue to be vulnerable (Garmezy, 1993). The notion that there is room for vulnerability in resilience is supported by Lothe and Heggen who found evidence in famine survivors that individuals can be vulnerable in certain areas at certain times and that even in the presence of successful coping, there can be much vulnerability (Lothe & Heggen, 2003).

Garmezy (1991) similarly argues that individuals who demonstrate competence through functional adequacy despite extreme negative affect, may indeed be exhibiting the highest levels of resilience (Olsson, Bond, Burns, et al., 2003). That is, resilient individuals are not invulnerable or invincible to stress. Measures of psychological well-being through outcomes of clinical presentations may therefore only provide part, and sometimes a misleading impression of a young person’s resilience. Other competencies under stress, such as achieving a sense of satisfaction with life might help elucidate other parts of the resilience puzzle.

Again, outcome focused studies of resilience are criticised for having as many definitions of resilience as there are studies (Olsson, Bond, Burns, et al., 2003). What unites these seemingly unrelated studies though is a pattern of effective performance (Gartland, 2008). Thus, focusing on adaptation to adversity constitutes an important and useful way of operationalising the construct of resilience.

**Resilience as multidimensional.** Process focused resilience research aims to understand the mechanisms that act to modify the impact of the risk setting, as well as any developmental processes by which young people successfully adapt (Olsson, Bond, Burns, et al., 2003). The current thesis seeks to assess both risk factors which intensify reactions to adversity (make more vulnerable) (see previous chapter) and protective factors that aim to ameliorate the response to adversity (make more resilient) (Olsson, Bond, Burns, et al., 2003). Throughout the development literature, resilience promoting factors have been investigated within three broad areas: (i) the individuals themselves through traits, dispositions, attributes, and skills; (ii) their social supports, such as families and peers; and (iii) and their societies and environments such as school or broader communities (Garmezy, 1993; Lothe & Heggen, 2003).
Conceptualising resilience as a process which spans these broad areas requires consideration of the range of risk and protective factors with varying degrees of impact for any risk situation across various points of development (Olsson, Bond, Burns, et al., 2003). It is unlikely that any one risk factor contributes solely to competence at a range of levels. Rather, it is often multiple risk factors and an interaction of these that determine competency at a range of different levels. Just as risk factors can produce a chain of negative events, protective factors can generate a chain of positive reactions leading to favourable psychosocial and psychological outcomes (Olsson, Bond, Burns, et al., 2003). Thus, both the occurrence or absence of psychopathology raise questions about which dispositional features of the individual and what social/environmental factors may explain why some individuals develop psychological problems and why some do not (Daud, et al., 2008).

In terms of individual processes, the literature has identified a range of protective factors, including temperament, intelligence, self-esteem, sociability, communication skills, and personality traits such as self-efficacy and locus of control (Betancourt & Tanveer Khan, 2008; Olsson, Bond, Burns, et al., 2003). Evidence of these Western derived strength and cognitive/dispositional factors in young refugees is now emerging. For example, Cortes and Buchanan (2007) identified resilient themes among Columbian child soldiers which facilitated trauma recovery from war. These included a sense of agency, social intelligence, empathy, affect regulation, shared experience, care giving features, a sense of future, hope and growth, and morality and faith. Similarly, Fernando (2006) found that religiosity through Buddhist practices emerged in ‘resilient’ war affected Sri Lankan children. Attention to attachment has also been critical in understanding children’s resilience. Though most famously described in the classical studies by Winnicott (1965), there is strong evidence for the protective role of attachment in the child refugee literature (Garbarino, et al., 1991). Empirical support for these individual characteristics is limited to child populations and to date, have not been generalised to older adolescent/young adult populations.

In terms of social support, researchers have noted the importance of distinguishing between support received from different sources, such as family, peers, and significant others. Despite the emerging focus on peer relations as a form of social support, for many young people from different cultures, the family remains the primary support (Olsson, Bond, Burns, et al., 2003). Weine (2008) indeed notes that any
resilience framework must place the family as the key context for refugee youth as these youths live in families in which multiple traumas and losses may interact with social and economic difficulties, cultural transitions, and possible parental mental illness. For young refugees, families also contain resources and strengths that may be protective against negative outcomes (Weine, 2008). Regarding family factors, the general literature on youth and immigrant groups have identified positive parent-child relations, parental warmth, cohesion and care within the family, a close relationship with the family, intactness, strong work ethics and aspirations, as all protective (Weine, 2008).

Specifically regarding refugees, Annan and Blattman (2006) found evidence for the integral role of family connectedness in the re-integration of child soldiers and long term mental health outcomes in war affected youths in Uganda. Emphasising the importance of family relations in positive adaptation, Punamaki, Qouta, and El-Sarraj (2001) also found that children of the Intifada (Palestinian uprising against the Israeli occupation of the Palestinian territories), who had strong family cohesion with both their mothers and fathers, exhibited lower levels of PTSD than those that experienced dysfunction in the family. The importance of good maternal mental health as informed by Ajdukovic’s (1995) program of research also supports the integral role of family factors in the protection from adversity.

Perhaps the most comprehensive research on refugee families comes from Weine and colleagues. Their research with Bosnian refugee families in the United States has documented multiple areas of family life in which family members report engaging in helpful responses to trauma related stressors and strains (Weine, 2008; Weine, et al., 2006; Weine, et al., 2005). That is, families have found ways to manage changes in family roles and obligations through adaptive methods such as providing hope, fostering flexibility, tolerance, and trust in the family, as well as promoting family togetherness (Weine, 2008). Moreover, families manage difficulties in communication by sharing good memories, talking with children, and expressing their emotions. Refugee families respond to changes in relationships with other family members through several strategies such as sending money home, planning an eventual return, and maintaining a transnational family that help maintain a sense of connectedness with the larger family and its members. To cope with changes in their connection with the ethnic community and nation/state, family members adopt several
strategies, including teaching young people the history and language of their country of origin and strengthening ethno-cultural identity (Weine, 2008).

The quantitative impact of family strengths on refugee youth is not well studied. However, a number of small and mostly cross-sectional quantitative studies have identified protective resources that buffer against pre-migration trauma and resettlement stress in refugee youths. These include family support (Beiser, Turner, & Ganesan, 1989), parental well-being and lower caregiver distress (Melville & Lykes, 1992), intact or reunited families (Montgomery, 2005; Rousseau, Rufagari, Bagilashya, & Measham, 2004), family connection to the large community/social support, and family connections to the culture of origin (Servan-Schreiber, Lin, et al., 1998). Other family research has demonstrated that family stories, family rituals, and family routines are associated with changes in family processes and improved health behaviours and outcomes (Weine, 2008).

The domain of culture, which cannot be separated when talking about refugees in a family context, poses difficulties as well as strengths for young refugees (Weine, 2008). Commonly cited strengths include a sense of obligation to family, a work ethic, and support from the same ethnic community. Research with refugees has indicated that a stronger cultural identity may play a protective role as well as a degenerative role regarding mental health outcomes (Liebkind, 1993).

Other studies also show that social support moderates the impact of trauma and is a main predictor in problems such as PTSD (Kuterovac-Jagodic, 2003), internalising and externalising problems (Kliever, Murrelle, Mejia, Torres, & Angold, 2001) and general psychological health (Farhood, 1999). Of the types of social support, it has been found that instrumental (tangible) support, emotional support, and support that fosters self-esteem are negatively correlated with PTSD (Betancourt & Tanveer Khan, 2008). Positive peer relationships have also been associated with greater self-esteem and social adjustment among refugee children (Lustig, Kia-Keating, Knight, et al., 2004).

In terms of societal-environmental factors, the literature has implicated two important but understudied environments: (i) the school environment, and (ii) the broader social/community environment. School experiences that involve supportive peers, positive teacher influences, and opportunities for success are positively related to resilience. The impact of the school environment can be both physical (e.g.,
opportunities to partake in sport) as well as social. Elbedour (1993), for instance, emphasised the importance of school’s in mitigating the effects of trauma. In displacement and refugee crises, the early provision of education has been argued as an important means of restoring predictability and social supports (Betancourt & Tanveer Khan, 2008). While Bond and colleagues found that perceived school performance and a supportive school environment play a key role in determining wellbeing outcomes among refugee youth (Bond et al., 2007), bullying at school can negate this effect through negatively impacting on wellbeing among youth (Wilkins-Shurmer et al., 2003). Perceived social status is associated with subjective as well as objective health outcomes in adolescents (Goodman et al., 2001). For refugee youth, school is a critical domain and subjective social status is an important reflection of a young person’s sense of belonging in the first social context outside of their immediate family (Goodman, et al., 2001).

In terms of the broader environment, ethnic community, neighbourhood, region, and country are also important the development of resilience. Many researchers have proposed that affirming non-punitive communities play an important role in developing resilience in young people (Olsson, Bond, Burns, et al., 2003). In the refugee literature, Montgomery (2008) found in a follow-up study of refugee children, nine years after they had arrived in Denmark, that it was not the traumatic events that predicted psychological problems, but a disruption to important community support. Similarly, Schweitzer, Greenslade, and Kagee (2007) through their qualitative research with Sudanese refugees resettled in Australia found that religious beliefs (which are maintained by an emphasis on religion in the community), and social support acted as buffers against adversities Sudanese refugees faced. Self-reported discrimination has been associated with negative health outcomes (Paradies, 2006) and a correlation between discrimination and stress symptoms was also found among Vietnamese refugees living in Finland (Liebkind, 1996). This association was not replicated, however, in refugees living in Australia (Fozdar & Torezani, 2008).

Bonding and bridging relationships are also viewed as particularly important to newly-arrived refugee communities (Loizos, 2007). Feeling part of one’s ethnic community has an important protective factor for refugee youth (Beirens et al., 2007; Hyman et al., 2000) and is particularly important when belonging in other domains of social life is challenged, for example, in school or the broader Australian community.
These findings are not surprising given the widely accepted reality that social networks and social supports are major determinants in health outcomes (Berkman & Glass, 2000).

In summary, despite popular usage, resilience has been used loosely and differently within the refugee literature. It is examined within risk settings, in terms of protective processes and according to a range of different criteria. Thus, resilience is seen as both a process and outcome of adaptation. Outcome focused approaches emphasise the maintenance of functional outcomes and process focused approaches emphasise various risk and protective factors that act in concert to mediate the effects of risk (Olsson, Bond, Burns, et al., 2003). These risk and protective factors comprise specifically of dispositional attributes, family characteristics, and external support factors such as positive school experiences, good peer relations, and positive relations with a community and/or culture.

Although it is important to identify risk factors, and to this point, this thesis has contended that risk and resilience serve as complementary and equally necessary concepts in the empirical investigation of refugee psychological well being, the establishment of protective factors that are present in the individual, family, peer, and broader school and cultural/community system are important to identify. Hence, the conceptualisation of resilience in this way has shifted the focus away from deficits to individual competencies and capacities (Daud, et al., 2008). The benefit of studying resilience is that it is closely linked with intervention in that protective processes can inform the development of targeted interventions, contrary to the narrower approach of minimising risk. To understand resilience and resilient outcomes, protective factors and processes that influence successful outcomes despite specified risks need to be identified (Luthar, et al., 2000).

An important feature of the multidimensional definition of resilience is that it reflects an strength based ecological understanding of refugees that views refugee mental health in the context of central factors to the individual and that considers risk and protective capacities and resources as not occurring in isolation, but in conjunction and interaction with each another (Betancourt & Tanveer Khan, 2008; Punamaki, et al., 2001).

The current thesis uses this ecological perspective of resilience to expand on findings from the child research and operationalise resilience to explore their impact on
psychological well-being through both mental health as well as psychosocial outcomes in young adolescent/adult refugees. Herein, resilience is defined as “the dynamic process involving an interaction between both risk and protective processes, internal and external to the individual, that act to modify the effects of a stressful life event and influence the attainment of desirable psychosocial and emotional outcomes (Luthar, et al., 2000; Rutter, 2006b). Risk of course is used to describe psychosocial adversity or events that would be considered a stressor or traumatic to most people and that may hinder normal functioning (Betancourt & Tanveer Khan, 2008).

**Operationalising and measuring resilience.** The confusion in definitions of resilience highlights the need for appropriate measurement of the construct itself. At the time this research was conceived, a literature search revealed few if any adequate resilience measures that could capture the ecological aspects of young refugees. This is probably due to the lack of uniformity and clarity in defining resilience (Gartland, 2008). Even to date, research has yet to fully establish a reliable measure of resilience (Gartland, et al., 2011). For example, Windle et al. (2011) in their methodological review of resilience, using known published criteria for systematic review of measures, identified nineteen resilience measures (four were revised versions of original scales). They found inadequate information regarding the psychometric properties of all scales, with the Connor Davidson Resilience Scale assessed has having the best psychometric properties, despite the limited conceptual and theoretical backing to a number of its scales (Windle, et al., 2011). Their findings led these authors to conclude that no gold standard measure of resilience currently exists to inform the direction of research in this area (Windle, et al., 2011).

Windle et al’s. (2011) review yielded eight resilience measures targeted at adolescent/youth populations. Despite the limited reported information around psychometric properties, many of these measures were only recently developed and therefore not available at the time of recruitment of participants for this research program. Nonetheless, closer inspection of these individual measures revealed that all eight measures were not appropriate for use in the current thesis for reasons including: lack of public availability, limited to an understanding of stress or coping ability, lack of generalisability to a refugee population, lack of theoretical (including ecological) rationale, or a sole emphasis on individual resiliency (e.g., ego resiliency).
Similarly, in a prior review by Ahearn et al. (2006), six adolescent resilience measures were identified, yielding only one acceptable measure (i.e., The Resilience Scale, Wagnild & Young, 1993) for a population of adolescents. Although the scale was again reviewed in the 2011 review (Windle, et al., 2011), this measure focused only on resilience as an individual or personality construct.

Promising work in the measurement of resilience, however, emerged with the study conducted by Gartland (2008), which was later published in 2011 (Gartland, et al., 2011). To this author’s knowledge, this was the first attempt to operationalise a theoretical and ecological understanding of resilience in a young person’s population. The aim of Gartland et al.’s (2008; 2011) study was to psychometrically validate a resilience measure using a large sample of chronically ill and non-chronically ill adolescents in Australia. Through a series of studies attempting to operationalise, norm and validate the construct of resilience, these authors found support for the robust elements of resilience reviewed in the literature with young people and reviewed in this research with respect to refugees. The resultant Adolescent Resilience Questionnaire, Revised (ARQ-R), comprises five major domains/subscales (individual, family, peer, school, community), with each subscale (except community which comprises a single overall domain) containing subdomains.

Within the individual domain, conceptual subdomains include negative cognition, confidence with self and future, empathy, social skills, and emotional insight. Within each of the family and peer domains, conceptual subdomains included connectedness and availability. Within the school domain, conceptual subscales include supportive school environment and connectedness. The community domain comprised only one conceptual domain- a sense of connectedness. The ARQ-R is directly informed by an ecological model, which synthesises robust findings from the literature regarding resilience. The ARQ-R was developed to identify young people with personal characteristics associated with resilience, who are positively engaged with their family, peers, school, and communities (Gartland, et al., 2011). These young people are more likely to show resilient outcomes in times of adversity. Conversely, the ARQ-R can assist to identify individuals who show deficits or poor engagement in some or all of the areas, who may be vulnerable in the face of adversity (Gartland, et al., 2011). Unfortunately, though, a limitation of the ARQ-R is that it has not been validated in a refugee population.
The present study therefore represents the first attempt to operationalise a construct of resilience using an ecological framework to understand the relationship between resilience and mental health in young refugees. While the ARQ-R is attracting attention in the resilience literature (Gartland, et al., 2011), it is yet to be tested within a young refugee group exposed to war trauma and adversity across a pre-, peri-, and post-migration period. Thus, this research represents a very early attempt to explore resilience in young Australian refugees. While an implicit assumption in this ecologically based approach is that the greater range of capabilities resources available to the individual, the more likely he/she will be able to navigate adversity; such a hypothesis has not been tested within a young refugee population, and furthermore where the Australian context is seen as relevant to the outcomes investigated.

Quality of life. Unquestionably, studies focused on negative mental health outcomes are essential in validating the mental health effects of trauma, paving the way for universal conceptualisations and fostering psychological interventions to help those experiencing distress. What has emerged from this literature, and argued throughout this thesis, is the need for an enhanced understanding of the refugee experience. More specifically, it is argued that it is necessary to utilise a range of psychosocial outcomes in order that the refugee experience is appropriately conceptualised (Correa-Velez, et al., 2010; Lustig, Kia-Keating, Knight, et al., 2004). This strategy therefore allows refugees to be considered not as products of their past, but rather as individuals with agency, new futures, and potential success (Correa-Velez, et al., 2010).

A trend is now occurring in mainstream refugee research whereby other disciplines or frameworks are drawn upon to broaden the conceptualisation of psychological well-being in young refugees. While this body of literature about the concept of “well-being” in refugees is large, like resilience, it is difficult to compare findings, as well-being is often defined differently, and most often in relation to past trauma.

Ahearn’s (2000) conceptualisation of refugee well-being frames well-being in a holistic manner, emphasising both agency and ability to not only live, but be well. He defines psychosocial wellbeing as consisting of the “ability, independence and freedom to act, and the possession of the requisite goods and services to be psychologically content” (Ahern, et al., 2006, p. 4). Correa-Velez et al. (2010), expand this definition to
argue that well-being is directly tied to the broader social environment within which individuals live, and in particular, the degree of openness and social inclusion within the host community.

Like resilience, well-being can be thought of as both a resource for, and an outcome of, successful adaptation in refugee youth (Ager & Strang, 2008). As a resource for successful adaptation, subjective well-being can aid youths to be better equipped for the challenges of settling well in their new country. As an outcome, subjective well-being can be an important indicator of how youth engage with and are affected by the challenges of life in their host country. Thus, the host community is critical in the extent to which it is welcoming, offers opportunities to belong and flourish (Correa-Velez, et al., 2010). In a review of the psychosocial literature, however, Ahearn (2000) concluded that no adequate scale of wellbeing for refugees could be found.

The World Health Organization (WHO) utilises the concept of quality of life to capture health and well-being as a complete state of physical, mental, and social well-being, rather than just an absence of disease (WHO, 1997a). They use ‘quality of life’ as an indicator of well-being and subsequently define it as: “…an individual’s perception of his/her position in life, in the context of the culture and value systems in which he/she lives and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept incorporating in a complex way the person’s physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of the environment” (WHO, 1997b, p. 1).

Using this definition, the WHO operationalised the construct of well-being through The WHO Quality of Life Questionnaire (WhoQoL). Consequently, the construct and measure have been adopted internationally. Importantly, the WhoQoL also been culturally validated (Ohaeri, Awadalla, El-Abassi, & Jacob, 2007). For example, Ohaeri et al. (2007) used confirmatory factor analysis to successfully demonstrate the validity of the QoL construct with a Sudanese sample. Similarly, studying differences in quality of life between Iranian refugees and Swedish primary health care patients, Ekblad, Abazari, and Eriksson (1999) endorsed the quality of life construct through domains including physical health, psychological health, social relationships, and the environment. Cultural differences were noted whereby Swedish patients separated individual and environmental qualities of quality of life, contrary to
Iranian refugees, who emphasised a holistic integration of these domains. Notably, in line with Correa-Velez et al.’s (2010) suggestions, Iranian refugees noted acceptance by Swedish society to be a major prerequisite in their quality of life (Ekblad, et al., 1999).

Other qualitative studies that have not utilised the WhoQoL in their assessments have also endorsed multidimensional conceptualisations of well-being and quality of life. Using content analysis to examine interviews with Mozambican refugees in Malawi, Ager, Ager, and Long (1995) found support for a quality of life profile consisting of: (i) physiological needs (e.g., access to adequate quantity of food, water/fuel supplies, and health facilities); (2) safety needs (e.g., protection from assault, security of possessions, and adequate shelter); (3) belonging needs (e.g., intact family, experience of friendship); (4) esteem needs (e.g., involvement in productive activity, and access to education); and (5) transcendence needs (e.g., affinity with home/land, personal freedom, and confidence in the future) (Ager, et al., 1995).

McCarthy and Marks (2010) similarly tested a well-being framework previously established for children and adolescents in the UK, on a group of young refugees and asylum seekers to explore the meaning of well-being to refugees. Themes emerging from their participatory research methods comprised meaning of well being around the self (physical and psychological), relationships (with family, friends, and others), and the environment (possessions, home, school, local and national). These authors concluded that current conceptualisations of well-being can be appropriate for young refugees in that they want to feel safe and secure, be allowed to be themselves, have the same opportunities as others and have meaningful relationships with family, friends, and their wider community (McCarthy & Marks, 2010).

In an Australian context, Sobhanian, Boyle, and Bahr (2006) used the Quality of Life Inventory (QOLI) to measure life satisfaction in former detained refugees in Australia. They found large differences across time periods (during versus after detainment in a detention facility) on quality of life domains including, health, self-esteem, goals and values, money, work, play, learning, creativity, helping, love, friends, children, relatives, home, neighbourhood, and the community (Sobhanian, Boyle, Bahr, & Fallo, 2006). These findings support the argument that well-being in refugees is directly tied to subjective experiences of the host society.
Correa-Velez at al. (2010) also followed up 127 young refugees (aged 12-18) over three years of settlement from different nationalities. In their first year in Australia, young refugees reported high levels of wellbeing, subjective health status, happiness, positive feelings about home, high levels of perceived school performance and school support, good attachment to peers, and a strong sense of ethnic identity. They also reported moderate levels of a sense of control, and perceived social status at school, in their ethnic community and the broader Australian community. The key challenges reported included living in fragile family situations and experiences of social exclusion, with bullying and discrimination reported in at least one in five participants. Despite this, high levels of wellbeing on arrival to Australia among young refuges was observed and this was maintained over the first three years (Correa-Velez, et al., 2010).

Although a range of predictive factors were important to positive well-being, experiences of social inclusion or exclusion, were among those most important. That is, subjective social status in the host community, discrimination and bullying were significant in determining well-being. These authors argued that perceived discrimination reflected an interaction between the individual and his/her host community (Correa-Velez, et al., 2010; Mesch, Turjeman, & Fishman, 2008). Others have indeed argued that this may be one of the most important barriers to the integration of ethnic minorities (Mestheneos & Ioannici, 2002). Thus, wellbeing is determined by the extent to which one is able to become a valued citizen within his/her new country (Correa-Velez, et al., 2010). The opportunity to flourish, to become at home and belong, is powerfully shaped by the prevailing social climate and structures that are openly inclusive or exclusive. The powerful role played by factors in the host country found in this thesis so far supports these arguments. Despite the range of nationalities interviewed in this important study by Correa-Velez et al. (2010), cultural differences in their experiences of well-being were not reported.

In sum, quality of life and resilience studies reflect broad but relevant positive and psychosocial constructs in refugees’ lives. The alternative focus on these constructs represents an important step towards a more comprehensive understanding of refugee psychological well-being and mental health. The current study therefore extends the previous findings on negative mental health, to explore quality of life and resilience. An important question in exploring these outcomes is to examine how they
relate to more traditionally understood concepts of mental health. Regarding the construct of resilience, this has not been done operationally where resilience is represented in an ecological balance of risk and protective factors. Moreover, although some attempts have been made to explore cultural differences in quality of life in terms of refugees comparatively with the host society (Ekblad, et al., 1999), cultural differences among refugees themselves in quality of life and resilience, have not been examined.

**Aims and hypotheses**

Recognising the need to explore psychological well-being from a psychosocial and ecological framework, which considers positive mental health factors such as resilience and quality of life alongside negative mental health factors, the present study had the following aims:

1. To explore the relationship between negative and positive constructs of mental health – that is the relationship between PTSD, anxiety, depression, somatisation, resilience, and quality of life in a sample of young refugees.
2. To examine and operationalise the construct of resilience, using an ecological framework, in young refugees exposed to trauma and adversity.
3. To explore quality of life, using an ecological/psychosocial framework, in young refugees resettled in Australia.
4. To explore the impact of overall resilience and resilience domains (individual, family, peer, school, community) on PTSD, anxiety, depression, and somatisation.
5. To explore overall resilience and resilience domains (individual, family, peer, school, community, and overall) on quality of life.
6. To examine cross cultural differences in resilience and quality of life among young refugees exposed to trauma and adversity.

The following hypotheses were made:

1. That greater overall resilience would be associated with lower scores on PTSD, depression, anxiety, and somatisation.
2. That greater overall resilience would be associated with higher scores on quality of life.
(3) That greater quality of life will be associated with fewer symptoms of PTSD, depression, anxiety, and somatisation.

(4) That a differential relationship will exist between the different domains of resilience (individual, family, peer, and community) and psychological disorders including PTSD, anxiety, depression, and somatisation.

(5) That there will be differences in both resilience and quality of life across different cultural groups of young refugees.

**Method**

The method outlining participants of this study, measures and procedure used in the current investigation is described in Chapter 5. What is described here however are some points in relation to the selection of the preferred resilience and quality of life measures, namely the ARQ-R and the WHO-QoL-Bref.


Several considerations were made in the selection of this measure. First, although this measure was originally developed for an adolescent population, its utility to young people in this sample (which includes adolescents) is in its ecological framework. Given the absence of driving theories behind the resilience construct and gold standard tools in measuring resilience (Ahern, et al., 2006; Windle, et al., 2011), the ARQ-R was selected to address these gaps. Given that the ARQ-R is derived from an ecological framework and that this framework has been shown to give an appropriate understanding of the refugee experience, suitability of this measure for the current sample was considered highly appropriate.

Second, the ARQ-R was chosen for its good face validity with young refugees. That is, the language used in the ARQ-R was appropriate with a refugee sample with limited English reading skills. Third, because the ARQ-R was designed and normed on young Australians, it was appropriate to use with the current sample of young refugees who have lived in Australia minimally for a year, and maximally seventeen years (on average about five years); and whom many were also attending Australian secondary and tertiary/technical institutions, settings where the ARQ-R was originally developed.
Finally, in addition to yielding an overall resilience score, the ARQ-R has five major sub domains (individual, family, peer, school, and community). The individual domain incorporates the domains of negative cognition, confidence, empathy, social skills, and emotional insight. The family, and peer domains incorporate a connectedness and availability domain while the school domain incorporates a school environment and connectedness domain. As the current study is an exploratory study into the concept and construct of resilience in young refugees, the subdomains within each of the individual subscales were not subjected to individual analysis (e.g., negative cognition as a scale was not explored, but rather the main domain of individual resilience). Suffice to say, these separate subscales are important in elucidating the construct of resilience.

*World Health Organization - Quality of Life Inventory Brief version (WHO-QoL Bref)* (WHOQOL Group, 1996). This measure was chosen for its utility across a range of cultures and populations. Fortunately, despite the variation to which well being is defined and measured, the WHOQoL-Bref has been validated for use with different cultural populations. The WHOQoL is divided into subscales including a psychological domain, a physical health domain, a social domain, and an environment domain.

*Brief Symptom Inventory (BSI)* (Derogatis & Spencer, 1982). As discussed in the General Method (see Chapter 5), negative mental health outcomes of PTSD, anxiety, depression, and somatisation were measured using the Brief Symptom Inventory.

**Results**

*Data handling of resilience, quality of life and negative mental health outcomes.* Data in this study were subjected to screening and cleaning processes described in Chapter 5. Selected items in the ARQ-R were reverse coded and total scores on this measure were derived for each of the resilience sub-domains (individual, family, peer, school and community) and for resilience overall. Similarly, WHO-QoL-Bref total scores were calculated for each of the sub-domains (psychological, physical, social, and environmental) and for QoL overall. BSI data were handled as described in the previous chapter. T-scores were used again to split the data from each disorder into
three distinct groups: (i) a “High/Diagnosable” group, (ii) a “Moderate/Partial Symptom group (not diagnosable)”, and (iii) a “Low/Mild (not warranting intervention group)

Data analyses comprised a series of descriptive, correlational, regression and group based (ANOVA and MANOVA) analyses, performed using SPSS. All analyses were performed with totalled raw data scores where possible as opposed to using transformed or standardised scores. A significance level of 0.05 was set for all analyses. The scale range for all variables of interest in this study (i.e., PTSD, anxiety, depression, somatisation, resilience and quality of life), along with means and standard deviations scores are shown in Table 23.

Table 23.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Scale</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>1.00 - 4.00</td>
<td>1.93</td>
<td>0.75</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0.00 - 4.00</td>
<td>0.90</td>
<td>0.84</td>
</tr>
<tr>
<td>Depression</td>
<td>0.00 - 4.00</td>
<td>0.95</td>
<td>0.91</td>
</tr>
<tr>
<td>Somatisation</td>
<td>0.00 - 4.00</td>
<td>0.76</td>
<td>0.79</td>
</tr>
<tr>
<td>Resilience Total</td>
<td>1.00 - 5.00</td>
<td>3.38</td>
<td>0.48</td>
</tr>
<tr>
<td>Quality of Life Total</td>
<td>1.00 - 5.00</td>
<td>3.64</td>
<td>0.50</td>
</tr>
<tr>
<td>Resilience domains:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>1.00 - 5.00</td>
<td>3.38</td>
<td>0.45</td>
</tr>
<tr>
<td>Family</td>
<td>1.00 - 5.00</td>
<td>3.54</td>
<td>0.82</td>
</tr>
<tr>
<td>Peer</td>
<td>1.00 - 5.00</td>
<td>3.50</td>
<td>0.65</td>
</tr>
<tr>
<td>School</td>
<td>1.00 - 5.00</td>
<td>3.25</td>
<td>0.61</td>
</tr>
<tr>
<td>Community</td>
<td>1.00 - 5.00</td>
<td>3.09</td>
<td>0.80</td>
</tr>
<tr>
<td>Quality of life domains:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>1.00 - 5.00</td>
<td>3.56</td>
<td>0.70</td>
</tr>
</tbody>
</table>
As seen in Table 23, PTSD had a scale score of 1-4, where a score of 2.5 is indicative of diagnosable PTSD. Anxiety, depression and somatisation were measured on a scale of 0-4, where “0”=symptom not at all experienced and “4”=symptom was extremely experienced. Resilience and quality of life were measured on a scale of 1-5, where for resilience “1”= symptom almost never experienced to “5”= symptom almost always experienced; and for quality of life, “1”=very dissatisfied with item to “5”=very satisfied with item. In sum, for negative mental health variables, higher scores indicated higher psychopathology. For resilience and quality of life, higher scores are indicative of higher resilience and higher quality of life respectively.

**Correlations of negative mental health outcomes, resilience, and quality of life.**

Pearson’s correlations were performed to examine the relationship between all variables of interest (i.e., PTSD, anxiety, depression, somatisation, resilience, and quality of life). These relationships are presented in Table 24.

Table 24, *Pearson’s Correlations between PTSD, Anxiety, Depression, Somatisation, Overall Resilience, and Overall Quality of Life (N=82).*

<table>
<thead>
<tr>
<th></th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PTSD</td>
<td>--</td>
<td>.56**</td>
<td>.53**</td>
<td>.51**</td>
<td>-.32**</td>
<td>-.37**</td>
</tr>
<tr>
<td>2. Anxiety</td>
<td>--</td>
<td>.80**</td>
<td>.73**</td>
<td>-.46**</td>
<td>-.31**</td>
<td></td>
</tr>
<tr>
<td>3. Depression</td>
<td>--</td>
<td>.71**</td>
<td>.46**</td>
<td>-.43**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Somatisation</td>
<td>--</td>
<td>-.54**</td>
<td>-.30**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Resilience</td>
<td>--</td>
<td>.37**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Quality of Life</td>
<td>--</td>
<td>--</td>
<td></td>
<td></td>
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</tbody>
</table>

**p< .01**

Table 24 shows significant relationships between all variables of interest. There were strong correlations among the negative mental health variables (as shown in the
previous chapter), with the strongest relationships exhibited between anxiety and depression and anxiety and somatisation. Each psychopathology variable (i.e., PTSD anxiety, depression, and somatisation) was moderately and negatively correlated with the each of the resilience, and quality of life variables. A moderate and positive relationship was also observed between resilience and quality of life. The relationships between resilience domains and quality of life domains are also presented in Table 25.
Table 25.  
*Pearson’s Correlations between Resilience and Quality of Life Variables (N=82).*

<table>
<thead>
<tr>
<th>Variable</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
<th>8.</th>
<th>9.</th>
<th>10.</th>
<th>11.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Resilience</td>
<td>--</td>
<td>.92**</td>
<td>.82**</td>
<td>.83**</td>
<td>.75**</td>
<td>.51**</td>
<td>.37**</td>
<td>.09</td>
<td>.41**</td>
<td>.43**</td>
<td>.34**</td>
</tr>
<tr>
<td>Individual resilience</td>
<td>--</td>
<td>.69**</td>
<td>.72**</td>
<td>.60**</td>
<td>.37**</td>
<td>.34**</td>
<td>.12</td>
<td>.37**</td>
<td>.40**</td>
<td>.32**</td>
<td></td>
</tr>
<tr>
<td>Family resilience</td>
<td>--</td>
<td>.64**</td>
<td>.53**</td>
<td>.37**</td>
<td>.31**</td>
<td>.12</td>
<td>.33**</td>
<td>.41**</td>
<td>.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer resilience</td>
<td>--</td>
<td>.49**</td>
<td>.33**</td>
<td>.36**</td>
<td>.11</td>
<td>.39**</td>
<td>.32**</td>
<td>.37**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School resilience</td>
<td>--</td>
<td>.34**</td>
<td>.32**</td>
<td>.04</td>
<td>.37**</td>
<td>.37**</td>
<td>.30**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community resilience</td>
<td>--</td>
<td>-.01</td>
<td>-.18</td>
<td>.08</td>
<td>.13</td>
<td>.02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Quality of life</td>
<td>--</td>
<td>.81**</td>
<td>.83**</td>
<td>.60**</td>
<td>.87**</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical QoL</td>
<td>--</td>
<td>.47**</td>
<td>.38**</td>
<td>.60**</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Psychological QoL</td>
<td>--</td>
<td>.46**</td>
<td>.66**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social QoL</td>
<td>--</td>
<td>.48**</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Environmental QoL</td>
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</tbody>
</table>

**p < .01**
Table 25 shows significant relationships across the resilience and quality of life variables. All resilience subscales correlated highly with resilience overall, with exception to community resilience which was moderately correlated with overall resilience. Individual resilience was strongly correlated with family, peer and school resilience and moderately correlated with community resilience. Family resilience likewise, shared a strong relationship with peer resilience, and had a moderate relationship with school and community resilience. Peer resilience was moderately correlated with school and community resilience, whilst school resilience was moderately correlated with community resilience.

Among the quality of life variables, physical, psychological, and environmental quality of life were highly correlated with quality of life overall, with social quality of life being moderately to highly correlated with overall quality of life. Physical quality of life was moderately correlated with psychological and social quality of life and highly correlated with environmental quality of life. Psychological quality of life was also moderately correlated with social quality of life and highly related to environmental quality of life. Social QoL was also moderately related to environmental quality of life.

Significant positive correlations in the small to moderate range also existed across the individual, family, peer, and school resilience domains and psychological, social and environmental quality of life domains. It is noteworthy that none of the resilience domains were significantly related to physical quality of life. Similarly, community resilience did not significantly correlate with any of the quality of life domains.

**Resilience profiles in PTSD, anxiety, depression and somatisation.** To explore the relationship between resilience and negative mental health (PTSD, anxiety, depression, and somatisation), three groups were formed using cut off scores in each of the disorders, as described in the previous chapter. That is, for each disorder, a high symptoms group, a partial symptom group, and a low/no symptom group were formed. Resilience domains within each of these groups were then examined. The resulting
profiles are presented respectively for each disorder in Figures 4-7.

Figure 4. Resilience profile for low \((n=44)\), partial \((n=20)\), and high PTSD \((n=18)\) groups.
Figure 5. Resilience profile for low (n=42), partial (n=23), and high anxiety (n=17) groups.

Figure 6. Resilience profile for low (n=41), partial (n=21), and high depression (n=20) groups.
Figures 4 through 7 display a consistent pattern of resilience across each symptom group. That is, across all symptom groups for all disorders, those with fewer symptoms appeared to have higher resilience scores. Only in the case of depression, was the partial depression group lower in school and community resilience than the high depression group. Similarly, those with partial somatisation were lower in school resilience than those in the high somatisation category.

**Resilience score differences in PTSD, anxiety, depression and somatisation groups.**
To assess for significant group differences in resilience domains, a series of one way multivariate analyses of variance (MANOVAs) were conducted. Using the PTSD groups (low, partial, high) in the first analysis as the independent factor and the related resilience domains (individual, family, peer, school, community) as dependent factors, the MANOVA revealed a non significant multivariate main effect for PTSD group, Wilks’ λ=.82, F(10,150)=1.56, p=.12, partial η2=.09. Given the non-significant multivariate effect, no further analyses of the data were made with respect to PTSD groups on resilience domains.

