Improving mental health and wellbeing in recently-arrived refugee families and children

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Doctor of Psychology

2011

RMIT
Improving mental health and wellbeing in recently-arrived refugee families and children

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Psychology

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June 2011
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:

______________________
Jenny Tsoupas

10 June, 2011
Acknowledgements

I wish to thank the following people in the production of this thesis.

First and foremost, I would like to extend a special thank you to all the children and parents who agreed to participate in this research. I am grateful for their time, honesty, and willingness to share their experiences with me. Without their support and involvement, this research would not have been possible. I wish them all the best in the future.

I would also like to thank the staff at Foundation House, The Western English Language School, MacKillop Family Services, The Napier Street Child and Family Resource Centre, and Debney Meadows Primary School for their support, advice, and assistance.

I would like to thank my supervisors, Dr Sophie Xenos and Dr Mervyn Jackson for their patience, practical advice, and encouragement throughout this project. I would also like to extend a special thanks to Dr John Reece who provided critical advice and support during data analysis.

I thank all my family and friends, especially my mum for being the best mum anyone could ask for, Linda and Tony for their generous support when times got tough, Kylie for her kind words and patient ears, and of course Nari, Dave, Dan, Kerrie, Holly, Marianne, Annaleise, Cath, Kath, Adam and Mary for their friendship and for encouraging me to keep fit, healthy, and happy throughout this process.

Last but not least, I would like thank my wonderful partner Stephen for his never-ending love, support, encouragement, and for keeping me sane every time my computer refused to work properly. I could not have completed this thesis without him – I love you lots.
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ANOVA: Analysis of Variance
CDI-S: Child Depression Inventory-Short Version
CI: Confidence Interval
CSEI: Coopersmith Self-Esteem Inventory
DEECD: Department of Education and Early Childhood Development
DHAC: Department of Health and Aged Care
DIAC: Department of Immigration and Citizenship
DSM-IV: Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition
DSV-IV-TR: Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision
DV: Dependent Variable
EMDR: Eye-Movement Desensitisation Reprocessing
GAD: Generalised Anxiety Disorder
IDP: Internally Displaced Person
IHSS: Integrated Humanitarian Settlement Strategy
IPT: Interpersonal psychotherapy
IV: Independent Variable
MANOVA: Multivariate Analysis of Variance
NESB: Non English Speaking Background
NET: Narrative Exposure Therapy
NGOs: Non-Government Organisations
NICE: National Institute for Health and Clinical Excellence
OR: Odds Ratio
PASW: Predictive Analytics SoftWare Statistics
PLS: Plain Language Statement

PPW: Participation Progress Worksheet

PTSD: Posttraumatic Stress Disorder

RCI: Reliable Change Index

RCMAS: The Revised Children’s Manifest Anxiety Scale

RCOA: Refugee Council of Australia

RCT: Randomised Controlled Trial

RCTV: Rehabilitation and Research Centre for Torture Victims

RMIT HREC: RMIT Human Research Ethics Committee

RSFQ: Rainbow Session Feedback Questionnaire

SD: Standard Deviation

SEM: Standard Error of Measurement

SVQ: Social Validity Questionnaire

TF-CBT: Trauma Focused - Cognitive Behavioural Therapy

TRF: The Teacher Report Form for Ages 6-18

UDHR: Universal Declaration of Human Rights

UNHCR: United Nations High Commissioner for Refugees

VFST: Victorian Foundation for Survivors of Torture

VicHealth: Victorian Health Promotion Foundation

WELS: Western English Language School

WHO: World Health Organization
Abstract

The devastating and traumatic experiences that refugees must endure can have a significant impact upon their mental health and wellbeing (Fazel, Wheeler, & Danesh, 2005; Steel et al., 2009). Studies indicate that the prevalence PTSD, depression and other mental health problems are much too high in refugee populations (Fazel et al., 2005). However, a review of the literature reveals a paucity of research investigating the wellbeing of refugee families, refugee parenting practices, and their parenting needs in resettlement. This is particularly unfortunate given that parents can play a central role in helping children cope with the negative effects associated with trauma and displacement (Goodkind & Deacon, 2004; Weine et al., 2008). In addition, despite the development of many effective mental health prevention initiatives targeting the general population (e.g., Barlow & Parsons, 2004; Barrett & Turner, 2001; Cardemil, Reivich, & Seligman, 2002; Feldner, Zvolensky, & Schmidt, 2004; Foxcroft, Ireland, Lister-Sharp, Lowe, & Breen, 2004), comparatively few prevention programs have been developed for refugee children. Indeed, of those that have been developed, very few have undergone systematic evaluation for effectiveness.

Therefore, there is an urgent need to strengthen the evidence base relating to refugee parenting practices and needs after resettlement. Without an understanding of their strengths and skills, as well as the parenting challenges and difficulties refugee parents face, it is impossible to design interventions to effectively support Australia’s refugee families. There is also an urgent need to evaluate the effectiveness of mental health prevention initiatives currently in use with our refugee population. Without such evidence, there is no way of knowing if these interventions are helpful. Therefore, the aim of the current research is to address these gaps by implementing
two strategies (comprising of Study One and Study Two of this thesis) to improve the mental health and wellbeing of recently-arrived refugee children and families to Melbourne.

Study One aimed to extend the refugee parenting literature through the use of focus groups with recently-arrived refugee parents to explore the parenting strengths and challenges associated with raising a family in Melbourne. This study also aimed to generate suggestions from refugee parents themselves about the types of interventions they believed would be most helpful in supporting refugees in their parenting roles. A total of 21 refugee mothers from Somalia, Eritrea, Ethiopia, and the Sudan, with ages ranging from 22 to 43 years ($M = 33.9, SD = 6.9$) participated in Study One. Participants attended one of three focus groups and were recruited from two playgroups and one primary school from around Melbourne. Transcriptions of focus group discussions were analysed using thematic content analysis in order to identify the key ideas and concerns raised by the participants.

Participants revealed much success and resilience in their parenting roles. However, they also reported that everyday life was stressful because of the many parenting and other challenges they faced. A wide range of difficulties and intervention suggestions were described however, the main parenting challenges identified related to; (a) the separation from their extended families and social supports; (b) difficulties with discipline and fears related to child protection; and (c) fears about Australian/Western influences and acculturation. Participant provided several interventions suggestions addressing these challenges however, the most salient suggestions related to the expansion and promotion of family reunification programs.
The results from Study One have significantly contributed to the refugee parenting knowledge base. To the researcher’s knowledge, this study represents the first instance in which the positive aspects of refugee parenting have been explored and documented in detail, and represents the first instance in which parenting challenges have been explored in recently-arrived refugee parents to Melbourne. Suggestions provided by these participants should be considered and used to inform the development of mental health promotion initiatives, and to inform policy as well as service provision reform aimed at supporting refugee families and promoting their wellbeing. However, further research exploring perspectives from refugee fathers, refugee parents from other cultural groups, as well as those from other locations across Australia are strongly recommended.

Study Two aimed to strengthen the evidence base of mental health prevention initiatives designed for refugee children. Therefore, an evaluation of The Rainbow Program for Children in Refugee Families (Victorian Foundation for Survivors of Torture, 2002) was undertaken. A mixed qualitative and quantitative approach was adopted, with the quantitative evaluation component utilising a quasi-experimental pre-post test design. Children were recruited from the Western English Language School (WELS) in Melbourne, and a total of 21 recently-arrived refugee children from Africa and Asia, ranging in ages from 7 to 12 years ($M = 10.6$ years, $SD = 1.4$) participated in this study. Eleven children referred by the school’s welfare co-ordinator participated in the intervention, while the control group ($n = 10$) were selected by the researcher to match the intervention group in terms of age, gender and culture.

The results of this evaluation revealed some interesting findings. Qualitative results indicated that the Rainbow Program displays very high social validity and that
the program makes a positive contribution to the settlement experiences of recently-arrived refugee children. However quantitative results exploring the program’s effect on risk and protective factors for mental health, and on symptoms of anxiety and depression were non-significant when compared with the control group. However, given the small sample size, the study lacked the statistical power necessary to detect whether statistically significant effects were present. Therefore, it is highly recommended that future evaluations of the Rainbow program involve a much larger sample size. The researcher also recommended that future evaluations involve a follow-up period of at least 12-months, and that the parent’s component be run concurrently with the children’s component. Finally, this study highlights the urgent need for the development of culturally and linguistically sensitive, valid and reliable assessment measures of refugee children’s mental health.
Chapter 1: Introduction and Aims of the Current Research

Introduction

Humanitarian crises and unstable political situations around the world uproot millions of men, women and children every year. The most recent United Nations High Commissioner for Refugees (UNHCR) statistics indicate that at the end of 2009, there were 43.3 million refugees, asylum-seekers, and forcibly displaced people worldwide (UNHCR, 2010). Unfortunately, this figure represents the highest number of displaced persons since the mid-1990s and regrettably, prevailing circumstances mean that many will never be able to return to their homes.

Australia is one of nine countries that operates a formal resettlement program to help those in need of humanitarian assistance (Department of Immigration and Citizenship [DIAC], 2007). However, the devastating and traumatic experiences refugees must endure before their arrival to a safe country like Australia can have a significant impact upon their mental health (Fazel, Wheeler, & Danesh, 2005; Steel et al., 2009). Importantly, refugee children are particularly vulnerable to their pre-migration experiences (Guarnaccia & Lopez, 1998; Lau & Thomas, 2008). However, studies have consistently demonstrated that much of the distress reported by refugees is related to post-settlement stressors, rather than their prior exposure to trauma (Miller, 1999; Silove, Steel, & Watters, 2000).

Fortunately there is also strong evidence to suggest that providing a positive resettlement environment can help to protect refugees from suffering the long-term ill-effects of their refugee experiences (Guarnaccia & Lopez, 1998; Lie, 2002; Miller, Weine, et al., 2002). With this in mind, Australia has a responsibility to understand the challenges that our resettled refugees face as well as the strengths and skills they
possess, in order to support a smoother resettlement process and thus promote their health and wellbeing. Investing in the mental health of this community has benefits not only for the refugees themselves, but for the Australian public in general. By promoting their mental health, refugees will be better placed to make a positive contribution to Australia’s economic, cultural and social life (Victorian Health Promotion Foundation, 2002).

Unfortunately, a review of the literature reveals that there is a paucity of research about the impact of the refugee and resettlement experience on refugee families. The parenting literature has also largely ignored refugee parenting practices and needs after resettlement. This is particularly unfortunate given that parents can play a central role in helping children cope with the trauma and displacement (Goodkind & Deacon, 2004; Weine et al., 2008). Additionally, despite the development of effective mental health prevention initiatives shown to improve the mental health and well-being in the general population, comparatively few prevention programs have been developed for refugee children and their families. Indeed, of those that have been developed, very few have undergone systematic evaluation for effectiveness. Therefore, there is an urgent need to develop such interventions and strengthen the evidence base by undertaking evaluations of mental health prevention efforts targeting our refugee population.

**Aim of the Current Research**

The aim of the current research was to implement two strategies that are designed to improve the mental health and wellbeing of recently-arrived refugee children and families.

The aim of the first approach was to extend the refugee parenting literature and generate intervention ideas for the improvement of the wellbeing of refugee
parents. Interventions and support services targeting refugee parents have benefits for the entire family because healthy and happy parents are in a stronger position to positively influence their children’s wellbeing.

The aim of the second approach was to evaluate The Rainbow Program for Children in Refugee Families (Victorian Foundation for Survivors of Torture [VFST], 2002) a school-based, mental health prevention program designed to make a positive contribution to the settlement experiences of recently-arrived refugee children. An overview of how this thesis addresses these aims is provided next.

Organisation of the Thesis

Based on these aims, Chapter 2 briefly describes important background information about refugees and the refugee experience. This information will include important definitions, a summary of Australia’s Humanitarian program, a description of Australia’s refugee population, as well as an overview of the risk and resilience factors associated with being a refugee.

Chapter 3 provides a summary of the mental health impacts of the refugee experience. It is presented in three parts for clarity. Part I and Part II pertain to the mental health impacts of PTSD, depression, and other mental health problems in refugee adults and refugee children respectively. A summary of the controversies surrounding the application of Western diagnoses to individuals from non-Western cultures is also provided. Part III provides a summary of the effects of the refugee experience on refugee families and refugee family parenting tasks. The literature gaps highlighted in this review provide a rationale for Study One.

Chapter 4 presents the results of the Study One - The Parenting Strengths and Difficulties of Recently-Arrived Refugee Mothers in Melbourne. Through the use of focus groups, this study explores the parenting strengths, challenges, and the services
and/or resources requested by recently-arrived refugee mothers. With the knowledge gleaned from this study, suggestions for mental health promotion and prevention initiatives are recommended.