Figure 7. Resilience profile for low (n=44), partial (n=18), and high somatisation (n=20) groups.
In the second one-way MANOVA, using anxiety groups (low, partial, high) as the independent factor and the related resilience domains (individual, family, peer, school, community) as dependent factors, the MANOVA revealed a significant multivariate main effect for anxiety group, Wilks’ $\lambda=.782$, $F(10, 150)=1.96$, $p<.05$, partial $\eta^2=.116$. Follow up of significant univariate main effects for anxiety group were obtained on individual resilience, $F(2,79)=6.07$, $p<.01$, partial $\eta^2=.133$; family resilience $F(2,79)=5.59$, $p<.01$, partial $\eta^2=.124$; and peer resilience, $F(2,79)=9.21$, $p<.001$, partial $\eta^2=.189$. There were no univariate main effects for school resilience ($p=.146$) or community resilience ($p=.164$). Significant anxiety group differences in individual resilience were observed between the low and the high anxiety group ($p<.05$). Similarly significant group differences in family resilience, were observed between the low and the partial group ($p<.05$), and the low and high anxiety group ($p<.05$). On peer resilience, significant differences were observed between the low and the partial group ($p<.05$), and again between the low and high anxiety group ($p<.05$).

In the third one-way MANOVA, using depression groups as the independent factor (low, partial, high) and the related resilience domains as dependent factors (individual, family, peer, school, community), the MANOVA revealed a significant multivariate main effect for depression group, Wilks’ $\lambda=.751$, $F(10,150)= 2.30$, $p<.05$, partial $\eta^2=.133$. Significant univariate main effects for depression group were obtained for individual resilience, $F(2,79)=4.99$, $p<.01$, partial $\eta^2=.112$; family resilience, $F(2,79)=3.73$, $p<.05$, partial $\eta^2=.086$; peer resilience, $F(2,79)=5.48$, $p<.01$, partial $\eta^2=.122$; school resilience, $F(2,79)=5.37$, $p<.01$, partial $\eta^2=.120$; and community resilience, $F(2,79)=3.50$, $p<.05$, partial $\eta^2=.081$. Post hoc analyses revealed significant depression group differences in individual resilience between the low and partial depression group ($p<.05$), and the low and high depression group ($p<.05$); in family resilience between the low depression and high depression group ($p<.05$), in peer resilience between low and high depression groups ($p<.01$), in school resilience between low and partial depression groups ($p<.01$), and in community resilience between the low and partial depression groups ($p<.05$).

In the final one-way MANOVA, using somatisation groups (low, partial, high) as the independent factor and the related resilience domains as dependent factors (individual, family, peer, school, community), the MANOVA revealed a significant multivariate main effect for somatisation group, Wilks’ $\lambda=.724$, $F(10,150)=2.62$,
Follow up analyses revealed significant univariate effects for the depression group on individual resilience, $F(2,79)=5.69$, $p<.01$, partial $\eta^2=.126$; family resilience $F(2,79)=6.03$, $p<.01$, partial $\eta^2=.130$; peer resilience, $F(2,79)=7.13$, $p<.01$, partial $\eta^2=.153$; school resilience, $F(2,79)=8.14$, $p<.01$, partial $\eta^2=.171$; and community resilience, $F(2,79)=3.77$, $p<.05$, partial $\eta^2=.087$. Post hoc analyses revealed significant differences between low and high somatisation groups on individual resilience ($p<.05$), between the low and high somatisation group ($p<.01$) on family resilience, between low and high somatisation groups on peer resilience ($p<.01$), between low and partial somatisation groups on school resilience ($p<.01$), between the low and the high somatisation group on school resilience ($p<.05$), and between the low and the high somatisation group on community resilience ($p<.05$).

**Resilience domains as predictors of PTSD, anxiety, depression, and somatisation.**

Given the general pattern observed between non-symptomatic and symptomatic groups in each of the disorders, it was of interest to assess the role of resilience domains in predicting mental health difficulties. As there is limited a priori knowledge towards the priorities of importance among domains of resilience, a series of standard regressions were performed to explore the predictive nature of resilience domains in PTSD, anxiety, depression, and somatisation.

The first standard multiple regression using the resilience domains as predictors and PTSD as the dependent factor, revealed that the linear combination of individual, family, peer, school, and community resilience accounted for a significant, albeit modest, proportion (12%) of the variance in PTSD, $F(5,76)=3.21$, $p<.05$. Table 26 presents the regression values for each predictor in the PTSD model. As seen in Table 26, community resilience was the only unique significant contributor to the PTSD variance ($\beta=-0.28$, $t=-2.41$, $p<.05$).

The second standard multiple regression using the resilience domains as predictors and anxiety as the dependent factor, revealed that the linear combination of individual, family, peer, school, and community resilience accounted for 19% of the variance in anxiety which was significant, $F(5,76)=4.81$, $p<.001$. Inspection of beta weights for this analysis, however, revealed no significant unique contributors (see Table 26). Although the linear combination of resilience predictors explained significant variance in anxiety, their individual contribution was not significant.
According to Tabachnick and Fidell (2001), in regression models containing multiple predictors, it is not uncommon to have relatively low beta weights across the predictor set. Given that this standard approach did not identify individually significant predictors, it was of interest to employ a data driven approach to the regression to test whether this outcome would be replicated.

Accordingly, the stepwise procedure was applied to the variable set. This analysis revealed that the combination of resilience domains significantly predicted 19% of the variance in anxiety, $F(1,80)=19.91, p<.001$, with peer resilience as the only significant unique contributor in the model, $\beta=-.45, t=-4.46, p<.001$. Similarly, although the standard approach to predicting PTSD described above, revealed community resilience as a significant individual predictor (see above), stepwise analysis confirmed this as a unique predictor, $\beta=-.35, t=-3.30, p<.01$, in an overall significant model, $F(1,80)=10.87, p<.01$, explaining 11% of the variability in PTSD.

The third standard multiple regression using resilience domains as predictors and depression as the dependent factor, revealed that the linear combination of individual, family, peer, school, and community resilience accounted for 19% of the variance in depression which was significant, $F(5,76)=4.71, p<.01$. Inspection of beta weights for this analysis again revealed no significant unique contributors (see Table 26). Applying the data driven stepwise approach to this variable set, the model predicted 17% of the variance in depression, $F(1,80)=17.07, p<.001$, with individual resilience as the only significant unique contributor in the model, $\beta=-.42, t=-4.13, p<.001$.

The final standard multiple regression using resilience domains as predictors and somatisation as the dependent factor, revealed that the linear combination of individual, family, peer, school, and community resilience accounted for 26% of the variance in somatisation which was significant, $F(5,76)=6.63, p<.001$. Inspection of beta weights for this analysis again revealed no significant unique contributors (see Table 26). Applying the data driven stepwise approach, the model predicted 24% of the variance in somatisation, $F(1,80)=26.07, p<.001$, with individual resilience as the only significant unique contributor in the model, $\beta=-.49, t=-5.11, p<.001$. 
Table 26.
Regression analyses predicting PTSD, anxiety, depression and somatisation with individual, family, peer, school and community resilience domains (N=82).

<table>
<thead>
<tr>
<th>Variable</th>
<th>PTSD</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Somatisation</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>B</td>
<td>SE B</td>
<td>β</td>
<td>B</td>
</tr>
<tr>
<td>Individual Resilience</td>
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<td>.12</td>
<td>-.19</td>
<td>-.05</td>
</tr>
<tr>
<td>Family Resilience</td>
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<td>.20</td>
<td>.05</td>
<td>-.07</td>
</tr>
<tr>
<td>Peer Resilience</td>
<td>-.19</td>
<td>.19</td>
<td>-.16</td>
<td>-.12</td>
</tr>
<tr>
<td>School Resilience</td>
<td>.13</td>
<td>.16</td>
<td>.11</td>
<td>.04</td>
</tr>
<tr>
<td>Community Resilience</td>
<td>-.69</td>
<td>.27</td>
<td>-.28*</td>
<td>-.07</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.17</td>
<td></td>
<td></td>
<td>.24</td>
</tr>
<tr>
<td>Adjusted $R^2$</td>
<td>.12</td>
<td></td>
<td></td>
<td>.19</td>
</tr>
<tr>
<td>$F$</td>
<td>3.21*</td>
<td></td>
<td></td>
<td>4.81**</td>
</tr>
</tbody>
</table>

*p<.05, **p<.01
**Differences in resilience scores across quality of life groups.** Another aim of this chapter was to explore the role of overall resilience and its domains (individual, family, peer, school, community) on psychosocial outcomes such as quality of life. To examine this relationship, three quality of life groups were formed using the quality of life raw data. Frequency analysis in SPSS was used to identify three distinct groups of participants - lower QoL, moderate QoL, and high QoL. Resilience profiles for each of the three groups (low, moderate, and high overall QoL) are presented in Figure 8. Figures 9-12 respectively present the resilience profiles broken down by low, moderate, and high groups of quality of life subdomains, including physical quality of life (Physical QoL), psychological quality of life (psychological QoL), social quality of life (social QoL), and environmental quality of life (environmental QoL).

![Resilience profiles for overall Quality of Life groups](image)

**Figure 8.** Resilience profiles for overall Quality of Life groups - low (n=27), moderate, (n=26), and high (n=29).
Figure 9. Resilience Profiles for Physical QoL groups- low (n=22), moderate (n=23), and high (n=30).

Figure 10. Resilience Profiles for Psychological QoL groups- low (n=27), moderate, (n=32), and high (n=23).
Figure 11. Resilience Profiles for Social QoL groups - low (n=31), moderate (n=27), and high (n=24).

Figure 12. Resilience Profiles for Environmental QoL groups- low (n=29), moderate, (n=25), and high (n=28).
As seen in Figure 8, a consistent pattern was observed between the low, moderate, and high QoL groups across resilience domains. That is, the low QoL group displayed lower levels of resilience, compared with participants who rated their QoL as moderate and high. Participants who rated their QoL as high also demonstrated higher levels of overall resilience than those who rated their resilience as moderate. This pattern was observed across all domains of resilience, with exception to community resilience, wherein the high QoL group demonstrated similar levels of community resilience to those in the low QoL group.

When separated categories of physical, psychological, social, and environmental quality of life were examined by splitting the data into low, moderate, and high QoL groups, a similar pattern emerged whereby those with higher QoL across psychological, social, and environmental domains displayed higher resilience across all resilience domains (see Figures 9-12). The exception to this was in the physical QoL, where scores of resilience among lower groups were more comparable with those in the higher physical QoL group, with slightly less resilience observed in the moderate physical QoL group (i.e., a U curve relationship was observed in resilience scores across the low, moderate, and high physical QoL groups) (see Figure 9). The significance of group differences in all QoL groups was tested using a series of MANOVAs described below. MANOVAs were chosen to protect against inflated error and the inter-correlations between selected dependent variables.

**Significance testing of quality of life group differences on resilience domains.** To assess for significance of group differences among participants with low, moderate, and high levels of overall QoL, a Multivariate Analysis of Variance (MANOVA) was conducted, using QoL group (low, moderate, high) as the independent factor and resilience sub domains (individual, family, peer, school, community) as the dependent factor. The MANOVA revealed a non-significant multivariate main effect for quality of life group, Wilks’ $\lambda=.817$, $F(10,150)=1.59$, $p=.11$, partial $\eta^2=.09$. Therefore no follow up analyses were conducted.

In the second MANOVA, investigating differences between participants with low, moderate, and high physical QoL across resilience domains (individual, family,
peer, school, community), the analysis again revealed, a non-significant multivariate main effect for physical QoL group, Wilks’ $\lambda = .868$, $F(10,136)=1.00$, $p = .45$, partial $\eta^2 = .07$.

In the third MANOVA, investigating differences between participants with low, moderate, and high psychological QoL across resilience domains (individual, family, peer, school, community), the analysis revealed, a non significant multivariate main effect for psychological QoL group, Wilks’ $\lambda = .849$, $F(10,150)=1.28$, $p = .24$, partial $\eta^2 = .07$.

In the fourth MANOVA investigating differences between participants with low, moderate, and high social QoL across resilience domains, the analysis revealed, a significant multivariate main effect for social QoL group, Wilks’ $\lambda = .786$, $F(10,150)=1.92$, $p < .05$, partial $\eta^2 = .11$. Follow up tests of between subjects groups revealed significant univariate effects for individual resilience, $F(2,79)=6.84$, $p < .01$, partial $\eta^2 = .15$; family resilience, $F(2,79)=6.83$, $p < .01$, partial $\eta^2 = .14$; peer resilience, $F(2,79)=4.29$, $p < .05$, partial $\eta^2 = .09$; and school resilience, $F(2,79)=5.76$, $p < .01$, partial $\eta^2 = .12$. There were no main effects for community resilience ($p = .42$). Post hoc analyses revealed differences between participants with low versus high social QoL on all domains of resilience ($p < .05$), except community resilience, with high social QoL participants exhibiting higher individual, family, peer, and school resilience. There were also differences in individual resilience between participants with moderate social QoL and high social QoL ($p < .01$) and in school resilience between participants with moderate social QoL and high social QoL ($p < .01$), again, with higher social QoL participants experiencing greater individual and school resilience.

In the final MANOVA investigating differences between participants with low, moderate, and high environmental QoL across resilience domains, the analysis revealed, a non significant multivariate main effect for environmental QoL group, Wilks’ $\lambda = .868$, $F(10,150)=1.10$, $p = .36$, partial $\eta^2 = .06$.

**Resilience domains as predictors of quality of life.** To investigate the predictive quality of resilience domains in quality of life overall, a standard multiple regression was performed. Given the non-significant multivariate effects observed in the analyses above and the high correlation between the quality of life subscales and QoL overall (i.e., $r$ values between .60 and .83), separate standard regressions to predict subscales
of QoL were deemed unnecessary. Overall, the model using resilience domains to predict overall QoL was significant, Adjusted $R^2=.15$, $F(5,76)=3.74$, $p<.01$. The model accounted for 15% of the variance in overall QoL. Inspection of beta weights indicated there were no unique significant contributors in the model. Applying a similar data driven approach with stepwise regression, a similar result was found with regard to the statistical significance of the model in predicting overall QoL, Adjusted $R^2=.12$, $F(1,80)=12.05$, $p<.01$. Beta weight inspection using the stepwise technique revealed peer resilience as the significant unique predictor in the overall QoL model, $\beta=.36$, $t=3.47$, $p<.01$.

**Cross cultural influences in resilience and quality of life.** The last aim of this chapter was to examine cross cultural influences in resilience and reported QoL. In doing so, mean and standard deviation scores for each of the resilience and quality of life measures were obtained and compared across cultural groups. These are presented in Figures 13 and 14 respectively.
Figure 13. Means and standard deviations for resilience scores (domains and total) across cultural groups.
Figure 14. Means and standard deviations for quality of life profiles across cultural groups.
Significance testing of cultural group differences in resilience scores. To investigate the significance of mean differences in resilience and quality of life overall, two separate one way analysis of variance (ANOVAs) were performed using culture as the independent factor and total score resilience and total score QoL as the dependent factors. The analyses excluded the Middle Eastern group given the small sample of Middle Eastern participants in this study. In the first ANOVA using total score resilience as the outcome measure, a significant effect for cultural group was found, $F(3,68)=3.66$, $p<.05$. Post hoc analyses, however, revealed no significant pairwise comparisons across cultural groups on total resilience scores. Thus, cultural groups did not differ significantly on overall resilience.

To explore whether cultural differences existed in the separate resilience domains, a one way MANOVA was performed using each if the resilience subdomains as outcome factors and cultural group as the independent factor. The MANOVA revealed a significant overall multivariate effect for culture, Wilks’ $\lambda=.52$, $F(15,177)=3.23$, $p<.001$, partial $\eta^2=.20$. Significant univariate effects were observed for family resilience, $F(3,68)=5.01$, $p<.01$, partial $\eta^2=.18$, and peer resilience, $F(3,68)=5.83$, $p<.01$, partial $\eta^2=.20$. Although the test examining cultural group on family resilience was approaching significance, this effect was non-significant ($p=.058$). There were also non-significant effects for school ($p=.187$) and community resilience ($p=.297$). Regarding family resilience, post hoc analyses showed significant differences between the Sudanese and Togolese groups ($p<.01$), with the Togolese group demonstrating higher scores on family resilience, but not for any other pairwise group comparison. Regarding peer resilience, post hoc analyses showed significant differences between the Karen and Horn of African group ($p<.01$), with the Horn of African demonstrating higher peer resilience scores. No other significant pairwise comparisons were found on the measure of peer resilience.

Significance testing of cultural group differences in quality of life scores. In the second ANOVA using overall QoL as the outcome, although approaching significance, no significant cultural group differences were detected, $F(3, 68)=2.62$, $p=.058$. To explore whether any cultural differences existed in the separate quality of
life domains, a one way MANOVA was performed using each of the quality of life subdomains as the outcome factors and cultural group as the independent factor. The MANOVA revealed a significant overall multivariate effect for culture, Wilks’ $\lambda=.610$, $F(12,172)=2.95$, $p<.01$, partial $\eta^2=.152$. Significant univariate effects were observed for physical QoL, $F(3,68)=6.38$, $p<.01$, partial $\eta^2=.22$, and psychological QoL, $F(3,68)=2.77$, $p<.05$, partial $\eta^2=.10$. No significant univariate effects were observed for social QoL ($p=.727$), or environmental QoL ($p=.282$). Regarding physical quality of life, post hoc analyses revealed significant differences between the Horn of African and the Togolese group ($p<.01$), the Sudanese and Togolese group ($p<.05$), and the Karen and Togolese group ($p<.01$), with the Togolese reporting higher physical QoL scores in each of these pairwise comparisons. Regarding psychological QoL, despite a significant univariate effect, post hoc comparisons detected no significant differences between cultures on psychological QoL.

**Discussion**

The aim of this chapter was to explore positive and psychosocial factors in mental health among young refugees through an investigation of resilience and quality of life. The chapter also aimed to examine the relationship of resilience and quality of life to negative mental health outcomes (PTSD, anxiety, depression, and somatisation) and explore differences in cultures on resilience and quality of life. Findings and interpretations related to these aims and their associated hypotheses are discussed below.

**The relationship between resilience, quality of life and negative mental health - PTSD, anxiety, depression and somatisation.** Overall, this study observed moderate to high negative correlations between the mental health disorders, PTSD, anxiety, depression, somatisation, and resilience and quality of life respectively. Similarly, resilience and quality of life were also moderately to highly correlated. Thus, the hypotheses that mental health problems would be negatively associated with resilience and quality of life and that resilience would increase with quality of life were supported (i.e., hypothesis 1, 2, and 3).
These findings contradict suggestions made in previous literature (Garmezy, 1991; Luthar, et al., 2000) that high resilience can be observed alongside high distress symptoms and that individuals. Whilst it may be that resilient individuals can in fact display successful coping in the presence of high negative and/or distressing emotions (Luthar, et al., 2000), the present findings suggest that resilience decreases alongside poorer mental health and increases alongside better perceived quality of life. That is, a poorer resilience can underscore mental health difficulties or mental health problems can deplete one’s resilience capabilities. Similarly, a lower resilience capability can make it harder to achieve greater quality of life or a lower quality of life can deplete resilience capabilities.

The present findings suggest that the resilience construct is relatively stable in terms of its relationship with traditional constructs of mental health disorder and quality of life. While often criticised in the literature for its a-theoretical and vague character, the present findings, which saw resilience operationalised using an ecological model, demonstrated its soundness as a valid criterion construct.

Notably, when subscales of resilience were examined, the community resilience sub-domain, although still significant, was less correlated with overall resilience than the other resilience subdomains. This could be explained by the ARQ-R’s early development and ongoing refinement as a measure. The ARQ-R was originally devised to capture neighbourhood/community resilience in terms of connectedness to an immediate neighbourhood or setting. It is possible that differences occurred in what the present sample classed as their immediate ‘neighbourhood’ and their ‘cultural community’, which might explain the lesser coherence between community and overall resilience compared to the other domains. Alternatively, the weaker relationship between community resilience and overall resilience could be due to the independence or uniqueness of community resilience (relative to other resilience domains) to overall resilience. That is, this construct, relative to the individual, family, peer, and school domains may have greater variation in what constitutes connectedness to a community, particularly a culture/ethnicity based community.

With regard to subscales of QoL, all domains (i.e., physical, psychological, social, and environmental) showed similar relationships with overall quality of life. Generally, as expected, significant relationships occurred across the cross section of
resilience and quality of life domains with all relationships in the moderate positive range. Of particular note, are the findings that community resilience did not significantly correlate with any of the quality of life domains; similarly, no resilience domains were significantly related to physical quality of life.

Regarding the first finding, it appears that community resilience has little bearing on quality of life experienced. Whether or not community connectedness is high or low, quality of life is not affected; likewise, whether one has a low or high quality of life, has little bearing on one’s connectedness to the community. This finding adds weight to the uniqueness of community resilience in that either all participants experience it similarly or that great variation exists in what is constituted by community resilience. Regarding the latter finding, it appears that physical quality of life has little bearing on one’s level of resilience. Given that young refugees in this sample have all experienced war torn conditions, it is possible that satisfaction with physical elements of life may have been compared or referenced with physical conditions in their home countries, thereby producing equivocal impacts on overall and individual domains of resilience.

Differences in low, moderate, and high disorder groups on resilience. In relation to the association between mental health disorder and resilience, inspection of resilience profiles in those with low, moderate, and high symptoms of disorder revealed a profile as expected. That is, lower resilience was associated with more psychological symptoms. Significance testing of these associations confirmed these observations for all disorders except PTSD. That is, irrespective of membership to a low, moderate, or high symptom group for PTSD, levels of resilience did not differ (i.e., resilience levels are similar irrespective of whether one has PTSD or not).

For anxiety, depression, and somatising disorder, however, significant differences in resilience scores were observed across low, moderate, and high groups. In relation to anxiety, lower and higher groups differed on individual, family, and peer resilience, suggesting the influence of family and peer resilience matter in terms of anxiety. It is uncertain why these resilient influences impact more on anxiety, but it may be the case that the family and peer group represent immediate forms of social support that might be readily accessed in the experience of high anxiety.
For depression, differences were observed between low and high groups across all resilience domains. This is not surprising given that depression constitutes the severe experiences of sadness and helplessness (Beck, Guth, Steer, & Ball, 1997; Beck, Steer, & Brown, 1996). Such symptoms are likely to affect every facet of one’s life and vice versa such that if one domain is affected, a snowballing of withdrawal from them all is more likely.

For somatisation, differences were also found in all resilience domains between the low, partial, and high somatisation groups. Since somatisation represents a general distress or ‘global’ symptomatology incorporating affective and anxiety symptoms (Kirmayer, 2001; Westermayer, et al., 1989), it is unsurprising that all resilience domains are affected and that all resilience domains should affect somatisation.

**Resilience predictors in PTSD, anxiety, depression and somatisation.** This study was particularly interested in the differential influences of resilience domains to predicting each of the four disorders. Predictive analyses revealed that the combination of individual, family, peer, school, and community resilience accounted for significant variance in scores on all measures of mental health (PTSD, anxiety, depression, and somatisation).

Regarding PTSD, community resilience was confirmed as an important unique factor in a model that considered each domain as important. That is, community resilience was central to predicting this disorder. This finding could be explained by the possibility that connectedness and belongingness to one’s community (or lack thereof) may directly influence one’s development and/or maintenance of PTSD symptoms. Given that trauma can be a collective experience (Alexander, Eyerman, Giesen, Smelser, & Sztompka, 2004), wherein whole cultures and communities are collectively perpetrated against, producing a traumatic psychological effect shared by the group, it is possible that such experiences within the group disabled the usual support mechanisms available to the individual to deal with the trauma. Likewise, if the community is functioning well despite trauma, then the individual may be likely to be better resourced for dealing with traumatic events. This explanation is not dissimilar to what is observed mostly through case studies, as the phenomenon of ‘collective or cultural trauma’ (Alexander, et al., 2004). Slowly becoming recognised
as a scientific phenomenon, collective or cultural trauma refers to the cultural experience of trauma where members of a collective feel they have been subjected to terrifying horrendous events leaving indelible marks on the groups consciousness, marking memories and changing future identities (Alexander, et al., 2004). When others in the collective are traumatised, there is greater likelihood of trauma ‘transmission’, which if long lasting, can impact significantly on new generations. While empirical research is growing to support this interpretation, ethnographically and anecdotally, the phenomenon is well supported (Alexander, et al., 2004). Given that community resilience did not appear as a unique factor in any other disorder, these findings emphasise the importance of going beyond individual experiences to include an understanding of the collective or cultural experience when analysing traumatic contexts and PTSD in refugees (Giacaman, Shannon, Saab, Arya, & Boyce, 2007).

With respect to anxiety, only peer resilience stood out as a significant unique factor in anxiety. This makes reasonable sense as anxiety can be driven by fears associated with perceived negative evaluations by others. For young people adjusting to a new life, such fears may be amplified through the absence of a supportive peer(s).

Similarly in terms of depression, individual resilience was a standout unique predictor of depression. This is not surprising since individual or internal factors such as negative cognition or poor self-esteem play a pivotal role in the onset and maintenance of depression. According to Gartland et al. (2011), one surprising finding in the development of the ARQ-R was the identification of a “negative cognition” factor in the individual resilience subscale. These items were intended to gauge deficits in self-efficacy, confidence as well as optimism/hope. It is possible that items from this measure then were picking up on such correlates of depression and therefore may explain why individual resilience had a unique impact on depression.

These authors made the point that such resilience indicators or negative items are not generally included in resilience measures as they generally assess the possession of a resource rather than a deficit (Gartland, et al., 2011). The unearthing of a negative cognition factor (subscale) in their study therefore addressed the sense of helplessness and lowered internal locus of control, usually seen in depression. By inadvertently measuring negative cognitions, the present study offers support to the idea that individual resilience impacts greatly on depression, potentially via the
mechanism of negative cognitions, sense of helplessness, and low internal locus of control. Of course, this explanation would require further testing to confirm why individual resilience exerts a unique effect in the presentation of depression in young refugees.

Regarding somatisation, individual resilience also stood out as a unique driver of somatisation symptoms. This could be suggestive of the overlap observed in depression and somatisation (seen in both the present and other research). It could also suggest that because physical symptoms, which are observed in somatisation, have a direct individual element to them. Hence, it is unsurprising that it would also play a key role in somatising symptoms.

In summary, while it is apparent that different components of resilience have differential impacts of different disorders, it is important to note that all elements are important in predicting mental health disorder. Although these findings require replication, they could be helpful in assisting clinicians prioritise areas to focus on in treatment planning (e.g., bolstering community supports in presentations of PTSD, or enhancing individual cognitions in treating depression).

**Differences in low, moderate and high groups of quality of life on resilience.** In exploring the role of resilience in mental health, it was of particular interest to examine its relationship with alternative mental health or psychosocial constructs such as quality of life. Mean score analyses of QoL groups (low, moderate, and high) revealed a consistent pattern of higher levels of resilience in those reporting higher QoL. This was a consistent pattern across all domains of resilience, except community resilience, where those with higher QoL actually reported lower levels of community resilience.

The general finding that higher levels of resilience are observed in those with higher reported QoL again, adds credibility to the soundness of the resilience construct. As was the case with its relationship with mental health disorders, resilience was observed in the expected direction in relation to QoL.

However, the finding that those reporting high QoL also tended to report lower levels of community resilience requires some interpretation. It could have been the case here that those with a higher QoL are engaged in aspects of life outside their own community and therefore experience, and report, higher QoL. The idea that
Community resilience may not be as important in producing a high QoL supports an integration model, whereby individuals who access support and resources from a range of spheres within society are more likely to have better QoL. That community resilience is low, may encourage one to seek out other avenues to support good quality of life, thereby relying less on their community for such support. Of course, a lower level of community resilience was pivotal in the development of PTSD, suggesting that the role of community resilience may be more complex in determining mental health outcomes.

The present study also revealed that young refuges with low, moderate or high quality of life did not differ in terms of their overall resilience and on four of the five resilience domains (only the low, moderate and high social QoL groups differed). Taken together, this suggests there may be factors outside resilience that are considered important or influential on one’s QoL. A lower or higher physical, psychological and overall quality of life might be determined for example by factors outside the individuals characteristics and resources, by which resilience is generally constituted. These factors could be tangible or material and could include access to health care, employment opportunities, etcetera.

There were however differences between low, moderate and high social quality of life groups across resilience domains. The MANOVA revealed significant differences in all resilience domains between low and high groups of social QoL, with exception to community resilience, where social QoL group membership did not differ in community resilience. That is, resilience in individual, family, peer, and school is higher in people with a high social quality of life. Community resilience, on the other hand, does not appear to differ with lower to high social QoL. While difficult to interpret this could suggest that community resilience is not required to have a high social QoL – so long as other factors are present, the specific refugee community is relatively less important.

**Resilience predictors in quality of life.** Predictive analyses investigating the influence of resilience factors on overall QoL showed that peer resilience was significantly unique in predicting quality of life. The uniqueness of peer resilience makes reasonable sense considering the role that peers have across a range of domains that are considered important in an adolescent or young person’s life. Because having stable peer relationships seems to improve quality of life substantially, bolstering peer
activities for young refugees remains an important endeavour. Nonetheless, given the previous analyses suggesting that having a higher QoL does not presume greater resilience, it would be prudent to be mindful of factors other than resilience that could be contributing to a higher QoL.

**Cultural differences in resilience.** Finally, this study found no significant effects for culture in overall resilience. Though the lack of difference between cultures could be explained by the possible constriction in sample size, they do nonetheless imply that culture does not impact on general resilience in young refugees.

By and large, few cultural differences were observed for separate resilience domains (i.e., individual, family, peer, school and community). However, this study did observe some cultural differences in both family resilience and peer resilience. That is, the Togolese group was higher than the Sudanese group in both family resilience and peer resilience; and that the Horn of African group was higher than the Karen group in peer resilience.

One explanation for the difference observed between the Togolese and Sudanese group in family and peer resilience, could be that Sudanese refugee families both in Australia and overseas are more fractured and separated, whereas the Togolese are be more intact as a refugee group. In this particular sample, the Togolese refugees largely migrated together with immediate or with extended family members. Additionally, a portion of this sample arrived in Australia on reunification visas suggesting that essential familial support was available immediately following migration. Although this does not explain the Togolese being higher on peer resilience than the Sudanese, it may be that peer support is more available to the Togolese as a result of the intactness of a ‘community’ of peers. That is, the Togolese group in this sample arrived in the same ‘migration wave’, which could explain greater opportunity to develop peer support. As the Togolese population in Australia is small and concentrated in single regional areas, opportunities to build familial, peer and cultural connections may enhance experiences and subsequent reporting of greater family and peer resilience. The ‘newness’ that comes with early resettlement could further enhance the need to foster such connections.

In contrast, the Sudanese diaspora is widespread and family and peer supports appear more fractured due to ensuing war, and therefore not so readily available.
Tribal division across the Sudanese refugees living in Australia could also discourage bonds between young Sudanese refugees living in Australia. These particular differences speak to the broader findings in this thesis that young Sudanese refugees appear to be a particularly vulnerable cultural group. In addition to displaying greater mental health difficulties, young Sudanese in this sample also demonstrate lowered family and peer resilience relative to other cultural groups studied.

The young Karen in this sample also demonstrated less peer resilience, particularly when compared to the Horn of African group. In addition to factors described in the last chapter, this might also be attributable to characteristics of the culture being ‘shyer’ or ‘quieter’ than other cultures. As will be seen in the qualitative study in the proceeding chapter, the Karen group in this sample described themselves as a ‘quiet’ people. Such cultural shyness may limit potential to develop peer resilience outside a cultural group, alongside reduced peers available from one’s own culture, thereby increasing the vulnerability of young Karen refugees.

In contrast, the Horn of African group reported higher peer resilience. This could represent the presence of a more available peer group, developed not only as a result of greater community ties but also opportunities to recruit friendships through the course of settlement. The young age at arrival among the Horn of African group gives further evidence for greater opportunities to consolidate peer relationships. Of course, the characteristics of the Horn of African culture, being a more “expressive” culture (see next chapter), may have contributed to the reporting of greater peer resilience. Moreover, as supported by the qualitative findings, the Karen young people in this study overwhelmingly reported a loss of friendships developed from childhood and within refugee camps, reporting longing and missing of aged peers. The unavailability of previously forged supports may have impacted on the perceived lower level of peer resiliencies.

Despite the differences observed above, highlighting the Sudanese and Karen as relatively more vulnerable groups, it is noted though that overall, there was little cultural variation observed among cultures in total resilience scores as well as the resilience domains. This could be indicative of the lack of power that comes with a smaller sample size, but may also be indicative of the heterogeneity of trauma experiences and responses within the sample, washing out any cultural effects on overall resilience.
Cultural differences in quality of life. In assessing the role of culture in overall quality of life, no statistically significant differences between the cultural groups were found. This suggests that being of a certain culture does not influence quality of life in Australia for young refugees. Exploring the individual subscales of quality of life domains however revealed cultural differences in physical quality of life. That is, the Togolese differed with each of the Horn of African, Sudanese, and Karen group, with the Togolese reporting better physical QoL across all cultural comparisons. The overall better reported physical quality of life among the Togolese group could be explained by a ‘honeymoon’ settlement effect. Given that the Togolese were still in resettlement phases of their migration journey, it is likely that services such as health care or even more general support are more accessible during these times, enabling a better perception of physical quality of life. Indeed, during this phase, is where most refugees receive initial settlement support (CMYI, 2002). The recency of Togolese arrivals may also have enabled a more recent comparison with conditions back home, which may have explained their greater assessments of physical quality of life relative to other cultures. Moreover, the Togolese in the present sample were resettled in a major regional centre in Victoria. It is plausible that this lifestyle could afford a better quality of life versus those resettled in densely populated metropolitan areas, again leading to greater perceptions about physical well being.

This factor is supported by the qualitative observations reported in a later chapter where it was noted that visitors would often frequent participants’ houses bearing material donations such as televisions, computers, and furniture. That is, the resettlement stage often brings heightened awareness among charities and communities which enacts support from a variety of sources. It is unknown whether the reduction or absence of this kind of ‘charity’ leads to poorer quality of life or other mental health outcomes.

Finally, despite the statistical finding showing there may be significant effects for culture in psychological quality of life, these differences were not significant when post hoc analyses were applied. Thus, like other domains of quality of life including social and environmental quality of life, there existed no differences between cultures on assessments of psychological quality of life.
Conclusions

Mostly, psychological studies with refugees have examined exposure to traumatic events, and subsequent post-traumatic stress reactions. This approach has provided a much needed and important understanding of the complex and sometimes severe mental health issues faced by young refugees. But the strong focus on trauma and mental health problems has unfortunately been unbalanced with an equally comprehensive understanding of positive adaptation in refugees. This thesis is important as it represents an attempt to address the gaps in knowledge about what effective responses and factors are associated with resilient outcomes for refugees. Additionally, it has attempted to determine whether resilient responses vary across cultures, which could then allow interventions based around promoting resilience to be tailored to certain cultures.

It is now generally accepted that not all individuals exposed to trauma go on to develop PTSD or other disorders (Perrin, Smith, & Yule, 2000). With respect to refugee populations, this awareness has led some researchers to explore positive concepts such as resilience, well-being, coping, and adaptation (Doron, 2005; Hooberman, Rosenfeld, Rasmussen, & Keller, 2010; Schweitzer, et al., 2007). However, the operationalisation of these constructs with refugees has been the subject of considerable methodological debate and criticism (Perrin, et al., 2000). By providing a clear, theory-related definition of resilience, the study reported in this chapter was able to shed some light on the question of the role that resilience plays in adaptive outcomes in young refugees who have experienced trauma.

Although measurement of resilience is still in early development stage and further psychometric testing required (Gartland, et al., 2011), it was evident that all the different forms of resilience are protective in offsetting mental health problems and contributing to quality of life. However, that for particular problems or outcomes, certain elements may be more protective than others (e.g., community resilience in PTSD or individual resilience in depression) and that depending on which disorder or outcome is assessed, different types of resilience are emphasised.

While cultural differences exist in part in resilience and quality of life, these differences might be more indicative of circumstances that surround transitions to resettlement and settlement and the likelihood that some refugee cultures may be
more fractured and vulnerable from war than others, than a difference in ‘culture’ per se. Nevertheless, the latter differences are still important to elucidate. Regarding these subgroups of cultures within already vulnerable populations, the Sudanese and the Karen appeared more vulnerable to resilience deficits and poorer quality of life outcomes than the Togolese or Horn of African groups. Mobilising additional supports to these cultures or to individuals who exhibit similar deficits could be worthy therapeutic endeavours.

Given the exploratory nature of this study, however, the findings remain subject to further examination and replication before their generalisability can be established. Nonetheless, this study has shown that important relationships exist between both negative and positive mental health factors, offering support for the need to see these factors together in the assessment of refugee well-being.

The study reported in this chapter has also shown that young refugees can bring a wealth of resources and strengths to help them offset or cope with mental health problems, alongside tasks of rebuilding a life of good quality. The construct of resilience in particular appears to be stable in terms of its expected relationships with mental health disorders and quality of life, warranting continued examination and validation of the construct.

Up to this point, this thesis has utilised traditional quantitative methodologies to investigate negative mental health, resilience and quality of life. Though it has shown that a balanced approach is needed to more broadly understand well-being and the refugee experience, one factor still lacking is a subjective investigation of the refugee experience and well-being. The next, and final, results chapter will therefore attempt to enrich this understanding through utilising a qualitative methodology to explore the ‘refugee experience’ and psychological well-being more holistically through the voices and narratives of young refugees themselves. Importantly, it will attempt to add to the understanding already gained from empirical methods through an elaboration of themes that intersect with negative mental health, resilience and life quality.
CHAPTER 9: A QUALITATIVE STUDY OF THE REFUGEE EXPERIENCE

Overview and introduction

Up to this point, this thesis along with much of the refugee literature has utilised quantitative techniques of enquiry to explore psychological well-being in a culturally diverse group of young refugees in Australia. Qualitative studies, which aim to explore symbolic interactions, individual narratives, and underlying meanings within the refugee experience, have been relatively few. The potential consequence of this lack of qualitative enquiry may be that information about the refugee experience is less than optimally understood in terms of context and meaning (Ungar, 2004).

The predominant framework for understanding the refugee experience has been the psychiatric epidemiology (or traumatology) approach. Criticisms of this approach, which range from broad philosophical disapproval to technical concerns (Tipping, 2010), were described earlier in this thesis (see Chapter 4) and therefore are only briefly mentioned here. First, an excessive focus on ‘psychopathology’ without consideration for cultural applicability can result in the de-contextualisation of refugees’ suffering and experiences. Moreover, it potentially reduces complex socio-political and historical experiences, individualising social suffering that occurs more accurately as a direct result of political violence (Tipping, 2010). Summerfield (2005) summarises these concerns cogently in his discussion of the over-medicalisation of trauma response and the over-readiness of imposing Western concepts to refugees.

Second, the psychiatric epidemiological approach is often criticised for inadequately assessing the multiple effects of sequential stressors. Refugees are not survivors of discrete events, but rather they experience a range of stressors that accumulate over pre-, peri- and post flight periods. Although the sequential or prolonged experiences of trauma is acknowledged in the upcoming DSM-V, advocates of qualitative approaches maintain that viewing pre-migration events as the primary determinants of distress detracts from the influence of post-migration stressors and internal characteristics on mental health and well-being. In this way, refugee experiences are cumulative and the trauma experienced is complex, influenced by pre-,
peri-, and post-migration factors - as well as internal and external factors, such as culturally determined attitudes and behaviours, previous skills, resettlement, etcetera (Tipping, 2010).

Third, psychiatric epidemiology is criticised for its methodology, which typically utilises one-off interviews that ask about trauma, sometimes inappropriately. This contrasts with that found in therapeutic settings which typically provide sufficient time to build trust and engagement with clients in discussions around trauma. Critics therefore maintain that the research model cannot properly and openly explore such issues without engagement that occurs over time. Moreover, because the psychiatric epidemiology approach often relies on clinical interviews, self-report measures and other psychometric tools, the causes or underlying reasons to psychological distress are often poorly understood (Tipping, 2010). The rationale for employing qualitative methodologies then, is that they address the criticisms levelled at the quantitative approach by providing the opportunity for developing a deeper understanding of the refugee experience.

The present chapter aims to deepen the understanding of psychological wellbeing in young refugees through a complementary qualitative methodology that obtains firsthand accounts of mental health and refugee experiences from pre- to post-migration phases. It begins with an introduction to qualitative and mixed methods enquiry before describing the methodological approach and method of the present study. The findings of the study reported as themes are then presented and discussed.

The qualitative approach to the refugee experience

Proponents of qualitative approaches propose that research with refugees shift from deficit models (where positive functioning is ignored) to strength based models. The previous chapter utilised a strength based understanding to explore resilience. The present chapter extends this by incorporating a qualitative perspective. Originally emerging with the world view associated with constructivism, qualitative methodologies in refugee research are increasing. These approaches tend to focus on psychosocial aspects, phenomenology, and subjective impacts of the refugee experience to help develop a broader understanding (Rubin & Rubin, 2005).

Qualitative research is defined as “situated activity that locates the observer in the
world. It consists of a set of interpretive, material practices that make the world visible….qualitative research involves an interpretive, naturalistic approach to the world (Denzin & Lincoln, 2000, p. 3).

Qualitative studies are exploratory, and generally use interviews or focus groups to develop an understanding and/or build theories based on patterns in the data (Rubin & Rubin, 2005). Findings derived from such methodologies therefore reflect one’s own experience as influenced by his/her belief systems, spiritual and cultural identity and experience. Miller and colleagues (2002) argue that a subjective or ‘narrative’ approach is most effective in capturing the “essentially historical and comparative aspects of the refugee experience…. as it emphasises the sequential or temporal description and evaluation of experience” (Miller, Worthington, et al., 2002, p. 342).

Narratives facilitate the sequencing of specific life experiences (e.g., encounters with discrimination following persecution), and an understanding of the significance of these experiences to an individual in relation to the overall experience of meaningful existence (Tipping, 2010). There is clear acknowledgement in the refugee literature that narrative perspectives are of value (e.g., Berman, 1997; Berman, 2000; Khawaja, et al., 2008; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005; Miller, Worthington, et al., 2002; Neuner, et al., 2004; Punamäki, Ali, Ismahil, & Nuutinen, 2005). Hence, qualitative methodologies represent an ideal way to provide an understanding of refugee experiences from a transcultural perspective and from the point of view of the participant, complemented by the observations of the researcher.

Refugee studies utilising the qualitative approach

Relative to quantitative studies, few studies have invited young refugees to be informants of their own experiences, particularly regarding concepts of mental health/psychosocial well being (Crivello, 2008; McCarthy & Marks, 2010). One widely cited study by Whittaker et al. (2005) used Interpretative Phenomenological Analysis (IPA) with their interview data to explore individual and collective understandings of psychological well-being in young Somali refugee and asylum-seeker women in the United Kingdom. A sense of coping and moving forward with life featured centrally in understandings of psychological well-being. This included dealing with emotions
quickly, not dwelling on problems, being strong, and getting on with life. Family and community were seen as important sources of support that could help during difficult situations, although sometimes trust was an issue. Internally drawn religion (as opposed to ritual and religious practice) and services for providing support also featured as strong supports. Themes of identity also featured prominently in psychological well being, as well as conflicts between cultures and acculturation experiences.

In another commonly cited study by Guerin, Guerin, Diiriye, and Yates (2004) that investigated concepts of mental health and illness among Somali refugees resettled in New Zealand, there was overlap in Somali ideas of mental health and Western classifications, particularly in relation to conceptions of schizophrenia and mild or moderate depression or anxiety. Two themes emerged: (i) severe mental illnesses (e.g., schizophrenia) encompassed ideas of madness or spirit/ghost possession; and (ii) mental health as related to social or situational issues, in contrast to individualistic concepts seen from a Western perspective (Guerin, et al., 2004). Concepts of depression, anxiety, and PTSD were unknown in the Somali community (Guerin et al., 2004, p. 61). For example, few Somali considered war-related trauma as the direct cause of their problems, instead citing reunifying their families or other resettlement stressors as being the direct causes (Guerin, et al., 2004). These two studies highlight that the context in which mental health is understood for refugees can vary in terms of internal, social, and familial influences across both causation as well as coping.

Regarding an Australian context, Khawaja et al. (2008) explored coping across the three migratory stages in adult male and female Sudanese refugees. Coping strategies with difficulties cited across these three stages included the use of religious beliefs, social support networks, and cognitive strategies to reframe beliefs about inner strength and acceptance of their situations and circumstances, and articulating their wishes and aspirations for the future. Similarly, Schweitzer et al. (2007) found that religious beliefs, social support, personal qualities such as a fighting attitude, and less so, comparing one self’s situations to other were most important in coping with difficulties associated with war time and settlement experiences. Participants in both these studies comprised adults; a comprehensive youth study concerning well being and coping in different cultures has not yet been conducted. However, some preliminary information is provided in the study by Correa-Velez et al. (2010) who
explored predictors in subjective wellbeing among young refugees settled over three years in Australia. Subjective social status in the host community, discrimination, and bullying were significant in predicting subjective outcomes of well being.

Towards a mixed methods approach to the refugee experience

Qualitative approaches sit across numerous fields, disciplines, and subject matters, but common to all is that they take an emic (insider) perspective, contrary to an etic (outsider) perspective (De Jong & Van Ommeren, 2002; Phan & Silove, 1997). Although, pure qualitative methodologists argue that proving legitimacy is not a challenge for qualitative research (Summerfield, 1999), emic perspectives are not widely acknowledged in the scientific literature on refugees mainly because of the perceived lack of rigour in exploring ‘subjective’ matter.

One way to address the challenge of assuring rigour is the adoption of a mixed methods approach (De Jong & Van Ommeren, 2002; Tempany, 2009). Traditionally distinctions are drawn between quantitative and qualitative approaches, where the former emphasise objective measurement and casual relationships between variables (not processes), and the latter emphasises the socially constructed nature of reality, situational constraints, and the relationship between the researcher. There is danger, however, in viewing the approaches as a dichotomy, as in many cases, such as content analysis, qualitative methodologies share more overlap with quantitative ones (Marvasti, 2004).

Ahearn (2000) also proposed that where the method of data collection and the type of data collected is linked, the weaknesses of one approach are complemented with the strength of another. This combination of practices, empirical materials and different perspectives is a technique used to improve rigour, depth, and understanding to any given phenomenon (De Jong & Van Ommeren, 2002; Tipping, 2010).

Despite the value of a contextualised understanding which is emphasised by much of the literature in social work, critical psychology, medical anthropology, and psychiatry and medicine (Ungar, et al., 2005), mixed-method studies exploring refugee mental health are infrequent. To date, there has not been a mixed method study that has explored cross cultural comparison of refugee mental health. This chapter describes the
third substantive results chapter of this thesis, and the second part of the mixed methodology (qualitative study) aimed at exploring refugee youth mental health.

**Aims**

The qualitative study described in this chapter had the following aims:

1. To gain a contextualised understanding of psychological well-being and the refugee experience through participants’ own narratives on mental health, well-being, and resilience across the pre-, peri-, and post-migration phases.

2. As culture was expected to influence perceptions and responses, a further aim was to explore cultural differences in young refugees’ narratives around mental health, well-being, and resilience across the pre-, peri-, and post-migration phases.

3. In keeping with the principles of participatory action research, often advised for youths (CMY, 2005), a further aim was to explore the psychological needs and potential solutions as seen by young refugees themselves.

**Method**

The overarching methodology of this thesis was described in Chapter 5. This section outlines the qualitative aspects of the broader mixed methodology in greater detail, designed to complement the previous quantitative studies described in Chapter 7 and 8. This part of the mixed methodology utilised in-depth individual and group interviews, complemented by researcher observation. The subjective nature of issues explored could not rely exclusively on fixed interview structures. Therefore, while a semi-structured interview was used in the individual and group interviews, an iterative qualitative process was applied.

**Participants.** All participants who took part in the quantitative component of this study were invited to participate in individual and focus group interviews. Of the 82 participants recruited to the study, 51 (62%) consented to individual interviews and
focus group interviews. The number of males and females and their ages, categorised by cultural group are shown in Table 27. All participants were refugees and had experienced at least one war related trauma. Most lived in the western regions of Melbourne or were living in Victorian regional areas. All participants held at least a basic level of conversational English and most were either engaged in labouring/factory work, schooling including, secondary school, TAFE/university, or English language classes. All participants either though themselves or an interpreter were emotionally and intellectually capable of verbal reflection. As described in Chapter 5, they were recruited with the assistance of community elders and leaders.

Table 27.
**General demographic characteristics of qualitative study interviewees (N=51).**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Horn of African (n=11*)</th>
<th>Sudanese (n=10)</th>
<th>Togolese (n=15)</th>
<th>Karen State (n=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>15</td>
<td>16</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
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<td>21</td>
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</tr>
<tr>
<td>Mean age in years</td>
<td>17.5</td>
<td>17.85</td>
<td>21.16</td>
<td>18.75</td>
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<td></td>
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<td>16.1</td>
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</table>

*One participant from HoA declined recording but permitted note taking.

**Measures and Procedure - Individual and focus group interviews.** Prior to commencing the focus group and individual interviews, a semi-structured interview schedule was developed (see Table 28 or Appendix G for interview schedule). The schedule aimed to elicit responses that characterised participants’ experiences at three stages of the refugee experience – pre-migration, peri-migration, and post-migration. This broad transitional approach was taken to maintain consistency in the theoretical
approach to this thesis (i.e., transitory and ecological perspective of refugee experiences). The interview schedule incorporated open-ended questions, though it was designed to be flexible so that responses could be clarified and follow-up questions to be asked where appropriate. The interview schedule was designed by the researcher, as informed by a literature and subjected to adaption and review through the supervision process and community leader/elder consultation process.

The interview schedule was divided into two parts – a group part and an individual part. The group part of the schedule contained questions that were not specifically related to traumatic event exposure and more personal experiences of the individual, but rather, related to their experiences generally as a refugee through the three migratory stages. The individual part of the interview schedule was designed to be administered after the group questions, with individuals themselves, so as to provide opportunities for them to expand on group responses and to talk in private about their personal journeys (see Table 28 for individual interview questions; also seen in Appendix G, Part 2 and Part 5).

The developed interview schedule was given to community leaders prior to administration to assess appropriateness for a given culture. This also provided an opportunity for the researcher to gain feedback on the presentation and content of the interview from a cultural perspective. Aside from the adaptation of questions to ensure greater simplicity and clarity, no major amendments were made to the questionnaire and interview questions remained similar across the cultural groups. Interviews were organised with the assistance of community representatives or cultural liaisons, usually selected by a community leader/elder. In some instances, the community leaders acted themselves as the cultural liaisons. Cultural liaisons were briefed about the study and assisted with the recruitment of participants by providing information about the research and directing queries about the study to the researcher. Liaisons were instructed to emphasise that participation was entirely voluntary and that individuals could withdraw from the study at any time. Cultural liaisons helped to organise dates and times for interviews to take place and met the researcher and her assistant (final year psychology student) with prospective participants. In other cases, participants self-referred to the study through the snowballing technique or by seeing information flyers about the study. Help to recruit participants was also obtained from the
researcher’s contacts, who were professionals working and experienced in the fields of youth or refugee mental health.

Interviews were conducted at the organisation’s premises or affiliated premises (e.g., church house, meeting rooms at public housing estates, non-government organisations). During each interview session, a cultural liaison was available, and where paid qualified interpreters could not be found, acted with the consent of participants as interpreters. Each focus group comprised 4-5 participants. Each focus group was led by the researcher and/or her assistant. Every attempt was made to ensure a balanced gender and age distribution across focus groups, though all groups were kept culturally homogeneous. This was thought to be appropriate given language constraints as well as cultural familiarity. Such a design also helped to achieve the aims of exploring cultural differences at a more detailed homogenous level.

Prior to commencing the focus group interviews, participants were briefed about the aims as well as any potential benefits of the study and assured confidentiality (in the absence of disclosure of self-harm/threat to other). They were also taken through the Plain Language Statement and Consent Forms. For participants under 18 years of age, a plain language statement was also provided to caregivers, in order to assist their understanding of the study aims; management of the information shared with the investigator; and the participants’ or their right to withdraw their child at any time from the study. In most cases, participants were given the plain language statement and consent forms prior to the testing session so they could think about their participation, or discuss their participation with families if desired or necessary. This process did not replace the formal administration of the plain language statement and consent forms however, which occurred just prior to the interviews being conducted.

In addition to explaining the study and participants’ rights, the briefing sessions were also aimed at engaging participants to the research through promoting trust and rapport. Just prior to beginning the interviews, a rapport building exercise was conducted (e.g., sharing something about our hobbies, aspirations). Participants were encouraged to be open, and were informed that no right or wrong answers could be made, and that responses would have no bearing to migration status or capacity to receive services. To enhance cultural sensitivity, participants were informed they did not have to answer certain questions if they did not wish to.
Most participants were given the choice to participate in either or both the focus group and individual interview and the majority who took part in the focus group interviews, also participated in the follow up individual interviews. Follow up individual interviews were conducted in a closed interview space (e.g., another room). The focus of the interviews was on the refugee experience through phases of pre-, peri- and post-migration, emphasising mental health experiences, resilience, quality of life, and refugee needs.

A total of nine focus groups were held (3 with HoA; 4 with Karen, and 2 with Sudanese), each lasting approximately ninety minutes. Each individual interview took approximately 20 minutes to complete. It is noted that interviews with the Togolese participants were completed mostly on an individual or informal small group basis (e.g., with a sibship or small friendship group) within a participant’s home, as was preferred by the participants and community liaisons and leaders. Reasons for this approach included the lack of transportation among the more recently arrived Togolese and the dispersion of the community across a regional centre in Victoria. Focus groups with Togolose participants were conducted in similar formats to that described for other cultural communities, and the individual interview schedule was conducted one-on-one in a separate room or in the absence of other group or family member. Some Togolese participants expressed a desire for a family member (e.g., a parent) to be present during the interview and this was accommodated.

All interviews were completed in English, with some assistance from an interpreter when required. Most participants did not request interpreters, perhaps because of length of time lived in and acculturation to Australia, or in part due to reluctance to ask for an interpreter given a lack of confidence in English and asking for help. This may have been especially the case in the presence of peers who appeared competent at English. Those who utilised interpreters tended to have a shorter residence in Australia (e.g., less than one or two years). Interpreters were used in instances where it was necessary to convey complex concepts either by the researcher or the participants.

All interviews were audio recorded for transcribing purposes, but participants could decline the audio recording if that was their wish. Clarifying questions and active reflective listening were used throughout the interviews and participants were encouraged to give feedback about being involved in the research.
All participants who consented to the study, whether they partially or fully completed the interviews were given a $40 supermarket gift voucher to compensate them for their travel and time in partaking in the interviews. At the end of the interviews, the researcher informed participants that an invitation would be made to return to a sitting at a later date to corroborate themes derived from the interviews/narratives. All participants agreed to this, and approximately 40% attended these follow up ‘sittings’ or debriefing sessions. Participants were also given the contact details of the researcher if they had follow up questions or queries and told they could access their interview transcripts if desired by contacting the researcher.
Table 28. 
*Interview schedule used for focus group and individual interviews (Karen cultural group used as example).*

<table>
<thead>
<tr>
<th>Migration period of interest</th>
<th>Focus Group Questions</th>
<th>Individual Interview Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-and peri-migration experiences</td>
<td>1. Tell me about the good things about life <em>before you came to Australia</em> (eg. in your home country, another country or the refugee camp).</td>
<td>1. Tell me about your story – (eg. what brought you to Australia?; what are your experiences as a refugee/asylum seeker?, what was involved in your journey to Australia?)</td>
</tr>
<tr>
<td>Pre-and peri-migration experiences</td>
<td>2. Tell me about the bad things about life <em>before you came to Australia</em> (eg. in your home country, another country or the refugee camp).</td>
<td>2. How do you think your experiences as a refugee have affected you? (for example, how has it affected your mental health? or your physical health? or how does your culture influence your mental health and well-being? Or what are your biggest problems at the moment?)</td>
</tr>
<tr>
<td>Post-migration experiences</td>
<td>3. Tell me about the good things about <em>living in Australia</em>.</td>
<td></td>
</tr>
<tr>
<td>Post-migration experiences</td>
<td>4. Tell me about the bad things about <em>living in Australia</em>.</td>
<td></td>
</tr>
<tr>
<td>Post-migration experiences</td>
<td>5. What do you think are the biggest problems for Karen [or Sudanese/Togolese/HoA] people in Australia?</td>
<td></td>
</tr>
<tr>
<td>Pre-, peri- and post-migration experiences, and mental health</td>
<td>6. When Karen [or Sudanese/Togolese/HoA] people feel sad, what’s that like? When they feel troubled, what’s that like? What does the word mental health or mental problem mean to Karen [or Sudanese/Togolese/HoA] people?</td>
<td></td>
</tr>
<tr>
<td>Pre-, peri- and post-migration experiences, mental health and resilience</td>
<td>7. Is there anything that helps Karen [or Sudanese/Togolese/HoA] people to cope with problems such as feeling sad, scared or troubled? How do Karen [or Sudanese/Togolese/HoA] people cope when they are troubled? (eg. talk to other friends, talk to my family, rely on myself).</td>
<td></td>
</tr>
<tr>
<td>Pre-, peri- and post-migration experiences, resilience and quality of life</td>
<td>8. “What do you, your family and other people from your culture do to stay healthy mentally (in your mind), physically, emotionally or spiritually (in your heart)?” (eg. playing sports, belonging to a club, your church).</td>
<td></td>
</tr>
<tr>
<td>Pre-, peri- and post-migration experiences, mental health, resilience, quality of life and needs</td>
<td>9. What do you think people need to know to be able to help refugees or Karen [or Sudanese/Togolese/HoA] people? (eg. how can people who work with refugees/Karen [or Sudanese/Togolese/HoA] people help?, how can things improve for refugees and Karen [or Sudanese/Togolese/HoA] people?, how can we help Karen [or Sudanese/Togolese/HoA] people who feel sad or scared?)</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous or culture specific</td>
<td>10. Is there anything that I have missed but you would like to tell me about or share?</td>
<td></td>
</tr>
</tbody>
</table>
Ethical considerations in the conduct of focus group and interviews

The present study posed a number of ethical considerations. First, it was important to acknowledge that in obtaining consent, participants may have felt compelled to complete the interviews, despite wanting to stop. The researcher was aware that the circumstances (e.g., formality) of the research process may have provided social expectations for compliance. Care was taken therefore to ensure that participants and their families fully understood and agreed to what would happen and how their information would be handled.

Second, it was clear from early consultations with community leaders and elders that confidentiality and safety needed to be assured. By soliciting individual and personal stories through the focus groups and individual interviews, care was taken by the researcher and her assistant to attend to the challenges posed by personal disclosure. As individuals were highly exposed to war and possible mistrust of authority, it was important in this study to emphasise the voluntary nature of participation and the options for withdrawal from the study. As there was likelihood for discussing traumatic experiences, it was also necessary to inform participants where they could go for support as well as whom they could go to discuss their treatment through the research.

All participants in the research were briefed before the focus groups about the naturalness of distress when talking about trauma and upsetting events, and pathways for support were provided (e.g., through their community organisation, through direct referral). Information pamphlets in English and relevant language translations were provided to all participants for Foundation House – a support organisation for refugees and asylum seekers experiencing emotional problems. Participants were also informed that throughout the interviews, if they became upset, they could pause, postpone, reschedule, or terminate interview. Although the researcher is a psychologist with experience in trauma, it was important to utilise these skills for the purposes of facilitating referral in cases where participants became distressed rather than providing direct counselling. This ensured that a dual role was avoided and that participants were aware they were engaging in a research project and not
psychological counselling. The limits of confidentiality were also discussed with participants. Of course, this was a difficult boundary to implement given that trust had been built over a number of months (sometimes a year) with participants and in some instances their families.

Third, it was important for the researcher to allow participants to consider the benefits (or not) of participation. Some communities approached in this thesis had histories of being “over interviewed”. It was therefore important to make clear how information was going to be used, interpreted, and who would have ownership of results. Moreover, it was important for the researcher to consider, what benefits might be brought to the community as a result of participants taking part in this study. Although participants were compensated for their time with supermarket gift vouchers, it was necessary to consider what could be tangibly and intangibly offered. To this effect, interviews were framed in context of sharing stories to promote understanding. Care was taken to ensure that assurances were not made regarding counselling, job seeking, and migration status etcetera.

Some organisations expressed concerns that there may be expectations that could not be fulfilled by the research, such as “solving their problems”, “or assisting with employment opportunities”. Explaining what benefits there may or may not be to partaking in the research was therefore helpful. Through consultation with leaders and elders, it was agreed that participants would be informed that whilst the research could not assist with job seeking, migration status etcetera, benefits that could be met included a chance to tell their story, that facilitation to counselling services could be provided if necessary, and the results be returned to the community to be shared with leaders and decision makers in the community. Thus, preliminary themes arising from the focus groups were fed back to communities through a series of feedback and debriefing sessions with each community. These sessions were important interactive sessions that allowed leaders/elders to comment on the findings and discuss the implications for their communities.

Fourth, it was also apparent through conducting the focus group and individual interviews, the important role that elders and community leaders held not only as ‘gatekeepers’ to a vulnerable community, but also as a resource to individuals of that community. In this sense, participants appeared comfortable, if not more so, with their presence at times throughout the interviews. Indeed, where they met inclusion criteria,
many leaders offered their participation – this modelling rather than appearing coercive was helpful and supportive to participants.

Implicit within all of these challenges was the need for cross cultural sensitivity. It was important to be respectful and sensitive to the customs, values and beliefs of the different cultures worked with through this thesis. Care was taken to establish trust and accessibility to the community. In order to establish these, the researcher engaged in multiple meetings with individuals and communities to establish rapport before even discussing research, attending sports matches, travelling to homes to meet with entire and extended families, sharing food and beverages, and demonstrating an interest in customs, beliefs, and traditions. These activities allowed the researcher to gain further insight to the experiences of young refugees, but also encouraged a collaborative, open, and trustful relationship with them.

Finally and not often discussed in refugee mental health literature, the process of ‘disengagement’ was as important, if not more, as the process of engagement. A healthy boundary and balance with researcher time was therefore important to establish from the outset, and clear guides about what and could not be provided by the research was also important to convey. In disengaging, the researcher ensured that contact was maintained with leaders in the post data collection phase, and that debriefing sessions were held and email updates provided at spaced out times through the post data period. The researcher also availed herself to contact in the post research period, until the need for contact dissipated. At this time, although ties with the communities are still robust, contact is less frequent and more ad hoc, and less related to the research per se.

Results

Data analyses: The Thematic Analysis (TA) method. For the analysis of data (i.e., interview transcript data, focus group transcript data, research journal, field notes, and observation), an ethnographic approach was employed using the specific method of Thematic Analysis (TA). Created by Braun and Clarke (2006), TA is a foundational research method used in qualitative research to identify, examine and extract patterns and common meaning from text (Braun & Clarke, 2006). The text is coded and corroborated according to a developed coding scheme (Tipping, 2010).
The TA method for data analysis was chosen because it can be applied flexibly across a range of theoretical and epistemological approaches. This is contrasted with other techniques considered in this thesis such as conversational analysis (CA) (Sacks, 1972; Sacks, Schegloff, & Jefferson, 1974) or interpretative phenomenological analysis (IPA) (Smith, Jarman, & Osborn, 1999) which often rely on a particular theoretical or epistemological position. Additionally, the TA method is compatible with aspects of this thesis in that it is accessible to researchers developing skills in qualitative analysis, it is consistent with a participatory research paradigm, and it is capable of summarising key features from large datasets (Braun & Clarke, 2006).

Moreover, this method is consistent with the British Psychological Society’s guidelines for the assessment of the quality of qualitative research, designed to improve if not parallel the ‘rigour’ seen in many quantitative studies (see Elliott, Fischer, & Rennie, 1999). That is, the methodology is designed to meet the expectations around level of detail deemed appropriate in the transcribing process; level of consistency and coherency around themes; appropriateness and recursive cross referencing of data items with other data items and the overall data set; and the level of active participation required by the researcher. Finally, the TA method was chosen for its suitable and successful use in cross cultural explorations (Hoban & Liamputtong, 2012; Liamputtong, Haritavorn, & Kiatying-Angsulee, 2012) and young refugee populations (McCarthy & Marks, 2010). The TA process consists of six phases which are summarised in Table 29.
Table 29.
*Summary of Braun and Clarke’s (2006) six phase method for conducting thematic analysis (TA)*.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Data familiarisation</td>
<td>a. Data is transcribed verbatim</td>
</tr>
<tr>
<td></td>
<td>b. Transcripts are read</td>
</tr>
<tr>
<td></td>
<td>c. Transcripts are re-read</td>
</tr>
<tr>
<td></td>
<td>d. General ideas are noted</td>
</tr>
<tr>
<td>2. Generation of initial codes</td>
<td>a. Interesting features in the entire data set are coded</td>
</tr>
<tr>
<td></td>
<td>b. Data relevant to each code is collated</td>
</tr>
<tr>
<td>3. Theme search</td>
<td>a. Codes are collated into potential themes</td>
</tr>
<tr>
<td></td>
<td>b. All data relevant to potential themes is gathered</td>
</tr>
<tr>
<td>4. Review of themes</td>
<td>a. Themes in relation to coded extracts and data set are checked</td>
</tr>
<tr>
<td></td>
<td>b. A thematic map is generated</td>
</tr>
<tr>
<td>5. Naming and defining of themes</td>
<td>a. Ongoing analysis for refinement of themes and overall story</td>
</tr>
<tr>
<td></td>
<td>b. Generation of clear definitions and names for each theme</td>
</tr>
<tr>
<td>6. Production of manuscript</td>
<td>a. Vivid compelling extracts are selected</td>
</tr>
<tr>
<td></td>
<td>b. Selected extracts are finalised</td>
</tr>
<tr>
<td></td>
<td>c. Themes and overall story are related back to research questions and the literature</td>
</tr>
</tbody>
</table>

During Phase 1 of TA, data are transcribed orthographically by the researcher, and the transcripts are read and re-read for the detection of early meanings and patterns. Ideas are noted in preparation for coding in subsequent phases. In this thesis, Microsoft Word was used by the researcher to transcribe verbatim the individual and focus group interviews. All identifying information was removed from the transcripts. Individual and focus group data were collapsed to create one large dataset.

During phase 2 of TA, a list of initial codes is generated to systematically organise the dataset into meaningful groups (Braun & Clarke, 2006). Interesting features of the data are coded and often refer to elements of the data that are repeated and that can be accessed in a meaningful way. Codes can contain either semantic or
latent content. Text extracts can double up across different themes, so that extracts can be encoded, coded once or many times. Accounts that depart from the dominant story are also included at this stage. Coding of data is either ‘data driven’ (themes are dependent on data) or ‘theoretically driven’ (coding occurs around specific questions that the researcher is answering) (Braun & Clarke, 2006). The process of coding can be manual or through specifically designed software programs such as Nvivo or Atlas.ti.

Although software packages for analysing qualitative data were considered in this thesis, it was decided after consultation with experienced software users to analyse data manually without the aid of these packages. The primary reason for doing so was so the researcher could give full and equal attention to each data item in the analysis of constructs and development of themes. Text and extracts were therefore organised and coded using copy, cut, and paste functions in Microsoft Word, alongside coloured text and highlighting. Coding occurred using a combination of data driven and theoretically driven methods. Although not outlined by Braun and Clarke (2006), the present thesis used an independent research assistant to code approximately 20% of the transcripts to help ensure inter-coding reliability. An agreement rate of .80 was obtained.

During phase 3 of TA, data extracts that are relevant to codes are collated and the codes are organised into potential broader themes (Braun & Clarke, 2006). Visual representations (e.g., tables, mind maps, organising pieces of paper into piles) can be used to sort different codes into themes. Codes can take the form of themes themselves, form subthemes or be discarded. This phase results in a number of initial themes and sub-themes, whereby all data points are coded (Braun & Clarke, 2006). In the present thesis, the prevalence of a theme was not dependent on quantifiable measures (e.g., “50% prevalence of a pattern) but on whether it depicted something important to the overall research question and whether it characterised some level of patterned response or meaning within the dataset (Braun & Clarke, 2006). Thus, a theme might be counted at the level of the individual data item or determined by the number of speakers who articulated the theme.

During phase 4 of TA, themes are checked in relation to the coded extracts and the data set as a whole (Braun & Clarke, 2006). Some initial themes may be discarded, while others can be collapsed or broken down again. Data within themes
are checked for coherency with the themes. Each theme is then contrasted with other themes to clarify identified distinctions or overlap. This phase results in an understanding of how themes fit together, or how they may be discordant. An overall ‘story’ which is told by the themes is also achieved (Braun & Clarke, 2006).

During phase 5 of TA, refinement of themes is continued and definitions and labels for themes and subthemes are produced (Braun & Clarke, 2006). Collated extracts are organised into internally consistent accounts that are accompanied by a narrative. A ‘story’ is derived for each theme and each theme is reconsidered in terms of its ‘fit’ with the ‘overall story’ that the data tells in relation to the research question.

During phase 6 of TA, compelling extract examples (e.g., quotes) are selected and finalised to provide support and sufficient evidence to demonstrate the prevalence of a theme (Braun & Clarke, 2006). Although not outlined by Braun and Clarke (2006), the present thesis included the additional step of presenting the themes back to a sample of participants (all interviewees were invited to attend this session, but not all chose to do so). This was to ensure that themes were as close to the original narrative as possible. Themes were accepted by participants and community leaders/elders.

**The researcher as an active participant observer.** Implicit in a positivist paradigm is that the relationship between the researcher and ‘subject’ is unbiased by personal values or interactions between them (Tipping, 2010). In contrast, the qualitative approach views the relational aspect as necessary in bringing in the element of subjectivity, wherein the participant is viewed as the expert and the researcher is viewed as an agent of change who will unavoidably shape the findings. The qualitative process therefore demands a degree of reflexivity or critical reflection on oneself as researcher, the relationship between the researcher and participant, and the research process itself (Tipping, 2010).

To enhance this qualitative process, a research journal was maintained through the duration of this thesis, though its contents pertained mostly to the current study. The journal contained reflections from reading materials, meetings with supervisors, peers and consultants to the project (e.g., cultural leader) as well as from the focus groups and individual interviews themselves. Observations and field notes were also recorded in the thesis journal to capture the naturalistic context in which participants
were interviewed (e.g., their immediate environment) as well as the broader context in which their stories were being told.

The thesis journal documented some varied cultural observations. Among the HoA young people, there appeared an instant openness and exuberance in reporting emotions and opinions about matters raised with them. Most of the young HoA turned up much later than the scheduled time for their interviews and concepts and time appeared abundant for them, with many happy to continue talking about their experiences. Most participants did not feel shy to talk about their experiences in Australia and were lively in their descriptions and responses, particularly the females. The young HoAs interviewed were resourceful, and able to mobilise support from one another during interviews when required. A sense of camaraderie was observed; although many were not friends, living closely in the housing estates assured a sense of familiarity and comfort with one another. Some were married, already with their own children who were present during the interviews. When impressions were discussed with leaders, they indicated this was not surprising. They described a culture changing over time from initially arriving with limited confidence, to now being able to mobilise supports and services, with the advantage of learning from each other and previous refugee cohorts. The leaders contrasted this with other less established communities.

This was not to replace the losses that these young people had endured however. Many lost their fathers at a young age and were living with their mothers and siblings and some were old enough to report windows of memories of their war time experiences. Notwithstanding these losses and the personal stories of war, the HoA young people were keen to display confidence, and sense of moving forward with opportunities in the West. Females were keen to express their fashion, most choosing not to wear traditional Islamic clothing, despite their strong held views on religion and pride in their Islamic heritage and culture. Both males and females strongly identified with popular Western culture (e.g., preferred an informal interview setting with rap music, eating pizza). For many HoA participants, time and distance from their countries of birth left them with few memories and memories lacking in detail.

Similarly, the Sudanese participants were also enthusiastic in responding to questions compared with other cultural groups. They displayed more openness and
detail when talking about their homeland situations, the Sudanese diaspora, and their own mental health. They were keen to especially draw links between their diaspora and negative mental health symptomatology. Speaking of returning to Sudan was prominent in almost all casual conversations. The Sudanese were an extremely diverse group, with multiple ethnicities, languages, and religions observed. Prior to Australia, most had lived with parents, though after arrival, they lived with other relatives reflecting the number of parents lost through death or separation.

The openness of the Horn of African and Sudanese participants was contrasted to the Karen participants, who although were keen to participate in the research, were reserved and modest through the focus group interviews. Compared to other cultures observed, more time was spent engaging young Karen participants, alongside greater prompting in obtaining responses. It was surprising to the researcher (given leader expectations information would not be forthcoming), however, that over time, reservations in talking appeared to lift and an unexpected openness was observed. The Karen participants appeared to avail more help to each more often than other cultural groups, often translating for each other, assisting, or speaking for one another. Males took the lead more in focus groups, although females tended to dominate when talking about emotions.

The informal nature of interviews with the Togolese participants allowed the researcher to observe participants in their natural Australian environments. The Togolese community is settled in regional Victoria and many were living in rented accommodation such as Edwardian houses. Many were living with extended relatives reflecting the prominence of family re-unification processes among this group. It was noted that relatives among this group tended to arrive at separate times to Australia and thus, separation from families was not only frequent, but re-union, if it occurred, was also broken up. Many Togolese said they felt cold in Australia, even during the summer, having come from Togo where the temperature can be intense. This was often evidenced by heaters being turned on high in houses. These noticeable changes in living highlighted stark contrasts in the pre-migration and post-migration environment. Relative to other cultures studied in this thesis, the Togolese demonstrated remarkable enthusiasm for their new lives in Australia. The majority of participants and their families expressed overwhelming happiness at having resettled in Australia.
Naturally, the Togolese were less versed in English than other cultures and a cultural liaison was used to assist with interpreting, in the absence of any formal availability of translators of Ewe. As with other participants with more limited English, these participants were less expressive. Despite this, many young people did not need interpreters and were happy to proceed with interviews on their own. There was immediate friendliness, smiling and warmth and families were accommodating, frequently offering food and coffee. It was evident that families stayed together often, displaying a sense of togetherness, and when interviewed young people preferred to have their parents present. They also preferred to be interviewed with their siblings where possible. In some families, the young females were relatively reserved, often allowing male members to speak on their behalf. Nevertheless, the Togolese females overall tended to speak as much as females from other cultures studies.