Chapter 5 provides a summary of the mental health interventions employed in resettlement countries to reduce distress and improve the wellbeing of refugees. This summary highlights that the majority of mental health treatments and mental health promotion and prevention initiatives employed with refugee populations have not undergone systematic evaluation. Thus, empirical evidence supporting their effectiveness does not exist. This provides a strong rationale for the evaluation of The Rainbow Program for Children in Refugee Families (VFST, 2002), a mental health prevention program designed specifically for recently-arrived refugee children. This evaluation forms the basis of Study Two, and is presented in Chapter 6. Finally, a general discussion of findings, the issues encountered when conducting research with refugees, limitations of the current research, and directions for future research is provided in Chapter 7.
Chapter 2: Background Information about Refugees

Statistics indicate that there are currently 43.3 million forcibly displaced people worldwide (UNHCR, 2010). This figure includes 15.2 million refugees, 983,000 asylum-seekers and 27.1 million internally displaced persons (IDPs). Refugees from Afghanistan and Iraq account for almost half of all refugees under UNHCR’s responsibility. Women and girls represent 47% of the refugee and asylum-seeker population, and 41% of refugees and asylum-seekers are under the age of 18. In 2009 alone, more than 18,700 unaccompanied children lodged an application for asylum (UNHCR, 2010).

The UNHCR’s role and the Definition for Refugee

The UNHCR was initially formed in 1950 by The United Nations General Assembly to help and protect Europeans who were still displaced after World War II. Today, the UNHCR is responsible for leading and coordinating international action so that refugees from all over the world are protected (UNHCR, 2007). The UNHCR is also mandated to safeguard refugee rights and wellbeing, and this mandate is outlined in the 1951 Convention and 1967 Protocol Relating to the Status of Refugees (UNHCR, 1967). According to article 1A of these two documents, the legal definition of a refugee is a person who:

owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual
residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it (UNHCR, 1967, p. 14).

This definition is generally accepted and used by most governments and agencies around the world. However, as this definition applies to only a fraction of those forced to flee their homes, many have criticised this definition for being out-of-date and vague (e.g., Millbank, 2000). Consequently, refugee research studies often use a broader definition of refugee in order to capture all of those individuals in refugee-like situations (Tempany, 2009).

**Refugees, asylum-seekers and illegal immigrants.**

There is often confusion about who is a refugee, an asylum-seeker, and an illegal immigrant. Refugees are people who meet the UNHCR definition of a refugee and who have been recognised as such by the UNHCR, or by the Australian or other governments. In contrast, asylum-seekers are people who have crossed an international border in search of safety, have applied for protection as a refugee, and are awaiting determination about their application (UNHCR, 2009).

However, the terms asylum-seeker and illegal immigrant are increasingly, and erroneously being used interchangeably (Koser, 2001). Illegal immigrants are defined as people who enter a country without the required authorisation from the country they are entering. While asylum-seekers may also (but not always) enter a country without the appropriate authorisation, they are distinct from illegal immigrants because upon entry into a country, they make a claim for asylum. Importantly, under Article 14 of the Universal Declaration of Human Rights (United Nations General Assembly, 1948) everyone has the right to ask for protection from persecution and to seek asylum, and therefore asylum-seekers cannot be considered illegal immigrants unless their application for protection is eventually rejected.
**Refugees versus migrants.**

Although similar in many respects, refugees and migrants are fundamentally distinct from one another in important ways. They are similar in that they both leave their homes and in the process of doing so, experience post-migration stressors and cross cultural challenges associated with moving to a foreign country. They are fundamentally different however, because migrants make a conscious decision to leave their homes for a better life and choose the country that will become their new home. They can also make preparations regarding employment, and learning about the culture and a new language. Migrants are also able to pack their belongings and say goodbye to family and friends. Importantly, if things do not work out as planned in the new country, migrants also have the option of returning home (Miller, Worthington, Muzurovic, Tipping, & Goldman, 2002).

Therefore, refugees are distinct from regular migrants because they do not choose to leave their homes, but are forced to flee for their lives, often without any time to prepare. They are also often exposed to extreme and prolonged periods of stress and trauma before, during, and after fleeing their homes (Refugee Council of Australia [RCOA], 2011a). Further, many refugees do not have the option of returning home, ever. Although some migrants may have also experienced trauma and the violent loss of loved ones, their decision to move is not forced upon them and is generally motivated by economic imperatives (Bhugra & Jones, 2001; Stevens & Vollebergh, 2008).

**The UNHCR and Australia’s Humanitarian Program**

Australia contributes to the international protection of refugees by supporting the UNHCR’s mandate to protect refugees by backing the following UNHCR solutions; (a) voluntary repatriation, (b) local integration, and/or (c) resettlement.
Australia contributes to the first solution by providing aid to the countries which produce refugees in order to improve conditions in those countries so that refugees can return home. Australia also supports the second solution by providing aid to those countries in which refugees most often flee to (e.g., Pakistan, Iran, and the Syrian Arab Republic) in order to help these countries cope with the large number of refugees they receive (UNHCR, 2010). However, voluntary repatriation and local integration are not always viable solutions. Therefore, Australia contributes to the UNHCR’s third solution by providing a humanitarian resettlement program (DIAC, 2007, 2010d).

Australia’s Humanitarian Program has two components; (a) the onshore, and (b) the offshore resettlement program. The onshore component exists to process asylum-seekers. Most asylum-seekers enter Australia lawfully as tourists, visitors and students. However, some also arrive without authorisation by boat or aeroplane (RCOA, 2010). These asylum-seekers are given bridging visas until their application is determined by the Refugee Review Tribunal. As a signatory to the 1951 Convention and 1967 Protocol, Australia must provide protection for asylum-seekers who are found to meet the UNHCR’s refugee definition. Those meeting the definition are awarded a Protection Visa (subclass 866) (DIAC, 2009c).

Australia is one of nine countries around the world that operates an offshore resettlement component. This program helps refugees living outside of Australia and who are in need of humanitarian assistance (DIAC, 2007). The offshore component awards two classes of permanent protection visas: (a) the Refugee Class Visas - for refugees, and (b) the Special Humanitarian Program Visas – for individuals from refugee-like situations. Special Humanitarian Program Visas exist because Australia
recognises that many people who suffer gross human rights violations do not always meet the UNHCR’s refugee definition.

The DIAC sets an annual quota for the visas it grants under the onshore and offshore programs. This quota is based on several factors including estimates of (a) the number of people needing protection in Australia, (b) the number of refugees overseas requiring resettlement according to the UNHCR, (c) the views of individuals and organisations in Australia, and (d) Australia’s capacity to provide assistance. On average, around 13,000 people have been granted Refugee or Humanitarian class visas annually over the last five years. In 2009-2010, the Australian Government announced an increase in its humanitarian program to 13,750 places, with 6,000 set aside for the Refugee category and 7,750 places to be available for those entering under the onshore and Special Humanitarian programs (DIAC, 2009b).

**Who are Australia’s refugees?**

The resettlement priorities of Australia’s Humanitarian Program have generally changed in response to changing global humanitarian needs. Therefore, the topology of recently-arrived refugees in Australia reflects the changes in conflict around the world. For example, in 1999 to 2001, the resettlement program granted visas to those mainly from Bosnia-Herzegovina. However, since 2002 the greatest number of resettlement grants have been awarded to those from Africa, namely from the Sudan (DIAC, 2007).

In line with UNHCR recommendations, Australia’s current Humanitarian Program gives priority to the resettlement of people from Africa, the Middle East and South-West Asia. For example, in 2008-2009, Australia granted visas through the offshore program to refugees from Africa (33.2%), the Middle East and South West
Asia (33.5%), and Asia and the Pacific (33.1%). A small percentage (0.2%) of grants were also made to people from Europe and the Americas (DIAC, 2009b).

Australia has also responded to the special needs of female refugees. In this regard, Australia is a world pioneer in its efforts to allocate Women at Risk visas. Australia has recognised that women and their dependent children, because of their gender and age, are a particularly vulnerable group of refugees – especially when not accompanied by an adult male (RCOA, 2011b). Australia’s commitment to protecting such women is reflected by the number of visas it has, and will continue to grant for women under these circumstances. Australia has set aside 12% of the refugee visa quota specifically for women classified as being at risk (DIAC, 2009a).

**Integrated Humanitarian Settlement Strategy (IHSS)**

Australia has also recognised that refugees will face particular resettlement challenges and will require services in addition to those of regular migrants. The Australian Government has therefore implemented the Integrated Humanitarian Settlement Strategy (IHSS) to provide settlement assistance to refugees arriving in Australia. The IHSS aims to provide support for the successful resettlement of refugees by offering on-arrival reception and assistance, case co-ordination information and referrals, accommodation services and short-term torture and trauma counselling. Refugee and humanitarian entrants can also receive free English language tuition. Furthermore, refugees and asylum-seekers are also provided with financial assistance for basic living essentials, access to work rights and to Medicare (DIAC, 2007). Although integral and helpful to the initial resettlement period, some refugees in Australia continue to experience difficulties and hardship upon their resettlement. An exploration of the stress and trauma experienced by refugees helps to put these difficulties into context.
Three Phases of Traumatic Experiences

The literature generally classifies the stress and trauma refugees experience in a chronological sequence that is related to the phase in which the trauma exposure occurs (Watters & Ingleby, 2004). These categories are pre-flight, flight, and resettlement.

**Pre-flight.**

Before fleeing their homes, refugees are often exposed to years of persecution, discrimination, harassment, and human rights abuses (Gorst-Unsworth & Goldenberg, 1998). They may have also survived a range of trauma associated with war and political conflict including: genocide, clan fighting, revenge killings, witnessing and/or being victims of torture and sexual violence, witnessing parents’ fear, panic, and/or helplessness, imprisonment in concentration/work camps, separation from caregivers, death or disappearance of family and friends, loss of all possessions, destruction of their homes, severe hardship, hunger and poverty (Candappa & Igbinigie, 2003; Cardozo, Talley, Burton, & Crawford, 2004; Carlson & Rosser-Hogan, 1991; Crowley, 2009; Hinton et al., 1993; Kamau et al., 2004; Keyes, 2000). Children are particularly vulnerable, and are sometimes kidnapped or recruited into armies and forced to commit war atrocities (United Nations Children’s Fund, 2009). War and political turmoil associated with this phase can seriously disrupt the education and social development of children (Lustig et al., 2004).

Experiences of torture in the pre-flight stage followed by cumulative exposure to traumatic events have been shown to represent the two greatest risk factors (accounting for 23.6% and 10.8% of inter-survey variance respectively) in the development of PTSD in war-affected and refugee populations (Steel et al., 2009). This finding provides compelling support for the “dose-response” phenomenon.
reported in many refugee studies (e.g., Cheung, 1994; Steel, Silove, Phan, & Bauman, 2002; van Ommeren et al., 2001) where the prevalence rate and severity of PTSD symptoms increases in proportion with the level of trauma experienced.

**Flight (or displacement).**

Refugees are eventually forced to flee their homes and escape to safety. Escape can often take refugees through three to four different countries. Protracted periods in refugee camps are also not uncommon. Flight is often unplanned and done at short notice. Sometimes it is necessary to escape secretly to prevent discovery of such plans. There is often no time to prepare physically or psychologically for the escape, or to pack belongings. They are also unable to return home due to prevailing circumstances (RCOA, 2010). Flight is a perilous time for refugees. Many Vietnamese refugees fleeing in boats perished at sea – being victims of both pirate attacks and the elements (Hinton et al., 1993). Cambodian refugees travelling on foot after fleeing from labour camps experienced fear, danger, and deprivation (Carlson & Rosser-Hogan, 1991). And time spent in refugee camps is often protracted and characterised by fear. Conditions in camps are usually over-crowded and insecure, with the threat of human violence, disease, and starvation ever present (de Jong, Scholte, Koeter, & Hart, 2000). Amid the turbulence of flight, children must also endure important stages of psychological development. Separation from parents and caregivers is also common during this stage (Lustig et al., 2004).

**Re-settlement.**

Living in exile is usually highly distressing for refugees (Keyes, 2000; Miller, Worthington, et al., 2002). Although refugees may initially experience euphoria in resettlement because immediate threats of danger are removed, as their losses are
realised and refugees are confronted with foreign cultural norms, their mental health status may start to decline (Barrett, Sonderegger, & Sonderegger, 2001; Keyes, 2000). Indeed, recent findings consistently show that much of the distress reported by refugees is related to post-settlement, rather than exposure to traumatic events during the pre-flight and flight phases (Miller, 1999).