Overall observations of overt happiness seemed to match the expressions of hope in the Togolese participants, which is consistent with the experience of peace and safety at first arrival to a settlement country. Alternatively, it was observed that this could have reflected in part a reluctance to speak trustfully with the researcher about their experiences. A few families noted feeling unsafe and threatened as a result of racist remarks from neighbours. This tended to keep them inside, and sometimes with blinds and curtains closed.

**Emergent themes**

Transcribed individual and focus group data were examined together for themes. The following section presents the main findings (themes) drawn from the transcribed interview data. Data extracts (quotes) will be used to illustrate the emergent themes. A summary of the main themes is presented in Table 30.
Table 30.

Summary of themes derived from qualitative analysis of transcript data from individual and focus group interviews.

<table>
<thead>
<tr>
<th>Main theme</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-migration stories of personal journey</td>
<td>a. Reasons for flight (freedom and opportunity)</td>
</tr>
<tr>
<td></td>
<td>b. Personal trauma, separation, and loss</td>
</tr>
<tr>
<td></td>
<td>c. Collective trauma and loss</td>
</tr>
<tr>
<td></td>
<td>d. Positive experiences (memories, strength, identity and meaning)</td>
</tr>
<tr>
<td>Peri-migration camp life and hardships</td>
<td>a. Arduous flight</td>
</tr>
<tr>
<td></td>
<td>b. Physical hardships</td>
</tr>
<tr>
<td></td>
<td>c. Disease and illness</td>
</tr>
<tr>
<td></td>
<td>d. The worth of money</td>
</tr>
<tr>
<td></td>
<td>e. Additional trauma and ongoing threat to safety and security</td>
</tr>
<tr>
<td></td>
<td>f. Isolation and exile</td>
</tr>
<tr>
<td></td>
<td>g. Positive experience (family, community and education)</td>
</tr>
<tr>
<td>Post-migration and settlement</td>
<td>a. Early settlement and the environment</td>
</tr>
<tr>
<td></td>
<td>b. Day to day living: (basic needs, safe society and new systems and quality of life)</td>
</tr>
<tr>
<td></td>
<td>c. Educational and employment opportunities</td>
</tr>
<tr>
<td></td>
<td>d. English as a precursor to success</td>
</tr>
<tr>
<td></td>
<td>e. Cultural and community distance</td>
</tr>
<tr>
<td></td>
<td>f. Developmental and intergenerational challenges</td>
</tr>
<tr>
<td></td>
<td>g. Homesickness and missing family</td>
</tr>
<tr>
<td></td>
<td>h. Social exclusion and racism</td>
</tr>
<tr>
<td>Mental health constructs, experiences and strategies</td>
<td>a. Constructs of mental health problems</td>
</tr>
<tr>
<td></td>
<td>b. Anger and forgiveness</td>
</tr>
<tr>
<td></td>
<td>c. Ways of dealing with mental health difficulties (dealing with it on own, informal networks, stigma, external help, alcohol and holding on to memories)</td>
</tr>
<tr>
<td>General coping and resilience</td>
<td>a. Physical activity</td>
</tr>
<tr>
<td></td>
<td>b. Social activity</td>
</tr>
<tr>
<td></td>
<td>c. Spirituality and faith</td>
</tr>
</tbody>
</table>
**Main theme** | **Subthemes**
--- | ---
Solutions | a. Promote shared understandings  
b. Ways to generate understandings  
c. Culturally specific solutions  
d. Recreation and sport

*Theme 1 – Pre-migration and stories of personal journey*

One of the major themes observed was the personalisation of stories and journeys. Each participant revealed unique and personal stories of life before the wars and migration, alongside individual struggles, trauma experiences and stories of internal strength. Subthemes within these experiences revolved around topics concerning: (a) reasons for flight, (b) personal loss and trauma, (c) collective loss and trauma, (d) personal strength, and (e) idealised memories of life before flight.

*Reasons for flight: War, democracy, persecution, & seeking safety.* Most participants reported war, violence and “trouble” in their homelands as major reasons for flight. Other participants offered more underlying explanations such as the lack of democracy, lack of freedom of speech and freedom, unstable political situations, and the need for safety. For the Karen participants, the lack of a homeland and “nationlessness” (i.e., an independent Karen State), democracy for ethnic minorities and ethnic persecution were especially prominent as a reason for flight. As many of the Karen had been born in refugee camps or on the Thai/Burmese border, they had seen very little of Burma. This had enhanced their need of ‘nationlessness’ and they were noticeably upset when discussing these issues. Examples of such ideas are:

“I feel like I don’t belong to this [world/war]...I don’t have a country...I am not ... to do anything. I don’t have a chance to live. Like in Australia, many people here can ... freedom. Also, if we want to do something, yes, we can do it. The main thing is we want freedom. We want to live in freedom country. Burma country is military - [owned by] military government, but we want ... country be free like many people - many ethnic groups live in Burma. Everyone wants democracy, but they don’t give the democracy to any ethnic groups. So that is the problem.” (Karen male, aged 27).

“It’s felt very sad for us because our Karen people, they do not have a lot of free life...When they live in Burma, in their own village, then when the Burmese [soldier] come round then they just destroy our village and [sometimes they kill] our people...burn our village...bomb our village. So we had to move out and come to the camp.” (Karen male, aged 22).
“In my village, we've got electric. When we live there, we have the electric fence - they put around the fence because somebody came and destroy their electric fence...they put around the fence - like a bamboo fence - and before the bamboo fence, they put a bomb. A bomb because somebody can - they worry that somebody can destroy their electric - and then, in my village, we had to - in one year - once a year, we had to go, build the new fence, every year, every villagers had to go there. One day, 2003, I'm not sure - one villager went to build the fence and they take the soil, they didn't know outside the soil and they put a bomb, they didn't know. When she dig the soil, the bomb explode, she lost her leg and someone heard - like hear - two or three - near my house. I think, what explosion? I very scared and they put in the - they carry in front of my house, oh my God, I said. I scare, every year we have to go there and in some ways, they put a mine on the - when we live there, we are doing - we planted the - not vegetable, like a coffee - we plant and we sell the seed in the city. We got many there - how can I say? Like a garden...In the garden, they put some - some garden, they put a mine. Yeah, you can’t go, we scared everywhere it was out there. Yeah, that why I scare - I don't want to live there. We have many problem there. Yeah, but just now I am safe, but I scare for my village, my people. It's very far.” (Karen female, aged 19).

For the Sudanese, and to an extent the HoA’s, in addition to seeking safety from war, there was despair at the notion of being isolated from one’s own country as a direct result of a divisive civil war.

“We left Sudan to seek security and protection from war...there’s war always going on around you. I came here for protection and safe life.” (Sudanese female, aged 18).

“The most important issue that makes us to migrate to Australia is war in South Sudan, then coming to Sudan capital was even worse being isolated in your own country. It’s worse being isolated in your own country, a refugee in my own country!” (Sudanese female, aged 23).

For many of the HoA youths, reasons for flight were often given as second hand information- that is, what their parents told them as a result of being too young to understand or remember.

“I don’t remember anything besides what my mum’s telling me- she wanted to leave because my dad passed away from the war...There was a lot of war going on and too much violence wars, especially between our own people: Somalians. There have been - they have two different tribes - not two but several different tribes and then they’re fighting their own people - too much fighting...these people fighting...yeah...wasn’t safe. Yeah my Mum bring us here so we can have a better life.” (HoA female, aged 18).

“Yeah back like in 1991 there was a civil war and well I'm not sure if there's going to be another one but you can’t guarantee because the government is really - he's very like - what’s that word - dictative... and so basically no one has freedom of speech and all that.” (HoA male, aged 18).

Several refugees cited direct individual and/or family persecution as major reasons for forced migration. This was especially evident in Togolese stories, which also cited violence, war, and lack of freedom and democracy as reasons for flight.
“We left Togo because there was no peace in our country. The government were fighting its population and in Togo 1993 it was military government. We have the problem... My father was in the military – in 1993... the government killed him. The situation is North vs South Togo. Some want democracy but government don’t like democratic so devise to 2 groups. Dad fighting for democracy. Because of situation my dad had to flee- they beat him but he would not die. When the trouble, my father escaped... they tried to kill people... he try to cross country with bicycle. When they try to help him, they get him. We had to take our bicycle across the river and joined together 1 year later.” (Togolese female, aged 21).

“My mother is deceased. My Dad died, mother was all the time worry that she had heart attack. I was young and don’t remember. [Name removed: Uncle] looked after me since when I was young. They shoot my father. When I grew up my uncle tell me that police want to shoot my uncle too cos they look similar, but they shoot my father... they shoot wrong man, wanted my uncle... life was hard no food, medicine... my countrymen dying around me... it was worse when we were in Ghana we saw on TV my countrymen dying in Togo.” (Togolese female, aged 17).

“In my country I saw too many people I care about die. Police killed civilians – In Togo there is no democracy... no freedom... troubles... They fight and fight in Togo that’s why they bring us to Benin.” (Togolese female, aged 13).

“Had to leave because troubles in Ghana- if you go in the bush for firewood, shootings and get scared. Safer in the camp.” (Togolese male, aged 12).

For the Karen participants, personal persecutory experiences related more broadly to the persecution of Karen people, as an ethnic minority.

“My father here on visa class 201 [in country special humanitarian]. Political issues brought us here. We had UN screen..... Back home they spied on teachers and arrested teachers, watched students who demonstrated. The North and South Togo are divided – it is a trouble situation – they tortured my father with electrical – he was on a ‘red list’ in 92... As teachers they arrested because talk of economy... torture to give information to police department... then not allowed to tell about what happened. our political situation was trouble. Found out he is red list of names.... so he had to leave to border.” (Togolese female, aged 15).

“My grandfather was a judge and he was in opposition and so one day the government invite him to go to a meeting in Togo but after that meeting he didn’t return back home. My father and uncle went to find out where he was... So I went to my lawyer and finally the police want to kill me why I continue to ask about my father, so my father come to Benin. My mum is in Ghana. We experiences persecution because we are from South and they are from North. People in south in danger. We chose America but by grace of god we came to Australia.” (Togolese female, aged 18).

“Yes, my father lived in the headquarters, because the village is close to the [Karen Army] headquarters... Later I interest to become a soldier. I interested, like to go with father but my mother didn’t like, because I am the only son. Yes, and because my father has to move to another [unclear]. But my mother is still working in that ... so we have to separate... my father go to his duty, to the Karen State, and I have to stay in the camp with my grandmother and sister...... in 1994, the headquarters is fell... fall down yes... War, yes, because [unclear] to the headquarters, so... the war is three months, four months, so many Karen people die there. So [unclear] so they have to leave the headquarters... my father come back in camp. But he just stay in the camp one week or few weeks and he go back to the Karen State because he has the duty.” (Karen male, aged 24).

Interviewer: Yes, it’s... [unclear] because I think my father was underground movement, so for him to become a Karen soldier, he just go and join for them. And you had to leave because of the fighting in
Reasons for flight: A better life with opportunity. A search for a “better life” was spoken in the context of the desire for safety and security from war and persecution. About half of the participants cited poverty, difficult life circumstances, an inability to access adequate healthcare and a lack of education as driving triggers towards seeking refuge in camps. The opportunity to learn English, attain an education, and other skills at camp provided the impetus for many families to flee or send their children to refugee camps. Others cited seeking refuge in camps as a way of attaining medical attention to prevent death from sickness and disease. Many Karen refugees stated that they were sent to refugee camps for reasons of safety and health care by their parents.

“I came here for such a good life, to seek security from war, to get a better education and living of a better and hopefully good life...I can say that my experiences as a refugee have not affected my life, if anything it has now given me opportunity for a safer life and to explore my potential. I migrated because of the financial problem of not having what you want. Health was of a concern as you could not afford medicine when get sick. Not so many good jobs available and the infrastructure is poor [in Sudan].” (Sudanese male, aged 25)

“OK...well yeah my family...we had a hard life in Africa...seeing that we were Eritreans in a Sudanese land we could not get job and continue further studies and stuff...it was actually illegal us being there...my dad had job but not enough for seven kids...you know...seeing we were a big family and there’s seven kids- my mum had two daughters which died from diseases that could be prevented if we were here in Australia. I was six and don’t remember much...but my mum told me that’s why we come here.” (Sudanese female, aged 18)

“We came because we got sick all the time...there was no treatment. People die in my country if there was no food. Also there no jobs in Benin or Togo, so sometimes no food at all to eat. In Africa, have to pay money to go to school. If no money you cannot go to school. Went to prep to 6, then I stayed home. In Benin you get sick and sleep without eating, we came to have these things again.” (Togolese female, aged 14)

“One of my relatives come to Australia. I want to go but I miss my family and my mother and father. We applied for [unclear] and we wait for two years I think...I come here ... Our family is lucky, lucky because some family, they apply to come to Australia - very difficult country to come there. We apply to come to Australia for the Refugee Visa and in 2005, December we leave the camp, and we stay in the guest house five days. I want to try to Australia, but I never dream to come to the country, like Australia, but it is I think an opportunity for me to come.” (Karen male, aged 22)

“I lived in Burma 20 years, then I - one of my uncle called me to come to the camp, you can study, like English and that sort of thing, but one of my - my aunt told me, don't go there, it's just a refugee....no shelter...but I just want to go there because I want to get...most English when we go to the camp, I have to scared [laughs] because, you know, we don't have ID to pass the gate and I very scare and one of my cousin pick me up with motorcycle and then we - I go to camp. Then I - how do you say - UN, I
registered there and I want to come to Australia for better life, better opportunity... job... yeah.” (Karen male, aged 25).

“If my parent - my grandparent bring my brother, sister, to the camp, they get a chance after they die in the village.” (Karen male, aged 22).

The experiences of the Karen and Horn of African refugees described above are contrasted with some of the Togolese experiences. Rather than fleeing towards camps, many Togolese reported an avoidance of camps in order to escape wretched living conditions, spreadable diseases, and extreme violence within camps. The Togolese in this case were referring to the 2005 camp riots arising from frustration with a perceived lack of progress in resettling refugees, and resulting in the destruction of buildings and property in the camp.

“It’s not safe in the camp for us. Something bad happened. Police had to bring us up to camp. We not want to be in camp but police was pointing gun up into the air. Some people sleep in the bush... in the roadside. Had to run away when police came... they say we have to go back to camp. People say... no... They start to beat people, break arms, beat people with blood and so on.” (Togolese male, aged 15).

“We came to stay in Benin. I didn’t really know Togo. We didn’t stay in refugee camp cos there were lots and lots of people and people get sick there. My parent doesn’t want us to get sick... we hear people die at the camp so we stay in house with other families.” (Togolese male, aged 13).

**Personal trauma, separation, and loss.** Participants displayed a sense of fortitude in describing their own personal and family traumas. Naturally, questions concerning these experiences evoked upset and high distress on occasions, but overall, participants were willing and wanting to share their stories. These stories ranged from happy memories of childhood through to vivid descriptions of individual trauma and threat to life, separation from family and friends, loss and bereavement. For a significant number of refugees in this sample, this included the death of a parent. Often the inter-related experiences of trauma, separation, bereavement and/or loss melded in a single personal story. As a result of forced decisions to move to camps, many individuals were separated from members of their immediate families as well as extended families. These separation experiences tended to continue through migration journeys, for instance, moving from camp to camp, and from leaving camps to resettlement countries. For many participants these experiences of loss and separation were more traumatic than other events.
“We lost our father and did not have our mother. Don’t feel comfortable without mother. ...our mum went different way. My mother was refugee in Benin with her other children. We were with grandmother in Ghana- old lady. My mother [in] Australia before send for me. At the time for me, really bad, they killing people, finally even my father involved. Made me very scared all the time. When I remember things makes me scared. It came about they shot a school child wanting to enter through their gate. It was really fearful.... [Sister speaks through translator] ...At night people come broke your doors, can’t do anything. When getting night, she fears. The house where living. It happened with the people in their house but not directly. Don’t feel happy when it comes to recall these things- sometimes when you’re in bed and you’re asleep your mind recalls these things. They come and you can’t sleep again.” (Togolese female siblings through translation, aged 13 and 15).

“I had a very unhappy awful life with the situation in Benin and Togo. I had malaria many times but the serious one when we went to hospital with my brother. Going to the hospital feeling like you were going to die. The pray of my mum help me...I almost died... my brother malaria was in hospital for 3 months...in coma for a long time. At hospital many people dying every day with 2 people share one bed. We are poor and didn’t have any money...any food. We don’t have separate bedrooms, so when want to cry couldn’t cry. My mum cry because we can’t go to school and she doesn’t know so my mum cry every day.” (Togolese female, aged 15).

“Being in Africa is like living in the dark...you don’t know...nothing is sure...it’s a matter of chance......how am I going to look after my parents. Not a day you don’t think about these horrible things. I am in Australia because my parents were in political party. My mother lived in Benin (7 years) and Refugee camp (Kbomassee). A remote camp, she called for me. I supported myself living in a capital city, it was hard for me not to see my parents.” (Togolese male, aged 25).

“I see girl losing legs with bombs outside camp; mines being put outside; mine put in garden.” (Karen male, aged 25).

“How I came to Australia... In Burma and it’s very difficult to stay in Burma and my parent they lived not in the city, like they live in the mountain and Burmese soldier of the army they always go to the mountain and they burn the house and my parents they are working as a farm, so they burn everything and also they kill people. My parents ran away and my father he step on the like - blow - so he lost his leg in that. So, that’s very difficult for my mum and also she has eight children but now I have only four because four are already passed away... Yeah, including my brother. Yeah, so then my parents they asked me do you want to – and they sent me in the city like maybe a priest in a family and one day she came and asked me do you want to go to stay in Thailand...that’s how I refugee with my sister and brother”. My father passed away when I was in Thailand. [Interviewer asks: How did so many of your family members pass away?] “Yeah. By leaving my older three sister, they got sick because they have not enough food. My parents they always have to run in the jungle, yeah. My other brother, he passed, he was maybe 32 years he passed away, yeah. [Interviewer asks: So you’ve had a lot of heartbreak, haven’t you?] Yeah, yeah, a lot, yeah.” (Karen male, aged 24).

“Why I’ve been a refugee, firstly we had no place but - we did have place....our place was destroyed so we ran, we afraid to live in there. There are many things - when we live in our village, the first ... soldier came all the time, they ask for chicken, our ... if we plants, they always ask ... another group - many group Burmese soldier...Government military. We had different village and the other village was burnt - they burnt villages...yes, we as I ran with my mum, with my one sister, other brother - my younger brother and we ran. Just my father and - I couldn’t remember, my father was arrest to carry [bullet] - how do you call? [Porter] - They caught porter to carry bullet - soldier arrest him and to carry their guns, their equipment to go... The whole village, they tried to save themselves. I remember really getting to another village and then my father - [that’s] one - one day - one night my father - I don’t know, he arrived in this village, he said [unclear] to our place, just keep moving on and we’ve moved ...we by foot, three days, at night and day we walked and we got in the border. “[Each] early morning I went to my grandfather place to get fish, because my grandfather catch fish with net, in morning he pick up, there’s lot fish. When I went to his place I always saw the soldier came and asked the fish
with a gun. Since then I feel scare about the gun and soldier. [Interviewer asks: You were a young boy?] Yeah, young boy, and when I get into the camp, high soldier guide us, control us, they don't want to we go outside. Sometimes let you go outside [find ways to water], we used to find ways to water in our village. We just got the food extra when we go at [night]. We always afraid the soldier sometimes police [unclear], I still afraid there. My experience when I ... my aunt to the other camp called Umpiem, we had to cross three hours' drive - three hour drive, we had to cross many car guard - the place where soldier stop the cars... on the way to pray to pass one car, but I could not get past and was arrest. Yes, we'd stay the car very calm. Firstly the soldier ask, when they stop the car, have you got ID? Let me see your ID, the first they ask and they say, [unclear] but I got ... in Thailand, if you don't have ID, get out, [so we] had to get out the car and when you get out the ... the car, they let the car going and they call us into their guard and they ask in Thai, but we don't understand Thai, it's very hard. The first day with my father, they [unclear] my father, because I was still young, 14, ... then I was feel very sorry for my dad because they pointed to - with a gun to my father's head. Are you soldier? They asked. I just take [somewhere] [laughs] and my father said, no, because my father has tattoo, most soldier have tattoo and they thought my father was. They - later they asked money, my father has some money but my father lied, but we have for travel - only for travel, no money, they said, I will shoot you [unclear] I told my dad, give the money, and he give the money - he gave the money and nearly dark, we sit out the whole day there, nearly dark they asked us to catch the bus, let the car in Thailand ... leave the car in Thailand, we catch the car, we go back. Since then, I feel more afraid of soldiers with policemen. The second time I was arrested again, this time I feel a little bit naughty[?], before I came here, I had to visit my aunty, to say goodbye, to see my cousin and the place, too, some of my friend, they live in that camp. [Unclear] some of my friends, they from the other camp, they came to Mae La camp, they had no school ... I like to go and - to their camp and see how the - I pass through when I go, when I come back I was arrested. I be in jail one day and one night, this the first time I be in the jail, where I see many bad things in the jail, even pregnant woman, they arrest, they put in the jail just for one day. Later, you relatives or something had to pick up, give money, because some Burmese people - Burmese or Karen - they looking for [unclear] into Thailand. [Tak], the big city, the one close to the other camp, 2 hours' to 3 hours' drive. There were a lot of the illegal, they came in there, they were arrested every day. Then I'd been once in there and I know more about how the ... is doing. When I talk now, I can still see all I get through and I feel sad and I control myself to be strong - to keep strong, even. Even it sad, it's very sad for me [cries]."

(Karen male, aged 25).

"Because of the military government, they burn our farm, our village, our villages. They don't want to give us a chance to live in Burma. Also, no school, also we have to live in the jungle - no hospital. Many people die by malaria in the jungle. Also, many people die by landmine. Also, many people became the disabled - they are suffering by their life until now. The war - the civil war is not finished until now. Many of my friends they live in the camp or inside Burma...yes...I have bad experience when burn my village...many people die and hurt." (Karen male, aged 27).

"Yes, and I moved to the Karen State again and study. It's very hard in the Karen State at that time. Especially in the summer, because the village is called the [unclear] - that was a ... school, ... school, and it has the house, the school, very good condition, but especially in the summer when the military soldier come attack, they cannot come attack, but they come in the airplane and drop bomb. [Interviewer asks: You remember this? Yes, I remember. We have to study in very early morning. In afternoon at 12 we have to stop. We have to go to hide in the cave. We have to find some cover, got to dig the hole. In the morning we have to go to school. In afternoon we have to go back to the family." (Karen female, aged 18).

"He say that we live in the camp together and there's in the camp - we stay - live in the camp. Is not enough food and so my father look for job outside of the camp and he sent money sometimes, like 500 baht, Thai. In a few month, just in a few months his father was killed and since they never see his father again. He never heard from his father. They just pray the house, like how do we call? Like funeral. They make funeral without body. Something like that, yes. Interviewer: How old were you when that happened?] Ten, just not more than 10 years. [cries].” (Karen male, aged 22).
“Saying goodbye to your family, loved ones is the hardest thing, not a day goes by when I don’t think about who I have lost because of the war. I mourn the ones I lost and miss desperately the ones still at home.” (Sudanese female, aged 18).

“No one should have to say goodbye, not knowing when you are going to see your parents again, especially young people who need them. When you are not with your family everyday you are thinking about them and hoping they are safe.” (Sudanese male, aged 22).

“When we go to camp, I didn’t see my brother and sister...I didn’t know where they are and was worry they die.” (Karen male, aged 19).

This death of a parent, particularly fathers, was a prominent theme across all participants, especially the Sudanese and the HoA youth. For the HoA youth, many fathers had died when their children were in their early childhood years (1-8), underscoring the number of HoA women and children fleeing to refugee camps. For many HoA youths, there was little recall of events of the past. Most knew their parent(s) had arrived to Australia to escape war, but had not received any information from their mothers about particular events – that is, HoA mothers appeared to shield much of the history of war and personal experiences with their children. Nonetheless, there were some HoA’s, who remembered their wartime experiences quite vividly.

“Yeah, my father, he didn’t come with us, what you call it- when I was one...he was taken as hostage. He was part of the ethnic group targeted...he wasn’t fighting against them. so they captivated [captured] and killed him (later clarified as wasn’t fighting against opposing tribe but killed by them in spite of his non-involvement in war).” (HoA female, aged 18).

“OK, I left Somalia when I was a little kid. My dad passed away during the civil war, I went to Kenya refugee camp. I was eight, my mum couldn’t handle it there, it would be too hard for her as a single mum so we came here.” (HoA male, aged 18).

Collective trauma and loss. In addition to the personal experiences described above, there were many reports among participants, particularly the Karen, of shared loss and trauma. For some Karen, it was difficult to reconcile a peaceful safe life in Australia with ongoing suffering in Burma and the Karen State, not only towards families and extended families, but for the Karen culture overall. During individual and focus groups, the Karen often preceded responses with “we Karen people…” or “in our culture…”, even when describing their personal situations, re-enforcing their sense of loss and empathy for fellow Karen.

“How can I be happy here? I think about my people...still danger for them, still dying for them. I always think, how my village today? Are they safe?” (Karen male, aged 25).
“When my people unsafe, I feel nervous and unsafe too. I know I am safe but I feel the pain back in my home.” (Karen female, aged 19).

“I’m not a soldier, I’m not a person who suffering inside Burma. I live in Thailand in camp. Sometimes I feel very upset about my people who are suffering inside Burma. Even though I’m arriving in Australia, sometime I think about my Karen people who, they live inside Burma or Thai/Burma border. They are still suffering. They know that they need freedom...democracy, but in their heart they want to talk with someone. They don’t have the chance. They are not allowed to talk, but I am here, they have ... in Burma or Thai/Burma border many of Karen people live there want to shout, they want to talk, but they don’t have a chance, yes. Me, that’s [only one] I’m ... here and talk to you ... very powerful. Also good chance to talk to you and very ... I’m ... only me that’s talking, but so many Karen people in the camp. In the Burma they are not allowed to shout or they have no chance. Nobody hear ... them in Burma or ... I’m very happy to talk to you.” (Karen male, aged 27).

“My mum, my grandparents all became the refugee. Our life is very difficult. I never ... my life in 20 years ago... Why I was born in refugee camp because of the Burmese military. Because of the military government, they burn our farm, our village, our villages. They don’t want to give us a chance to live in Burma. Also, no school, also we have to live in the jungle - no hospital. Many people, my people.. die by malaria in the jungle. Also, many our people die by landmine. Many people became the disabled - they are suffering by their life until now. The war - the civil war is not finished until now. Many of my friends they live in the camp or inside Burma... Yes, they still living there. The [unclear] in the camp ... they need the money for them ... to go to school or to buy clothes ... to do they said, don’t forget us.” [cries][Interviewer: I think this would make a difference as well. As you said, it’s like your voice is for them]... I mean my [unclear] is stronger than them. They are a lot of people but they can’t tell anyone. They can’t shout - no-one hear their voice, but me, can hear. Hopefully you can hear my voice. Also, you record my voice and you will take my voice to... [Interviewer: To share it]...to share to other people, so many people will hear my voice what happen in Burma, what happen in Australia for the refugee people who arrive in Australia - how they feel. They will know more about that. It’s good - thank you for coming”. (Karen male, aged 27).

“No, but I feel very sad. If I compare my life in Karen State and camp, and now, the situation is worse in Burma. I saw my Karen people - not only my Karen people - other ethnic groups, they suffer from the military attack them. They are [under] attack. I feel very, very, very sad. When I compare my life and now, for the... not me - my people and my live there for the past - in the past, the situation is very bad than ...” (Karen male, aged 22).

“If I saw at the Karen people are treat badly for Burmese people - soldier, and Karen people get hurt very badly, some...[unclear] lost their land [for him], it’s really bad. Then, only the kids left...they don’t know anything, that they kill them...it’s bad for the Karen people.” (Karen male, aged 22).

The sense of collective trauma experience was also expressed by a smaller number of Sudanese participants.

“There are many refugees who still live with the trauma of the war. This is very important for people to know. Our Sudanese people all around the world are suffering because Sudan is still broken and people are still dying. I experience the pain of Sudanese, my tears are not only for me and my family” (Sudanese male, aged 25).
The Sudanese and Karen experiences though were contrasted with HoA and Togolese responses where less evidence through interview transcripts was found for shared collective experiences of trauma or loss.

“In Africa, grandparents and parents teach their sons to fight, fighting is a survival, you have to look out for yourself in Africa or you won’t survive. Families fight families to survival and African versus African.” (Togolese male, aged 25).

The HoA participants similarly reported a distance or separation of their own from that of their countrymen’s experiences, their parents’, and older generations. They often reported being of a young age during the war and being shielded from their parent(s) and grandparent(s) traumatic experiences. Nonetheless, an affinity and respect was observed among HoA’s with respect to the stories of their elders.

“Its – now I know how my mum, I respect her so much but I know what she went through.” (HoA female, aged 19).

“Insecurity in my homeland has brought me here. My experiences as a refugee haven’t affected me that much as I was quite young but seeing the older people is another story- there is a lot of grief in the older ones, that what affects me.” (HoA female, aged 19).

**Positive experiences: Finding good memories, strength, identity and meaning.**
Stories of good times prior to migration and resilience during war and flight were not uncommon among refugee participants in this study. There was strong identification and affinity with homelands and a strong desire among Sudanese and Karen participants to return home once their countries were in peace. Other refugees described experiences of strength or growth and a shaping of identity arising from their wartime experience. Many participants reported deriving meaning and making sense of their experiences as a central part of their recovery from war. There were also those who experienced challenges to their identity in terms of bi-culturalism.

**Good memories:**

“My life has good memories. My dad teaching and my mum stay home help look after us or our pets. I remember we have a pig, a dog and little cats and kittens. I really like my animals and play.”[Later, participant describes sadness at the slaughter of her pig for food]. (Karen female, aged 18).

“Nothing is sweeter than being in your homeland and the beauty of your home. There was war, but there are beautiful memories. Remembering the richness of my motherland.” (Sudanese male, aged 22).

“I was less stressed back then than I am now. The people were friendly and easy to trust. Life was kind of good in a sense that there was not too much to worry about.” (Sudanese female, aged 18).
“Choosing between being Sudanese, and being Australian. Integration is a big problem for me. Also, there are so many culture here, I have difficulty keeping up with my Sudanese culture.” (Sudanese female, aged 23).

By far the most reported positive experience or good memories during pre-migration life were the experiences of family life with immediate and extended family. A sense of togetherness among family and friendships drove a sense of camaraderie which endured through their migration journeys.

“We had war all around us. My family lucky, we stay together. We always play and stay together in family, it’s like safe for us with family. Yeah, that really helped me, I have good memories.” (Karen female, aged 21).

“We spend a lot of time with our family and friend yeah, just my friends and just girls together...Also because we have church we see our family and friends, that’s what good in refugee camp.” (Karen female, aged 18).

“The one good thing was the true togetherness people had back home which we don’t feel here...I mean family is really important for us, you know what I mean?” (HoA Female, aged 18).

“I really like playing with my friends in Ghana, walk around, play soccer...don’t remember Togo. Went to school in camp was good with my fiends but had to walk far to go to the high school.” (Togolese male, aged 15).

“Benin got a good democracy, we happy when we there, we play with friends, singing and dancing.” [brother speaks:] “Benin was good because I had a lot of friends who are refugee boys. Some from Togo, some from different countries, speak different language, some English, some French. In Benin, they have democracy. Now if you say anything bad, they aren’t going to kill you...I was safe in Benin...I have a lot of friends there...playing.” (Togolese siblings, female 21, male 17).

**Strength and courage:**

I got a fever and the doctors said I might die. My brother also had fever. I was rushed to the hospital and we had to share beds. I was so frightened but know I had to stay positive and stay alive to help my family...I never gave up, even though the doctors said me and my brother will not live.” (Togolese female, aged 15).

We had to hide for many days and dig holes in the jungle because the Burmese soldier, they look for us. I so scared but I just close my eyes and keep hoping they will go away. When I think back I don’t know how I survive...you have to be strong.” (Karen male, aged 19).

**Identification and affinity:**

I had a great family always love me also, friends that were always together that I was raised with from primary school to higher school and all the teenager things. I mean...I loved Sudan...I love Sudan. People are friendlier and easier to trust...I cannot wait to return to my homeland...it may be time...for me...I need to go home...My experiences have allowed me to grow the idea of me fighting for my rights and how important peace is to have in a country. I hope to succeed economically with my new ideals and share this with those back home.” (Sudanese female, aged 23).
Meaning:

“My experiences as a refugee have actually taught me how to manage to live with others, and made me a stronger person because, you can control yourself when you are provoked to do things and teach how to handle problems when they arise.” (Sudanese female, aged 23).

“Too much war and lack of resources led me to Australia. I can appreciate life so much more and small things so much more because I know what it’s like to have nothing and will make the most out of this opportunity for life.” (HoA female, aged 19).

“My refugee experiences make me to help others... if I been through that I can tell people and share... I want to be a missionary... for sure, that’s my goal now for my life.” (Karen female, aged 18).

A small number of participants were unable to report on any good memories, positive experiences, or find meaning to their pre-migration experiences.

“I can honestly say there were no good things about living with war always going on around you and living in refugee camps.” (Sudanese male, aged 24).

“There is nothing good about my life before here - nothing good in war and camp, nothing good about being a refugee.” (Togolese female, aged 14).

“I can say that my experiences as a refugee have not affected my life, if I can say anything I guess, it has given me opportunity for a safer life to explore my potential. But overall, I find no meaning in the war or my experiences as a refugee.” (Sudanese male, aged 17).

As many participants had spent most of their lives in refugee camps before migrating to Australia, difficulties recalling life before camps was evident in a significant number of participants. This was especially true for the Karen, many of whom were born in camps. In contrast, the HoA refugees reported having left refugee camps at a very young age, with about 80% reporting few if any memories of life in their countries of birth. Instead, many HoA reported second hand information and vicarious learning experiences from their parents which entailed stories of hardship inflicted upon their parents.

“I was two when I left Somalia so don’t remember anything besides what my mum tells me... she tells me that it was hard all the time because they had to hide to keep safe... the war and everything... my dad’s passing... they had to hide and things so they get to Kenya... they had to hide belongings... yeah they were pretty black conditions my mum tells me about...” (HoA, aged 18).

For the younger HoA’s, there was a sense that parents had protected them from their own experiences of war by not telling them of past traumas.

“Like I have no clue what went on and that in the war, and I’d rather not... my mum and dad don’t talk about it because they want me to just think ahead, not the back, the past and everything...” (HoA male, aged 15).
For other HoA participants, there was a reluctance to talk about their own or past experiences of their parents, and in some other cases little desire to learn about the experiences of their parents. Within these sentiments there was a strong desire to not dwell on past events, but rather look forward to the future. These participants distanced themselves from the identity of a ‘refugee’.

“If you look back your necks going to get stuck and you’re not going to be able to twist it forwards – and by the time you look back forward everything’s already past you.” (HoA male, aged 19)

“I don’t reckon a lot of refugees like to talk about their past because I don’t think they...I don’t know...it’s just that it’s the same old story over and over, you know...being a refugee’s not me, you know...I’m not part of that same story.” (HoA male, aged 18).

Identity was not frequently discussed, though numerous data extracts were found to illustrate that identity among this group of young refugees was indeed diverse. That is, there appeared to be many ways in which the young people defined themselves, bringing diversity into an understanding of the refugee experience and what a ‘refugee is in Australia. Some participants had a strong sense of what it meant to be a ‘refugee’, describing themselves as survivors with direct and indirect refugee experiences; others had arrived on family re-unification visas, and others relied on what parents had told them to complete their memories. For some, positive wellbeing, good mental health, and good adaptation required to some extent a de-identification with being a ‘refugee’. Acculturation had played a part in moulding an ‘Australianised’ identity.

“When does one no longer become a refugee? People always talk about me as if I’m a refugee, but I’m Australian now and have lived here for most my life now. As long as I am a ‘refugee’ I am perceived differently or people feel sorry for me...I’m past that trauma and stuff. I’m not a refugee anymore.” (Sudanese female, aged 18).

“We’re just like Aussie teenagers... We hang with em and do stuff like shopping, clubbing.” (HoA female, aged 19).

**Theme 2: Peri-migration and Camp life and hardships**

All participants reported difficulties in the peri-migration period, which entailed the point of flight, travelling to, and living in refugee camps. As many participants lived in camps for years leading to migration to Australia, these aspects formed most of
their memories when asked about life before Australia. Memories of their lives before camp were distant compared to those of prolonged camp life. As mentioned above, the HoA participants were had difficulty recalling pre- and peri-migratory experiences given their young ages at the time.

**Arduous flight.** Participants described onerous, often long and dangerous flights and journeys to refugee camps. For the Karen, often multiple journeys were made to different camps.

“My journey really hard, we had to walk nearly two weeks, we had to climb the mountain and down, we did nearly three mountains to get to the camp. For many Karen with child, they carry through mountain and relative help carry. There is no car so we walk and it very hard. We had to stay two nights - they slept two nights on the way. For men they may walk only one day and then sleep one night apart for them with children and families who take longer - have to sleep two nights.” (Karen female, aged 20).

“I was, I think when I was five, we have to fled once or twice I think, because the Burmese they just make troubles… I remember we have to sleep under a tree. We carry mats, only a mat and some food. We have to sleep for like two days or three days and then we came back to our house, we have to dig a hole for like - if Burmese soldier come in, so we have to go in to the hole very back at the house.” (Karen female, aged 23).

“The camp … because we always have to move one place to another - if some problem between enemies come, then we have to move to another camp. That is not good for us, so we have to move, so moving is, how to say…When I was young, I think I just like, how old six or something - at night we couldn’t sleep at home - we have to go and sleep in - we have to dig the ground and we sleep in the cave something at night.” (Karen female, aged 18).

**Physical hardships.** All participants reported extreme physical hardship, with the main one being an overwhelming lack of food and water. Although most participants reported an irregular basic rationing of food in camps, food, and water came at risk to personal safety and with sacrifice from parents. Participants reported a need to hunt and/or fish outside of camps, with risk of capture from authorities and militia.

“He [father] just work for someone else and he got rice, not many, like four…. four container that is. For they cook rice for his brother, sister, and nothing left for his mum, just for their [them]. Sometimes my mum went to my grandparent house and look for rice, just small rice, and he eat…but not his mother.” (Karen male, aged 19).

“Not enough water,…people are lined up with a bucket in a long line. Sometime they got fighting if you come first - some people changed the bucket, this is my bucket, I came first. Sometime they fighting because of water…some people have to wait 12 or 1am to dig water.” (Karen male, aged 24).

“Sometimes, at the weekend, my dad went outside, but we had to, before my dad went outside, we prayed that we’re, that my dad would be safe. When he get outside and take a bamboo and to carry it to our home, the floor is made of bamboo. So sometimes, bamboo is break down and then we have to get another one…all the time, I scared for my father.” (Karen female, aged 21).
“It was hard in camps, no food, no fishing, we had to work in the gardens. If you go in the bush for firewood, there are shootings and get scared. Safer in the camp. We had to walk far to get food. Had to go to other people, not help a lot. Very hungry. Not safe in the camp. Something bad happened. Police was pointing gun up into the air. Some people hide sleep in the bush. Had to run away when police came.” (Togolese male siblings, aged 13 and 15).

Disease and illness. Another major reported hardship was the overcrowding, and ill health and disease experienced by refugees in camps. Many participants, especially among the Karen and Togolese reported the death of loved ones through malnutrition and disease. For some participants, illness was cited as their purpose for fleeing to camps so that medical attention or hospitalisation could be sought.

“My older brother, because we have not enough in medicine or something, we don’t have - we have Thai clinic but we have to go, but we are just Karen and we don’t have any ID so cannot go there. So now we only have [unclear] camp. So he’d been very sick like maybe nearly three months - no three weeks. So we know we have to go to ... refugee camp because they have like two hospitals I think - yeah two hospitals. But we went there but maybe something happened - my brother was dying, maybe is not enough medicine, not enough doctors to take care of my brother.” (Karen female, aged 20).

“In Benin you get sick and sleep without eating. I had malaria many times but the serious one when we went to hospital with my brother. Going to the hospital feeling like you were going to die. The pray of my mum help me. When I think back to Benin I feel awful and unhappy.” (Togolese female, aged 15).

“In camp, there is no water supply, no food supply... To be a refugee it’s quite sad what you see people beaten and those things. Camp life miserable. There is conflict between leaders in the camp. What is really sad is that you don’t know what is going to happen to you, if someone sick, very slow to take action so you see your countrymen dying, can’t do anything because camps in the forest too far from city. Therefore can’t do anything. In camps, countrymen die and not being able to do anything about it. Not knowing what’s happening from day to day is hard. Even a little sickness can kill you. Government sent spies to camps so when do arrest can be dangerous. They are looking for my dad.” (Togolese female, aged 15).

“Couldn’t sleep at night time because there would be too much on my mind about the camp. Everyday my life in danger in Ghana...we don’t have food, we have to get the coconut and drink the coconut only...everyday there’s no food...so of course I feel my life in danger all the time. People lots of people died in the camp because lack of food and no medicine.” (Togolese female, aged 20).

The worth of money. All participants spoke of benefits of having money in camps. The Karen reported the necessity of money to pay bribes to officials (e.g., Thai police) to ensure their own or family members’ release when caught outside camps or where threat was present. The Sudanese and Togolese reported the necessity of money to pay for education and schooling within camps, which was often a deciding factor in fleeing towards the safety of camps. As a consequence, education was often interrupted or terminated due to a lack of financial means.
In Benin if you go to school...they tell you to give money for 1 month, if one month you go after you give money again. I cannot go to school because I did not give money.” (Togolese female, aged 13).

“In Africa, have to pay money to go to school. If no money you cannot go to school. Went to prep to 6, then I stayed home.” (Togolese female, aged 15).

“Money was important living in exile. You had to be prepared for paying for your safety.” (Sudanese female, aged 23).

“When we want to go out or get in trouble, the Karen people in the camp get together and collect the money...they help each other to pay the guards and police. If we caught and no money, they take us to prison.” (Karen female, aged 18).

**Additional trauma and ongoing threat to safety and security.** Alongside daily experiences of physical hardship, traumatic experiences appeared a common part of camp life and the refugee experience. Fears for safety were commonplace both within and outside the camps.

“Time was scary how they kill people, shooting all the time. Once they shot school child in school exercising, I was fearful and scared.” (Togolese female, aged 13)

“There was nothing good in the camp. Refugee camp was hard life, too much suffering. Too much war in my country. Ghana in refugee camp safer but can’t be in own country but also the camp was not safe. People get raped and conflict and bashing all this time in camps.” (Togolese female, aged 13)

“If you don’t got money you suffer, problem with food, if you have hard work, can get money, lots of people in refugee camp suffering no money. There is violence in refugee camp, some people come to refugee camp at might to steal a goat, little chicken, maybe they hit you, beat you, collecting from you by force.” (Togolese male, aged 17)

“Being in a different country with different people was scary. In Benin there were lots of beatings in the camp I saw. In the camp in Benin we had to camp in the bush, not good because of snakes. Night time was very scary and some people fighting in the camp scary.” (Togolese male, aged 25)

“Yes, very hard to live in the camp because we are not allowed to go outside. We are barbed wire. Yes, so...in the camp. So when we are - sometimes we want to go outside to find hunting - to hunt in the jungle or when the Thai soldier, they catch us. That’s very difficult to live in the camp. Also sometimes we want to find a job outside the camp in the Thai village - the Thai town but cannot.” (Karen male, aged 25)

“In 1995, January 29, the camp is attack. They want to attack the camp. We have Thai soldiers to protect us, but we are not ready. We don’t know they come here. We are easy target, but they come ... in the morning. I was very afraid. I will tell this story...we plant our vegetables in the morning in December - January, it’s very cold. We are watering the plant, I heard the gunshot. I think the Thai soldier, they have shoot something, but it come - was [unclear] mortar, the big gun from... mainly the other people, they are run for cover, but it foggy. I don’t know what I have to do. We find a tree - the big tree - for the cover, and I think it many hours. Some refugee they are soldiers, so they were given the gun from the Thai soldier - they came with the hill, because the camp is surrounded by hill, and they attack. In the morning until the afternoon - 12, 11, yes, 11.30 they come back - they go back. After that, every night we have to ready. We sleep and we have to ... a lot of stress...my fear in the camp.” (Karen male, aged 22)
“Like we cannot go outside. Like for our little girls we have to work here with Thai guard. They just like if they saw someone that attractive to them, they just want to destroy. You have to be careful like if you go out or like - if ever we walk around in the area unless we are with my friends.” (Karen female, aged 19).

**Isolation and exile.** One prominent theme arising from interviews with Sudanese participants was the sense of additional isolation from seeking asylum within one’s own country, where hostility for being different was experienced. Similar experiences of isolation were reported among those fleeing to countries such as Egypt.

“The reason why I had to migrate to Australia is because I was living in that country as a refugee as my own country was in war, so living in that country was a bit of a challenge in a sense that you are always reminded that you are an outsider, so there was no stability. You would be attacked by your own countrymen.” (Sudanese male, aged 25).

“It was really hard living in the refugee camp and especially in Egypt where we were living. Sometimes people would discriminate and stalk you for being different. They didn’t want us there.” (Sudanese male, aged 23).

**Importance of family and community life.** Not all camp life was traumatic or negative however. A significant portion of participants reported positive experiences around opportunities to be together with family and community. Most participants acknowledged this as a source of coping in overcrowded and dangerous camp situations.

“I have a chance to live together with my family and I had a lot friend. If I compare my situation to other family who separate, I feel I am very lucky. This helped me to survive in camp, if no family, suffering a lot in camp.” (Karen female, aged 23).

**Importance of structured life: education.** Participants also saw the structure of routine through education as a means of coping with everyday life in camps. For many, education instilled a sense of hope for the future, despite the quality of education being constrained itself (e.g., basic education up to year 8) or the cost required to keep a child in school. It also represented an opportunity to maintain links with a community life with peers.

“I have a chance to go to school and learn English. I go to school and learn about Australia When I turn 15, I could not go to school anymore because, no more teachers for this class. I very sad because I miss out my education.” (Karen female, aged 20).

“School keep me alive in camp. I love to see me friends every day. One day my mother have no money and I could not go to school no more. I miss my friends very much.” (Togolese female, aged 17).
Theme 3: Post-migration experiences: Settlement to Australia

**Early settlement and environmental changes.** A wide range of reactions was observed in terms of participants’ experiences of early arrival. Some described overwhelming positive experiences upon first arrival, which continued well into settlement, while others had mixed expectations, were less positive, and/or slower to adjust to a new way of life.

“I love this country, when first I was at the airport I was so joyous.” (Togolese female, aged 20).

“We always pray to God to come to Australia. We prayed for America but God helped us to come to this country. We are really happy. We can go to school and eat and be something tomorrow...When we first came, I think back on all the stuff that happened to us and can’t believe it’s a miracle...really happy here.” (Togolese female, aged 15).

“It’s very challenging being in Australia. You don’t know what you’re going to face. You don’t know how the environment is going to be, you are diving in the dark. We don’t know. There’s excitement but also fear in coming here.” (Togolese male, aged 25).

“When I first came here it was different obviously. Yeah but you just have to adjust to the environment. It was different but it wasn’t like as bad as we thought it was going to be because there were people from where we come from and all that. So we just blended in and slowly by slowly we got used to the society and all that.” (HoA female, aged 18).

“When we first came, the Karen women, us, they are so homesick; they want to go back to the camp, yes. They all cry, they want to go back to the camp. And now if they have the airfare they go back the next day, like today...” (Karen male, aged 19).

Most participants noted the vast contrast in weather conditions and environments between their new and old homelands. The cold was a most notable difference for the Togolese particularly. Fewer found that the experience of weather change became easier once one adjusted to the new conditions.

“The weather is not like Africa, its cold here in Australia.” (Togolese male, aged 25).

“Like many of our people, especially the older people like even they can’t go out because it, it’s cold, very cold and it’s hot, very hot. So they don’t...” (Karen female, aged 18).

“One of the shocks if you ask me would be the weather. The body can adjust to the weather. The weather is not really a problem...just a problem for few days.” (Togolese female, aged 15).

**Day to day living: Basic needs in a safe society.** Participants reported many positive advantages of being in Australia. Healthcare was very highly rated, with participants appreciative of the facilities available to them. The basic right to education and food
enjoyed in Australian society was also surprising to some newly arrived refugees. Most participants marvelled and appreciated the choice and availability of food, especially new cuisines. The provision of shelter and a clean, safe environment were also mentioned as stark contrasts to their situations and lives in their homelands.

“Australia is peaceful yeah, and very accessible to health services, doctor and stuff.” (HoA female, aged 16).

“If I get sick I can go to the hospital. Food here is great so much and too many choices – pizza!” (Togolese female, aged 13).

“School is free here, you can also buy food to eat.” (Togolese female, aged 20).

“Getting good treatment for the medical condition I have now (arthritis). I am not getting good medical help.” (Sudanese male, aged 23).

“The environment is so clean and there is shelter to live in here. Good food to eat, of course we didn’t have these basic things in Africa.” (Sudanese female, aged 23).

**Day to day living: New systems and structures.** All refugees interviewed had left their homelands devastated by war. Arriving in Australia was vastly different for many reasons. One recurring theme was the noticeable difference of living with freedom, peace, and relative stability in Australia. There was a common perception that laws were clearer and often “fairer” than that of their homelands. Compliance with laws and citizens abiding by regulations underpinned a sense of order and safety for these young refugees. Some participants reconciled the surprising experience of not to being in punished by authorities when they had not committed a crime. For girls and young women, there was a gained sense of equality and appreciation that laws also offered some protection to women, which was not available in their homelands.

“No war here, it’s a peaceful country. Rules and regulations and order is good here.” (HoA female, aged 16).

“In Australia it’s democratic and the government is a good person. The police will tell you the good things and bad things. If you do bad things they tell you not to do again so you can know how the country is.” (Togolese male, aged 25).

“The peace is my favourite, there is no crisis here as is in our country. Every day no problem.” (Togolese female, aged 14).

“In Australia, you can’t just kill a person like in Africa, they not do bad things like that.” (Togolese female, aged 18).
“We aren’t punished if we don’t break the law here. No punishment of innocent party.” (Karen male, aged 19).

“Men and women are more equal here which is good. You’ll be secure when it comes to men and other stuff and even if you know someone’s going to do something they’ll get punished for it. So if someone commits a crime then it applies and protects women and men as well. I would be married to some guy I barely know now. I’m so glad I’m in Australia where they can’t do that to girls. I have some choices about who I go out with.” (HoA female, aged 20).

Often participants expressed difficulties with learning the process and systems associated with the host society. With a lack of English, this was exacerbated and at times, anxiety was experienced in learning cultural systems and mores.

“Women have trouble sometime. A mother, like they like they have to go to like Centrelink something like that. They have to fill the form of, of their child or is their husband working? Yes. They have to go and they can’t speak English so it’s hard for them, yes. Sometimes there is like, even they can’t sleep or eat.” (Karen female, aged 21).

“I have a car insurance but I was very worried, I was very, I was very worried about the car accident. I worried for I have to pay a lot of money because we have accident. I cannot live, you know, another guy he just called me to this and to, sometimes he called me twice a day, want me to pay money. I don’t know what going to do because this. My friend, she helped me, she often busy and I very worried. Uh, I cannot live. I don’t know what have to do. And one month they asked me to go to the legal service for make the permit. I go there. When I went there they interview me about the, what happened and he asked me to contact, to contact the solicitor. Yes I have to do by myself. One woman come to my house and she, she told me like to fill the interview. Like, they want to sue, sue me. And one out of the organisation come and ask me to prepare a folder evidence, yes. I, I told them how much bill and everything is file so I should. I don’t even know how to, how to...” (Karen male, aged 22).

Day to day living: General quality of life. Many participants found quality of life had significantly improved in Australia. The Togolese community in particular spoke of being overwhelmingly pleased of their new living conditions.

“Everyone has one room, in Australia you have big house. In Benin only one room to sleep, we sleep all, 10-11 people in one room. It’s difficult because no money to spend in Africa. We [my parents] don’t have a job but we have good life here. We are so grateful to live in Australia.” (Togolese female, aged 13).

“Australia is good country. We play in parks and everywhere we can go to. We have a big(!) house to live in together and its quiet here. We like playing outside with our friends with our bikes.” (Togolese male, aged 15).

“The financial difficulty of not having what you want is not there anymore. Health is better as you can afford medicine. There are more jobs and infrastructure is good here.” (Sudanese male, aged 17).

“Australia is a great country with a lot of room for good life and chances to success at sport, going out and school.” (Sudanese male, aged 24).

However, good quality of life also came at a financial price with many refugees reporting day-to-day living to be financially challenging. Centrelink or social welfare played a crucial role in assisting with the resettlement of all participants. However,
many participants spoke of difficulties they had in dealing with the governments and bureaucracy. With limited English language skills, navigating financial difficulties and bureaucracy was often difficult for them.

“Lifestyle here is better, but everything’s more expensive.” (HoA female, aged 16).

“Centrelink is not enough.” (Togolese female, aged 20).

“Yes, the income is very limited and they have to pay rent. So sometimes that financially they not very coping well but when it’s - so sometimes they... He really worry and then sharing their problem and they also know the problem and they know their mum is worried so they also very stressed and they share the money burden.” (Karen female, aged 18).

“Oh, sometime we all have to go to Centrelink and that’s when there is a paper or letter from Centrelink and they don't really understand and because also a paper or just because they don’t understand take them up and down and very busy and you know, we are so confused and having trouble with the paper work...” (Karen male, aged 19).

**Educational and employment opportunities.** Many participants cited education and employment as the main opportunities in Australia and this was a prominent theme discussed during interviews. A sense of responsibility to achieve success was an underlying motivation in participants hunger for education and employment. Many of the refugee youth had been encouraged to go to Australia by their parents and/or other family members to pursue a better life, which would also ensure a better life for family back home. Education and employment were perceived as a means to achieving this improved lifestyle. They were also seen as vehicles through which hopes and aspirations could be realised. Culturally, it was interesting to note that many HoAs or Sudanese had completed or were finishing their formal educations, whilst for the Karen, who were older on average were just beginning their schooling, reflecting the years of interrupted education for this particular group, compared to those who and arrived earlier at younger ages.

“Having a chance to go to school, no health concerns and can afford to buy the things that I want. Having a chance to work and earn a living and may be even afford to go on holidays.” (Sudanese male, aged 19).

“We have many opportunities to do what we like, working or completing study.” (Karen male, aged 19).

“We can live life to the fullest hear, over there, our life is limited. Here it is a modern world.” (Sudanese male, aged 22).
A new way of life was expressed among adolescent participants. They stated if they had grown up in their countries of birth, life would have been very different. Education and employment therefore represented an opportunity for young African females to break away from traditional practices of leaving their mothers to live with new families to marriage.

“Well if I was - I always think of it like if I was back in Africa at this age right now I would have first of all got married off and then probably had three kids, on my third kid right now or I don't know - I wouldn’t be studying either as it would be very expensive to so mum probably wouldn't afford it. So basically I think that’s how it would be there. For me now here, it’s just like - I’m just looking forward for my dream and all that.” (HoA female, aged 19).

“The one really good thing about Australia is the possibility that we can explore our potential...whatever we want to pursue. In Sudan that’s impossible.” (Sudanese female, aged 18).

Some participants were also aware of the contrasts between opportunities available to them compared to their parents.

“I guess now that I have grown up, now I understand that I have to take my opportunities because from where I’ve grown up. It was hard for my parents as well so they came here because they wanted to give us opportunities so I’m going to take advantage of what I have, so yeah.” (HoA male, aged 18).

**Education opportunities:** All participants had things to say about education and study. English language skills always rated highly as a means of progressing with education or gaining employment. There was a wide range of experiences of either looking for work/study options or already engaged in these activities. Most refugees found the educational system in Australia gave them more opportunities than that of their homeland. Higher education was among the many aspirations reported for these young refugees’ futures. However, opportunity for education this did not always mean it was easier for them. Many reported having not only to adapt to the new country and culture in addition to learning a new language, but also excel in their studied fields. At times, participants spoke of pressures applied by parents and families for their children to achieve good results, comparable to that of Australian youths. Some spoke of the high expectation they felt the community had of them in addition to internal and familial pressures to succeed. Implicit in this was the desire for role modelling and leadership among the youth in communities.

“The education system here is great so it gives us the best path in life.” (HoA female, aged 16).

“We have an opportunity to have education and Government support. In the camps maybe they have very busy education and then there’s not international standard and then even they have busy...”
education... There’s very good opportunity for them to come here and get very good education.” (Karen male, aged 19).

“Studying gives us more pressure as we have to be as good as the Aussie kids.” (HoA male, aged 19).

“I think these days’ refugees and that come over, they’re young kids, probably the parents put stress on their children to do good in school you know?” (HoA male, aged 18).

“In Africa, whatever, you get to a certain stage for studying and then you can’t pursue your career or whatever. In this country you can actually go to uni and stuff like that... You can get better jobs here, too, and something that you like.” (HoA female, aged 19).

“High expectations from family and society. My community for example think I’m smart because I passed school. There’s a pressure on me to be a role model for other Africans, I’m scared to fail my community.” (HoA female, aged 19).

For the young refugees interviewed in this study, there was a common awareness of the importance of starting education at an early age. Older youths reported taking pathways towards employment rather than education. Underpinning this outcome was the cultural view that an older adolescent/young adult was considered appropriate for employment. Sometimes, this outcome or expectation reflected their senior position in a sibship or where responsibilities befell on youth to earn incomes to support the family.

“Young people who go to school, high school system, they may have less problem little bit but other people who went to adult education, AMES, they have more trouble.” (Karen female, aged 23).

“If they come here as a 16 year old...it’s just like oh no, it’s too late, I can’t study, I’m like mentally already past my state of learning or whatever. Then they start working or going into factories and stuff like that. Those people I would advise them to - go get an education because anyone can study at any time of their age and just when you - when you’re educated you know what you want and you’re just more open about everything; about the world. It gets more about - you learn more about yourself too because then when you’re educated it’s like oh, maybe I am smart. I can do this. I can do that. So they shouldn’t lock themself up and just lock up their minds and their brains. They should go pursue. They also - they probably do have a dream. You never know until you actually do something about it.” (HoA female, aged 19).

*Employment opportunities:* While many participants were positive about the work options in Australia, nearly all were conscious of the difficulties in gaining employment especially with limited English. Participants with early hopes of obtaining particular jobs were often disappointed by not being accepted due to limited English language skills. For others, choices were too overwhelming, creating uncertainty about which path to choose.

“Find a job it’s hard.” (Karen female, aged 21).
“She said like because we have a language problem sometimes the job that we would like to do they can’t really do it or maybe not, so we feel like we are not represented and not happy.” (Karen female through interpreter, aged 20).

“You have a lot of chances that make you become worry because too many chances out there.” (Karen female, aged 23).

“And sometimes we don’t know ourselves what we are good at and if we do that one and we’re not sure ourselves, oh can I do that or not?... So it’s helpful, like for you to, yes, to find a job. Or maybe, their one is easy but I think, oh maybe I can’t do this...yes.” (Karen female, aged 19).

Participants reported that making the decision to find employment or choosing a course of study was influenced by government welfare departments’ and job assistance programs, which participants stated, encouraged them to gain employment over education. One Karen participant spoke of an employment assistance agency encouraging them to lower their expectations and except any work being offered. The Karen spoke of being given limited tuition in English through resettlement programs, which they felt was not sufficient to competently grasp English. They explained the pressures around the expectation to immediately start study or work and become contributors to their new community. Often the sheer choice of career options was confusing. With limited experience of work and study, many found they were unsure were their skills lay.

“When the Karen people arrived and if they want to study, the job agency try to push them to looking for work, and it’s hard for them to.” (Karen female through interpreter, aged 21).

“She says she really want to work, but the thing is once you came here your English is not very equivalent and then they want to study English and they want to get up the line but they feel the Job Network [employment assistance agency] push them very hard just to work, whether they are ready or not, so that’s very negative thing for her.” (Karen female through interpreter, aged 20).

“We get 510 hours of English Language tutor. Oh, that’s not enough. Yeah that’s not enough.” (Karen male, aged 24).

“Good thing is there’s opportunity to study but one thing she feel negative is that there’s a [employment agency name removed] that you have to register and then they really push young people very hard because young people want to study but the [name of agency]...push them to looking for work. They sometime even say you come here as a refugee and then you want to do something good in the future, you have very high dream. Why don’t you think to work and to earn some money for your current situation? So that’s something negative.” (Karen male through interpreter, aged 22).

“When most of the Karen come to here, they don’t know about the new country. They are unsure if to study or something. And then maybe some people maybe think that they are lazy or something or sometimes if they don’t get job straight away. But really they are confused about how to live in this country.” (Karen female, aged 19).
Some participants spoke of a strong desire or need to give back to their communities back home through their choice of career. This also included working overseas. These participants also appeared to possess a clear sense of purpose, direction, goals, and hope about their future. For others, direction and purpose was not always clear.

“In my future I think I have to when I’m finished school... I would like to work with community, social work.” (Karen male, aged 19)

“I’d love to work for World Vision... in another country and help people.” (Karen female, aged 18).

“I do not know what my purpose is. I don’t know how to start my new life in Australia. I sometimes think there is not much point to this... my struggles, now I am here, I don’t know which way to turn.” (Togolese female, aged 20).

**English as precursor to success.** For all of the refugees interviewed, learning English was an important issue and poor English was seen as a major impediment to successful adaption, particularly scholastic achievement, gainful employment, and community integration. All participants conveyed a good understanding of the implications of not learning English. The Horn of African youth, for example, were very aware of the helpfulness of leaning English and commencing tuition at an early age. Many saw the lack of English language as a risk factor to isolation in the community and broader problems around segregation and exclusion. They noted that young mothers are especially vulnerable given their needs to prioritise children over learning English.

“My aunties - they've been here but some of them don't know English so they find it difficult. So I think the only - I reckon the only barrier is the language. If they knew the language then everything would be more easy.” (HoA male, aged 15).

“It’s harder for them to communicate with the people there. That’s how they form groups in the community because they can’t really communicate with the other cultures. It’s like every culture - it’s not just with the African community - it’s every refugee. They tend to stick with their own because they understand each other more which means they don’t get too see how other people are like and that’s how the judging and everything starts and they don’t get to communicate with other cultures. They just isolate themselves and segregate themselves to their groups.” (HoA male, aged 19).

“Basically if you look for help and learn the language quickly then that should help you because then it won’t be as hard. It’s still hard being a different culture living in a country that’s not yours. It’s still hard to find jobs and get an education but learning the language helps a lot.” (HoA male, aged 18).

“Yeah, it’s very scary because they [Australians] talk very fluently.” (Karen male, aged 19).

“Sometimes she work with...the other[unclear] Indian girl and then sometimes she doesn’t really work properly... But she doesn’t really know how to explain for her to understand and they’re really frustrated and sometime because you can’t do job properly, you can’t say something that you want to say and it make you feel really sad too.” (Karen female, aged 19).
“English. I don’t know English yet, and then what to do. Want to be an accountant and work in bank. I also want to be a doctor but will want to be delivering children. I have to learn my English first.” (Togolese female, aged 13).

Participants from less established refugee groups in Australia found it hard to communicate with the broader community using English, and felt the community could be more patient with their developing language skills.

“Most Aussie people they speak very quick yeah. They need to speak slowly. That is the main thing. Just try to understand why they’re quiet of like this, you have to know that they didn’t understand or didn’t get what you are talking about. You have to be patience on them.” (Karen female, aged 18).

The Karen and Togolese communities, being newer to Australia, lacked confidence in using English and talked of the energy and time spent practicing English. They were keen to communicate with others in English and saw a need to increase opportunities to practice the English language. For some Karen, opportunities to speak with non-Karen were not only an important way to learn English, but seen as a step toward greater adaptation more generally.

“I think some, some Karen people they are not good at English but they are not afraid. They are try and they, they speak not, so it is not good but they try... They try with other nationalities, they try to speak English, is good for them...but they scared too.” (Karen female, aged 18).

Cultural and community distance. Interview data from all cultural groups indicated there was a sense of isolation from the communities they had moved from. Their homelands operated at a different pace and time frame and the ‘new’ communities were different, creating a sense of alienation. Some participants spoke of the distance they experienced between their neighbours. Moving into spaces where the neighbours were not culturally similar, tended to isolate them from countrymen also living in Australia. This was contrasted with their homelands where it was commonplace to have regular contact with neighbours. This, in part, resulted in some participants feeling isolated and disconnected in their new homeland.

“People are kind of isolated here and keep to themselves; life is at a fast pace and time goes so fast.” (Sudanese male, aged 22).

“Like here in Australia we live with our neighbours but we don’t know each other. That is strange for the Karen people.” (Karen female, aged 18).
The exception to this finding appeared to be in the HoA participants, who having been resettled into a neighbourhood comprising already settled Horn of Africans, felt it was advantageous to be settled in the early days with familiar countrymen and women and other people who were also refugees. For a majority of the HoA, having arrived at an early age, the settlement process was also much easier.

“We live in an area such as [suburb name removed] where everyone is basically, most likely, to be a refugee. Therefore you’d feel like you’re home anyways... Being around so many refugees. Otherwise if, for instance, that a refugee was put in a place where there’d be like Aussies – complete Aussies and stuff like that, that feels alone and isolate.” (HoA male, aged 18).

“It’s the good thing about [names of two suburbs removed] sort of district areas... They bring in all the refugees together and makes them feel at home.” (HoA male, aged 15).

“It’s easier because I grew up here, so I don’t like know my other country.” (HoA male, aged 19).

“It’s pretty good here, especially if you have grown up here, it’s easier.” (HoA female, aged 16).

Other participants reported a distance from their own homelands in their attempts to make a new settled life.

“My biggest problem is feeling like I belong to a country here [Australia] by name but not meaning.” (Sudanese male, aged 23).

“Australia is an individualist society. It’s hard to know where I fit in either of my countries now.” (Togolese male, aged 25).

**Developmental and intergenerational challenges.** Many developmental and intergenerational challenges were present for the young refugees interviewed in this study. Most participant concerns stemmed from living and communicating with older and elder refugees. A range of issues was spoken about including: the pace of acculturation in young people relative to their elders, the changes associated with developing into adulthood in a new culture, intercultural marriage, traditional diets, and the lack of elders in the community. The sense of youth adapting more quickly, appeared to also have implications for the loss of cultural traditions and practices as well as traditional roles held by older and younger generations. For some, there was conflict between immersing themselves in their new homeland and future, yet having to deal with the elders and their own desire to keep strong links to their traditional culture.

“Being young we learn here fast, not good for older ones.” (Togolese female, aged 13).
“Our old culture dies out here as people become transformed into the cultures of their current country.” (HoA male, aged 18).

“I’m balancing all my time with study and demands of my new culture. I have concerns about losing my good customs, that’s sad.” (Sudanese male, aged 25).

“My mother and grandmother and the oldies. I feel sorry for them. Because they can’t and choose not to speak the language, they can’t really have a future here. They lose their power over us...you know?” (HoA male, aged 18).

“I hate these older Somalian women who are always discriminating because I don’t wear a scarf. They get on my nerves, man.” (HoA female, aged 18).

“I think our younger Karen people like to keep secrets but not the teenagers that grow up now I think. Like those younger than me are at my age. They really now adapt to this country behaviour...like Australian teenagers now.” (Karen female, aged 19).

Some of the young HoA women particularly found it difficult to reconcile disapproval of intercultural relationships and felt this was unpermitted by their elders.

“A bad thing is living in Australia would make young people form relationships with people of different - what is it called - different nationalities. In the end if they do form a relationship they will not be able to continue this relationship as they’re from different cultures. This is something that’s bad because parents will not allow marriage different cultures.” (HoA female, aged 16).

Cultural preferences around food were also a source of intergenerational tension and an indicator of concerns among a culture that traditions could decline.

“Our one thing is for food - like my mum she want us to eat our meals with rice, every day with rice and my brother he was adapt to - he said mum it’s okay even if I don’t eat rice I’m still alive, I can eat other things. Since I’m born until now I have to eat rice every day, every day so I get bored and mum said you Karen’s you born, you born like us and your genes are like us - so like you can’t live without rice. So you have to eat meals like with rice like mum cook every day. Like sometimes we skip out meals and we eat other things and they don’t like it.” (Karen female, aged 20).

Unlike the other refugee groups interviewed, among the Karen and Sudanese participants, there appeared to be a lack of elders and/or leaders in their community. The majority of the refugees were young. In the Karen community, for instance, the elders play an important role offering guidance, counsel, and support. With many elders having perished in the war or remaining in homelands and refugee camps, many young Karen felt unsettled and found it hard to deal with their new lives without this assistance. The young Karen missed not having elders to gain help and guidance from and empathised with the young adult Karen not having as many elder Karen available for support. That is, responsibility appeared to fall on older youth to fulfil leadership and guidance roles and role modelling for the younger Karen. They identified that confidence and courage here was needed to step up to this challenge.
“Yeah, they say [unclear] less obedient because in Australia they seem like the young people they are brought up free to speak or to express their feeling or opinion, but young Karen people make most of their - they grew up control by their parent's guideline so it's very different in that they don't have - they lack of confident. We have no leaders to show us.” (Karen female, aged 21).

“The older people missing like bad for their other older Karen people.” (Karen female, aged 19)

“In Sudan, all our wise older people and fathers died in the war. I am worried for where that leaves us as a people. Many Sudanese are suffering this loss. In Australia we have to rely on our friends a lot and each other to learn because the wisdom and experience was taken from us.” (Sudanese female, aged 18).

**Homesickness and missing family.** Almost all interviewees expressed missing family and friends back in homelands or other resettlement countries. The use modern technology among the youth in this study was an essential way to stay in touch with parents, siblings, relatives and friends back home. However, most participants had limited or no contact with family or friends from home. The HoA participants were an exception, with many having arrived at an earlier age with little or no memory of life before conflict in their home countries, had acculturated to an Australian life with less need to ‘stay in touch’ with families. Family reunification programs also meant that many had extended family members already in Australia. A prevalent theme across the other three cultures was a hope to be re-connected with family members through family re-unification visas. Even though most participants arrived with immediate family or extended family members, it was not uncommon for them to be separated from other immediate family members. The lack of intactness was a source of loneliness and distress for many participants.

“You know like when people, when they feel very sad, they miss their home, country, because now in my environment the other people who I know, I think maybe that’s all. He just want to go bed again and again. Yeah, he feel really bad. Mostly he feel homesick... I think when we go and visit he just talk about he want to go back. He feel really sad, just not happy here anymore, something like that.” (Karen male through interpreter, aged 19).

“You can communicate with your friends and relatives with the computer. If I didn’t have this I not know what to do, I want to see my family so badly.” (Karen male, aged 19).

“Oh I miss my sisters so much. I wish for them to be here so we can be together, but this might not be possible.” (Togolese female, aged 13).

“Every day I miss my parents I wish to go home to see them.” (Sudanese female, aged 18).

“Being a refugee in childhood, and having no parents to grow up with, moving from place to place...I miss them. Life is tough without parents and family with you.” (Sudanese female, aged 23).
Social exclusion and racism. Most participants found racism to be prevalent in the community. They reported theft, damage to property, verbal abuse, exclusion, and violence stemming from racist intentions. Prejudice and discrimination were experienced in the workplace, public spaces, school, and within homes and neighbourhoods. There was a perception that Australians looked down on refugees due to their difference and a perceived lack of respect felt towards people from other cultures. The Karen, for example, reported instances of property damage carried out by local youths and felt these attacks were carried out due to prejudice towards their ethnicity. A small number of Togolese participants also reported racist abuse whilst walking in public spaces and in their neighbourhoods and schools. For another small group, there was a sense of luck in not being targeted in an ongoing way.

“Our neighbour children visit our house and sometimes they turn on the tap and then keep the water running and sometime will get the egg and then throw it.” (Karen female, aged 16).

“Some young kids, aged maybe 12 or 13...when they walk out the kids walk out in front of their house they throw the stone and stuff and then sometime they get into the backyard and they steal the bike or something like that. They like treat them with no respect.” (Karen female, aged 19).

“Life is challenge everywhere you got bad kids and good things. Walking back from shopping centre and people throw eggs at us.” (Togolese female, aged 15).

“Racism is really bad here...I think the number one problem probably racism but I haven’t – that hasn’t occurred to me often so that’s pretty good.” (Sudanese male, aged 22).

“The last time it happened to me. I was crossing the street, like how you cross the street and the green light was for me and I was going...the teenager boys in the car and the green light was on for me....they rushed towards me....I thought they were run me over.....they put up the rude finger...it really frustrates me and I couldn’t do anything about it”. The teacher says say back ‘I’m better than that’ but I just ignore it and walk away. I don’t react, I just go and tell the teacher.” (Togolese female, aged 15).

At other times, racism was less overt.

“People can be nice but because they know they have to because racism is against the law. But people ...they remind you subtly this is not your place.” (Togolese male, aged 25).

“Some people are not great – racism here” They say to my father, ‘Is it true that people sleep in trees?’ People misunderstand us, we are from an educated society in Ghana. [His] degree not recognised. Those things are the bad side, they just look at your background.” (Togolese female, aged 15).

“We find it hard to get rental accommodation, it’s a shortage for many refugees. The real estate agents don’t give us houses due to our financial status, but also possible racism.” (Sudanese male, aged 16).

At times prejudice was evoked when English was not spoken in public.
“And like once when I was, when I came back from the school and like we were with friends and like we were talking in our language. And one of the guys like he asked for the cigarette... And then we said, we don’t have any. And then we speak in our language and he shouted at us like, you and you speak your language. Why don’t you speak English?” (Karen female, aged 18).

Racism was also prevalent within schools. Despite the positions of trust and care entrusted by refugees in teachers at schools, many participants reported experiences of feeling let down by authorities entrusted to help and support them. Their accounts highlighted their views of prejudice towards them.

“The Year 8 or 9—they put their bike you know on the place that you put the bike. Then the English children they stole the bike. The Karen guy then he know that this guy stole his bike because of racism and that they bully him all the time. They put a cigarette on the head and then he know that they get fight – the teacher saw this and the teacher you know he don’t know the reason fully. But he was on the white side and he said he has stolen your bike. You’re poor. They can buy a bike if they want it...” (Karen female, aged 18).