Resettlement stressors, which are also referred to as acculturation stressors, that have been reported in the literature include: separation from family members, loss of community, lack of social support, loss of important life projects, loss of valued social roles, a lack of environmental mastery including difficulties with language, poverty, inadequate housing, unemployment, and discrimination (Beiser & Hou, 2001; Gorst-Unsworth & Goldenberg, 1998; Keyes, 2000; Miller, Worthington, et al., 2002). New family roles, patterns, and family dynamics in resettlement countries may also lead to stress in the family. Children may also acculturate faster to their new environment than their parents, which can sometimes lead to significant family problems (Lustig et al., 2004). In addition, the detrimental effect on mental health in asylum-seekers as a result of mandatory detention practices and uncertain asylum status in Australia has also been demonstrated (Silove et al., 2000).

In a qualitative review of the literature, Crowley (2009) identified several risk factors associated with poorer mental health in refugee children living in resettlement countries including: parental unemployment for longer than six months within the first year of resettlement, inability of parents to cope with stress, uncertain residency status, parental physical and/or psychological impairment, parents’ underestimation of stress levels in their children, language difficulties, residual physical health problems incurred during pre-flight and flight phases, cultural conflicts, low socioeconomic status, and the experience of racial violence. However, unaccompanied refugee
minors are also described as a particularly vulnerable group who are at a greater risk of developing psychiatric and mental health problems than other traumatised children (Huemer et al., 2009).

It is highly likely that post-settlement stressors interact with the effect of previous trauma, creating or exacerbating risks for ongoing mental health problems in asylum-seekers and refugees. This may occur via two pathways. First, trauma may interfere with an individual’s capacity to negotiate challenges, thereby increasing their vulnerability. Conversely, ongoing stress in a resettlement country may block an individual’s capacity to heal from the trauma (Lie, 2002; Miller, Worthington, et al., 2002). Fortunately, the recent push towards understanding how resettlement stressors interact with prior trauma in refugee populations has highlighted the importance of addressing resettlement issues in order to improve refugee wellbeing.

However, in response to what many researchers see as an overemphasis on the difficulties and mental health problems experienced by refugees after their resettlement, researchers are increasingly turning their attention to the strength and resilience that many refugees possess and display (Watters & Ingleby, 2004).

**Resilience in Refugees**

The literature indicates that many refugees have and do adapt well in resettlement countries despite their histories and the continued adversities they encounter in resettlement (e.g., Fox, Burns, Popovich, Belknap, & Frank-Stromborg, 2004; Geltman et al., 2005; Slodnjak, 2000). Exploring and paying attention to refugee protective or resilience factors is crucial, not only because it shifts the focus away from individual deficits towards individual strengths, competencies, and capacities, but because it can also help to guide and better inform mental health
prevention and treatment programs and policies – not just for refugees, but for all
members of the community.

Protective and resilience factors maintain health by moderating, lessening or
altering an individual’s response to hazards in the environment, thereby improving
one’s chances of not succumbing to negative outcomes (Rutter, 1985). Individual
protective factors tend to mirror the features of positive mental health, such as healthy
self-esteem, emotional resilience, positive thinking, problem-solving and social skills,
stress management skills and feelings of mastery (World Health Organization [WHO],
2004). Indeed, refugee research has demonstrated that social support is an important
protective factor that helps to promote emotional adjustment. For example, Geltman et
al. (2005) reported that unaccompanied refugee minors who described feelings of
loneliness in resettlement were at a significantly increased risk for PTSD compared to
those who did not feel lonely ($OR = 3.38$, $95\%$ CI [1.49, 7.68]). Refugee research has
also demonstrated that the role of spirituality, personal disposition, attitudes and
beliefs may also help to promote emotional adjustment (Almqvist & Broberg, 1999;
Geltman et al., 2005; Schweitzer, Greenslade, & Kagee, 2007; Schweitzer, Melville,
Steel, & Lacherez, 2006).

Refugees are survivors of unimaginable hardships, and as such, are a profoundly
resilient group from whom there is much we can learn (Lustig et al., 2004). Therefore,
researchers have an obligation to highlight refugee strength and resilience, as well as
to honour and respect their competencies, capacities, and ideas as it provides a more
comprehensive picture of the refugee experience (Schweitzer et al., 2007).

Summary

Refugees are survivors, and as such, must be recognised as a resilient group
who can and do lead successful lives in resettlement (Lustig et al., 2004). However, as
a consequence of their experiences, the mental health and wellbeing of refugees is sometimes profoundly affected. These problems can also persist long after individuals have reached a safe resettlement country (Miller, Worthington, et al., 2002).

Therefore, the next chapter will review the mental health outcomes in refugee adults, children, and families as reported in the refugee literature.
Chapter 3: Literature Review - The Mental Health Impact upon Refugees

Whilst the sequelae of the refugee experience encompasses and affects many areas of psychosocial functioning (such as individual functioning, community structure, education, economics, and politics) this section will be restricted to a review of the literature investigating the prevalence of mental health outcomes in refugee populations, in particular adults, children, and families. Research has singled out mental health as of special concern in refugee populations, leading to an extensive body of literature in this area (Heptinstall, Sethna, & Taylor, 2004). This literature is important to health professionals not only because of the large number of people who are adversely affected by the refugee experience, but because many of these individuals will require access to, or be confronted by mental health services from outside their cultures of origin. Therefore, the development of a knowledge base which will help to inform more culturally appropriate practice to help promote optimal outcomes is essential (Keyes, 2000).

The number of studies investigating the prevalence of psychological disorders in refugees is extensive, but the majority of these studies have focussed on posttraumatic stress disorder (PTSD) and depression (Turner, Bowie, Dunn, Shapo, & Yule, 2003), with some studies also investigating disorders such as psychotic illnesses, anxiety disorders, and alcohol abuse (e.g., Bhui et al., 2003; Fazel et al., 2005; Steel et al., 2009). Therefore, this chapter begins with a brief description of PTSD and depression, as well as the controversies surrounding the application of these diagnoses in the refugee field. Whilst not claiming to be exhaustive, Part I of this chapter will present a review of the mental health literature for refugee adults, and then in Part II, a review of the mental health literature for refugee children will follow. Finally, the negative
impact of the refugee experience on families and on parenting capacity is described in Part III.

**Posttraumatic Stress Disorder**

The current edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association [APA], 2000) describes PTSD as an anxiety disorder which follows a direct, personal experience of a traumatic event. The traumatic event must involve actual or threatened death or injury to the person or to others, and to which the person responds with intense fear, hopelessness, or horror. The traumatic event is usually described as being outside the range of usual human experience, such as exposure to military combat, violent assault, torture, rape or natural disasters. The person must then display persistent symptoms that fall into three broad categories: (a) re-experiencing of the trauma (e.g., through intrusive recollections or dreams of the trauma); (b) avoidance and numbing symptoms (e.g., avoiding places that remind them of the trauma or diminished interest in activities), and; (c) increased arousal symptoms (e.g., hyper-vigilance or sleeping difficulties).

Although these are typical and expected reactions following a traumatic event, for a person to be diagnosed with PTSD, the re-experiencing, avoidance and arousal must occur for longer than one month after exposure to the trauma, and these symptoms must cause significant distress, and/or impairment in important areas of the person’s functioning. The criteria for PTSD are slightly different for children. Instead of responding with intense fear, hopelessness or horror, the response in children must involve disorganised or agitated behaviour (APA, 2000).

PTSD is one of the most disabling of the anxiety disorders and causes significant impairment in occupational and social functioning, high rates of suicidality, and is associated with more medical illness (Marshall, Beebe, Oldham, &
Zaninelli, 2001). However, the exact burden of disability arising from PTSD in refugee populations is unknown because most surveys do not record the functional impairment associated with the disorder (Fazel et al., 2005).

**Depression**

Most people experience sadness in their life in response to experiences of loss, failure and stress. However, clinical depression is a much more intense and longer lasting mood disturbance that significantly interferes with one’s day-to-day functioning. Major depression is characterised by chronic feelings of sadness, irritability, anger and anhedonia. It involves cognitive symptoms, such as thoughts of worthlessness, diminished ability to think, and suicidal ideation. It is also characterised by physical symptoms, such as changes in appetite, sleeping patterns, tension and fatigue (APA, 2000). Currently, major depression is the world’s third leading cause of burden of disease and it is expected to rise to first place in 2030 (WHO, 2008). However, the application of Western mental health diagnoses such as PTSD and depression to non-Western refugee individuals has generated much controversy. As such, it is pertinent to present an overview of this debate.

**Controversy surrounding psychiatric diagnoses with refugee populations**

The application of psychiatric diagnoses to non-Western refugee populations has generated much debate and has proved very controversial in the refugee field (Ehntholt & Yule, 2006; Phan & Silove, 1997; Rousseau, 1995). Some researchers have argued that applying psychiatric diagnoses to refugees is inappropriate because these diagnostic labels cannot account for or do justice to the pervasive effects of the refugee experience, such as the disintegration of a community’s social and cultural fabric (Rousseau, 1995). Others also argue that assigning psychiatric labels to trauma
survivors unnecessarily pathologises and medicalises normal responses to abnormal experiences (e.g., Summerfield, 1999). However, in response to these criticisms, cross-cultural researchers and clinicians argue that these labels allow for, and encourage those in authority to allocate the resources required to take action, offer help, and alleviate the person’s distress (e.g., Ehntholt & Yule, 2006).

Nicholl and Thompson (2004) provide an excellent summary of other controversial issues specific to PTSD. In this summary, Nicholl and Thompson highlight that non-Western populations place different values and meanings on PTSD symptomatology and in doing so put the validity of the PTSD construct into question. For example, in some cultures, rather than being unwanted re-experiencing of the traumatic event, dreams of the dead are perceived as positive and comforting. Nicoll and Thompson also highlight Bracken’s (2001) controversial proposition that PTSD is a socially constructed syndrome based on Western notions of individuality, and as such, may not be valid in collectivist cultures. In addition, the current construct of PTSD ignores collective traumatisation even though entire ethnic groups are traumatised through acts such as genocide (Weine et al., 1998). However, Nicholl and Thompson state that despite these controversies, the majority of cross-cultural researchers and clinicians acknowledge that PTSD symptomatology is applicable to refugees.

There is less controversy surrounding the cross-cultural application of depression compared with PTSD. In a World Health Organization (WHO) sponsored cross-cultural study on the symptomatology of depression in 573 individuals from Canada, Iran, Japan, and Switzerland, the results indicated that more than 76% of depressed people reported a common pattern of depressive symptoms (WHO, 1983).
These symptoms included sadness, absence of joy, loss of interest, anxiety, tension, lack of energy, reduced concentration, and a sense of inadequacy.

However, other cross-cultural studies have reported a variation in the expression of this disorder. For example, Phan and Silove (1997) provide an excellent examination of the disparities between Western and Vietnamese expression of depression. In this article they highlight the fact that Vietnamese language does not have a word for depression and conversely, that there are no accurate English translations or meaningful English idioms for a number of familiar Vietnamese medical terms describing depressive-like expressions. For example, the English equivalent of suy yeu than kinh, suy nhuoc than sac, and xao tron tam than include “weakness of the nerves”, “debilitated appearance” and “disturbed mental state” respectively.

Although most researchers in the refugee field accept that PTSD and depression can affect refugees and that many of their symptoms are universal, the literature also indicates that the expression and course of these illnesses are culturally determined. Culture-specific symptoms may lead to the under-recognition or to the misidentification of psychological distress, which may lead to inappropriate, or no treatment at all. As a result, cross-cultural experts advocate that clinicians develop the following cultural competencies: a sound knowledge of the concepts of mental health and illness of both cultures; that they adopt an open, interested, and respectful attitude towards the non-Western individual’s expression of distress; and to consider this expression within their social and cultural backdrop (Kirmayer, 2001; Phan & Silove, 1997).
Part I: Prevalence of Mental Health Issues in Refugee Adults

As previously mentioned, the majority of studies have focussed on PTSD and depression, but other disorders such as other anxiety disorders, substance abuse, psychotic illnesses, and somatic complaints have also been investigated. Therefore, Part I of this chapter will present a review of this mental health prevalence research specific to adult refugee populations.

PTSD in adult refugees.

The majority of studies investigating the mental health outcomes in refugee populations have focussed on PTSD (Watters, 2001). This is not unexpected given that trauma is a necessary precursor to PTSD, and that refugees are generally exposed to multiple traumas, much of which is usually outside the realm of usual human experience (Fazel et al., 2005). Indeed, it has been estimated that between five and 35% of refugees have experienced extreme forms of trauma such as torture and other human rights abuses (Baker, 1992).

One of the first investigations of PTSD in refugees was conducted by Kinzie, Fredrickson, Ben, Fleck, and Karls (1984). In this seminal study, 13 Cambodian refugees who had survived between two and four years in a Pol Pot labour camp and who had resettled in the United States were interviewed by Kinzie and his colleagues. The sample was composed of five males and seven females who were drawn from an adult refugee psychiatric clinic. These individuals were interviewed because their symptoms were more persistent and severe compared with other Cambodian refugees attending the clinic. Kinzie et al. (1984) reported that all 13 individuals met DSM-III criteria for PTSD and noted that their symptoms were very similar to those seen in European concentration camp survivors. This study was important because it was one
of the first to provide cross-cultural validity for PTSD as a diagnosis, which was the aim of the study.

Since the Kinzie et al. (1984) study, PTSD has been documented in refugees in various phases of dislocation and resettlement, and from all over the world including: South-East Asian countries (e.g., Carlson & Rosser-Hogan, 1991; Mollica et al., 1993; Steel et al., 2002), the Balkans (e.g., Favaro, Maiorani, Colombo, & Santonastaso, 1999; Momartin, Silove, Manicavasagar, & Steel, 2004), the Middle-East (e.g., Gorst-Unsworth & Goldenberg, 1998; Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004), and Africa (e.g., Fox & Tang, 2000; Kamau et al., 2004; Schweitzer et al., 2006). These findings add further support for the cross-cultural validity of PTSD. However, PTSD prevalence rates reported in these studies have varied widely and appear to be influenced by the phase of dislocation and resettlement that they are in, the level of traumatic exposure, and their country of origin, but this is not always the case.

For example, PTSD prevalence rates for refugees residing in refugee camps have ranged between 0.8% for refugees in Kakuma refugee camp (Kamau et al., 2004), to 50% for former-Yugoslavian refugees living in a refugee camp for an average of 3.5 years (Favaro et al., 1999). Variations in PTSD prevalence rates have also been reported for refugee populations who have resettled in the West. For example, Steel, Silove, Phan and Bauman (2002) reported a PTSD prevalence of 4% in a population-based study of 1161 Vietnamese refugees who had been living in Sydney for an average of 11.2 years, while Carlson and Rosser-Hogan (1991) reported a PTSD prevalence rate of 86% in a randomly selected community sample of 50 Cambodian adults who had been living in North Carolina for an average of 3.5 years. Although one could infer from these studies that an inverse relationship exists
between time in resettlement and PTSD prevalence rates, other studies contradict this observation. For example, Laban et al. (2004) determined that the PTSD prevalence rate increased from 31.5% to 41.7% in a group of Iraqi asylum-seekers who had resided in The Netherlands for less than 6 months, and for more than 2 years respectively. Although, it has been hypothesised that asylum-seekers may unconsciously endorse higher levels of distress and psychiatric symptoms in order to obtain refugee status (Hollifield et al., 2002) however, it is also crucial to remember that uncertain asylum status is a well-known stressor shown to exacerbate mental health problems (Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997).

Unfortunately, there are drawbacks to such extreme variation in prevalence data. These include: (a) that PTSD estimates at the lower end may contribute to the neglect of refugee mental health and conversely, (b) that PTSD estimates at the higher end may stigmatise refugees and fuel assumptions that refugees are riddled with psychiatric illness and are not resilient (e.g., Fazel et al., 2005). Therefore, in an attempt to determine a more reliable prevalence estimate for PTSD in refugees, and to explore the potential sources that may explain this variation, Fazel et al. (2005) and Steel et al. (2009) conducted two of the most extensive meta-analyses of the refugee mental health literature to date.

While Fazel et al. (2005) calculated an overall weighted PTSD prevalence estimate of 9% from 17 refugee surveys with data comprising a total of 5,499 refugees, Steel et al. (2009) calculated a much higher overall weighted PTSD prevalence estimate of 30.6% from 145 surveys, comprising a total of 64,332 refugee and conflict-affected individuals. Differences in the inclusion criteria used in each meta-analysis and the greater proportion of individuals with a history of torture in the
Steel et al. (2009) analyses is the most likely reason for the significantly different PTSD estimates produced.

Although it may be important to determine which PTSD prevalence estimate is the most accurate, either estimate is still too high. Both estimates indicate that refugees suffer from much higher rates of PTSD compared with Western civilian populations. For example, the 12-month PTSD prevalence rate in Australia is estimated at 1.3% (Creamer, Burgess, & McFarlane, 2001). Similarly, in Europe, this estimate is 1.1% (Darves-Bornoz et al., 2008).

An important finding to also emerge from these meta-analytic reviews is that PTSD prevalence rates are significantly affected by methodological issues related to sample size, sampling method, instruments used, and use of interpreters rather than same-language interviewers. However, results are also shown to significantly depend upon risk factors and the characteristics of the refugees under investigation including the type and severity of trauma experienced, ethnic group, age, duration since displacement, host-country, and post-settlement stressors.

Although limited by the number of studies published, a review of the longitudinal refugee adult literature demonstrates that PTSD symptoms can abate, become exacerbated, and even emerge some-time after resettlement (e.g., Boehnlein et al., 2004; Hauff & Vaglum, 1994; Weine et al., 1998). These observations are consistent with PTSD symptoms in Western civilian populations, where PTSD has also been shown to run a variable longitudinal course (McFarlane, 2000). These studies indicate that approximately 30% of Western individuals with PTSD generally continue to suffer from chronic PTSD symptoms, and about 80% will also meet criteria for at least one other DSM-III-R disorder (Kessler, Sonnega, Bromet, Hughes,
& Nelson, 1995). Therefore, these findings suggest that traumatised refugees will most likely remain a vulnerable group even after their resettlement to a safe country.

**Depression in adult refugees.**

Studies investigating the presence of depression in refugee populations are relatively sparse in comparison to those investigating PTSD (Lindert, von Ehrenstein, Priebe, Mielck, & Braehler, 2009). Nevertheless, depression prevalence rates are available for refugee populations in various phases of dislocation and resettlement, and from all over the world including: South-East Asia (e.g., Hinton et al., 1993; Hubbard, Realmuto, Northwood, & Masten, 1995), the Balkans (e.g., Favaro et al., 1999; Turner et al., 2003), Africa (Fox & Tang, 2000; Kim, Torbay, & Lawry, 2007), and the Middle-East (e.g., Jamil et al., 2007; Laban et al., 2004). However, as observed with PTSD, the prevalence data for depression also varies significantly from study to study.

For example, prevalence rates for depression in refugees residing in camps range between 31% in a random sample of 1121 internally displaced Sudanese women (Kim et al., 2007) to 85.5% in a random sample of Sierra Leonean refugees (Fox & Tang, 2000). Lower prevalence rates for refugees in resettlement are generally reported, yet study results infer that as length of time in resettlement increases, the prevalence of depression may also increase. For example, Hinton et al. (1993) found a depression prevalence rate of 5.5% in 201 Vietnamese refugees upon their arrival to San Francisco, while Schweitzer et al. (2006) reported that 16% of adult Sudanese refugees met criteria for depression up to 2 years after their resettlement to Queensland. Further, Laban et al. (2004) reported that the prevalence rate of depression increased from 25.2% in Iraqi asylum-seekers residing in The Netherlands
for less than 6 months, and up to 43.7% in those who had been living there for more than 2 years.

With such wide variations also reported in prevalence rates for depression, Fazel et al. (2005) and Steel et al. (2009) also endeavoured to determine a more reliable prevalence estimate for depression in refugee populations. From 14 refugee surveys with data comprising a total of 3,616 adult refugees, Fazel et al. (2005) calculated an overall weighted prevalence estimate for depression of 5%. In contrast, a 30.8% prevalence estimate for depression was calculated by Steel et al. (2009) from 117 surveys and 57,796 refugee and conflict-affected individuals. Although the depression estimate calculated by Fazel et al. (2005) is very similar to the 4.1% prevalence rate for major depression in Australia (Australian Bureau of Statistics, 2007) and the 6.6% prevalence rate in the United States (Kessler et al., 2003), the method employed by Fazel et al. (2005) to calculate their estimate has been criticised for underestimating and undervaluing the distress and difficulties experienced by refugees (e.g., Miller et al., 2005).

Again, the meta-analytic studies conducted by Fazel et al. (2005) and Steel et al. (2009) highlight that prevalence rates for depression can vary for the same reasons that PTSD prevalence rates do – as a result of factors related to study design and sample characteristics. Taken together, these findings underscore the need for more accurate and systematised measurements of health outcomes in refugee populations (Hollifield, 2005).

**Other disorders in adult refugees.**

Although the human suffering caused by the refugee experience commonly manifests with symptoms of PTSD and depression, other disorders are also frequently found in refugee adults including anxiety disorders, substance use, psychosis, and
somatic complaints. In addition, co-morbidity between these disorders is also commonly reported. The refugee literature pertaining to these disorders are briefly described in turn.

**Generalised anxiety disorder and panic disorder.**

In their meta-analytic review, Fazel et al. (2005) identified five studies reporting the prevalence rate for generalised anxiety disorder (GAD). The studies identified provided data for a total of 1,423 adult Vietnamese, Cambodian, Hmong, Cuban and Haitian refugees. The prevalence of GAD in these studies ranged from 1% (Westermeyer, 1988) to 21% (Hubbard et al., 1995) but the overall weighted prevalence for GAD estimated by Fazel and colleagues was 4%.

Some research suggests that panic disorder is highly co-morbid amongst refugees from Vietnam and Cambodia with a PTSD diagnosis. For example, 60% of Cambodian refugees (Hinton, Ba, Peou, & Um, 2000) and 50% of Vietnamese refugees with PTSD (Hinton et al., 2001) were suffering from panic disorder. These results are consistent with investigations in non-refugee populations, such as Vietnam veterans, who also have a high rate of co-morbidity between PTSD and panic disorder (Mellman, Randolph, Brawman-Mintzer, Flores, & Milanes, 1992).

**Anxiety in general.**

Although the study of PTSD has dominated the anxiety research field in refugee populations, a large proportion of studies have utilised questionnaires such as the Hopkins Symptom Checklist-25 (HSCL-25) to investigate the prevalence of clinical levels of anxiety. For example, Cardozo et al. (2004) reported a 42% prevalence rate for clinical anxiety in Karenni refugees living in a Thai refugee camp, as they scored above the cut-off on the HSCL-25’s anxiety subscale. Similarly, Hermansson,
Timpka, and Thyberg (2002) reported an anxiety prevalence rate of 43% using the HSCL-25 in a sample of war-wounded refugees, 8 years after their arrival in Sweden. Keller et al. (2006) found a much higher level of anxiety in their convenience sample of refugees from a variety of cultural backgrounds who were seeking treatment in a torture treatment program, with 81.1% obtaining scores above the questionnaire’s cut-off.

**Substance use and abuse.**

Substance use has been shown to be a commonly reported co-morbid disorder in people with a history of trauma. For example, up to 75% of combat veterans with lifetime PTSD have been shown to meet criteria for alcohol abuse or dependence (Jacobsen, Southwick, & Kosten, 2001) and up to 80% of women seeking substance abuse treatment report histories of sexual and/or physical assault (Hien, Cohen, Miele, Caren Litt, & Capstick, 2004). However, the literature generally indicates that substance misuse is relatively uncommon in refugee populations, even in refugees who have been living in the West for over 10 years.

For example, low rates of substance-use disorders of between 1% and 4% have also been found in Vietnamese and Cambodian refugee community samples living in Australia and the United States for between 10 to 20 years (e.g., Marshall, Schell, Elliott, Berthold, & Chun, 2005; Steel et al., 2002). Even in a clinical sample, Boehnlein et al. (2004) found no cases of alcohol or substance abuse in 23 Cambodian refugees who had initial diagnoses of co-morbid PTSD and major depressive disorder. However, the base rate for alcohol abuse disorders is generally lower in Asian populations compared with Western populations which may account for the low prevalence of substance misuse (Au & Donaldson, 2000).
Nevertheless, some studies indicate that substance and alcohol abuse may be a problem for some refugees resettled in the West. For example, Bhui et al. (2003) found that the use of Qat, a leaf which is chewed like tobacco and with amphetamine-like properties, was common in a community sample of adult Somali refugees living in the UK. Qat was used by 40% of this sample, which is higher than the 31.3% rate of Qat use found in an epidemiological sample living in Somalia (Odenwald et al., 2005). In addition, Farias (1991) reported that alcohol abuse was a prominent problem amongst 31% of traumatised male Salvadoran refugees seeking assistance in the United States.

Taken together, the literature indicates that substance abuse in refugee populations warrants our attention, even though these issues may not be as common in traumatised refugees as in other traumatised populations.

_Psychotic illness._

Disorders and problems that do not necessarily stem from refugee experiences but may be adversely affected by them include psychosis (de Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009). In the aforementioned meta-analytic review of serious mental disorders in refugee populations, Fazel et al. (2005) identified only two studies reporting on psychotic illness (i.e., Hauff & Vaglum, 1995; Westermeyer, 1988). These two community sample studies provided a total of 226 adult Vietnamese and Hmong refugees resettled in the West, with an overall weighted psychotic illness prevalence rate estimated at 2%. However, a much higher prevalence rate for psychotic symptoms has been reported in a random sample of 180 Somali refugees living in the community in London. For example, Bhui et al. (2003) found that nineteen men (21%) and sixteen women (18%) had at least one active symptom of
psychosis, and that experiences of being lost, kidnapped, or a lack of shelter or water was associated with probable psychosis.