“Even teacher when they study together...they give more favour for the European students. They are all refugees in the class but they help the white student.” (Karen female, aged 18).

Similarly in the workplace, racism was reported by all participants but mostly, the older Karen youth. Some spoke of two disparate sets of standards for Australian employees and for refugee employees. The Karen also spoke of their perceptions around others looking down on them, limited tolerance and hostility. Generally there was a feeling that migrant unemployment was tied to racism.

“I have experienced racism at work. I have...two supervisor – the other one good. He asked me to work late, the same rule with the other Aussie when he holiday – the other one stop my role and not allowed to work late but Australian ask and he says yes. All the time this supervisor he asked me to do the job that the other people doesn’t want to do. Like putting us under him.” (Karen male, aged 24).

“But in the workshop, when I did apprentices in Mitsubishi, a worker, he look down me. He said always you’re no good go home, you don’t need to come here anymore...but he always get other guy to work— It’s very sad some attitudes that people have – they feel very angry and have a lot of hate for other people inside them. But I know in Australia people are good and very nice. Yeah and very upset when they see that and nearly cry you know.” (Karen male, aged 22).

“The employment of people like us is not the same for Aussies. Were different and because of this they don’t hire us.” (Sudanese male, aged 22).

Experiences of racism were increased when participants travelled in groups. About half of the participants, with representation from all cultural groups, stated that social gatherings among cultures were viewed negatively by some in the community. This was commonly linked with the perception that others in the community perceived young people travelling in groups were seeking to perpetrate violence. This underscored perceived prejudice and suspicion in the community, and it was felt the
media portrayed young Africans (particularly Sudanese) in a negative manner. One HoA participant noted injustice in the lack of consequence for racist behaviour, which increased a sense of alienation. Another expressed anger at the perceived injustice perpetrated by Anglo Saxon community members against ethnic minorities.

“Racism, it’s when you’re with a group of our kind, like black people for instance, they think bad. In the city they think bad, you’re in a group. There’d be like black people in a group in the city, this is going to be bad news.” (HoA female, aged 19).

“People think we want to start a fight because there’s a lot of us.” (HoA female, aged 18).

“A white person they’ll do something, so something for instance a racism thing. Nothing happens to them, you know what I mean? Also if something happens, they call him by his name but then when a black person does something, it’s like African, African...they’re African.” (HoA female, aged 19).

“I reckon black would have every right to hate white people but I don’t think the other way round… Look how they used to treat black people back then. Asians and stuff hate the white bastards. They’ve been racist with the Asians, with the black people with everyone.” (HoA female, aged 16).

“Racism is still very alive in Australia. I experience it very much in my studies and my workplace as well as on the streets.” (Sudanese male, aged 25).

“The bad thing about Australia is the negative viewing that young Africans have in the media. They make it out like we’re all criminals and gangs.” (Sudanese male, aged 17).

Some HoA and Sudanese participants felt that the police were prejudice towards them.

“Yesterday, I got pulled over. Here he comes. Knock, knock, knock, knock. Pass your license, please. I was looking forever. You know my card’s been missing? I’m looking for it. Half an hour later gives it back to me. He’s checking my whole car if it’s registered and shit. He just didn’t believe me. I’m like yeah, it’s my car and stuff... They actually thought the car was stolen because it was really good.” (HoA female, aged 19).

“Guys – You know what our guys say to them, police try to be racist with them. They say take your badge off. Take your badge off. Then the police get scared, this guy’s serious...I know mates who get beaten up by police all the time”. (HoA female, aged 19).

Males and females tended to have different experiences of racism, with females reporting particular vulnerability compared to their male counterparts. For these young women, it was felt wearing a headscarf and its representation of religiosity, rather than skin colour, triggered more racism. Moreover, compared to their male counterparts, they felt less able to fight back.

“I have seen a lot of racism and people – at the start it was bad – but now it’s much better – at the start it was no good. People saying – talking about my scarf – why don’t you take it off? What are you hiding under there? It’s got better, but I still get bad comments about my scarf or skin colour and stuff. Stupid comments like that.” (HoA female, aged 18).
"You know what I’ve realised? They don’t act – they don’t act racism if we were like guys... They’re racist towards girls... They’re racist to the – they’re not racist to the guys because the guys will take care of them... “Guys tend not to be racialised as they don’t have anything symbolise their religion.” (HoA female, aged 19).

For some young women, there was talk of a need to be tougher towards racist abuse. For others, there were mixed emotions of disappointment and hurt at being abused in public presence, though a recognition that not all people in the community are racist. Many young HoA in the focus groups felt that travelling in groups provided a sense of empowerment – a way of fighting back towards racism.

“Too many people stare at you especially if you are a girl...you get more racism if they see a girl-not a racist if see group of guys, that’s why we have to show toughness.” (HoA female, aged 19).

There was this guy that was being racist to me. You know what I hate most? People don’t say something. They look at the guy like he’s really being really rude and stuff but they don’t do anything about it. Then – a black guy came up to him, it was like you don’t talk to her like that. I don’t even know the guy. Then the guy shut his mouth. He actually – he’s like get out of the train. He made him get out. Everyone was clapping.” (HoA female, aged 19).

“The thing is we are protesters. We look like we won’t do anything but we show ’em. Girl Power. Because, yeah, because we wear dresses and do our hair...and go together...We fight back.” (HoA female, aged 16).

Although the Horn of African young women felt their male counterparts were less vulnerable to racism, the Karen young women felt their male counterparts were more vulnerable. Indeed, among the Karen, a sense of helplessness and uncertainty prevailed in how to deal with the racism.

“Usually our Karen guys are short, the English are tall. So they look down like this and sometimes they smoke cigarettes and they put the ash like this on the head... They want to fight. Karen guys are small so they can’t like protect themselves ...So always on our Karen young guy, I really feel really sad for them.” (Karen female, aged 20).

“We don’t know what to do. Our Karen people are quiet, we want to say something but can’t.” (Karen female, aged 21).

A number of participants in the study however acknowledged that it was a minority group in the community that were racist. Others struggled with how to react and many
young HoA males stated fighting and showing toughness were common responses to racism.

“A lot of white people are really, really nice. But probably 25% are racist.” (HoA female, aged 16).

“Probably fighting I guess because I know some people that did that, but yeah, they get over it sometimes as well.” (HoA male, aged 18).

“Yeah. You know what people say? Niggers. What about the police, they said there’s niggers too.” Another female speaks, “No, but there’s good and bad in everyone, you know what I mean? But there are really good police people, yeah.” Other female says, yes that’s true too.” (HoA female, aged 19).

Others had different ways in dealing with racist abuse. One Togolese community member reflected upon her experiences a great deal, trying to see to get some positive from such situations. Another female Togolese prided herself on her difference, citing this as a helpful way of dealing with abuse.

“Facing the challenges- this is a problem but I’m just trying to do my best. Knowing that I can let it go...the pain will be a few minutes...the pain will stay for a while...it still hurts...it hurts inside...if you know them...if they harass you...but I just turn away...I’ve stopped doing the pain...I won’t listen to them. What’s brought me here is more important than what they say/do to me...those kids”. (Togolese female, aged 15).

“I’m the only one from Togo at my school [spoken with affirmation and pride]. Because I’m myself, I have a lot of friends.” (Togolese female, aged 15).

**Theme 4: Mental health constructs, experiences, and strategies**

**Constructs of mental health problems.** All cultures experienced some difficulties understanding the question of mental health in their cultures and clarification was often required. Across the cultural groups, participants tended to fall into two main groups. The first were those who thought of mental health issues as being either not something their culture experienced in the same way that Westerners did and/or a condition that did not exist. The second group felt mental health issues existed in similar ways to Westerners and approached them in a number of different ways.

Among the first group, the community was often cited as being the main source of help with difficulties in life, and the presence of ‘mental health problems’ was denied or queried. Most of the recently arrived Togolese, for example, many of whom comprised this first group, conveyed a sense of confusion around the concepts of depression or PTSD; indeed, they questioned the presence of these problems in
their community as defined in Western terms. Instead, they expressed a sense of happiness and elation, perhaps either a reflection of their more recently changed circumstances (i.e., peaceful resettlement to Australia), a perceived stigma in reporting mental health difficulties, or a genuine expression of positive well-being. Data extracts from the Togolese suggested they were overtly happy, giving assurance that they did not experience negative mental health. When questioned about concepts such as anxiety, depression, PTSD, participants in this group tended to associate mental health difficulties with extreme behaviours and constructs of ‘dangerousness’ or ‘craziness’.

“There is not really such a thing as mental health for people in my culture. When they feel sad or troubled they speak out and seek help which others close to them caringly give.” (Togolese female, aged 17).

Depression - there’s no depression. Mental health is about group life. If I face a problem then my family and community face it too. We don’t have counselling – we share things in our family and with relatives and the community.” (Togolese female, aged 15).

“No no we are happy....we are so happy...everything is good. “The people here are really nice, even on the streets. I can’t say anything is bad about Australia. I have no problems at the moment.” (Togolese female, aged 18).

Depression...no not us...it’s like they do crazy things and lock up. No we not like that....crazy in head like that.” (Togolese female, aged 14).

“When we are not happy, there is not a thing called depression. Only heard about depression when in Australia.” (Togolese male, aged 25).

The second group, which included the majority of the participants, were aware of negative “metal states” even though terms such as “depression”, were new frameworks for them. Common expressed indicators of depressed, anxious, or mood altered states included: sleeplessness, worry, less energy, tiredness, sadness, suicidal thoughts and actions, and deflated moods. Physical manifestations of psychological problems, which were understood by participants as psychological issues were also cited. These included breathing problems or ‘heaviness in chest’, sleeplessness, headaches, and lack of appetite. There were also signs that some experienced post traumatic stress symptoms such as flashbacks, nightmares, and extreme worrying. While for others, there was a direct experience of depression related to psychosocial issues such as unemployment. Most who experienced these symptoms dealt with them themselves with little to no professional support.
“Depression means thinking bad thoughts and can’t get help anymore.” (Togolese male, aged 15).

“In our culture for example, you can’t do nothing, we have depression because we can’t express ourselves, our voice, I want to work but I don’t have a job... We can’t express ourselves the way we need. In our culture means you have a lot of problems, you just have this problem and forget about yourself. It’s heavy, you can’t resolve at all. Sometimes killing themselves because no hope for the future.” (Togolese male, aged 17).

“When people in Togo get sad, it’s like here. But people want to kill themselves they go into sea and kill themselves. I saw that.” (Togolese female, aged 17).

“What happened to me, makes me tired a lot and always feel sad, not happy, no smile anymore. When we are not well, we cannot sleep.” (Togolese female, aged 20).

“Not happy, not smile anymore, no eating, try to enjoy my life but cannot do.” (Karen female, aged 19).

“I sometimes feel I cannot sleepy, fear and scary, dream a lot, remembering my past a lot.” (Karen male, aged 23).

“My past is always present in my mind. I can’t get it out.” (Karen male, aged 25).

Some Karen participants noted a “collective helplessness” when expressing concepts of depression, stress, or anxiety. They described their mental health experiences in social terms. As a group, they expressed uncertainty about who to turn to for help, whilst their community grieved too.

“Our Karen people suffer because of war. They can’t help themselves, everyone sad, everyone have trauma, they do not know how what to do.” (Karen male, aged 25).

“In the Karen culture, everyone experience this....what you say trauma....my friends, all families are same, they have their family die and we know other families they the same. I am sad for my friend’s family and the Karen families, they are our family too. We cannot go to for help because they need help too.” (Karen female, aged 20).

Though not prominent, one theme that was expressed by a few participants when asked about mental health constructs was the relatedness of homesickness to mental health. Many expressed loneliness and despair when describing their families back home. They described these with intense physical descriptors, implying they see loneliness and psychosocial factors such as unemployment as inextricably linked to emotional well being.

“I miss them so much I feel pain in my stomach, my throat. Like I can’t eat, have sickness.” (Karen male, aged 22).

“Depression to me is not having job, not having to see my family, that’s depression. Always sad because wanting to see my family, feeling alone.” (Sudanese female, aged 23).
“There is much worry I have because of my family in Africa and some in Adelaide. I can’t be with them and that’s why I am depressed. Also because it’s hard to find a job, no one will give me a chance, this makes me depressed for a long time.” (Togolese female, aged 20).

Anger and forgiveness. One emotional construct with which participants identified strongly was that of anger. Just under a quarter of participants interviewed expressed anger directed towards perpetrators of violence in their homeland (e.g., governments, militia, soldiers). A few participants spoke of their internalised anger, blaming themselves for various circumstances in their lives. Anger was spoken about more openly than emotions involving sadness or anxiety. Given the role of faith in participants’ lives’, anger was often described in parallel to forgiveness.

“I hate them, I just hate them. They destroy our life and kill our families. What can we do? I try to forgive them in my heart but I just can’t.” (Karen female, aged 20).

“When I think about it, I get angry inside and annoy myself. I get angry too because I can’t help my family, what can I do, I am just a girl and cannot fight back to soldier.” (Karen female, aged 18).

My faith teaches me to forgive others. Of course we are anger. But this is something we try to control. Our faith helps to forgive others.” (Togolese female, aged 18).

There is a lot of anger in my community. People don’t talk about it as much they prefer to drink it away, especially the young people. They are angry at the civil war and people who take their families away.” (Sudanese female, aged 23).

Ways of dealing with mental health difficulties. The young refugees in this sample reported coping with negative mental health states in several ways. Three primary, and equally common, strategies were identified, including: dealing with it on one’s own, using informal networks, and seeking external help. Other strategies included “holding onto memories” and the use of alcohol either on one’s own or with peers. Not surprisingly, the use of alcohol as a coping strategy was reported to ‘help forget’ or ‘deal with’ negative emotions.

“Dealing with it on own”. For participants who acknowledged mental health difficulties, most stated they dealt with these by “dealing with it themselves” through either: (i) suppression or ignoring emotional pain and/or (ii) “just getting on with it”. For some, this had positive effects. Members of the HoA focus groups wanted to move forward from their traumatic past, indicating dwelling on the negative mood states and trauma was of no use to them. Some did not want to know about their parent’s trauma either. Data extracts from the HoA and Sudanese suggest dealing with
it on their own was more common for these groups compared to the Karen and Togolese. They found embracing new challenges and activities as a helpful way of leaving their past behind and having a sense of starting over and moving forward. Although such behaviours could be understood as ‘avoidant’ strategies, users of these strategies presented positively, contrary to expressions, which may be interpreted as denial. Similarly, some interviewees stated that while they dealt with negative emotions on their own, generally it produced positive emotional outcomes.

“When it’s there, I try to think about something else. No point in thinking about it I tell myself, forget about it and try to push it down. Sometimes I play music to keep it away, doing something else keeps it away and I’m fine, that helps me.” (Sudanese male, aged 17).

“In my house, we don’t talk about it. I don’t want to know about it, it’s just in the past and we look to the future not the past.” (HoA male, aged 19).

“You just deal with it...you’ve got to man, what’s the point in dwelling on the past, you’ve gotta look forwards. I know what happened to me and my family was bad but it doesn’t help me to go there. I’d rather look at life with opportunities now and get on with these.” (HoA male, age 18).

“I rely on myself a lot, that’s how I am. I have learned how to keep it inside and don’t let it get on top of me.” (Sudanese male, aged 25).

“My silence being on my own, I love it. Especially when I have a lot of things on my mind like what happened to me...it’s like I am protecting myself. I don’t share it, I prefer to deal with it my way, on my own.” (HoA female, aged 19).

Others tried to put their trauma and grief to one side and move on with different results. The subtle but important difference from the previous group was suppression did not appear to have positive benefits. They reported covering sadness with hopes that negative mood states would pass. In some, there was a need to deal with their experiences prior to moving on. While another group of participants who used suppression or avoidance felt they could not share their experiences with others, instead internalising their negative emotions.

“Just angry inside, that’s it. Nothing more than anger. If I get angry I cry and then I’ll sleep and then I’ll forget about it when I wake up...until it starts again.” (HoA female, aged 19).

“We try to ignore our pain, we do what we have to do. It helps to ignore and say it’s not there, we try to overcome it. It’s hard to continue to ignore but it comes again.” (Togolese male, aged 25).

“When I remember it... 15 years in refugee camp...not something to share...I don’t like to share it...I don’t think they[friends, counsellors and family] could feel how I feel...don’t like to share...sadness is the same in all cultures, but this is my experience of sadness. I couldn’t tell anyone about it.” (Togolese female, aged 20).

“I do my best to push the bad feeling away, it bothers me and if I think about it more it gets worse. The problem is it keeps coming back. It goes for a while, then it comes back. In some ways I know I have to
face it but I can’t yet, I just keep it bottled up. There’s too much suffering to bring up you know.”
(Sudanese female, aged 23).

Stigma in the community towards mental health issues tended to push some respondents towards not dealing with issues, maintaining their internalisation and sense of isolation, finding solo activities to help deal with emotional pain.

“I get sad when think about my life in Ghana and Togo. I try hard to put it under control if I can’t control it I get frustration and anger. But I keep it inside from other people, they wouldn’t like it. They would treat me different.” (Togolese female, aged 15).

“I would not dream to tell anyone in my culture. I keep to myself. I just try to help myself. I don’t want to embarrass myself or my culture showing negative emotions and crying.” (Sudanese female, aged 18).

“For example like me, if I feel sad, I like to stay low and don’t want to talk to anyone and being careful I think what I am going to do. I don’t tell people. So I open loud music, yeah loud music for me and just think.” (Karen male, aged 22).

“We try to ignore our pain, we do what we have to do. It helps to ignore and say it’s not there, we try to overcome it. It’s hard to continue to ignore but it comes again. In my culture, there may be think I am crazy that stops me from talking about it more.” (Togolese male, aged 17).

Even for those who had managed to adapt well to Australia and create a new life, there was a sense that negative emotions were always with them.

“No matter how much I do well now, it’s always with me…it affects you, you can’t get rid of it”...I try to read a lot of personal development books to keep myself positive. I usually read biographies about people who have had dysfunctional backgrounds that end up achieving something great that can boost my confidence and faith..., but it’s always there you know?” (Togolese male, aged 25).

**Use of informal networks.** Some of the group found sharing issues with friends, family, and the community eased mental health burdens. For many respondents, utilising informal supports was the only way to deal with anxiety or depression. They did not feel conformable talking to “strangers” about their problems and preferred the support of their families or peers.

“Depression same, but how we get help for stress different. We take walks a lot. Mental health with physical, we go for walk and exercise. It’s just a matter of culture...we don’t know the person – why should I approach that person with my problems?” (Togolese female, aged 15).

“We keep it to ourselves, not like Australians, we don’t see counsellors. We experience our troubles with our families.” (Sudanese male, aged 17).

“If anything I would go to an age mate.” (Sudanese female, aged 18).
“As a culture we prefer not to share our difficulties to people outside our communities. That’s just the way we are. We share with the people we already know and trust.” (Sudanese male, aged 17).

The Karen shared problems with friends and family, though preferred immediate family and extended family members. The majority of the general Karen community was made up of young adults, many who left siblings, parents, relatives, and elders behind to forge a better life for the family in another country. For the Karen youth, one consequence of this decision was the strong sense of a dearth of family and elders in their community to whom they could turn for guidance and advice.

“If we Karen we have problem, it’s shame to speak to other people. We prefer speaking with our family when we have problem. Or we speak with other Karen...like my Karen friends.” (Karen female, aged 18).

“We Karen, we have no parents living here...and some our parents die....our leaders in Karen State and [we] have to find our own way and path. We try to find leader in youth to guide but hard because no one to guide and help our young Karen. I don’t know what will be for young Karen people.” (Karen male, aged 24).

All cultural groups indicated that there was an expectation that the community would assist and help them with their difficulties including mental health problems. They spoke of the need to resolve mental health issues from within the community.

“In our ethnic group and most countries in Africa, you have ‘group life’. If I’m facing a problem, if I can’t deal with a problem, I have aunties and uncles and they will support me....like if people have depression, actually we don’t have these things, it’s not our culture, when you have problems you just go to parents and everyone in the community will come around...we don’t have is the counselling...we share things in family, all our family members...if there’s a problem in my house, the community will come around.” (Togolese female, aged 17).

**Prevalence of stigma.** Whilst many refugees interviewed in this study cited their family and communities as supports for life difficulties, stigma associated with sharing mental health problems with family seemed to conflict with this perceived support at times. All participants agreed there was stigma associated with mental health problems and help seeking. Not only did interviewees not want to share burdens with others, they were concerned that shame and embarrassment may result, particularly for their families. This seemed to be a prohibitive factor towards disclosure to family members.

“Keeping up reputation is important. We had a stigma towards mental health. I don’t want to bring shame on my family you know?” (HoA male, aged 19).
“We don’t cry. When you cry in Africa they say you’re a woman. Sometimes I will hide my tears from my family.” (Togolese female, aged 15).

“If we see like [counselling service name removed], we not want people to know we go there. People think...how to say [pointing to head], like crazy or something like that. Even with family it’s not good to be this way.” (Karen male, aged 22).

Seeking external help. Across all cultural groups, trust was a key factor in being willing to seek help and disclose to strangers about mental health issues. HoA participants spoke of trust and safety being required to share emotions and thoughts. This was especially so if they had an unsafe past. The Karen spoke of trust being essential in sharing trauma because they were frightened of shame and embarrassment. The Togolese, however, spoke of not wanting to share their emotions with outsiders, feeling strangers could not experience empathy for them. Many of the young interviewees had a connection with or identified with a religious group. Some participants, particularly the Togolese, found support and comfort in their faith.

“If depression, you ask God to take from you. We wouldn't ask like a counsellor because they do not know how we feel, we use our religion and faith instead to fix our problem.” (Togolese female, aged 15).

“We Karen are Christian and we look to church to help us with our difficulties. We have our faith to help us and our church community. We trust our church community because they understand what we go through.” (Karen female, aged 21).

“We pray every day that things would work out for us. We get help through the bible and how to know God. Through church we are successful.” (Togolese male, aged 25).

Apart from a few HoA and Sudanese participants, most interviewees stated they and many from their culture would not access professional mental health support, despite having been given details on arrival regarding support services that could assist with mental health concerns. Apart from stigma or shame attached to seeking external help, it was hard for interviewees to understand what was being offered in terms of help or how this might help. Most of the community members had little idea of what a counsellor was or did. In many instances, and seen in some of the quotes above, there was a perception that counsellors were ‘different’ in terms of culture and experience.

“What can counsellors do for us? They don't understand African ways and the issues we go through.” (HoA female, aged 19).

“You got have trust man. Us Africans...we know there are counsellors this and that, but they don’t use em because its kept in the family...you know?. They wouldn’t know what it’s like to be African in this country.” (HoA male, aged 18).
“Yes, they, the government tell us about counselling when we come here. But we don’t know where this is and how you can get. You have to pay money?” (Karen female, aged 18).

Using alcohol. As mentioned above, the use of alcohol was spoken about prominently. Many youths stated that alcohol was used commonly through their communities, particularly among the adults and older adults. Alcohol was also used by some participants in this study, or their peers. Infrequently, it was used as a way to ‘fit’ in with their Australian peers or more commonly used as a way to deal with negative emotions.

“Yes, drinking alcohol is a big problem for the Karen people, especially older ones. The young Karen drink alcohol, sometimes because they bored, or they cannot find job. But this is big problem for us, I think they use alcohol to forget about their problems, yeah.” (Karen female, aged 20).

“If there is a big big problem, too heavy and you cannot resolved it at all, drinking alcohol – people killing themselves this way and killing their hope.” (Togolese female, aged 20).

“The biggest problem for our culture is the young people, they like to use alcohol a lot, a lot. The guys especially go out and drink and use their money to buy alcohol. Interviewer asks: Why is it a big problem in your culture? Participant responds: They drink away their problems, their pain I reckon, loneliness and their past.” (HoA female, aged 16).

Holding memories. Many interviewees spoke of the burden in carrying the memories of their experiences. All participants’ bared painful or upsetting memories, and expressed different ways of coping with these. Some learned to carry them, while others used alcohol or drugs to numb the experiences. For the Karen, the exposure and consumption of alcohol was a way of ‘fitting in’ with Australian culture. All cultural groups interviewed agreed alcohol abuse was commonplace.

“Yeah, some Karen they use drink...alcohol...they forget it but only a few minutes, only a few hours when you’re asleep and you forget about it, but when you wake up alcohol doesn’t help you anything... I experienced it. You know when I came here; I know me and my other friends, our behaviour changed. We learned to drink alcohol. We have some parties with friends invite us, and when we go to them, we have to live like them otherwise no friendship.” (Karen female, aged 16).

“Yes, alcohol, to help forget about what has happened...make us happy.” (Karen male, aged 24).

“When they’re sad they drink alcohol. It depends on the situation they have.” (Karen female, aged 22).

Although participants generally noted suppressive coping styles with regard to their bad memories, other participants reported the need to hold on to their memories and were active in efforts to not forget them. For these participants, holding on to memories was a way of connecting and fusing them with their pasts, so as to protect
themselves from future threat (a way of building resilience) and as a means of remembering loved ones lost and loved ones still suffering.

“I cannot forget what happened to me...my family...I need remember so I can go on and help people back home.” (Sudanese female, aged 23).

“It’s painful when I think what has happened to my family. I try to remember a lot. My mother says too angry but I cannot forget. I will not forget because the memories remind me about where I come from and what I can do for my future.” (Karen female, aged 20)

“I cannot afford to forget what has happened to me and my family. The memories make me stronger and help with the struggles I now face with life.” (Sudanese female, aged 18).

Although for others, holding on to the memories served to reinforce their anger as a means of giving their suffering some meaning.

“When I think about Burmese soldiers, I cannot forgive them what they do to my family and me and the Karen people. Just want to hate, so much angry for them. If I try to forget, I do not want to. I am not suffering like this, my angry remind me of what happen so I cannot forget.” (Karen female, aged 21).

**Theme 4: General coping and resilience**

Discussions about general coping were freer flowing than discussions about mental health constructs. A diverse range of coping methods for dealing with stress emerged among participants. These were grouped into the domains of physical activities, spirituality, social interaction/activities and spirituality and faith.

**Physical activity.** Participants spoke with enthusiasm about physical activities which tended to focus on team sports for males and social walking among females. A carryover of sports played in home countries tended to continue through settlement in Australia, with some participants expressing difficulty in learning the newer games in Australian culture, such as netball or Australian Rules football. Among Karen males, soccer and volleyball were mainly pursued, while female members tended to walk and dance. Karen males also noted the importance of dance among their gender in the Karen culture. While this was readily available through cultural festivals, Karen males noted great difficulty gaining access to sporting grounds. Restrictions were in place that meant they could not play ball games outside of designated sporting areas and booking venues was seen as an obstacle to pursuing their sport and means of coping with life. Nonetheless, the activities provided a sense of continuity for participants
transitioning through pre-, peri, and post-migration stages with familiar sporting activities.

“Yes, very difficult to have field. Some people they organise to play in park, but we cannot if we do play, people tell us to go.” (Karen male, aged 22).

“For the young Karen people, if they have a place to play soccer or any sport. Because after school they went to play any sport. They have no place to play. Sometimes they have big fight because of many reasons. There is no place to play so they just stay and walk around and watch. The young people say it would be good to have a place to play sport. It’s hard to book the place. The young people have to rely on the community leader to book the place.” (Karen male through interpreter, aged 22).

The HoA female participants cited walking as means of coping, while males preferred playing soccer. Unlike the Karen males however, the HoA males found accessing sporting areas much easier. For the Togolese, both genders cited playing soccer, walking and basketball among their physical activities, although females reported more dancing, singing and on occasion yoga. The Sudanese did not raise any specific involvement in physical activities. While the HoA females walked as a means of maintaining social contact with peers, the young Karen women walked more out of necessity arising from a lack of transportation. For most participants, positive mental states were gained from involvement in these physical activities.

“I play soccer for my local team. I am very fit and that really helps me.” (HoA male, aged 17).

“The elders, every morning, they gather up and go for a walk. Yeah, we walk 24/7 too just like the oldies, we walk every day. It’s not to stay healthy so much although it is to be stress free; it’s more to be with my friends.” (HoA female, aged 16).

“We don’t have much car in our community so we use our feet. Walking is our exercise, but it helps us to have no stress.” (Karen female, aged 23).

“When I was growing up we used to play volleyball, I think about volleyball a...lot.” (Karen male, aged 22). Church leader says: “Volleyball is like the national sport for Karen.” [Everyone laughs and nods].

“I like soccer. Playing basketball helps me cope.” (Togolese female, aged 13).

“Yoga and physical activity helps me.” (Togolese female, aged 15).

“Singing, dancing, soccer. We are physical, even the girls, we like to run to do these things together” (Togolese female, aged 14).

Social activity. All cultural groups found community social activities to be of great value to their well-being. They spoke of wanting to keep links to their cultural activities, having fun and creating positive emotions through culture. Activities to
achieve these aims included singing, dancing, walking, chatting, and cooking. Indeed participants often appeared more confident and animated when sharing their stories about dancing and singing. Community members saw performances as an opportunity to enjoy sharing cultural history. Traditional music and dance pursued by some young Karen however, was restricted. These young Karen spoke of complaints imposed by neighbours when they were trying to celebrate. They reported a sense of alienation at not being able to hold traditional parties or customs in their own homes.

“Like even when I’m sad I always sing. Yes ... so if I happy I singing.” (Karen female, aged 18).

“Folk dancing very important because dance we perform all the celebrations like new year also the community ask as to perform dance. Yes we like dance.” (Karen male, aged 23).

“We do dancing, singing and more dancing. We are doing more performance, this makes me happy. Sometimes people call us at a centre or school to dance for them. I love it so much.” (Togolese female, aged 15).

“The music play in their house, when you stay outside they can hear the noise and their neighbour shouts at them. Like when we dance or play an instrument, because we have no place we dance like in our backyard and the neighbours say it’s too noisy now, we cannot play.” (Karen male, aged 25).

Other important social activities that were helpful in relieving stress and achieving positive benefits included cooking and community gardening. Health benefits were cited too from meals being freshly prepared with plenty of rice and fresh vegetables. The Horn of Africans enjoyed drinking tea/coffee together as a group activity and many young women referred to drinking tea that was made of special blends of herbs they felt had medicinal calming qualities. The HoA females emphasised it as a social activity that recognised respect and friendship, particularly to elders.

“Yes singing and cooking, and eat together, and friends come to join, yes, and having dinner together.” (HoA female, aged 18).

“Eating healthy food. Always eat rice in every three meal. We have vegetables and other like curries and stuff.” (Karen female, aged 21).

“Spending time with family and my community for example in the community garden.” (HoA male, aged 15).

“We usually deal with stress by drinking this really thick tea. Coffee actually, it’s not tea.” Another female adds: “Like me she feels very strongly about that, because we drink it every day. They mix a whole lot of herbs and stuff. They’re heated up with this thing where they have a tea ceremony. It relieves your head, no headaches and stuff. Our mums drink it, our elders drink it, we all drink it together mostly, and it’s really good for you.” (HoA female, aged 18).
Most participants had close relationships with their families and community members and they spoke of the importance of families regarding their personal concerns. Interviewees also discussed a familiarity or acceptance with the idea that family issues would be discussed with community members. Apart from family, friends, and the cultural community, some participants had strong connections with other community associations, including the local church or school.

“We talk to each other. Close family members really rely on each other to get back on their feet again.” (HoA female, aged 19).

“If there are problems in our culture we call each other and sit around to talk. We always come together to try to be friends to help each other solve problems.” (Togolese female, aged 17).

“Well you can be comfortable in church, or you can talk to them openly. If you’re a member you can express anything you want, so you just come to them. Yes we go to church when we are kids so we are used to go, so if we don’t go we seem very unhappy.” (Togolese female, aged 15).

“Members of the grammar school is very supportive and helps me, and family so helpful and Presbyterian helpful too. It still hurts even when it goes away. It’s still with you if you know what I mean...but it helps with the support.” (Togolese female, aged 15).

“Our mother helps us. And our teacher helps us. If we don’t understand the teachers are here to help us solve.” (Togolese female, aged 13).

One Togolese participant on the other hand felt that although the cultural community was helpful in talking through problems, a point of absorption was reached in speaking with community members, particularly about shared experiences, and that it was helpful to seek the company of friends who were not Togolese in order to develop new experiences and move on. This was seen as an important step towards his recovery from trauma.

“I try to spend time with the community. I try to hang out with other nationalities as well though cos when I talk to Togolese they keep talking about what we experience and go through- I try to talk to get something different from other people outside my community, this is important for moving forward for me.” (Togolese male, aged 25).

**Spiritually and faith.** Spirituality did not feature as a key theme, though members of all groups noted the importance of faith and prayer. The Sudanese, Togolese, and Karen were mostly Christian, while to the Horn of African mainly followed Islam. Participants spoke of how prayer and faith gave them an experience of strength in difficult times. Hope was found in religious activities and helped with processing their experiences in life. For others, religious principles offered them comfort and
guidance. Members from each community also found religious practices gave them a link to their culture and homelands. In addition, they were able to have an opportunity to pray for those who were left behind.

“In Karen, we mostly rely on Christian or Buddhism as our strength.” (Karen male, aged 24).

“Islam is all about having faith in God. So knowing there is a great one above keeps us going, no matter what we are going through.” (HoA male, aged 19).

“Being a good Muslim, wife and daughter help me. Knowing there is something higher than me.” (HoA female, aged 19).

“Religion is the key for me, my experiences and my families’ experiences have taught us that if something bad has happened then something good will happen.” (HoA male, aged 16).

“I talk with my parents friends, teachers and I can pray and see the pastor. We pray every day and go to church. I don’t go to counselling we teach people with no hope to go to God”. (Togolese female, aged 15).

“I go to church and do my cultural practices remembering the richness and beauty and people of my motherland helps me stay healthy.” (Sudanese male, aged 22).

**Theme 5: Participant ideas for solutions**

In keeping within a participatory framework, participants were encouraged to express their own ideas to solutions that could be helpful to improving the refugee experience, mental health, and well-being. A number of subthemes were identified which included: promoting awareness and acceptance.

**Building awareness and acceptance.** The young refugees in this study reported a perceived lack of awareness among the general community of the plight of refugees. They cited concerns about a lack of respect and understanding towards them from the broader Australian community and were keen share a greater knowledge in the history of their culture and community. This included education about where refugees have come from, their journeys, and experiences of integration. Data extracts indicated this was most prevalent in the Karen community. Within a desire to share their stories was the hope that greater awareness and respect and acceptance could be developed, which would decrease a sense of alienation and aid resettlement and integration.

“Because they may understand more and like show respect to us. I would like to tell that the Karen people, their, the history and where they come from, the background... maybe them a website, if they want to know, a website, yes could share our story to help people understand us more.” (Karen male, aged 24).
“Understanding our social problem would be helpful, knowing the conflict of living in a different culture and showing my language and culture.” (Sudanese male, aged 24).

“They need to understand our culture practices more and stop targeting where we came from. Need to understand the richness of our country. The importance of our culture is great. Understanding will welcome us to a new society.” (Sudanese male, aged 22).

**Toward a more adaptive and humane host society.** One Togolese participant noted that much onus was placed on refugees to educate others and assimilate into the broader community. He stated that more effort could be made by the broader community to adapt to new migrants and learn ways to help refugees to integrate. For instance, English language was cited as a requirement for assimilation, yet little effort was made on the part of the broader community to understand that languages take time to learn, or that refugees themselves can be bilingual or multilingual. The hope for a harmonious multicultural society was this young man’s aspiration:

“Australians have different values, it’s an individualistic society. Australians demand much from refugees to assimilate yet don’t do much on their part. Adjustment is the hardest thing...Aussies do not blend...we need to blend so that we can create a new aroma.... we need a new flavour to our values. For example, I appreciate this research because not much effort or expectation from the community to understand yet a huge expectation from new migrants to fit in....we have to blend to create a new aroma.” (Togolese male, aged 25).

“There needs to be an understandable language between us all.” (Sudanese male, aged 24).

Similarly, the HoA participants stated that a greater level of patience and tolerance from the community would help broader societal integration, aiding their ability to begin a new life. They stated that sharing cultural differences with others would promote an understanding of shared aspects of humanity or “sameness”.

“We need an understanding of cultural differences...[as we are]...the same underneath.” (HoA male, aged 18).

“There are social differences between our cultures but with patience, tolerance and understanding we can learn to be more sympathetic towards each other.” (Togolese male, aged 25).

**Social solutions.** Participants cited various strategies to promote a greater understanding of refugees and cultural differences. The Karen explained that using websites to teach the histories and backgrounds of Karen people could be useful and social gatherings focused at bringing together Anglo and other non-refugee Australians and Karen groups could also promote greater shared understanding. Their strong desire for people to understand their culture, background, and history suggested
a need for “belonging” and social inclusion in the new community. The Karen participants stated that they are less outgoing than most Australians and see themselves as shy people. They were keen to forge friendships with Australians and be “more equal” in the community. “Mentorship” was offered as a practical means of social inclusion, a way to receive encouragements, strength and advice. Help and advice with the new culture and community was seen as especially beneficial in the absence of traditional supports such as family members or elders, who had deceased or were back in homelands.

“[Karen female, aged 19] We Karen are shy... we don’t talk to people unless they talk to us.... Maybe mentors could help with confidence help encourage us to open up strength and advice. Australian mentors would be good to help us share and be friends.”