Studies investigating psychotic illness in refugee camps and in clinical populations have also returned high prevalence rates. For example, Kamau et al. (2004) reported that 12.3% or 227 individuals attending a community mental health service in Kakuma refugee camp presented with psychotic illnesses (schizophrenia and bipolar disorder) over a three year period. This represented 0.25% of the total camp population. And finally, a high prevalence of psychotic symptoms in clinical samples has also been reported. For example, Kinzie and Boehnlein (1989) found a prevalence rate of 7% for schizophrenia and schizoaffective disorder in their clinical sample of 100 highly traumatised Cambodian refugees seeking treatment for PTSD and major depressive disorder. These researchers observed that although individuals with and without psychosis were similar in terms of demographics, trauma history and family history of psychosis, they hypothesised that vulnerability to post-traumatic psychosis may be caused by a specific neurophysiological vulnerability, which when coupled with developmental and environmental factors may cause gross impairment in reality testing.

_Somatic complaints._

The presence of somatoform disorders in survivors of torture have been well documented (e.g., Priebe & Esmali, 1997; Ramsay, Gorst-Unsworth, & Turner, 1993). Somatoform disorders are defined by the presence of physical symptoms which suggest a medical problem, but cannot be explained by a medical cause (APA, 2000). Given that many refugees have also had experiences of torture, the presence of somatoform disorders has been investigated by some refugee researchers.
For example, van Ommeren et al. (2001) compared 418 tortured and 392 non-tortured Bhutanese refugees living in camps in Nepal. These researchers found that tortured refugees were more likely to report persistent somatoform pain disorder (51% vs. 28%) and dissociative disorders (18% vs. 3%) compared with non-tortured refugees respectively. Laban et al. (2004) also compared the prevalence of somatoform disorders in two groups of Iraqi asylum-seekers. Those who had resided in The Netherlands for less than 6 months returned a prevalence rate of 4.9%. However, asylum-seekers who had been residing in the Netherlands for more than two years returned a significantly higher prevalence rate of 13.2%. This result was significantly different even after adjusting for sex, age, and adverse life events. The finding by Laban and colleagues suggests that post-migratory stressors (such as the process of proving an asylum claim) may interact with experiences of torture to exacerbate somatic complaints. Given that somatoform disorders contribute considerably to the burden of health problems and influences help seeking behaviour, more attention to somatoform symptoms than is currently afforded to refugee populations may be warranted (Laban et al., 2004).

Co-morbidity.

Co-morbidity, or the presence in an individual of more than one psychiatric disorder at the same time has also been studied in refugee populations. The general trauma literature highlights a substantial co-morbidity between PTSD and other psychiatric diagnoses, including depression, anxiety disorders, and substance use (McFarlane, 2000). However, co-morbidity between PTSD and depression in refugee populations is the most widely studied. For example, Momartin et al. (2004) reported that 40% of Bosnian refugees had co-morbid PTSD and depression. Favaro et al. (1999) also found that 65% of former-Yugoslavian refugees suffered with co-morbid
PTSD and depression. Higher rates of co-morbidity have also been reported by Marshall et al. (2005) who reported that 71% of Cambodian refugees with PTSD also met criteria for major depression, and that 86% of those with major depression also met criteria for PTSD. Finally, in the aforementioned meta-analysis conducted by Fazel et al. (2005), the researchers calculated that 71% of those diagnosed with major depression also had a diagnosis of PTSD, and that 44% of those diagnosed with PTSD also had a diagnosis of major depression.

Importantly however, research indicates that having more than one psychiatric diagnosis at the same time confers a significant risk to one’s ability to function in day to day activities. For example, Mollica et al. (1999) reported that refugees with co-morbid psychiatric diagnoses were five times more likely to be functionally impaired that those diagnosed with PTSD alone. Karam (1997; cited in Momartin et al., 2004) also reported that those with co-morbid conditions displayed greater symptom severity by a factor of three to five times greater than those with PTSD alone. More research is required to establish co-morbidity between other psychiatric diagnoses, but when working with traumatised refugees, it would be prudent to assess for conditions other than those relating to PTSD and depression, especially in light of emerging evidence that those suffering from co-morbid conditions stand out as a group because of their substantial level of psychosocial impairment (Momartin et al., 2004).

**Part I - summary.**

The application of psychiatric diagnoses to refugee populations has generated much controversy. However, most cross-cultural researchers accept that many symptoms of PTSD and depression for example, are universal although acknowledge that their expression and course may be culturally-determined. Unfortunately, study design issues and sample characteristics have also heavily influenced the
measurement of mental health outcomes in refugee studies. Nevertheless, the overall weight of the evidence indicates that mental health problems in adult refugee populations are much too high. Studies indicate that the prevalence PTSD and depression is higher in refugees compared with the general population, and that comorbidity between these disorders is common. Research also indicates that refugees can also suffer from a wide-range of other mental health problems which may be caused by and/or exacerbated by the refugee experience. With 43.3 million forcibly displaced people worldwide, the number of individuals suffering from, or who at risk of developing severe mental health issues, must be regarded as unacceptable. Therefore, mental health prevention strategies must become a priority. This is especially important given that resettled refugees have been shown to underutilise healthcare and psychological services (Chow, Jaffee, & Choi, 1999; Fenta, Hyman, & Noh, 2006)

**Part II: Prevalence of Mental Health Issues in Refugee Children**

Experiences of trauma can profoundly affect a child’s psychosocial development, behaviour, attitudes, beliefs, personality and moral development (Macksoud & Aber, 1996). Children are particularly vulnerable to these effects because of their incomplete cognitive development and underdeveloped coping skills (Lau & Thomas, 2008). Unfortunately, children in conflict-affected regions are often targeted as part of a deliberate strategy to terrorise, dominate or destroy adversaries (Derluyn, Mels, & Broekaert, 2009). The gravity of this problem is highlighted by the fact that UNHCR statistics indicate that 41% of those who are of concern to UNHCR are below the age of 18 years of age. More concerning is that 11% of these children are also under the age of five, and that in 2009 alone, more than 18,700 asylum
applications were made by children unaccompanied by a parent or caregiver (UNHCR, 2010).

The trauma, stressors, disruption, and losses associated with the refugee experience can put the psychological wellbeing of refugee children at risk. However, as found in the adult refugee literature, the majority of studies describing mental health issues in refugee children also focus on PTSD and depression (Crowley, 2009; Huemer et al., 2009; Lau & Thomas, 2008). Therefore, this section will present a review of the available literature about PTSD and depression in refugee children. A review of other mental health problems identified in the literature including; general anxiety, conduct disorder, simple phobia, and other childhood problems, will follow. It is important to keep in mind that the refugee child and adolescent mental health literature is also subject to the same controversies and issues influencing mental health prevalence rates in the adult refugee literature such as; the application of Western diagnoses to non-Western refugees, and the influence of study design and sample characteristics. For brevity, the term “children” or “child” will be used to refer to both children and adolescents in this thesis.

**PTSD in refugee children.**

The child refugee mental health literature is considerably less extensive compared with the adult refugee mental health literature. Nevertheless, PTSD symptomology has been documented in refugee children across a wide range of cultures. Three qualitative reviews examining the presence and prevalence of PTSD symptomatology in refugee children (i.e., Australian Human Rights and Equal Opportunity Commission, 2002; Crowley, 2009; Lustig et al., 2004) clearly demonstrate that PTSD symptomology is present in refugee children from; South East Asia, Lebanon, Afghanistan, Bosnia, Chile, Croatia, Central America, El Salvador,
Nicaragua, The Gaza Strip, Iraq, Kurdistan, Israel, Iran, Sudan, and Tibet. The reviews also indicate that PTSD prevalence rates vary just as widely as they do in adult refugees. For example, in Crowley’s (2009) extensive review of the child refugee literature revealed that PTSD prevalence rates ranged from 20% in a sample of 304 unaccompanied Sudanese refugee children approximately 1-year after resettlement to the United States (i.e., Geltman et al., 2005) and up to 70% in a sample of 265 refugee children from Bosnia-Herzegovina resettled in Slovenia (i.e., Slodnjak, 2000). However, much higher rates of PTSD were uncovered in the literature review conducted by Lustig et al. (2004).

In the review of the available literature pertaining to the stress reactions in refugee children, Lustig et al. (2004) found that PTSD prevalence rates reported in the pre-flight and flight phases of the refugee experience were generally very high, while PTSD prevalence rates after resettlement tended to vary more widely. For example, demonstrating high PTSD prevalence rates in the pre-flight stage, Lustig et al. (2004) cited the study by Goldstein, Wampler, and Wise (1997) who determined that over 94% of internally displaced Bosnian children surveyed met the full criteria for PTSD. Demonstrating high PTSD prevalence rates in the flight stage (i.e., while children resided in refugee camps) Lustig et al. (2004) cited studies by Paardekooper, de Jong, and Hermanns (1999) and by Duncan (2000). Paardekooper et al. (1999) found that PTSD symptoms were reported with frequencies ranging between 35% and 60% in a sample of Sudanese children living in Ugandan refugee camp. However, being an unaccompanied child and residing in a refugee camp may confer additional mental health risks. For example, Duncan (2000) reported that all 168 unaccompanied Sudanese male children residing in a Kenyan refugee camp suffered from PTSD symptoms, with 75% of these children suffering moderately or severely.
Taken together, these studies indicate that PTSD symptomology in refugee children is very high while they are being exposed to traumatic and stressful life situations. However, caution should be exercised here as studies investigating mental health in the pre-flight and flight phases are severely limited by their number and thus, may underestimate the resilience of refugee children living under these conditions. The lack of studies in these phases is not unexpected given the difficulties associated with conducting research with children living in refugee camps and in conflict-affected areas. Ethical issues, practical aspects, and the safety of both participants and researchers must be addressed when conducting research under these circumstances.

In contrast, studies of PTSD prevalence for refugee children in the resettlement phase are greater in number, and thus, vary more widely. For example, Lustig et al. (2004) described the study by Rothe et al. (2002) who found moderate to severe levels of PTSD symptomatology in 57% of Cuban children, four to six months after their resettlement to the United States. However a much lower rate was reported by Becker, Weine, Vojvoda, and McGlashan (1999). Becker and colleagues found that within their first year of resettlement, 30% of Bosnian adolescent refugees met criteria for PTSD, but that one year later, the PTSD prevalence had dropped to 10%. Becker et al. (1999) concluded that PTSD symptoms in refugee children may be transient and do not necessarily represent enduring psychopathology. However, remittance of PTSD was not as pronounced in a group of 40 Cambodian adolescent refugees followed for 2, 3, 6, and 12 years after their resettlement to the United States (i.e. Kinzie, Sack, Angell, Clarke, & Ben, 1989; Kinzie, Sack, Angell, & Manson, 1986; Sack et al., 1993; Sack, Him, & Dickason, 1999). In these studies, an initial PTSD prevalence rate of 50% was documented two years after their resettlement. This rate was then
observed to slowly decrease to 48%, 38%, and 35% after 3, 6, and 12 years respectively.

The longitudinal studies conducted by Kinzie et al. (1989; 1986) and Sack et al. (1993; 1999) constitute the longest investigations into the wellbeing of young refugees exposed to trauma as children, and are frequently cited to attest to the persistence of PTSD and poor adaptation after resettlement in vulnerable refugees (Lau & Thomas, 2008). However, the higher rates of PTSD and fewer instances of remittance of symptoms in the Cambodian sample compared with the Bosnian group followed by Becker et al. (1999) is most likely a function of the prolonged and more severe forms of trauma and torture experienced by the Cambodian refugees. In addition, it is also likely that being white Europeans, the process of acculturation into the United States was easier for the Bosnian refugees than for the Cambodian adolescents (Becker et al., 1999). Lustig et al. (2004) further suggests that that variation in PTSD prevalence rates observed in refugee children after their resettlement may also be influenced by the length of time since resettlement, parental wellbeing, parental unemployment, and by levels of family negativity or hope about the future.

In an attempt to determine a more reliable estimate for PTSD prevalence in refugee children who have resettled in the West, Fazel et al. (2005) conducted the first meta-analytic review investigating child refugee mental health. Fazel and colleagues calculated an average weighted PTSD prevalence rate of 11% from five studies comprising a total of 260 refugee children. This estimate is much lower than those cited by the majority of researchers and has been criticised on a number of fronts. For example, Ehntholt and Yule (2006) complain that the study inclusion criteria used Fazel et al. (2005) was too stringent, and de Anstiss et al. (2009) complain that the
estimate cannot be representative of the world’s refugee child population because the studies were drawn from only a limited number of cultural groups.

Whatever the most accurate PTSD prevalence estimate in refugee children, it is clear that the incidence of this disorder is tragically much too high. PTSD in refugee children is much higher than in children from the general population. For example, a 0.4% PTSD prevalence of PTSD has been determined for 11–15 year old British children (Ford, Goodman, & Meltzer, 2003) and 4.8% in American children (Kilpatrick et al., 2003). The rate of PTSD in Australian children is unclear.

Unfortunately, Pfefferbaum (1997) saliently points out that even the presence of partial PTSD symptomatology may be disabling even when full criteria are not met. This is particularly so given that PTSD can have a chronic course and may disrupt child development. However, as highlighted by Lustig et al. (2004) and Crowley (2009), it must also be borne in mind that many refugee children show exceptional resilience in the face of adversity and trauma and do not develop mental health problem.

**Depression in refugee children.**

The literature also demonstrates that depression is also commonly experienced by refugee children, and that depression rates are generally much higher in refugee children compared with those from a non-refugee background (e.g. Tousignant et al., 1999). As in other refugee prevalence research, the prevalence of depression also varies widely. For example, in a review of the mental health needs of refugee children resettled in the United States, Crowley (2009) reports prevalence rate variations of between 15% and 47%.

Although some studies report that rates of depression is usually lower than rates of PTSD in refugee children (e.g., Heptinstall et al., 2004), some studies have found
rates of depression to be equal to, or higher than, the reported prevalence rate for PTSD. For example, Servan-Schreiber, Lin, and Birmaher (1998) found the same proportion of children (i.e., 11.5%) met criteria for major depression and PTSD in their randomly selected sample of Tibetan refugee children living in India without their parents. Notably, Servan-Schreiber et al. (1998) observed that no child under the age of 12 was diagnosed with depression. Another study by Papageorgiou et al. (2000) reported a higher rate of depression (47%) than PTSD (29%) in their sample of Bosnian refugee children. Interestingly, these children were also living away from their parents, and had been relocated to live with Greek foster families to protect them from the dangers of war, and older children were found to be at greater risk of depression.

The studies by Servan-Schreiber et al. (1998) and Papageorgiou et al. (2000) highlight two important issues that are worthy of review. First, both studies found that older children were at greater risk of developing depressive symptomatology. Papageorgiou et al. (2000) suggest this may be due to the more advanced cognitive development and an inner conceptualisation of trauma found in older children. Second, both of these studies involved children who had been separated from their parents. The refugee literature indicates that depression tends to be associated with more recent stressful events and to the losses associated with traumatic events, while PTSD is more often associated with experiences of trauma (Momartin et al., 2004). As separation from parents is generally thought to be highly stressful for children, this may go some way to explain why researchers have observed rates of depression that are equal to or higher than PTSD in refugee children who have been separated from their parents. Given that stressful events may exacerbate depressive symptomology in
refugee children and that depression can run a chronic course, an examination of the long-term course of depression in refugee children is warranted.

Unfortunately, very few longitudinal studies with refugee children have been conducted. However, the longest investigation into the wellbeing of young refugees described in the previous section (i.e., Kinzie et al., 1986, 1989; Sack et al., 1993, 1999) also examined levels of depression. This study revealed that the prevalence of depression in a group of 40 Cambodian adolescent refugees generally decreased over time, but fluctuations were observed. For example, at 2, 3, 6 and 12 years after resettlement to the United States, depression was diagnosed in 48%, 41%, 7%, and 14% of the participants respectively. Although it is not yet fully established whether the effects of trauma and loss are carried into adulthood, this longitudinal study indicates that depressive symptom severity may lessen over time. However symptoms may persist or be re-activated when stressors arise (Sack et al., 1999). This observation is consistent with the general depression literature which also suggests that traumatic experiences in childhood make people more vulnerable to adult distress (Punamaki, 2001).

**Other disorders and problems in refugee children.**

As in the adult refugee literature, other mental health problems have been observed in refugee children. These include anxiety disorders, conduct disorder, simple phobia, as well as a range of other childhood problems. In addition, co-morbidity between these disorders is also common. The literature pertaining to these disorders are briefly described in turn.
Anxiety in general.

Some studies have utilised self-report questionnaires, such as the Revised Children’s Manifest Anxiety Scale (RCMAS) or the Hopkins Symptom Checklist (HSCL) to identify clinical levels of anxiety in refugee children. These screening instruments measure a variety of internalising and externalising symptoms of anxiety. Using the RCMAS, Papageorgiou et al. (2000) found that 23% of the Bosnian refugee children in their sample scored above the cut-off for a possible anxiety disorder. Using the HSCL, Felsman, Leong, Johnson, and Crabtree-Felsman (1990) reported high levels of anxiety in 12.7% of unaccompanied, and in 11.2% of accompanied Vietnamese refugee adolescents living in refugee camps.

Conduct disorder.

Conduct disorder is sometimes cited as a problem in refugee children, however a review of the literature provides mixed results. For example, Papageorgiou et al. (2000) found an association between war trauma experiences and conduct problems as rated by the foster carers for 95 Bosnian refugee children. Tousignant et al. (1999) also found a 6.4% prevalence rate for conduct disorder in an epidemiological sample of 203 refugee children, which was much higher than the rate of 3.3% found in their Canadian counterparts. And Fazel and Stein (2003) found that refugee children were about 0.4-0.5 times more likely to meet case criteria for conduct disorder than their matched immigrant or white British counterparts (matched in terms of age and sex only).

In contrast to these studies, Howard and Hodes (2000) found no difference in the frequency of conduct disorder as a primary diagnosis in 30 refugee children compared with matched non-refugee immigrant and white British children seeking help at a child and adolescent psychiatry clinic in London. Patel and Hodes (2006)
also found no difference in conduct disorder in a group of refugee adolescents attending a child and adolescent mental health clinic in London compared with non-refugee adolescents also attending the clinic.

**Simple phobia (specific phobia).**

Using the Diagnostic Interview Schedule for Children (DISC) to interview 203 adolescent refugees aged between 13 and 19 years in Canada, Tousignant et al. (1999) found a prevalence rate for simple phobia of 8.2% in boys, and a staggering 27.6% in girls. Although the sex ratio is consistent with that found in Western populations for simple phobia, the overall prevalence rate found in this refugee children’s group is considerably higher than the rate of 4.9% found in the Quebec Child Mental Health Survey (Breton et al., 1999). Similarly, an elevated rate of simple phobia was also found by McKelvey et al. (2002) who also used the DISC to interview 519 Vietnamese children living in Western Australia, many of whom were of refugee background. They found that 7.7% of children met criteria for simple phobia.

However, Tousignant et al. (1999) question the validity of simple phobia in refugee children. They suggest that perhaps simple phobia may actually be related to symptoms of PTSD, but this hypothesis requires tested. Nevertheless, the non-refugee literature shows that once a phobia develops, it tends to last a lifetime (Barlow & Durand, 2005) making the detection and treatment of specific phobias an important issue in this group of children.

**Other childhood problems.**

Given that children are at a vulnerable developmental stage and because they presumably lack the coping resources adults are more likely to possess, it is not unexpected that researchers have investigated and found the presence of other
disorders and problems in refugee children. Three comprehensive reviews of the refugee child literature (i.e., Crowley, 2009; de Anstiss et al., 2009; Ehntholt & Yule, 2006) provide a good summary of the range of problems identified.

Crowley (2009) identified problems related to conduct disorder, substance abuse, deliberate self-harm, poor general health, social problems, somatic complaints, obsessive compulsive disorder, mental retardation, autism, and schizophrenia. Externalizing behaviours, such as attention problems, aggressive outbursts, and rule-breaking behaviour were also identified.

In addition to these problems, de Anstiss et al. (2009) also identified some less researched psychosocial and mental health problems such as learning difficulties, impaired school functioning, dependency, hyperactivity, eating disorders, sleep disturbance, regressive behaviour, bed-wetting, nail-biting, sadness, extreme introversion, pervasive refusal syndrome (characterised by a refusal to eat, drink, walk, talk, or accept help and a refusal to engage in any form of self-care). De Anstiss et al. (2009) also highlighted that psychological disorders or problems such as intellectual disability, pervasive development disorders, psychosis, learning difficulties, and social and behavioural problems may not necessarily stem from refugee experiences, but are often adversely affected by it. Ehntholt and Yule (2006) also emphasise that grief reactions in children are rarely investigated and point out that separation anxiety can often appear.

Importantly, Lau and Thomas (2008) highlight that adverse psychological outcomes can be exacerbated by problems of malnutrition, disease, physical injuries, brain damage and sexual abuse. However, the paucity of research in these areas makes it almost impossible to draw conclusions about the prevalence, severity or persistence of psychological problems other than depression and PTSD in refugee children. More
research is obviously required. Nevertheless, people working with refugee children should be aware of the range of issues and problems that these children may experience and should arrange for appropriate assessment and treatment if concerned.

**Co-morbidity.**

The general child mental health literature indicates that co-morbid conditions with PTSD are common, and that a diagnosis of PTSD by the age of 18 significantly increases the risk of other lifetime diagnoses such as depression, anxiety, and alcohol and drug dependence (Pfefferbaum, 1997). Although the child refugee literature is not extensive enough to definitively state the same, studies indicate that co-morbidity between PTSD and depression in refugee children is common (Lau & Thomas, 2008; Thabet, Abed, & Vostanis, 2004). For example, co-morbidity between depression and PTSD over the 2, 3, 6, and 12-year follow-up period in Cambodian adolescent refugees occurred in 40%, 40%, 7%, and 18.5% of individuals respectively (Kinzie et al., 1986, 1989; Sack et al., 1993, 1999). However, the relationship between alcohol and drug dependence in refugee children with a history of childhood PTSD has yet to be confirmed, and more research is needed to establish the co-morbidity regarding other anxiety disorders and substance abuse in children.

**Part II - summary.**

Although it is important to remember that refugee children are survivors and that many refugee children will not develop mental health problems, experiences of trauma may profoundly affect their development (Macksoud & Aber, 1996). There is evidence to suggest that the prevalence of psychopathology among refugee children is higher than in local comparable groups, and in the general paediatric population (e.g., Fazel & Stein 2002; Tousignant et al., 1999). Nevertheless, refugee children are
under-represented in mental health service utilisation figures (de Anstiss et al., 2009), meaning that refugee children may not be getting the support they need to reduce their distress (Lustig et al., 2004). Given the sheer number of refugee children world-wide, this should qualify as a mental health emergency. Australia therefore has an obligation to make mental health assessment, prevention and treatment strategies a priority for these children.

**Part III: Effects of the Refugee Experience on Families and Parenting**

Experiences of trauma do not only affect individuals, but also has an impact upon everyone with whom that person interacts, especially family members. These effects may also be compounded when more than one person within a family, and in many cases when whole families have direct experiences of trauma and loss (Weine, Vojvoda, Hartman, & Hyman, 1997). However, there is a paucity of research into the effects of the refugee experience on refugee families. This is particularly unfortunate given that the family can play a central role in helping its members cope with trauma and displacement, especially when others from their community are lost (Weine et al., 2008). There is also a paucity of research into refugee parenting practices and the way in which these practices may be affected by the refugee experience. However, one could reasonably assume that refugee parents would find parenting particularly more difficult compared with other parents who have not had to live in dangerous environments or face the multiple stressors associated with the refugee experience, and who have not had to move into a culture with parenting philosophies and practices significantly different from their own.

Therefore, the final section of this chapter will review the role and function of parenting in general, and explore the ways in which parenting can be affected by parental and child psychopathology. In this way, the potential issues and problems
refugee parents and refugee families may be facing can be explored. Finally, what is known about the parenting issues and needs of those from refugee backgrounds will be reviewed.

**Parenting and psychopathology.**

Parents play an important role in the development and socialisation of their children (Bornstein, 2002). However, there is no universally accepted standard of what “good” or “effective” parenting looks like (Centre for Community Child Health, 2004; O'Connor, 2002). This is because parenting is a socially constructed role that depends upon, and evolves with social, cultural and historical changes (Ambert, 1994; Centre for Community Child Health, 2004). As such, the requisites and boundaries of parenting appear different in different cultures and in different contexts (Ambert, 1994). Nevertheless, it has been suggested that all parents, irrespective of culture aim to promote the health and survival of their children, teach their children the skills that are necessary to survive economically, and to encourage the attributes that are valued by a particular culture (LeVine, 1988). Therefore, although parenting practices may appear to be different, their function can be said to be the same across cultures.