“[Karen female, aged 18] Maybe we have like an Australian-Karen association. Maybe we organise every year a get together for Karen people and Aussies to be friends.”

**Telling the stories for those unable.** To address a need to help their fellow Karen recover from collective trauma, Karen participants thought it would be helpful to tell their stories and the stories of those who stayed in the camps/villages and had been left behind. They felt providing a voice to those left behind would ensure their stories were not forgotten. Moreover, in ensuring that mental health concerns could be addressed, the Karen perceived counselling given by a fellow Karen trained counsellor to be beneficial over non-Karen counsellors. Similary, they believed a service that was embedded within the community would be more accessible (e.g., outreach to homes). A moderate number of participants also expressed desires to return to their villages over time, in order to help those still suffering and in need. They stated employment in helpful areas of nursing, medicine, and teaching could help heal those not receiving help in their homelands.

“I have a desire to help to tell the story of the ones left being and stories of refugees. We not forget their stories too.” (Karen female, aged 25).

“I want to be a missionary to help my people.” (Karen female, aged 18).

*One day I learn English and go back Burma to teach my people English and help them.* (Karen female, aged 18).

“People should know that there are many refugees who still live with the trauma of war. This is important for people to know.” (Sudanese female, aged 23).
HoA participants felt that advertisements on television could be helpful to build
tolerance and assist the broader community to understand the HoAs and their ways.
Other solutions to challenges brought forward included a need for “togetherness” –
that is harnessing the support of others, which included peers and previous refugees,
to assist with the challenges of settling into a new country.

“Would be cool to see an ad on TV or internet or something about refugees and what they go through.
This would help the Aussies to understand us and that they shouldn’t be cared of us.” (HoA female,
age 16).

“We can hook up with other refugees in our community to help the new ones to settle in better.” (HoA
male, aged 19).

For many Togolese participants, practical assistance was paramount. There was a
strong community need to learn and gain assistance from other Togolese and refugees
outside of their community. These participants thought helping recent arrivals to
understand Australia and how its culture worked would be invaluable. The Togolese
also hoped for additional support to aid them with daily living, opportunities to gain
employment, with the latter seen as especially important in creating a ‘Togolese-
Australian’ community. The participant that reported hopes of a “new blend” of
society, also expressed a need for refugees to come together to assist one another in
the migration and trauma process. Some Togolese interviewees wished for more
Togolese social gatherings involving culturally traditional activities. This was thought
to keep cultural traditions and traditional ways of coping alive in their new homes.

“We need to be together, we can share ideas and no how to do together. If you are alone you can’t do
good things, share ideas, learn from each other.” (Togolese female, aged 15).

“We need to be taught and to have guidance from people who have been there already, especially
with migration and our trauma. We also need assistance in our applications.” (Togolese male, aged
25).

“We need to keep in touch with our culture- to dance and to sing together. We need to have chance to
spend with our community.” (Togolese female, aged 18).

Among the Sudanese, education of the broader community again was cited as a way
to facilitate a greater understanding of participants’ journeys and culture as well as the
difficulties confronted by Sudanese in integrating to their new homes. Many Sudanese
hoped for better support services to enable them to help themselves as a community,
but a majority spoke of a need to access additional information about services
available to them. With a growing diaspora, one prominent solution offered was a
development of sporting competitions and a social club that could enable young Sudanese from all tribes to access support from other young Sudanese.

“There is a negative perception of Sudanese people in Australia. It would help to change this by greater awareness of our culture and the wars of our beautiful country. Many come here to flee the war but they need more help getting homes, it’s hard for Sudanese to get rental housing, and Centrelink could help more. We need to know where we can go to get help.” (Sudanese female, aged 18).

“By providing more services, show refugees where they can access services and keep promoting this till they know. I would like to know what my rights are.” (Sudanese male, aged 23).

“The Sudanese community need healing. We need like a youth conference or gathering to get the tribes together. We need to support each other in Australia.” (Sudanese female, aged 23).

**Importance of peers.** The development of strong peer relationships however was not only identified by the Sudanese. All refugees in this sample spoke of peer to peer contact and support as pivotal to their success in Australia. Most groups spoke of the need to increase social contact within their own cultural groups, ranging from continuing traditional cultural activities to sports activities such as soccer or volleyball. Participants felt that peer support would be most helpful in assisting young people especially with the difficulties of arriving in an unfamiliar country. Limited access to facilities which allowed group physical activity was seen as a barrier to developing peer relationships and good integration. Improving access to sport was implied as a significant predictor of both keeping physically fit and mentally healthy.

“We need activities for young people to make friends with refugees and Australian people. If we can play sport together like volleyball, the young Karen would have somewhere to go to make friends.” (Karen female, aged 18).

“If we have mentor or someone like that to guide us, this would help us a lot.” (Karen female, aged 19).

“Having friends who have been through what you’ve been through would be helpful. More activities like dances would be good opportunity to meet people and get together with people our age.” (Sudanese female, aged 18).

**Active involvement in healing and recovery.** Most participants across cultural groups also expressed a desire to be actively involved in activities aimed at improving well-being among young refugees. A small number had already taken measures towards this through documenting stories on the internet or through film and documentary making through YouTube. When asked about barriers towards these activities, most participants cited a lack of confidence with English and lack of leadership and
resources around these endeavours. Despite these barriers, a small sub-group of these young refugees appeared to be forging their own paths in Australia, which was seen as a proactive step towards healing the past and carving out a future for themselves.

“We are making how you say...documentary about Karen refugees for YouTube. Important for us to tell a story, and tell for Karen people, and to heal our Karen. I want to study media to tell my story.” (Karen male, aged 27).

“We can’t sit around and say we need this, we need that. We have to be part of the healing ourselves and get involved with youth events and stuff like that. No one will do it for us, it’s up to us, the young people.” (Sudanese female, aged 23).

**Discussion**

The qualitative study described in this chapter extends traditional trauma research by focusing on the factors that enable a broader understanding of refugee mental health and well-being in the context of psychosocial factors and participants’ own narratives.

**Summary of findings.** The young refugees in this study described challenges and hardships throughout the migration periods and the majority, if not all, experienced a range of traumatic events and loss experiences. Some were able to recall life prior to migrating while others were not able (or chose not to) recall events or could recall only windows of memories. These narratives expressed by participants culminated into overall themes around: (1) stories of personal journey which incorporated reasons for flight, personal traumas, deprivation of necessities for life and loss experiences; (2) camp life hardships which incorporated arduous journeys to camp settlements, health and malnutrition, sickness, and additional trauma experiences; (3) resettlement and settlement experiences which incorporated observations of environmental contrasts, changes to quality of life, opportunities for education and employment, the importance of English language, cultural and community distance, developmental and intergenerational changes, homesickness and loneliness, and social exclusion and racism; (4) mental health constructs which incorporated perceptions of mental health difficulties, anger and forgiveness, and strategies for emotional problems; (5) general coping and resilience against life difficulties; and (6) solutions which incorporated participants’ own ideas around helpful strategies for improving refugee mental health.
and well-being. Within each theme, positive stories of resilience and personal resources for coping with difficulties were observed.

The themes in the present study are consistent with the sense of coping and moving forward that were observed by Whittaker et al. (2005). Like the Somali participants in Whittaker et al.’s study, many participants in this thesis dealt swiftly with emotions rather than dwelling on problems. Similarly, the importance of family and community life, the role of religion and changes in identity and intergenerational problems were also themes present in both studies. Moreover, regarding the themes around mental health constructs, the findings of this thesis support those of Guerin et al. (2004), who found that mental illnesses encompassed ideas of madness and that mental health was related to social or situational issues, in contrast to individualistic concepts seen from a Western perspective (Guerin, et al., 2004) or trauma experience per se. That is, participants in this thesis linked concepts of mental health also to social circumstances such as resettlement stress or difficulties in family re-unification.

These consistencies might be explained by the high representation of HoA participants in this study. Hence, this study has replicated the experiences given by Somali refugees in the UK, except that in the present study, this was a theme prevalent across both males and females (the sample in Whittaker and colleagues sample was female only), and replicated across youth refugee cultural subgroups. Irrespective of whether or not mental health constructs are couched in social and situational circumstances, the present findings do nonetheless also support Summerfield’s sentiments (1999) in that the priorities of survivors when asked, may lie in socio-economic concerns such as finding employment rather than psychological sequelae to trauma, despite that these latter factors may also be identified needs.

Contrary to Guerin et al.’s. (2004) study where concepts of depression, anxiety, and PTSD were unknown in the Somalian community however, many participants in this study reported consistent understandings and relatedness with these disorders, even if they were not able to ascribe a diagnostic framework or categorisation for them. Indeed, although these constructs may be similarly understood by young refugees, coping mechanisms on the other hand were diverse. Particularly noteworthy was the use of certain appraisals that young refugees displayed in describing their mental health difficulties or social circumstances. Consistent with the findings of Aptekar (2000), cognitive strategies such as comparing one’s situation to others back
home or ideas of forgiveness appeared important in understanding vulnerability or protection from mental health problems and other stressors. Understanding cognitive mechanisms alongside other protective factors are worthy of further research. These finding also offer support to McCarthy and Marks (2010) findings that psychological problems can manifest themselves in physical problems, as described by some participants here, and as found in Chapter 8.

Finally, these findings offer support to the Australian studies by Khawaja et al. (Khawaja, et al., 2008), Schweitzer et al. (2007), and Correa-Velez (2010) in that the predominant themes around religion, social support, and social exclusion were replicated in the current thesis. The role of religion, however, was less frequently cited by young people suggesting these strategies may not be as salient for younger refugees.

**Balancing the tensions.** It is difficult to synthesise the complexity of issues that young refugees are confronted with through their migration journeys. One way to understand these findings is to frame these experiences in terms of a series of tensions which refugees are constantly striving to balance. At the outset, refugees are required to reconcile many tensions. Having left an ‘institutionalised’ life, they are first confronted with reconciling a life of without freedom, with a free society that allows liberty, choice, and autonomy. They also report a struggle in balancing their hopes and aspirations for better and successful lives with the challenges faced around barriers to education and work. The reality for many is that their hope cannot be fully actualised, and instead the realisation that opportunities are limited, and not limitless. Moreover, the difficulties around practicing cultural traditions in the dominant Australian context were cited as a source of tension for these young refugees.

In a similar tension, what young refugees gain living in Australia is balanced with what is also lost. For instance, many of the things they have in Australia, they did not have in the refugee camps (e.g., education, sheltered and safe housing). Likewise some of the things they had in camps are no longer available to them in Australia (e.g., camaraderie, shared experiences, elders, and extended families). Similarly, the joys of a peaceful life in Australia without threat to physical integrity were fraught with different anxieties concerning their futures and acceptance. Having endured uncertainty and threat to physical life and integrity, they now deal with the threat or
anxiety surrounding grief and losses, and beyond that, uncertainty for their sense of future and worth. That is, with their physical wellbeing more certain, the shape of their future is not. Moreover, young refugees struggled with attempts to create a new life with happiness at the same time reconciling suffering of those back home or other loss and grief experiences, with tinged their new lives with sadness. In sum, the contrasts by which refugees currently live their lives has shaped their sense of well being, such that the influence of the past is constantly present.

*Fit in a new system.* Another way to understand the present findings is through an interpretation of the individual’s experiences and the host system. The present findings revealed the importance to refugees of understanding and ‘fitting in’ with the Australian system. Failure to integrate was seen as detrimental to good adjustment and mental health. The ‘systems’ in Australia were perceived by refugees to play a significant role, in that they enabled a peaceful and just environment, a sense of belonging, and restoration in meaning in life. Education and employment were key to achieving these things.

Although the young refugees offered many ways as to how the system could be improved to assist them, the underlying were constructs appeared to be around how the society and system perceived and received them. Having left homelands where they were persecuted and excluded, the young people were disappointed by very prevalent experiences of social exclusion, spanning across school, work, and public spaces. The refugee youths in this study questioned their place or belonging within their community and broader society. Through their narratives, a sense of who they were and how they are accepted seemed to be reflected in their desires not only to be heard but also, accepted and respected. This seemed to intersect with their identity through questions concerning their status as a refugee (e.g., will I be a refugee my whole life?; when will people treat me fairly or equally?; who am I now?; how am I accepted or regarded?).

Family was seen as a major source of belonging however, providing an ongoing connection to the past and in maintaining a cultural identity in the Australian context. Connections with peers were also important in providing a place to fit in the new society, and understanding from non-refugee Australians was an especially important part of successful settlement and well-being.
Conclusions

Young refugees in this study described a history of growing up in contexts of violence, uncertainty around safety and security, and multiple experiences of trauma and loss. The narratives in this study showed these experiences are compounded by challenges in navigating and reconciling a new culture and society. They remarked on vast contrasts between their old and new countries which presented challenges to their daily living, identity, sense of meaning, and cultural practices. Marked by shifts from uplifting and positive emotions through to experiences of despair, sadness and grief, adjustment was (and is) a long and ongoing process for many in this study. While the young refugees described some helpful personal resources, the impact of these adjustment processes on an already vulnerable group necessitates approaches that not only focus on therapy to promote emotional recovery but also those that help them to adapt to life in their host country whilst coping with the losses of home. These are discussed in the next final chapter.
CHAPTER 10: GENERAL DISCUSSION AND CONCLUSIONS

Overview

In this final chapter, a synthesis of the overall findings of this thesis will be presented and discussed with reference to their implications for the theoretical models described in this thesis. Following suggestions for future research in this area, the clinical, policy and practice implications for working with young refugees are also discussed. It will be seen that a broad ecological/psychosocial framework that utilises mixed methodologies is necessary to contextually examine mental health and well being in young refugees, where outcomes can be negative as well as adaptive and resilient.

Experiences of trauma no doubt test the resiliencies of young refugees making them more vulnerable to the post-migration environment. Young refugees display both vulnerabilities and strengths throughout their transitions to and from pre-, peri-, and post-flight experiences. These transitions reflect a range of experiences, wherein events and experiences of the past are inherently tied to the future and acculturative experiences of young refugees in Australia.

Revisiting the aims of this thesis

Applying an integrative, ecological theoretical perspective and mixed methodology (i.e., comprising quantitative and qualitative techniques), the present study had the overarching aim of exploring mental health and well-being in a culturally diverse young refugee population in Australia. Within this broad aim, several specific aims were identified within the five introductory chapters. Four empirical chapters then documented the exploration of these aims. Chapter 6 explored the characterisation of young refugees living in Australia to determine their characteristics and demographic make-up. Chapter 7 explored negative mental health to determine the prevalence of negative mental health problems (i.e., PTSD, depression, anxiety, and somatisation), particularly in a newly arrived group of young refugees to Australia, and the predictors which increased vulnerability to such mental health problems. Cultural differences in the presence of negative mental health problems (i.e., PTSD, depression, anxiety and somatisation) were also examined in this chapter. Chapter 8
moved beyond a focus on negative mental health to explore the positive or strength based and psychosocial outcomes of quality of life and resilience. It also examined cultural differences in resilience and quality of life among young refugees exposed to trauma and adversity. Chapter 9 aimed to augment the findings described in Chapters 6-8 through a contextualised qualitative study of negative and positive mental health, resilience, quality of life, and well-being through the pre-, peri-, and post-migration journey. It also examined cultural differences in the experiences of young refugees through the migration phases.

*Summary of overall findings in this thesis*

**Demographics and characteristics of young refugees living in Australia.** Among pre-migration factors examined in Chapter 6, the most commonly noted were the interruptions in education and/or employment. Any education that was received was limited and irregular, and employment either in young people and/or their parents was extremely rare, reflecting the disturbance that refugees endured during this time. Many participants reported illnesses experienced by themselves and family members, including fever, malaria, and malnutrition. Loss, separation, and even the death of a parent was not uncommonly experienced by young refugees. Grief was prominently reported by participants as a physical health complaint. The flight experiences of young refugees typically entailed travel with at least one parent and a sibling(s), although up to a quarter of refugees participating in this research had lost a parent through war rated death, usually a father. Most of the young refugees in this study were accompanied, arriving with at least one family member, usually a mother. Unaccompaniment was rare in this sample, and there were no asylum seekers.

The post-migration phase was characterised by the resumption of secondary schooling for many of the young refugees described here, and for the older individuals, the search for employment predominated over education. Most parents of young refugees were enrolled in English classes or searching for work. Most young refugees lived with their families and there were a few living with extended family members or alone. Some somatic complaints were raised in the post-migration phase and a moderate number of participants reporting experiencing trauma, anxiety, loss, and grief in addition to loneliness. Sadness and anxiety among parents was also
reported by the young participants, but it was not possible to quantify this as parents were not assessed in this thesis. Nonetheless, there was a perception, among young refugees that their parents experienced emotional difficulties.

Trauma experience in the refugee population is considered to be high (Daud, et al., 2008; Heptinstall, et al., 2004). It was not surprising therefore that all the young refugees in this study endorsed a range of traumatic events, the most commonly directly experienced being: lack of food and water (77%), lack of shelter (63%), ill health without medical care (61%), and the unnatural death of a family member or friend (47%). Events involving the deprivation of basic necessities for life, such as lack of water and food and ill health, were among those most commonly endorsed as the worst trauma experience, and rated alongside situations of the death of loved ones as well as war and conflict itself. These findings were discussed in Chapter 6 as supporting a human rights/basic needs framework which attributes the experience and consequences of war trauma to the deprivation and assault of basic human needs. The majority of young refugees cited difficulties in language, the experience of racism and discrimination and worries about loved ones and family back home. There was little uncertainly about being returned home for this young group of refugees, unlike that described in samples where migration status in uncertain (Steel, Momartin, Bateman, Hafshejani, & Silove, 2004; Steel, et al., 2006).

**Negative mental health and their predictors.** Approximately one quarter to a third of the sample in this thesis expressed difficulties consistent with a diagnosis for PTSD, anxiety, depression, or somatisation, supporting the hypothesis that greater mental health difficulties would be observed when compared to broader community studies. That is, the occurrence of mental health problems was significantly higher than typically reported in community studies (Fazel, et al., 2005). Similar rates were observed across PTSD, depression, and anxiety (up to 25%), while somatisation in this sample was slightly higher, at approximately 30%. The hypothesis that young refugees would experience a range difficulties other than those typically assessed (i.e., PTSD, depression), was therefore supported. The finding that a sizeable proportion of young refugees also exhibited partial or subclinical symptoms, added weight to the argument in Chapter 7 that young refugees are indeed vulnerable to negative mental health impacts.
Correlates to mental health disorders observed in this thesis included trauma exposure, age, and age at arrival (older experienced more difficulties), and death or loss of a parent. Self reported emotional problems (not assessed by psychometric measure but verbal self report) were related to PTSD, depression, and somatisation, but not to anxiety (although the association approached significance). This suggests that young refugees have understanding and insight to their own mental states, and that there is some familiarity with Western formulated emotional disorders. The strongest correlate to mental health problems, however, appeared to be a one or a combination of daily stressors in the post-migration period.

The hypothesis that the experience of trauma will be a significant predictor in the outcomes of PTSD, depression, anxiety, and somatisation was partially supported. With regard to PTSD, the model incorporating pre-, peri-, and post-migration factors (i.e., demographic variables, pre- and peri-migration trauma exposure, including separation, unaccompanied and parental loss, and post-migration hassles), was moderately powerful (20%) in predicting PTSD. This finding is consistent with previous literature, where trauma experience uniquely influenced PTSD symptoms (Fazel, et al., 2005; Kinzie, 1988; Mollica, et al., 1998; Steel, et al., 2002; Watters, 2001). The influence of post-migration stressors was not a unique predictor in PTSD, validating trauma experience as the unique stressor in the development of PTSD.

Using the same model to predict anxiety, the combination of pre-, peri-, and post-migration factors significantly, but not strongly (14%) predicted anxiety. Post-migration factors uniquely predicted anxiety, though the experience of trauma, consistent with expectation, was to a lesser extent, uniquely predictive of anxiety. Given that PTSD is an anxiety disorder sharing common characteristics with anxiety, it is unsurprising that trauma also impacted on anxiety symptoms. The prominent role that post-migration difficulties play in driving anxiety is consistent with previous findings (Montgomery, 2010), although in the present study, trauma experience was still related to anxiety.

Using the same model to predict depression, the combination of pre-, peri-, and post-migration factors significantly and moderately predicted this disorder; post-migration difficulties was uniquely predictive of depression. These findings offer empirical support to arguments that difficulties in the settlement period are more strongly associated with depression than PTSD (Kinzie & Sack, 2002; Sack, et al.,
Post-migration difficulties associated with racism, loneliness, securing employment, or communication with others may reflect deeper cognitive and/or social processes that activate depressed mood and low motivation over time. This was discussed in Chapters 7 and 9 in terms of a balance of conflicts and tensions and a need to belong and ‘fit in’. Racism experiences, for instance, may trigger alienation and a sense of thwarted belongingness, or employment expectations that initially come with the optimism of early resettlement might diminish over time with the realisation that language skills limit opportunities for employment. Over time, ongoing day to day stressors are more likely to entrench depression. Although the pre- and peri-traumatic experiences of parental death or unaccompaniment were not uniquely predictive of depression, these traumatic reactions may be more likely to elicit a depressive response based around grief and bereavement. Indeed, themes of grief and loss were featured in the qualitative findings.

Using the same model to predict somatisation, a common indicator of cultural symptomatology, the combination of pre-, peri-, and post-migration factors significantly and moderately (20%) predicted this disorder, through trauma uniquely predicted somatisation symptoms. These findings suggest a reliable link between traumatic event exposure and the physical manifestation of psychological symptoms (i.e., somatisation). It is possible this link is underpinned by mechanisms associated with neurobiological changes, increased physiological arousal, and poorer health (Elklit & Cristiansen, 2009). The overwhelming nature of trauma can also manifest in physical or pain related conditions, explaining the relationship between trauma and somatisation (Van Ommeren, et al., 2002). Somatisation is widely acknowledged as a manifestation of anxiety in non-Western cultures (Elklit & Cristiansen, 2009; Kirmayer, 2001; Westermayer, et al., 1989). Its prevalence and concurrence with more traditional Western diagnoses of PTSD, depression, and anxiety, offers support that with appropriate administration of testing, such constructs can be useful in understanding mental health in young refugees. Given the high comorbidity across disorders, the role of somatisation within this interrelatedness or indeed as an independent outcome of trauma should be explored.

In summary, the models used in this thesis to predict various disorders suggest that the combination of risk factors at the pre-, peri-, and post-migration phase work together to predict mental health problems. In some disorders, certain risk factors are
driving those disorders more (e.g., trauma in PTSD, post-migration difficulties in depression). Interestingly, although the role of trauma was significant in predicting the occurrence of psychopathology, when post-migration difficulties were added to the model, the level of prediction for disorders raised significantly. Notwithstanding the contribution that trauma makes to one’s vulnerability, findings from this thesis suggest that there are indeed other risk factors involved in the mental health experience of young refugees in Australia. This supports the move away from looking only at pre-migration factors in the refugee experience towards a more holistic approach that focuses also on post-migration factors (Montgomery, 2008; Porter & Haslam, 2005). This is not to suggest that pre-migration factors, in particular trauma exposure, are not important. One way of explaining these findings might be that psychopathology arises from a complex interaction of pre-, peri-, and post- migration factors which involve the individual and the environment/system in which the individual is embedded (Montgomery, 2010). The findings of this thesis also offer support to previous studies which have shown that Western frameworks for PTSD, depression, and anxiety are applicable and valid for refugee populations (Bronstein & Montgomery, 2011; Silove, 1999; Silove et al., 2007).

The hypothesis that cultural differences would be observed in the frequency of PTSD depression, anxiety, and somatisation was partially supported. Although frequency rates in this study suggested that the Sudanese and Karen groups displayed greater symptomatology across all disorders than other cultural groups, particularly compared with the Togolese group who showed little presence if at all for psychological disorder, significant differences were only found between the Sudanese and other refugee groups on anxiety, depression, and somatisation. Interestingly, the Karen also reported relatively higher levels of somatisation. This supports previous migrant research demonstrating higher somatisation amongst Asian cultures particularly (Cheung, 1993; Kinzie, 2001b; Westermayer, et al., 1989). No significant cultural differences were observed for PTSD. That is, frequency of PTSD did not vary across cultures.

The findings related to the cultural group differences in depression, anxiety, and somatisation, however, were explained by the possible underreporting of symptoms by the Togolese due to mistrust, lack of familiarity with research and Western mental health concepts, early settlement euphoria, or a genuine experience of
better emotional wellbeing. The finding that Sudanese and, to an extent, the Karen groups are more vulnerable than the Togolese or HoA was attributed to the ongoing conflicts these countries experienced at the time of testing, the collectivist identities of these cultures, parental absence, and a possible age-culture interaction, wherein an older age at arrival may allow greater opportunity to experience trauma and hardship as well as more post-migration adjustment difficulties. The difficulties associated with their unique post-migration circumstances and less opportunities to access support relative to the Togolese and HoA was also discussed (see Chapter 8 for explanation of differences across cultures in incidence of mental health problems). In all, the findings of this thesis show Sudanese and Karen communities to be more vulnerable to anxiety, depression, and somatisation. This is not to suggest that other cultures are not vulnerable, as indeed the incidence of PTSD, anxiety, depression, and somatisation (up to about a quarter of refugees) amongst them was high, and the incidence of subsyndromal difficulties was also high. While all young refugees irrespective of culture appear to be vulnerable, certain cultural subgroups might have additional vulnerability.

Positive mental health: Resilience. A notable finding of the present thesis is that the majority of young refugees did not exhibit mental health symptoms consistent with a diagnosable mental health disorder (despite displaying partial symptomatology). Nevertheless, young refugees in this thesis reported a higher incidence of mental health difficulties relative to that typically found in community based studies. Consistent with the findings of Montgomery (2010), one implication of such findings is that significant trauma exposure does not necessarily follow a trajectory of enduring psychopathology. Indeed, three quarters of the current sample did not meet criteria for a diagnosable mental health condition. This outcome provided the opportunity in this thesis to investigate the role that positive mental health, psychosocial, and resilience factors play in the understanding of psychological well-being in refugees. As anticipated, in ‘overall’ terms, higher resilience was displayed by participants less affected by PTSD, anxiety, depression, and somatisation. This finding is consistent with the general literature on resilience (Schweitzer, et al., 2007); though contradict previous arguments that high resilience can be observed alongside high distress symptoms (Luthar, et al., 2000). Whilst it may be that resilient individuals can in fact display successful coping in the presence of high negative and/or distressing
emotions, the present findings suggest that resilience decreases alongside poorer mental health and that mental health problems increase when resilience is lower.

Of course, as expected, the combination of all domains of resilience were significant in predicting all disorders of interest, though the percentage predicted by the model varied for each disorder. That is, the importance of all these domains together came to bear on the presence (or not) of psychological symptoms. However, in PTSD, community resilience was the only unique predictor. This was explained through a collective trauma lens wherein whole cultures and communities who are collectively perpetrated against, might produce a traumatic psychological effect shared by the group, disabling the usual support mechanisms available to the individual to deal with the trauma. Likewise, if the community is functioning well despite trauma, then the individual may be likely to be better resourced for dealing with traumatic events. Indeed, a community itself is resilient when it is less vulnerable to disturbance from external factors and more able to function and recover from crisis or major change (Mason & Pulvirenti, 2013; Norris, et al., 2008). Support for this explanation is found in the work of Montgomery (2010), who found that a disruption in community support was detrimental to well-being. The present findings are also consistent with studies that show cultural identity and support from one’s own community as major sources of resilience (Beirens, et al., 2007; Birman, Trickett, & Vinokurov, 2002; Liebkind, 2006; Liebkind & Jasinskaja-Lahti, 2000), and previous qualitative research which show community and social support as essential factors to the well-being of refugees (Schweitzer, et al., 2007).

Similarly in anxiety, peer resilience stood out as a significant unique factor in determining anxiety and was explained using the idea that anxiety is driven by fears associated with perceived negative evaluations by others. Therefore, if young refugees perceive judgement or negative evaluation from others, and therefore perceive less support from them, anxiety might be amplified. This is supported by studies reviewed earlier which have shown that a sense of belongingness and social support among peers, and subjective social status moderates anxiety levels promoting greater self-esteem and social adjustment among refugees (Betancourt & Tanveer Khan, 2008; Goodman, et al., 2001; Lustig, Kia-Keating, Grant-Knight, et al., 2004).

Likewise in depression and somatisation, individual resilience stood out as a unique predictor. The mediating role of negative cognition, sense of helplessness, low
internal locus of control, confidence and self-efficacy may have played a pivotal role in the onset and maintenance of depression. Similarly, because somatisation is considered an ‘individualised’ or ‘internalised’ manifestation of mood difficulties, greater somatisation could be explained by negative internal cognitions. These internal characteristics have also been found among resilient older adult Vietnamese refugees responding to natural disaster (Xin, Aronson, Lovelace, Strack, & Villalba, 2013) and resilient child soldiers where a sense of agency, empathy, affect regulation, a sense of future, and growth were seen to offset mood difficulties and facilitate recovery from war (Cortes & Buchanan, 2007). Indeed, contrary to the sample of child soldiers in that study, the protective presence of these factors has now been shown in the current youth sample, suggesting the maintaining role of these strength factors across a refugee’s development.

One surprising finding was that although the overall model of resilience was predictive of disorders investigated in this study, the role of family resilience did not appear to uniquely predict any disorders. This is surprising given the prominent role of family documented in previous research (Annan & Blattman, 2006; Punamaki, et al., 2001; Punamaki, Qouta, Miller, & El-Sarraj, 2011; Weine, 2008; Weine, et al., 2006; Xin, et al., 2013) and the qualitative findings of this thesis supporting family as a key context. This inconsistency perhaps reflects the degree of separation or loss of family members in the present sample resulting in an absence of support or an absence of the use of family supports given family members own struggles with trauma and resettlement. Indeed, the gap observed between the quantitative and qualitative findings of this thesis provides a good example for how mixed methodologies can not only be used to contextualise findings but also challenge them to improve the validity of findings, offering new lines of investigation for future research. Additionally, these conflicting findings may represent the complexity of the resilience construct in the extent to which different resilience domains along with other factors might influence each other. For instance, the degree to which family resilience is influenced by a ‘culture/community’, or the degree to which school resilience could be influenced by family resilience via parental involvement (Weine, 2008). Further research looking specifically at the inter-relatedness of resilience domains is required.
The resilience construct is not as well operationalised as other established psychological constructs (Gartland, et al., 2011; Olsson, Bond, Burns, et al., 2003). This thesis aimed to advance work in the resilience field generally and among refugees by directly measuring resilience in an overall framework utilising domains of resilience that include individual resilience, family resilience, peer resilience, school resilience and community resilience. Although particular domains were more prominent across different disorders, as a model, the present findings do offer some support to other refugee resilience studies which have found educational/school resilience (Oliver, 2012; Rana, Qin, Bates, Luster, & Saltarelli, 2011) and family resilience to be valuable as single predictors to well-being. They also help elucidate previous quantitative findings (Ssenyonga, Owens, & Olema, 2013) which have shown that resilience confers protection against PTSD, and qualitative studies which have explored the resilience construct more broadly in the well-being of refugees (Pulvirenti & Mason, 2011; Schweitzer, et al., 2007; Thomas, Roberts, Luitel, Upadhaya, & Tol, 2011). By measuring the unique impacts of different domains of resilience, these findings extend the literature by identifying elements of resilience that can be used in intervention research in this area. Indeed, resilience research has been fruitful in enabling interventions for refugees to be implemented and evaluated (Anticich, Barrett, Silverman, Lacherez, & Gillies, 2013; Baum et al., 2013; Ellis et al., 2013). It remains a challenge to further develop this research for refugee youths particularly (Ellis, et al., 2013) and to do so by utilising a more consistent investigative approach to studying resilience.

With respect to cultural differences, the Togolose group demonstrated higher family resilience than the Sudanese group, reflecting perhaps the limited family resource available to the Sudanese compared to the Togolese. Also, with respect to peer resilience, the Horn of African group had greater peer resilience than the Sudanese group, and the Togolese and Sudanese group had higher peer resilience than the Karen group. Examining these differences has helped to highlight the need to view refugee resilience in a cultural context, so that culturally and contextually distinct settings can be identified, as well as where protective processes can be generalised (Sleijpen, ter Heide, Mooren, Boeije, & Kleber, 2013; Ungar, 2012).

**Psychosocial well-being: Quality of life.** As also expected, quality of life was negatively correlated with found PTSD, depression, anxiety, and somatisation.
outcomes. It was also positively related to resilience in that participants with greater levels of quality of life also displayed greater resilience. One unexpected finding here related to those who reported a high quality of life. These participants tended also to rate their community resilience as low suggesting that a good quality of life may require one to seek experiences outside that of what the immediate neighbourhood/community offers. The finding that lower levels of community resilience predicts PTSD, yet at the same time can predict a better quality of life, suggests that community resilience plays a complex role in determining differential outcomes.

Although a strong positive relationship was found between quality of life and resilience, when participants were compared, those with high quality of life did not differ from those with a moderate or low quality of life on individual resilience domains (i.e., individual, family, peer, school, community), suggesting there may be other factors outside resilience that are considered important or influential on one’s quality of life. That is, quality of life might reflect more tangible factors such as access to health care, employment opportunities, as opposed to internal resources or social supports. When resilience domains were used to predict higher quality of life, these factors only accounted for 15% of the variance in overall quality of life. Therefore together, resilience factors have only partial and arguably minimal influence in overall quality of life. With regard to cultural differences, the Togolese differed to all other cultures with respect to physical quality of life, where the Togolese reported higher physical quality of life in all cases. This was attributed to the relatively recent comparisons that the Togolese may have been making with their homelands.

Qualitative findings in mental health, wellbeing, and resilience. The qualitative study in this thesis added a contextual understanding that placed the current findings surrounding young refugees in a political, social, personal as well as cultural context. Data from individual and focus group interviews added some extra validity to the quantitative findings described above, particularly in the understanding of the post-migration difficulties. Narratives expressed by young refugees related to themes around: (i) personal journeys of flight, traumas, deprivation, and loss experiences; (ii) hardships endured in the peri-migration stage through arduous journeys to camp settlements, sickness, and malnutrition and additional trauma; (iii) post-migration
resettlement and settlement experiences such as environmental contrasts, changes to quality of life, opportunities for education and employment, learning English language, distance between the community and culture, developmental and intergenerational changes, homesickness and loneliness, and social exclusion and racism; (iv) mental health constructs including perceptions of mental health difficulties, anger, and forgiveness, and strategies for emotional problems; (v) general coping and resilience against life difficulties; and (vi) solutions which incorporated participants’ own ideas around strategies to improve mental health and well-being.

Across each theme, positive stories of resilience and personal resources for coping with difficulties were observed. These findings were broadly discussed around the ongoing tensions that young refugees endure, even when threat to safety and physical integrity are alleviated. For instance, reconciling a free society, reconciling optimism and hope with the real challenges of language and education, and reconciling a new peaceful life with ongoing uncertainty about respect and acceptance. They were also discussed in terms of the interaction between individual experiences and the experience of the host society or system that is encountered. In order to live successful and well adapted lives, young refugees are required to interact and fit with the host system – how they are perceived and received, and the availability of peers are important factors towards this, as is the continuous role of family and functioning within the culture. Hence, for the young refugees in this thesis, the ongoing process of adaptation and adjustment were occurring without a certain endpoint of when their identity as ‘Australian refugees’ would be shed, and if not, how that uncertainty could be managed. The consequences of not doing so may result in poorer coping with past trauma, mental health difficulties, and isolation and exclusion.

Theoretical implications of findings from this thesis

Earlier in this chapter, theoretical models were presented to explain mental health outcomes in refugees (See Chapter 4 for discussion of theoretical frameworks). The findings in this thesis confirm earlier discussions that no one unifying model currently exists to explain mental health in young refugees. This is due to the complexity of experiences within the refugee experience as well as the focus that each theoretical
model has with regard to the different phases of the migration experience (e.g., Berry’s acculturation framework in the post-migration setting or traumatology in the pre-migration phase). The present thesis utilised an ecological/psychosocial approach as well as a pre-, peri-, post-migration model to frame this thesis. It was ecological in the sense that it focused on the individual within a system of supports and within a system of a host society, and psychosocial in the sense that it focused on the individual in the social/political and cultural milieu. It was also focused on pre-, peri-, and post-migration factors to arrange the different influences in mental health across a migration journey.

The findings of the present thesis have implications for understanding the pre-, peri- and post-migration model that was used as a lens throughout this thesis. First, this model was useful in organising the various risk factors that occur across each phase and that cumulative risks result in poorer outcomes. However, the findings of this thesis suggest that characteristics in each phase are not necessarily discrete factors and what occur in one phase, might occur again in subsequent phases. For instance, the occurrence of trauma, which is often cited as a pre-migration factor, can present across the peri- as well as post-migration phases. That is, young refugees in this study cited traumatic experiences throughout the pre-, peri-, and post-migration phases. This was illustrated in the qualitative study with young refugees citing trauma within camps in the flight stage and through bullying at school in the post-migration phase. Hence, it is important that the pre-, peri-, post-model recognise the continuity of factors across the phases.