Parenting also requires a balance between the parent’s resources and skills, with the needs of their children. How this balance is negotiated is strongly influenced and constrained by the family’s situation and environment (Hatton & Bacic, 2001; Kolar & Soriano, 2000). For example, living in unstable and traumatic environments brings added stress, and parents are sometimes unable to satisfy their children’s needs (Ajdukovic, 1996; Qouta, Punamaki, & Sarraj, 2005). Although the negative effects of trauma on an adult’s capacity to parent effectively is generally well recognised within the clinical community, surprisingly, these effects have not been sufficiently studied nor have they been reported widely in the empirical literature (Appleyard &
Osofsky, 2003; Berg-Nielsen, Vikan, & Dahl, 2002). However, the impact on psychopathology, particularly PTSD, depression, and anxiety on parenting behaviour have been documented. Given that these disorders are relevant to refugee communities, a brief review of the general parenting literature pertaining to the impact of these disorders on parenting will be presented next.

**Effects of PTSD on parenting.**

Fewer studies than expected have examined the effects of PTSD on parenting behaviour. However, several studies have investigated PTSD in Vietnam veterans and the effects on their children and families. Although some veteran families do very well, significant family dysfunction has been documented in others. For example, Davidson and Mellor (2001) investigated the family functioning of 50 Australian male Vietnam veterans with children aged 16 to 30 years. Sub-grouped according to fathers’ PTSD status (PTSD = 30, non-PTSD = 20), these families were compared with an age-matched group of 33 civilian families. The veteran group with PTSD reported greater family dysfunction than either the non-PTSD veterans or the civilian control groups. Family dysfunction in this study was characterized by less effective problem solving, less ability to respond to problems with appropriate affect, less healthy communication styles, and less interest and involvement with other family members.

The literature also indicates that war veterans with PTSD also show higher perpetrator rates of domestic violence (Galovski & Lyons, 2004). These findings have important implications because mothers who are victims of domestic violence often report difficulties in their parenting roles (Banyard, Williams, & Siegel, 2003). Conflict between intimate partners has also been shown to impact family relationships, the adjustment of children, and increase children's negative beliefs
about the care they receive from their parents (Cummings & Davies, 2002; Gonzales, Pitts, Hill, & Roosa, 2000; Kitzmann, 2000).

Some have argued that the emotional numbing characteristic of PTSD may lead to poorer relationships because this symptom reduces a parent’s ability and willingness to engage in and enjoy interactions with their children (Davidson & Mellor, 2001; Galovski & Lyons, 2004). Other studies investigating PTSD in mothers have posited that parenting may also be affected because mothers misperceive the distress exhibited by their children as anger or coerciveness, which they then try to avoid by tuning out or leaving the room so as to maintain their own emotional regulation (Schechter et al., 2006).

**Effects of depression on parenting.**

Although not all researchers have found a link between depression and poorer parent–child interaction (e.g. Frankel & Harmon, 1996; cited in Berg-Neilson et al., 2002), the majority of studies have clearly demonstrated that depressed mothers engage in less positive and more negative interactions with their infants (e.g. Carter, Garrity-Rokous, Chazan-Cohen, Little, & Briggs-Gowan, 2001; Lovejoy, Graczyk, O’Hare, & Neuman, 2000). For example, Cox, Puckering, Pound and Mills (1987) compared an urban working class sample of depressed mothers with two-year-old children to a matched control group of non-depressed mothers and their children. The researchers observed that in general, depressed mothers were less responsive and less able to sustain social interaction with their children. In this study, depressed mothers were also found to be emotionally insensitive and less attuned to their infant’s emotional state.

The general parenting literature has also observed that having a depressed parent also increases the likelihood of children developing psychiatric or adjustment
problems in the future (Appleyard & Osofsky, 2003; Lovejoy et al., 2000). Although the mechanisms by which maternal depression confers risk to children are not well understood, genetic transmission, observational learning, and/or impaired parenting itself may be the mechanisms by which psychopathology and adjustment problems are transmitted (Carter et al., 2001; Lovejoy et al., 2000).

**Effects of anxiety on parenting.**

Similarly, the general parenting literature overwhelmingly suggest that anxious mothers tend to be less sensitive and display behaviour which is marked by greater levels of intrusiveness, overprotection and over-control compared with healthy mothers (e.g., Warren et al., 2003; Weinberg & Tronick, 1998). Some researchers have posited that parental anxiety may interfere with parenting capacities by decreasing a parent’s ability to listen to or hear their children’s distress, and by their need to withdraw from their children and families so as to protect themselves from feelings of vulnerability (Appleyard & Osofsky, 2003).

As in parental depression, parental anxiety has also been associated with psychiatric or adjustment problems in children. For example, in a 6 to 8 year follow-up study, Merikangas, Avenevoli, Dierker and Grillon (1999) compared 58 children from 36 parents with anxiety disorders (panic with or without agoraphobia, social phobia, and GAD) with 57 children from 35 parents with no psychiatric history. They found that the children of anxious parents were 3.5 times more likely to develop an anxiety disorder than were children of healthy parents.
**Impact of child psychopathology on parenting.**

Although the number of empirical studies investigating the impact of child psychopathology on parenting is limited, the literature has found a moderate to strong relationship between child temperament and parent behaviour.

For example, research with traumatised children suggests that parents themselves become vicariously traumatised by their child’s traumatic experiences. In these situations, a complex system can be created whereby the parent’s reaction maintains and contributes to the dysfunction in both themselves and their children (Drell et al., 1993; cited in Appleyard & Osofsky, 2003). However, other studies investigating the ways in which parenting behaviour is impacted when children suffer from PTSD could not be located.

Studies have also found that depressed children describe their families as less cohesive, less supportive and less able to communicate effectively. They also report that their families are more controlling and conflictual, and have higher levels of expressed emotion than their non-depressed peers (Berg-Neilson et al., 2002; Kaslow, Deering, & Racusin, 1994). In addition, mothers and fathers of severely depressed children have reported high levels of disruption in their own interpersonal interactions, occupational functioning, and leisure activities (Asarnow & Horton, 1990).

Comparing the interactions of 42 anxious children with their mothers with 42 socially-competent children and their mothers, Dumas, La Freniere, and Serketich (1995) observed that the interactions between anxious children and their mothers were more aversive, while the competent children and their mothers influenced each other positively and reciprocally. Mothers of anxious children were observed to almost exclusively try to control their children’s behaviour, leaving the children with
insufficient opportunities to assert a developmentally appropriate degree of autonomy. Other reports of healthy parents granting less autonomy to anxious children than to non-anxious children have also been documented (e.g., Siqueland, Kendall & Steinberg, 1996).

Taken together, the studies clearly demonstrate that children are active agents in the child-parent relationship, who can both influence and be influenced by their relationship with their parents.

**Summary of parenting and psychopathology.**

This brief review clearly suggests that mental illness in parents often impairs their ability to parent as effectively as someone not struggling with mental health issues. Given that PTSD, depression, and anxiety are usually associated with the refugee experience, it is also likely that refugee parenting practices may be affected. Further, it is also likely that poor mental health in refugee children may also act as additional stressors for refugee parents, further impacting upon their coping and parenting abilities. However, it is important to note that most of the research on the effects of psychopathology on parenting outlined above is predominately from Western families, and between mothers and their children. Fathers do not often appear in parenting research (Berg-Nielsen et al., 2002). In addition, mental health problems in parents are frequently associated with other family or environmental factors such as low socio-economic status and substance use, factors that are in themselves associated with negative impacts on children (Smith, 2004). Therefore, care must be taken when extrapolating the outcomes of these studies and using them to inform our understanding about the potential effects that psychopathology may have on refugee families from diverse cultures. Nevertheless, the limited parenting research conducted with refugee parents indicates that these issues may also relevant to refugee families.
Parenting in refugee families under stress.

In the few studies investigating refugee parental interactions with their children, the findings are consistent with the impaired parenting practices found in distressed parents in the general population. For example, Ajdukovic (1996) interviewed 58 refugee mothers living in a Croatian shelter with their families, and found that after six months of displacement, the mothers’ behaviour towards their children had changed in two important ways. The mothers reported that after six months, they rarely talked to their children, and they generally reported feeling more nervous than they had been when interviewed six-months prior. In addition, the number of mothers using physical punishment increased over this time, with the increase approaching the \( p < .05 \) significance level. Ajdukovic (1996) also found that in those mothers whose adaption to displacement was poorer and whose relationship with their children was less favourable, their children displayed a higher incidence of mental health disorders. Although control groups were not used in this study, the findings suggest that the effects that displacement, trauma, and stress can negatively impact upon one’s parenting style and on the mental health of children.

Investigating the coping strategies utilised by the parents of 39 Iranian refugee children 3 ½ years after arriving in Sweden, Almqvist and Hwang (1999) observed that parents deliberately facilitated or discouraged different coping strategies in their children. For example, social withdrawal, daydreaming, playing war games and speaking about previous experiences of trauma were actively discouraged by the children’s parents, and in some cases, these activities were forbidden. In contrast, active competition and positive thinking were encouraged. There is some evidence to suggest that communication and talking about family tragedies and traumatic memories is beneficial for children as it helps them process information, correct their
misconceptions and regulate their emotions (Qouta et al., 2005). However, when parents and children have been traumatised, they often reinforce each other’s avoidance symptoms because they get locked into cycles of not talking about the traumatic events for fear of upsetting each other (Smith, Perrin, Yule, & Rabe-Hesketh, 2001).

The way a parent copes in stressful situations is the main mediator which can considerably alleviate or intensify the effects of stress and trauma on the child’s wellbeing. So when a parent experiences mental health difficulties, they not only provide poor support to their children but the distress they display is an additional source of stress for their children (Ajdukovic, 1996). Pfefferbaum (1997) also adds that parents serve as role models, and if parents cope poorly, their children are likely to fare less well too because they do not learn adaptive ways to cope with their distress. Further research on the impact of trauma and psychological difficulties on refugee parenting practices is obviously needed in order to better inform prevention and treatment approaches (Mghir, Freed, Raskin, & Katon, 1995). However, information about the parenting strengths, parenting difficulties, and parenting needs of refugee families after their resettlement is also important because these factors are not only important predictors of mental health (Qouta et al., 2005), but they can be used to inform mental health promotion and prevention initiatives. The next section will therefore review the available literature on the parenting needs of refugee families after their resettlement to Western countries.

**Refugee parenting needs after resettlement.**

Even with Australia’s multicultural reputation and long history of accepting and supporting refugees from all over the world, raising children in an unfamiliar environment would still be expected to present many challenges for refugee parents.
Not only must they face the typical challenges associated with raising children, most refugee parents must do so while learning a new language, finding employment, navigating through unfamiliar legal and social systems, and missing their family and friends. At the same time, refugee parents must also try to raise their children while dealing with histories of violence and loss, and in many cases, problems with mental and physical health and histories of torture (Gorst-Unsworth & Goldenberg, 1998; Miller, Worthington, et al., 2002). However, because the majority of refugee studies have focussed on the mental health sequelae of the refugee experience, in comparison, very little research has examined the issues facing recently-arrived refugee parents. Nevertheless, the following section provides a review of the available literature focussing on the difficulties refugee parents have reported upon their resettlement to Western countries.

**Separation from family.**

In exploring the parenting experiences of refugee resettled to Finland, Degni, Pöntinen and Mölsä (2006) interviewed 21 male and female Somali refugee parents. Although some parents found adjustment relatively easy, the majority reported experiencing significant difficulties. Parenting was described as especially stressful because they were not able to rely on extended family to share the childcare burden.

**Intergenerational conflict.**

The interviews conducted by Degni et al. (2006) revealed that intergenerational conflict was a problem for these Somali families, and that these parents cited a particular dislike for the freedom and lifestyle choices that were available to their children in Finland. It has been posited that migrant and refugee children acculturate faster than their parents because they attend school immediately upon their arrival in a
resettlement country and must learn to fit in if they are to succeed within the school environment. In contrast, parents often take a significantly longer time to find employment and learn the language. Conflict then ensues because children adopt different values and roles to those held by their parents (Poppitt & Frey, 2007). Intergenerational conflict was also found to be a problem for other refugee families resettled in San Francisco. For example Lipson and Omidian (1997) observed that the Afghani cultural values of family interdependence and strict obedience were in conflict with the independence and assertiveness that their children learnt in U.S. schools.

However, Miller, Worthington, et al. (2002) did not find evidence of intergenerational conflict in their sample of 28 adult Bosnian refugees in Chicago. Miller and colleagues reported that instead of being a source of distress, family relationships were a source of critical emotional and instrumental support. Buchanan (2001; cited in Miller, Worthington, et al., 2002) also found similar results in Latino and Russian immigrant families. Taken together, these studies indicate that intergenerational conflict may be less pervasive than previously thought, or may be specific to certain ethnic communities. It is possible that refugee communities from Europe experience less inter-generational conflict in resettlement compared with refugee communities from Africa/Afghanistan for example, because European refugees may be more likely to speak English as a second language prior to flight, and because European culture has more Western influences than African/Middle Eastern cultures do.