Second, the model was useful in providing a lens through which refugee accounts could be understood. The complexity of the refugee experience necessitates organisation around the particular risk and protective factors that occur across various phases of the refugee journey. This thesis highlighted the cumulative and combined role that certain factors play in determining both mental health difficulties as well as resilient outcomes. The model enabled a closer inspection of the influence of particular risks at certain times in the migration phase, which varied depending on mental health outcome. For instance, highlighted in this thesis was the important unique role of trauma in the incidence of PTSD and some extent anxiety and somatisation, whereas the important unique role of post-migration factors was evident in the incidence of depression.
While the structure of the pre-, peri-, post-migration model facilitates this analysis from a research perspective (indeed a majority of papers in the refugee literature cite this framework) (Bryant & Ahearn, 1999; Lustig, Kia-Keating, Grant-Knight, et al., 2004; Montgomery, 2010), it is also shown to be a useful clinical or therapeutic tool that facilitates the refugee narrative. It should be noted though that although the model imposes a linear structure, on a more abstract psychological level, the model should be understood with the idea that present experiences as shown in this thesis, are influenced by both the past and future experiences. That is, the pre-migration phases are often characterised by hopes for a safe and better life for the future, while the future is inevitably shaped by experiences and longing of past factors. In this way, the model describes the refugee experience as a series of transitions and adjustments where the past cannot be escaped or exited from a present experience. This is consistent with Silove’s (2005) arguments around a ‘continuum of stress’, by which traumatic events in the past merge with current environmental stressors, such that it is possible the post-migration environment prevents recovery from trauma via the milieu of practical difficulties, ongoing fear or anxiety, which runs contrary to a safe, supportive and predictable environment for recovery (Lindencrona, et al., 2008; Silove, et al., 1998). Over time, future work using the pre-, peri-, post model may draw out the complexities of refugee mental health and wellbeing further (e.g., explore interactions effects, models to understand comorbidity), enhancing the value of this organisational framework for understanding both negative and positive mental health.

Similar to the lens taken for the pre-, peri-, and post-migration model, an ecological lens was also used to investigate resilience, quality of life, and wellbeing in refugee youths. The ecological lens in this thesis was used to address some of the deficits in viewing refugee mental health solely in terms of disorder. The capacity to respond robustly to adversity is under-reported and neglected in the research literature. This strengths perspective allowed this thesis to examine young refugees within their ecological environment placing the individual central to a variety of other support structures including the family, peer, school, and community system. The utility of considering strength based factors was evident across Chapter 9, which showed resilience as understood in this thesis to be an important concept in the young refugee’s experience, either predicting or offsetting PTSD, anxiety, depression, and
somatisation. It found that threat does not only exist in traumatic events, but also those events that undermine or jeopardise the systems which support young refugees. That is, maladaptation was shown to occur when adversity was high and protective resources were weak (Montgomery, 2010, 2011).

This thesis has also extended current understanding of the resilience construct by demonstrating the role of particular forms of resilience, for instance, the role of community resilience in PTSD, peer resilience in anxiety, and internal/individual resilience in depression and somatisation. As post-migration problems predict psychological problems alongside trauma, and in some disorders more than trauma per se, the model of resilience used here can be developed to aid the acculturation experience of this population.

In considering the support the present findings offer to each of the other theoretical models described in Chapter 4, the ADAPT model proposed by Silove also stands out. The ADAPT model conceptualises the impact of mass violence on survivors. The model states that the refugee experience is defined by challenges to five systems which are necessary for psychosocial functioning. These include: (a) the safety and security system, which is threatened by the experience of traumatic events; (b) the attachment system which is threatened by loss and separation experiences; (c) the justice system which is threatened by human rights violations that result in losses of faith and justice values; (d) the identity-role system which is threatened by the loss of identity associated with trauma and the changes in roles and status resulting from resettlement; and (e) the existential-meaning system which threatens one’s values, culture, and belief systems.

Silove’s model encompasses multiple elements of the refugee experience that impact on psychological outcomes. Importantly, it conceptualises the refugee experience along a spectrum of adaptive through to maladaptive experiences that incorporate both resilient and maladaptive outcomes and the contextual circumstances commonly experienced by refugees exposed to war trauma. Thus, the model lends itself to understanding the current thesis’ findings. That is, the current findings provide support for all five systems, and elaborate on their manifestations. As described in Chapter 6, young refugees were exposed to a range of traumatic events that challenged the safety and security system, the worst of which included the lack of food or water, lack of shelter, ill health without access to medical care, the unnatural
death of family members or friends, the forced separation from family, and being close to death. Across these events, 35% to 77% of the sample endorsed directly experiencing these traumatic events. The deprivation of human rights framework used to explain these findings are consistent with the challenge to the safety and security system described by Silove.

Similarly, the maladaptive impacts of these traumatic events were demonstrated in Chapter 7, where trauma exposure was linked in a model predicting disorders, particularly PTSD, where it was unsurprisingly a unique predicting factor. As was the case in this thesis, the role of trauma in Silove’s model is acknowledged alongside psychosocial factors as influential in predicting mental health disorders. The finding that post-migration difficulties, particularly worries about family back home and racism and bullying (the two most endorsed post-migration difficulties) contributed to mental health problems suggests that the perception of threat to loved ones back home and ongoing threat around personal safety in Australia further challenge one’s sense of safety adding to psychological distress.

The separation, loss, and grief experiences dominating the qualitative interviews in Chapter 7 have implications for the attachment system (Silove, 1999). Grief processes occurred at the level of the family as well as the level of the individual. As such, this finding supports Silove’s (1999) assertion that refugee loss may affect interpersonal relationships. The maladaptive responses to these experiences was possibly seen in the depression and other mental illness experiences observed in Chapter 8, and in the grief processes described in Chapter 9.

According to Silove (1999), threats to the justice system can result in anger, often because integrity and humanity are abused and disregarded. In refugees, anger responses can be suppressed as a means to survival, but can be later triggered later by reminders of the injustice, in extreme case, resulting in more explosive anger responses. In this thesis, anger was identified as a theme for young people. Although extreme anger was not reported in the way described by Silove, anger appeared to be internalised by these young refugees, resulting in maladaptive avoidant strategies such as suppression or alcohol abuse. The findings of the present study extend the conceptualisation of the justice system to include internalised anger states as well as constructs surrounding forgiveness. Although the constructs of anger, forgiveness,
and their relationship to alcohol use were not explored deeply, this construct should be explored in further research.

The *role-identity* system described by Silove (1999) as one that is challenged by trauma and resettlement stressors was most prominent in this thesis’ findings. One of the dominant themes to emerge in this thesis was the experience of change to identity- identity in one’s culture, identity within the Australian culture, identity as a refugee etcetera through the adoption of a new life. Role status in the older refugees, particularly amongst the Karen group, was especially challenged where older siblings and young refugees seemed to experience more pressures to succeed and choose options that were not always parallel with individual ambitions. Cultural and collective identities were also challenged. The young refugees reported fears not only around losing their homelands but also their cultural identity and heritage. The identity and role system is therefore not only challenged by circumstances around trauma and (re)settlement but also around threat to homeland, ethnic, and cultural identities. This was discussed particularly for the Sudanese and the Karen in Chapter 9. While the majority of refugees in this sample were responding in what Silove (1999) terms as adaptive responses, maladaptive responses were evident in a few with some unable to reconcile these identities, resulting in possible passivity and isolation.

The *existential meaning* system according to Silove (1999) is threatened by trauma and mass violence, undermining refugees’ values, culture, and belief systems. Findings of the present study did not offer the same degree of support to this system as the other systems in Silove’s theory. This may not be surprising given that the nature of this construct may require deeper probing than perhaps afforded in the qualitative study. However, there was some evidence of existential doubt in this young group of refugees. As discussed in Chapter 10, the young refugees in this study conveyed a sense of ongoing struggle in their narratives. With an expectation of high hopes and dreams, upon arrival they seemed to face a new set of challenges and doubts. Doubts concerning safety and security were replaced with doubts over whether successful adaptation could be made. Such tensions were discussed in Chapter 10. According to Silove (1999), adaptive responses to an assault on the existential meaning system can result in adaptive responses and many young people, despite their doubts, displayed evidence of this adaptive thinking alongside the makings of hybrid identities. This was especially evident in the Horn of African
group. Of course, though less evident in this sample, more extreme assaults to the existential meaning system could result in alienation, loss of faith and depression.

Although Silove’s model requires further empirical testing, it is valuable in terms of its sensitivity to varied experiences among young refugees. Importantly it highlights the ‘humanness’ of the refugee experience and provides an important basis for potential social and community interventions, approaches that address social causes for social/individual problems (Silove, 2005).

Methodological limitations of this thesis

Despite identified methodological strengths of this thesis, some limitations need to be acknowledged. First, although necessary to meet the challenges in recruiting a reasonably sized sample, the non-random, snowballing method of recruitment (and assisted by cultural liaisons) utilised in this design may have impacted on the general representativeness of this sample to the wider refugee community. It is possible that accessing participants known to one another may have introduced an effect of similarity where participants who were known to each other, may have shared and/or been influenced by each other’s experiences, particularly in the settlement period. Moreover, the young group of refugees in this study may reflect a more ‘connected’ or higher functioning’ subgroup of refugees as opposed to a group that may be less adaptive or not affiliated with an organisation approached for this study. While attempts were made to make the sample as diverse as possible by recruiting from various organisations, it is possible that those who chose not to participate did so due to higher levels of depression, anxiety, or PTSD. Together these factors may reduce the representativeness of this sample of young refugees. Nevertheless, the snowballing method was considered purposive rather than representative, given the difficulties associated in engaging vulnerable communities and individuals to research.

Second, the small sample size is of importance when considering the generalisability of findings. Although the number of study participants in this sample exceeds that generally found in refugee samples, the relatively small number of participants may have also impacted on the representativeness of this sample. However, in proportional terms, and with exception to a slight over-representation of
Horn of African youth, the present sample approximates the population of refugee youth arriving in Australia between 2003 and 2010 with respect to country of birth and gender (CMY, 2010). Thus, it is argued, that the research findings reported in this thesis add meaningfully to the body of empirical research on youth refugee mental health, particularly in Australia.

Third, it is acknowledged that the present thesis used Western psychological tests to assess mental health. This may have impacted on the findings related to mental health difficulties either resulting in an underrepresentation or overrepresentation of mental health problems, particularly if cultural manifestations of PTSD, depression, anxiety, and somatisation were not examined (e.g., use of translated tools or other culturally derived assessment tool). Although an attempt was made to utilise culturally validated tools for a refugee population, findings are limited here with respect to a Western framework for understanding mental health problems. Nonetheless, the findings of the qualitative interviews were suggestive of the overlap of symptoms described by participants and those used in the Western framework. That is, to at least some extent, symptoms of PTSD, anxiety, depression, and somatisation were familiar to young refugees if not the terminologies surrounding them.

Fourth, language difficulties and cultural barriers could in part have increased errors in the measurement of certain variables, particularly those related to psychological symptoms. With a great diversity of languages spoken in this sample, it was impractical and not financially possible to have the questionnaire used translated in all languages. Where requested, however, questionnaires were interpreted using an interpreter. In some ways, this was more helpful to participants as clarifications and cultural understandings could be conveyed, increasing the validity of psychometric tools used.

Fifth, although efforts were made to establish trust with the communities approached, and that participants were open and availed themselves to be interviewed, stigma in discussing emotional concerns for individuals who may have been experiencing difficulties may have impeded their participation in this study. The problem of social desirability and stigma however, is not unique to refugee or other human participatory research (Babbie, 2005). To minimise this impact, the present thesis held individual interviews to enable participants to discuss emotional difficulties privately.
Sixth, participants provided retrospective accounts of their memories and experiences. As suggested by Schweitzer (2007), the use of retrospective accounts as part of qualitative methodology is always open to the potential reconstruction of events resulting from recall deficiencies and retrospective interpretation. This process may have in turn impacted upon the reliability of the findings.

Seventh, as this was an observational study, there was no comparison group with which the wellbeing outcomes of the refugee youth study could be compared (e.g., a non-refugee migrant group, or control group of young non refugee Australians). Future research that utilises large samples is necessary to confirm the finding that young refugees experience higher incidence of mental health problems than a comparative non-refugee youth sample. Indeed, to date a large population or epidemiological study of prevalence of mental health problems has not been conducted, despite strong commentary arguing the need for such research (see Fazel, et al., 2005; Porter & Haslam, 2005; Steel, et al., 2009). Nevertheless, the strength of this study was to be able to explore cross cultural heterogeneity and the impact of culture on mental health outcomes.

Eighth, this study examined outcomes of a culturally diverse population that have lived in Australia between 1-6 years. As acculturation was not specifically measured, it is possible that responses were shaped or influenced by broad acculturation processes entailed in becoming at home in a new host country. Measurement of this variable may have shed some light on the post-migration experiences cited by participants in this study. Furthermore, the heterogeneous nature of the sample in terms of time spent during the period of transition and in Australia needs to be considered in terms of the generalisation to the refugee population both in Australia and internationally. Having said this, it would be difficult to obtain a homogeneous and fully representative refugee sample, given the characteristics, experiences, political situations and cultures of young refugees change from refugee population to refugee population.

Ninth, this thesis was not able assess for organic causes in those presenting with somatising symptoms. Therefore it is possible some overlap may have occurred in organic versus non-organic causes to somatic complaints.

Finally, it is possible that there was construct overlap between the outcome variables for PTSD, anxiety, depression, and somatisation. For instance, the BSI was
used as the measure to assess symptoms of anxiety, depression, and somatisation. This may have impacted on the high levels of comorbidity evidenced in this study. Although, it is not uncommon for such global measures to share variability (despite discrete questions being used in BSI subscales). Moreover, these disorders can occur co-morbidly in clinical settings suggesting that the impact if any of the shared variance may be reflective of true overlap in symptoms rather than the use of the BSI to measure symptomatology per se. Similarly, with respect to the resilience variables, there may be some influence on particular types of resilience on others – for instance, the degree to which family resilience occurs may also affect the degree to which resilience may occur in community groups. The qualitative findings suggested that the role of the family and the community is closely linked. Construct overlap is a problem for many studies as causation is difficult to substantiate (Correa-Velez, et al., 2010). Moreover, ecological models of refugee adaptation are by their nature “interactional, with multiple causally reciprocal relationships existing simultaneously between domains” (Porter, 2007, p. 429).

Suggestions for future research

Several suggestions for future research arise from the current thesis. These include:

(1) **Address the problems of small sample size through increasing the sample size.** One major problem encountered in refugee research is the difficulties surrounding recruitment of refugee participants; the reasons for this are cited elsewhere in this thesis. One strategy might be to partner organisations and refugee services so that access to participants can improve. Another strategy is to increase incentives for participation, such as exploring ideas that the communities themselves are interested in exploring, payment incentives and/or reciprocal task arrangements such as providing workshops for communities.

(2) **Utilisation of a comparison group.** It was not possible in this thesis to use a comparison group for assessing the incidence of mental health problems (e.g., cross sectional design with other migrant group). Future research should aim to confirm the current findings concerning incidence of mental health problems using a large epidemiological study that assesses the mental health of young refugees. This research
would be enhanced with a focus on other factors that influence mental health, particularly in the post-settlement period.

(3) **Address the problems of retrospective reporting and increase prospective and longitudinal studies.** The difficulties of retrospective reporting by participants were mentioned above. In addition to these problems, in this thesis, it was difficult to establish pre-morbid mental health difficulties prior to the post-migration stage, and therefore difficult to determine if disentangle pre-morbid mental health issues, and the influence of risk factors across the stages that related to poor mental health reported in the post-migration stage. The use of prospective or longitudinal designs would allow mental health to be assessed across time to determine changes or fluctuations in mental health and resilience over time and assist in determining the differential role of risk and protective factors across each migration phase.

This thesis found that length of time in Australia was not significantly related to mental health suggesting that other acculturative factors may be important alongside pre-migration risk factors. Longitudinal studies would be useful to explore acculturative impacts over time in addition to fluctuations in mental health. It would be of further interest to map the mental health and well being of cultural groups over time to determine the trajectories for different cultural groups. It would be interesting particularly to follow up Togolese participants of this study to establish whether a similar mental health trajectory occurs for that of more established cultures. Likewise it would be of interest to investigate if moderately established groups such as the Sudanese and the Karen improve in their mental health and well being over time. These findings have important implications to how treatment interventions might be timed.

The accuracy of memories reported would also be enhanced through prospective or longitudinal research. Although it is difficult to assess mental health problems and resilience during the experience of war and/or trauma, there are a number of studies now that are exploring these factors in camp situations (Bolton et al., 2007; Sonderegger, Rombouts, Ocen, & McKeever, 2011). Prospective studies could also help to understand the particularly critical phase of peri-migration more and prepare young refugees for a challenges associated with adjustment in the post-migration phase. The prospective assessment of mental health, wellbeing, and
resilience (and other transitions and changes) might also help to define the process of a ‘refugee identity’.

(4) **Improve the cultural sensitivity of research designs.** Future research should seek to further validate tools, particularly the ARQ-R, for use with specific refugee populations. In the absence of validated tests, researchers should consider presenting material in the primary language of participants as well as utilising interpreters to enhance validity and understanding of mental health concepts. Future research could also explore cultural interpretations of the western derived concepts of PTSD, depression, anxiety and somatisation. Although this study found overlap between these constructs and mental health symptoms expressed by cultures, further work is required to understand cultural influences.

(5) **Employ mixed method research designs.** Future research should also consider a range of quantitative and qualitative techniques, that includes strength based variables and which emphasise qualitative enquiry to contextualise the refugee experience. Ecological and psychosocial approaches could be particularly helpful in theoretically framing these methodologies. In this thesis, although many qualitative themes overlapped with quantitative findings, more mixed methodologies are needed to contextualise, corroborate or even challenge quantitative findings. In this thesis, findings from the qualitative study were helpful in interpreting quantitative findings.

(6) **Replicate the findings of this thesis.** As some of the findings in this project are preliminary (e.g., resilience findings), future research should seek to replicate these findings. Few cross cultural studies are conducted in the refugee literature and more work is required here, particularly with respect to replicating the findings associated with the Sudanese and Karen groups. If replicated, further research might also help to ascertain why these subgroups may be more vulnerable than others or why some cultural groups might fare better than others in terms of mental health, resilience and well being. Similarly, it was argued in this thesis that an age-culture interaction may have occurred to produce the findings related to the Sudanese and Karen. Further research could explore interaction effects between important variables such as age-culture.

(7) **Seek to further explore and operationalise the resilience construct.** One of the major strengths of this study was to explore resilience as a strength based construct comprised of internal and external factors. Future research should seek to
replicate the current findings and explore further the resilience construct. An in-depth investigation into the different domains of resilience is recommended. Findings around the influence of unique predictors for each disorder (e.g., community resilience in PTSD) should be subject to replication. Moreover, although this thesis demonstrated a linear inverse relationship between mental health problems and resilience, the role of resilience is still debated in the literature (Betancourt & Tanveer Khan, 2008; Bonanno & Mancini, 2008; Rutter, 2012). That is, the issue of whether high resilience can exist alongside mental health problems should be further researched. The current thesis provides some evidence that resilience as defined and operationalised here can be a reliable and sound construct.

Findings from the focus groups also confirmed the importance of the role of family resilience, particularly with regard to family separation could be of value to further explore. Other protective factors that could be explored further lie in the community resilience domain, particularly the influences of dance, singing, music/singing, and sport. The role of traditional cultural practices and activities around music, dance and sport and their role in maintaining cultural connectedness could also be explored.

(8) **Gain further understanding of some main findings.** Future research could seek to explore the ideas developed from the qualitative findings. For instance, exploration of the dichotomies expressed by young refugees (e.g., hope versus the challenges; safety versus belongingness), exploration of the notion/identity of an Australian refugee, exploration of the ideas around belongingness and social/system inclusion and exclusion, exploration of cognitive processes underlying coping with mental health difficulties and stressors, in depth exploration of the link between mental health problems and social circumstances, and exploration of the links between alcohol and anger should prove beneficial.

**Practical, clinical, and policy implications of this research**

Findings of this thesis have important practical, clinical, and policy based implications. These are discussed below.

**Implications for general practice**
(1) The establishment of trust. This study has demonstrated the very important issue of establishing trust with individuals who have experienced trauma arising from war. Trust should ideally be built over a number of meetings and discussions of emotional health should occur once trust is established. Researchers, advocates, or practitioners should be flexible in terms of their use of concepts in exploring and assessing mental health difficulties, maintaining a view that while Western frameworks are possible to apply, that mental health constructs may be differently perceived and understood by different cultures.

Establishing trust with a young refugee should encompass a consideration of the role or influence elders or leaders in the young person’s community, and whether a relationship between the young person and his/her community exists. The community has been shown to be an important source of both suffering and strength in the lives of young refugees, especially those newly arrived or older refugees among the youth. Researchers, advocates, and practitioners could seek to establish networks and collaborative relationships with leaders in the community and draw from existing resources within to community to strengthen young refugee’s resilience (of course, if the young person permits, and weighing up confidentiality issues).

(2) Maintaining a whole perspective. As this research has shown, emotional well being is influenced by a number of factors, not just those typically associated with trauma exposure. It would be important to keep in mind the role of psychosocial stress or daily problems in the young person’s life. This might include attention to the experiences of racism and social exclusion, English language difficulties, and employment difficulties. Notwithstanding, in assessments around mental health, researchers, advocates, and practitioners should be aware of vulnerabilities not only to PTSD, but also other psychological symptoms and presentations, particularly somatisation. Attitudes towards mental health and cultural understandings of mental health should be applied where necessary (e.g., understanding in the use of suppression techniques; collective sadness and trauma). An approach that embodies strengths and hopes of young refugees, as well as their fears and mental health symptoms, is necessary (Kohli & Mather, 2003).

(3) Building resilience and protection. It is clear that young refugees already possess a range of protective skills that see them through a range of traumatic,
frightening, or stressful circumstances. They have a strong commitment to family and community, and a strong desire to achieve educationally and vocationally. They have broad international knowledge, multilingual skills, and awareness of a variety of cultures (CMYI, 2006). They also have their own ideas about the strategies that work. Researchers, advocates, and practitioners should endeavour to build on such existing strengths and strategies through asking what works or what does not work for them. With mindfulness of risk and resilience factors such as a young person’s age and age at arrival, or need to maintain cultural identity, particularly among older youth, young refugees can be well supported in their transition to life in Australia, their capacities to rebuild their lives, and achieve their goals (CMYI, 2006).

**Implications for policy**

(1) **Improve the ‘system’ for young refugees.** This thesis has shown that consideration of the individual should not be without consideration of the system in which he/she lives. The role of policy makers in organising structures and systems for which refugees encounter, is crucial in helping them to heal and overcome difficulties in the resettlements and settlement period. Advocacy to address systemic barriers such as access to accommodation or educational and employment opportunities should also be considered in policy development and practice.

Orientation periods and processes could be improved with extended sessions both before and after immediate arrival to Australia. “Booster” orientation sessions could also be introduced in the later re-settlement period to allow for young refugees to come into contact with the ‘system’ and follow-up issues they need clarification with. Anxieties and the expression of shock reported by participants in the days leading up and through the immediate arrival period suggest that more support could be provided through orientation and through case management to ensure that expectations and anxieties are managed.

Furthermore, although the young refugees in this study had adequate awareness of social services and government assistance agencies (e.g., Centrelink) there was a degree of uncertainty about the nature and extent of what agencies could offer in terms of support. Access to clear and appropriate advice and support in resettlement issues, and entitlements could be increased (e.g., increased awareness of
interpreters). Moreover, the refugees in this study had high hopes for improving their lives with good education and employment that led to career succession. Access to extended English lessons and vocational counselling to those requiring additional support (e.g., older youth) could help to increase access to more diverse educational and employment opportunities.

(2) *Engagement in school system.* Apart from receiving a good education, the school system plays a crucial role in assisting young refugees to integrate and maintain healthy functioning. The establishment of homework clubs in some Australian schools to assist young refugees with English and school subjects provides a good opportunity for refugees to increase their ‘fit’ within the system and increase learning opportunities. As young refugees see education and schooling as a means to successful adaptation and therefore a conduit to positive mental health, policy work in this area could focus on mental health initiatives for different cultures including young refugees to prevent mental health problems and improve resilience. Currently in Australia, such initiatives have been successful in achieving such goals, for instance the empirically supported FRIENDS program (Barrett, et al., 2000; Barrett, et al., 2001).

(3) *Increase social inclusion.* Findings of this thesis have shown that young refugees have experiences of social exclusion, either through discrimination or through not being able to participate in their chosen sports. Involvement in these kinds of informal or organised youth participatory activities were something identified as lacking but significant in helping to cope with difficulties. Consequently, refugee youth mental health and wellbeing could be improved through outlets of social activities that include sports and traditional dance, and song. The continuity of cultural practices and other coping practices successfully engaged in at pre-war and pre-migration are seen as essential to a successful transition to a new culture/society and improved coping and mental health. Opportunities that bring various refugee cultures together with non-refugee cultures could also increase integration and social inclusion. Establishing a sense of belonging in early in the post-migration period could be instrumental in offsetting pre- and peri- traumatic stress experiences and set young refugees up for better longer term wellbeing (Kia-Keating & Ellis, 2007).

(4) *Mentoring and learning from others.* The young refugees in this thesis identified a gap in their knowledge about system processes. The establishment of
‘mentors’ could be helpful in enabling them to gain knowledge from one another at the same time, increase their social inclusion. ‘Mentors’ could potentially come from a variety of sources including other more established refugee communities, previous refugees of the same cultural background, other migrant communities, and importantly from the broader non-refugee Australian community. The latter could be particularly useful in helping refugees to obtain a sense of belonging and acceptance from the broader community. As mentioned by a few participants, community or cultural sharing where elders from more established cultures/communities talk with elders in lesser established cultures/communities, could also strengthen refugees learning experiences. The promotion of sharing ideas and ways of doing things was a prominent suggestion generated by the young people. The exchange of cultures and ideas from mentors in the non-refugee Australian community would help to curtail the sense of isolation from one’s culture/community back home and exclusion in the current society expressed by young refugees in this thesis.

It is not surprising that many implications have been raised for the post-migration period, as many difficulties arise in this phase and most of the scope for intervention occurs in this phase (e.g., cannot prevent war). Results from both the quantitative and qualitative studies revealed this phase has a significant influence in predicting mental health and well being outcomes. While commonly viewed as a time for safety and hope, following the terrifying experiences of war, conflict and hardship, the post-migration period is a particularly vulnerable time for young people. This is not only due to the ongoing adjustments and uncertainties that need to be resolved in the post-migration phase, but also the cumulative experiences of the pre- and peri-migration periods. As this thesis has argued, these are indeed not discrete periods, but rather transitory periods where the past inevitably bears on the future and the future inevitably is influenced by the past. This research provides evidence, however, that the mental health of young refugees could be improved through sensitive and appropriate policies directed as minimising challenges associated with settling in a new country.
Clinical and mental health specific interventions

(1) **Increase identification and minimisation of impact of risk factors.** The findings from the quantitative data on vulnerability factors to PTSD, anxiety, depression, and somatisation showed that PTSD, anxiety, depression, and somatisation are influenced by a range of pre-, peri-, and post-migration risk factors. Recognising the factors across each phase will be helpful, with special emphasis on the role of trauma experience as well as post-migration difficulties as major risk factors. The role of trauma experience in PTSD of course should also be noted, recognising that trauma experience is varied, often multiple, repeated or prolonged, and that less overt trauma experiences such as lack of food or water/malnutrition can be experienced as more traumatic than events such as physical assault. Paying attention to other risk factors such as losses, separation experiences, unaccompanied, age, and age at arrival is also important. Recognition of the role of daily post-migration stressors is particularly important given their influence in predicting disorders such as PTSD, anxiety, depression, and somatisation. Working to identify the risk factors and reduce the impact of risk factors such as those found in the present thesis should be a focal point of clinical work with refugees.

Alongside recognising risk factors for young refugees, clinicians should also be mindful of comorbidity in youths who experience mental health difficulties. This thesis has shown a range of psychological problems can exist for up to 30% of young refugees living in Australia, with more vulnerability exiting in a portion of those who have subsyndromal symptoms. Assessment for a range of difficulties should therefore be conducted, with consideration to the overlap between somatisation and PTSD. Although more research is required to assess the drivers or common underlying causes of comorbidity, the presence of one disorder is conferred as risk for another.

Alongside an awareness of the mental health impacts, however, should also be awareness that mental health can also be placed in psychosocial terms (Miller & Rasmussen, 2010). This notion relates to findings from the qualitative study that show refugees are able to identify their own concerns and priorities in a clinical and research context and that mental health problems can be related to psychosocial functioning or socioeconomic terms, where trauma is not necessarily the driver of
mental health. That is identification of psychosocial risk and protective factors should also be made in clinical assessments.

(2) **Recognition of vulnerable cultural sub-groups.** This thesis found that there are sub-groups of refugees that have added vulnerability. These include the Sudanese and Karen youth. Interventions that specifically target risks and protective factors among this group are important. For instance, strengthening community resilience and ties for these groups as well as re-settlement and settlement programs could be helpful. Cultural differences in vulnerability should also be considered in light of culture as well as acculturative circumstances and the broad circumstances that currently exist in these young refugees homelands.

(3) **Build resilience.** The findings of the quantitative data suggest that building all main areas of resilience is an optimal strategy for reducing PTSD, anxiety, depression, and somatisation. As it is not always practical to target all sources of resilience and that indeed some sources of resilience are not available (i.e., time may only allow for a single intervention), targeting particular areas for certain psychological problems might be useful. That is, findings of this thesis could help the prioritization of areas to focus on in treatment planning. For example, this thesis has shown that building community resilience could be useful with PTSD symptom presentations, whereas targeting peer resilience in presentations for anxiety might also be most useful. Similarly, depression and somatisation could be most helpfully targeted through building individual and internal resources. This latter suggestion lends itself well to cognitive behavioural therapies which have been useful for offsetting these problems in samples comprising refugees and migrants (Murray, Davidson, & Schweitzer, 2010). Thus, while building resilience to mental health problems is related to a range of individual, peer, family, peer, school and community resiliencies, practitioners should be mindful of the particular unique roles that specific domains of resilience have in determining outcomes related to PTSD, anxiety, depression, and somatisation.

(4) **Provide therapeutic environment promoting safety.** As recommended by Papadopoulos (Papadopoulos, 2002) and Aristotle (Aristotle, 1999), a therapeutic care approach should be taken to help young refugees adapt to life in their host country and in particular cope with the losses of home and family. This involves building safe environments where young refugees are able to develop social networks and gain the support necessary for healthy development and adjustment. Practitioners and service
organisations should also consider the broader recovery goals of restoring a sense of safety, restoring attachment and connections to those who can offer support and care, restoring identity, meaning, dignity and value, and enhancing choice, a sense of control, autonomy, and mastery over their lives.

(5) **Provide opportunity for narratives.** This thesis through its qualitative findings highlighted the benefits of youths “being able to share and tell their stories” as a means of coping and gaining respect and acceptance. Providing opportunities for young refugees to tell and share their narratives through the pre-, peri-, and post-migration journey could help improve refugee well-being. The major themes drawn from this thesis demonstrates that the refugee experience is a diverse complex one, involving multiple and ongoing physical and psychological major life transitions. Each transition made is affected by the past or influenced by beliefs about the future. Assisting refugees with understanding the psychological transitions back and forth these seemingly linear phases in the refugee narrative might help practitioners to form a basis for understanding young refugee experiences as well as pinpoint areas of difficulty. That is, eliciting a journey narrative provides a useful framework from which to discuss the refugee journey, making connections between past experiences and their links to their present states and similarly for being able to plan the future while holding into account past and present experiences.

Tensions or dichotomies described earlier could also be challenged or addressed. It might be helpful for practitioners to explore young refugees’ tensions and challenges and assist them to incorporate their old and new identity and find ways to fit in with society while balancing the old systems and cultural traditions. In this way, it is not surprising that therapies which explore mental health through story telling of journeys, experiences, hopes, fears held in the past and future, such as narrative therapies have been such successful interventions for young refugees (Neuner et al., 2008; Neuner, et al., 2004; Robjant & Fazel, 2010). The findings of this thesis offer some theoretical support to narrative therapies which take into account the individual in the context of his/her political, cultural as well as social milieu. The current findings suggest however that therapies containing exposure for PTSD or other avoidance interventions (e.g., narrative exposure therapy, trauma focused CBT, CBT) may need careful planning due to the entrenched strategies that
some individuals and cultures have for dealing with emotional difficulties (e.g., suppression and forgetting techniques).

(6) **Utilisation of non-mental health practitioners.** The qualitative findings in this thesis indicated that young refugees would not readily access counselling or mental health support services. It is suggested here that social service agencies increase their workforce capacity to understand, address and refer emotional, mental health and adjustment issues in refugee youth. During initial resettlement, young refugees rely on social services and charitable organisations to provide the necessary support and advice to access these services. Such ‘frontline’ staff or if trained appropriately, ‘mental health brokers’, could act as a first point of contact to refugees to enable them a pathway to mental health services if required. This is not to suggest that specialist mental health services be replaced. Indeed, the findings of this study suggested a lack of clarity regarding pathways for health care. Increasing clarity around this access would therefore be an important consideration for policy makers, practitioners and refugee case workers. The training of health, educational, and/or social services staff to identify mental health issues and facilitate avenues/referrals for further support becomes especially important. Likewise, mental health practitioners should be encouraged to maintain contact with these agencies so as to facilitate better access to mental health care, which for refugees, often intersects with social needs and social care/welfare.

The concept of ‘mental health brokerage is not new and to date, has been used successfully in low resource countries which do not have good access to mental health facilities (Augustine, August 2012; Patel et al., 2010). Similarly, other frameworks exist which are designed to increase community capacities to deal with emotional well being following disaster and trauma. Brymer and colleagues (2006), for instance propose a tiered level framework for assisting with emotional problems after trauma or disaster. The three level framework comprises (1) Psychological First Aid; (2) Skills for Psychological Recovery; and (3) Specialist mental health treatment (Brymer, et al., 2006). Level 1 (Psychological First Aid) and Level 2 interventions (Skills for Psychological Recovery) are basic interventions (e.g., relaxation strategies) designed specifically for non-mental health professionals who have contact with communities exposed to trauma or disaster. Basic skills are provided to non-mental health professionals such as pastors, teachers or case workers who can in turn use
them successfully with those affected by trauma or disaster. In particular, these skills could be given to elders or key community members within refugee communities to increase support for young refugees. Unfortunately, this framework has not been adapted or tested for youth refugee communities, but provides a useful way of thinking about giving informal support and providing avenues of referral for specialist mental health assistance.

(7) **Utilisation of informal support networks.** The current findings regarding sources of resilience and low utilisation of mental health services suggest the use of informal support networks cannot be underestimated. Practitioners should be encouraged to bolster informal supports which provide an avenue in which refugee youths could be supported in their well-being. These informal networks include family members, peers, GPs, caseworkers, teachers, and community elders/leaders. Mental health support could also be given informally by communities themselves via frameworks provided above or through traditional strategies used by the community themselves.

(8) **Promote opportunities for family contact and/or re-unification.** Perhaps the most prominent concern expressed by young refugees was the longing for those left behind. These included immediate and extended family members as well as peers and elders. Practitioners should incorporate family issues in their assessment (e.g., assessment of family back home and present) and treatment plans with young refugees and look to strategies that help maintain contact with families and that help young people manage grief associated with separation and loss. Policy developers could also consider increasing information and access to family re-unification and/or other strategies that foster the maintenance of contact with families and friends in homelands.

**Final conclusions**

Approaching this thesis using integrated theoretical and methodological perspectives enabled a more contextualised understanding of the mental health and well-being of young refugees living in Australia. This thesis has expanded on existing knowledge of youth refugee mental health through a parallel investigation of pre-, peri-, and post-migration risk factors and resilience factors in mental health outcomes. It has also
expanded knowledge related to cultural differences in these outcomes and importantly offered fresh perspectives from young refugees at different acculturation stages, where narratives and perspectives of refugees themselves is often lacking. The study of a unique developmental age of youths and new cultural groups of refugees (Karen, Togolese) have also added to the limited knowledge base that currently exists around cultural differences in refugee experiences and mental health outcomes. It is concluded that refugees in Australia are indeed a diverse population comprised of multiple cultures and complex experiences which encompass a range of negative mental health issues but positive strength factors, which are influenced by a range of internal and social determinants.

While there is strong evidence to suggest that refugees are vulnerable to mental health problems, and that psychopathology is relatively high among them, there is now evidence emerging demonstrating resilience as a salient construct among this vulnerable group. As there is no ‘one refugee experience’ there is similarly no single construct or unitary discipline to explain mental health and well-being in young refugees. An inter-disciplinary approach, comprised of traumatology in addition to ecological/psychosocial approaches are therefore necessary to advance knowledge and practice in this field, to then enable young refugees to move from trauma towards resilience.
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APPENDICES

Appendix A:  RMIT University Human Research Ethics Committee Approval Letter
Appendix B:  Plain Language Statement - Participant (Project Information Sheet)
Appendix C:  Study Plain Language Statement - Parent
Appendix D:  Participant Consent Form – Participant & Parent
Appendix E:  Information Sheet for Organisations
Appendix F:  Recruitment Flyer
Appendix G:  Questionnaire Booklet and Focus Group and Individual Questions

(Karen example provided)