**Traditional discipline and child protective services.**

Lipson and Omidian (1997) also reported that Afghani parents were too scared to discipline their children in the traditional Afghani way because of stories they had
heard about children being taken away. The Somali participants interviewed by Degni et al. (2006) also revealed a conflict between traditional and Finnish disciplinary practice, which sometimes attracted involvement from welfare organisations. Negotiating acceptable disciplinary practices were also a major problem for 21 Somali mothers in Canada (Israelite, Herman, Khan, Alim, & Mohamed, July, 1999). These women not only described strong fears that their children could be taken away from them, but they also described being unfairly accused of child abuse, even when children had sustained injuries in innocent playground accidents. Adding to their worries, these refugee mothers also complained that their children had learned that threatening to call authorities with untrue claims of abuse was an easy way to control their parents. As a result, some women said that their children were becoming increasingly arrogant and disrespectful because they had learnt to use the system to their advantage. Unfortunately, problems with child protection authorities have also been reported by refugees living in Australia.

In an effort to examine why increasing numbers of refugee parents resettling in South Australia were coming into contact with Australian child protection systems Lewig, Arney, and Salveron (2010) ran focus groups with 130 refugees from eight cultural groups, and surveyed or interviewed 55 child protection practitioners who were currently working with refugee families. The researchers identified three key inter-related challenges facing refugee parents in their parenting roles, which increased the likelihood of parents being referred to child protection.

The first challenge identified by Lewig et al. (2010) was related to the strong tension between traditional cultural parenting beliefs and practices and Australian laws about discipline. Exacerbating this tension was a lack of information about acceptable parenting practices and Australia’s laws relating to the care of children.
For example, in some cultures it is acceptable to leave young children unattended because older children are expected to care for younger siblings in their parents’ absence, and because children are taught to seek support from neighbours if needed. However this practice is deemed unacceptable in Australia.

The second and third challenges uncovered by Lewig et al. (2010) related to the aforementioned difficulties of intergenerational conflict and separation from family. These parents also stated that they were unable or reticent to engage agency help because of English language proficiency problems, a lack of translated materials, not knowing what help was available, as well as negative experiences such as not being understood or listened to, and a lack of cultural understanding by agency staff. The participants in the Lewig et al. (2010) study clearly demonstrated that refugee parents are facing great challenges in their parenting roles, and could benefit from more culturally appropriate support. If this type of support is not offered and accessed, it places many more refugee families at risk of child protective involvement.

*Not able to support their children to succeed.*

In an attempt to explore the experiences of refugee Somali mothers resettled in Canada, focus group discussions conducted by Israelite et al. (July, 1999) revealed that raising their families was very stressful for these women. They complained that they did not have the resources or the support to help their children do well at school, and felt that behavioural norms in Canadian schools were undermining their ability to teach their children appropriate behaviour. These women also lamented that that their roles and influence as parents were not as important as they once were, and feared that their children would abandon their Somali cultural heritage. Because these women had placed their hopes for the future in their children, seeing their children fail in
terms of their academic achievement, behaviour, and cultural commitments, these mothers felt incompetent as parents.

**Altered social roles.**

The Somali parents in the Degni et al. (2006) study also revealed that being unable to claim the status of breadwinner was unbearable for some Somali men. This is unfortunately a commonly reported issue in the refugee resettlement literature (e.g., Lipson & Omidian, 1997). Meanwhile, the study found that Somali women were generally pleased about the increased availability and willingness of their husbands to provide direct help in raising their children. This finding highlights the strength and adaptability that refugee parents possess in adjusting to their new environments. However, reports of domestic violence, intergenerational conflict and divorce in this Somali community were also attributed to the widespread unemployment of Somali men. Therefore, employment opportunities for men in particular, could be especially salient in promoting harmony for refugee families.

**Lack of understanding by others.**

Other issues exacerbating Somali parenting difficulties was related to the shock and frustration displayed by Finnish authorities, teachers and social workers in response to the Somali cultural tradition of having a large family (Degni et al., 2006). A lack of cultural understanding by agency staff was also reported by participants in the Lewig et al. (2010) study. These findings clearly highlight the need for those working with refugee families to be made more culturally aware of refugee traditions, norms and values.
No difficulties.

However, other studies examining the resettlement issues of refugees did not uncover or report any difficulties related to raising families in their resettlement countries. For example, Casimiro, Hancock, and Northcote (2007) ran focus groups and/or interviewed 80 Muslim refugee women during their first five years of arrival in Western Australia. However, problems associated with English language competency, economic and job security; adjusting to a society that is not patriarchal; and the hostility expressed by some Australians towards them were the only difficulties reported. Similarly, Valtonen (1999) used in-depth interviews to explore the resettlement issues experienced by male and female refugees from Iraq, Iran, Afghanistan and Kuwait living in Toronto and Finland. However, only difficulties associated with their lack of involvement in economic, social, cultural and civil/political spheres were reported. Although, Valtonen (1999) did find that separation from family and male spousal unemployment was particularly detrimental to family harmony.

One could expect that the resettlement stressors raised by participants in the Casimiro et al. (2007) and Valtonen (1999) studies would most certainly have some negative effects on family relationships and family harmony. Therefore the absence of parenting difficulties reported in these studies is particularly intriguing. This is especially so given that in general, caring for their families is one of the most central and meaningful life task for women from traditional Islamic households (Friere, 1993, cited in Valtonen, 1999; Omar & Allen, 1996, cited in Casimiro et al., 2007). Either, the participants in these samples did not experience problems associated with raising a family in their new environments, that they felt that other stressors were more important, or that the participants were not asked questions to elicit these details.
However, clearly missing from this literature are reported difficulties associated with mental health issues. It is true that many refugees are resilient and do not suffer from long-term mental health problems and therefore, it is possible that participants in the samples surveyed were not suffering from psychological distress. However, it is also possible that refugees surveyed do not recognise Western concepts of stress and depression as mental health problems and instead consider their distress as simply the direct effect of missing their family and friends, the bureaucratic difficulties associated with trying to bring their loved ones to them, and the problems related to fitting into a new country (Guerin, Guerin, Diiriye, & Yates, 2004). If this is the case, then one would not expect refugees to raise issues of mental health problems in these interviews. This observation therefore raises an important practical implication for those working with refugee family members. It may be critical to ask refugees directly how they understand the cause(s) of their difficulties and how they as workers can best support them to deal and cope with their distress instead of assuming that Western mental health treatments for trauma, depression and anxiety are relevant and helpful.

**Part III - summary.**

Although research exploring the parenting needs of resettled refugees is particularly limited, it is clear that a proportion of refugee parents and families experience significant difficulties, challenges and fears associated with their parenting tasks. The research with refugee families reveals that parents struggle with a multitude of issues in resettlement countries. Issues ranging from a missing the support of their families in their parenting tasks, intergenerational conflict, discipline problems which sometimes brings them into contact with child protective services, not being able to support their children succeed, altered social roles, and a lack of cultural awareness
from workers have been reported. All these challenges occur within and on top of previous trauma and loss, and concurrently with the usual resettlement stressors associated with adjusting to a new environment such as learning a new language and finding employment. However, it is also important to note that refugee parents also demonstrate incredible strength and resilience in the face of their experiences and the difficulties they must face in resettlement, although the literature does not always highlight these aspects enough. Finally, it is also clear that government authorities, agency staff, and others working with refugee families must also increase their cultural awareness, recognise these family’s strengths, and develop more culturally-sensitive ways to meet their needs.

Despite the rare glimpses into the lives of refugee families that the studies reviewed in Part III provide, there is a significant lack of information about the parenting strengths and difficulties faced by this group. In bringing refugees to Australia, we have a responsibility to understand these strengths and challenges in order to support a smoother resettlement process, and to promote the health and wellbeing among recently-arrived refugee families. This gap in our knowledge is a compelling rationale for Study One of this thesis.
Chapter 4: Study One – The Parenting Strengths and Difficulties of Recently-Arrived Refugee Mothers in Melbourne

As discussed in Chapter 3, parents play a crucial role in the development of children’s social, emotional, behavioural and physical well-being (Bornstein, 2002). However, the circumstances under which refugees arrive in Australia, as well as the challenges they face upon arrival may place additional challenges on them as parents compared with mainstream Australian and other migrant parents. Refugee parents must not only raise their children in an unfamiliar environment in which they must negotiate typical resettlement stresses such as learning a new language, finding employment, navigating through unfamiliar legal and social systems, and missing family and friends, but they often do so while dealing with mental health issues arising from trauma, and in some cases, a history of torture (Bhugra, 2004; Gorst-Unsworth & Goldenberg, 1998; Miller, Worthington, et al., 2002).

Unfortunately, these added stressors and demands may negatively impact the capacity of some refugee parents to parent effectively. Obtaining firsthand accounts of what parenting is like for resettled refugee parents in Melbourne is vitally important as the parenting literature has largely ignored refugee parenting practices and parenting needs after resettlement. In addition, although organisations and individuals working with refugees may have developed great insight and important practical knowledge about what it is like for refugee parents to raise families in Melbourne, much of this information is undocumented and has not made its way into the published literature.
Study Aims

Therefore, the first aim of the current study is to extend the current parenting literature by exploring both the positive and negative aspects of parenting, as experienced by refugee parents raising their families in Melbourne. In doing so, it is hoped that mental health prevention and promotion initiatives, as well as the provision of other community and government supports can be better informed. The second aim of this study is to elicit suggestions from the refugee participant themselves about how clinicians, agencies and government can better support them in their parenting roles. Obtaining participant suggestions about the support they would like to see is an important aspect of this study as it provides the opportunity for refugee parents, an underrepresented voice in the parenting literature, to be heard. In collecting this information, the researcher also aims to address the ethical challenges inherent in research involving refugee communities.

Method

Participants

A total of 21 refugee mothers voluntarily participated in this study. Participants were recruited from three organisations in Melbourne; The Napier Street Child and Family Resource Centre, MacKillop Family Services, and Debney Meadows Primary School. Participants identified their cultural background as Somali (13), Eritrean (3), Ethiopian (3), and Sudanese (1). One participant did not state her cultural background. Participants ranged in age from 22 to 43 years, had an average of 3.6 children, and all participants endorsed Islam as their religious faith. More detailed information about the participants in the study is presented in Table 1.
Table 1

Demographic Data for Participants from Each Focus Group Setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>Napier Street</th>
<th>MacKillop</th>
<th>Debney Meadows</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of participants</td>
<td>6&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>Age in years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>Not collected</td>
<td>25.0&lt;sup&gt;b&lt;/sup&gt; (4.4)</td>
<td>36.6&lt;sup&gt;c&lt;/sup&gt; (5.0)</td>
<td>33.9 (6.9)</td>
</tr>
<tr>
<td>Range</td>
<td>Not collected</td>
<td>22 to 30</td>
<td>27 to 43</td>
<td>22 to 43</td>
</tr>
<tr>
<td>Country of origin</td>
<td>Somalia, 2</td>
<td>Ethiopia, 3</td>
<td>Somalia, 11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eritrea, 3</td>
<td>Sudan, 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not stated, 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in Australia</td>
<td>9.6&lt;sup&gt;c&lt;/sup&gt;</td>
<td>4.2</td>
<td>12.5</td>
<td>9.9</td>
</tr>
<tr>
<td>Mean</td>
<td>1 to 22&lt;sup&gt;c&lt;/sup&gt;</td>
<td>3 to 6</td>
<td>4 to 16</td>
<td>1 to 22</td>
</tr>
<tr>
<td>Range</td>
<td>1 to 22&lt;sup&gt;c&lt;/sup&gt;</td>
<td>3 to 6</td>
<td>4 to 16</td>
<td>1 to 22</td>
</tr>
<tr>
<td>No. of children</td>
<td>One</td>
<td>Two</td>
<td>Three</td>
<td>Four or more</td>
</tr>
<tr>
<td>One</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Two</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Three</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Four or more</td>
<td>1</td>
<td>2</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Not stated</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No. of single mothers</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<sup>a</sup>One participant stayed for twenty minutes only.  
<sup>b</sup>One participant did not provide a response about her age.  
<sup>c</sup>One participant did not provide a response about number of years in Australia.

**Sampling**

In research utilising focus groups, it is important to select participants that are able to provide insight into the topic being researched (Asbury, 1995; Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007). In the current study, participants needed to meet the following two criteria: first, be of refugee background and second, be a parent. A third criterion, of being over the age of 18-years was also included to overcome issues associated with obtaining parental/guardian consent. The study took a non-probabilistic, purposive sampling approach to recruit participants.
Although the literature recommends that focus groups are comprised of homogeneous participants in terms of gender, culture, and age in order to capitalise on their shared experiences, some researchers (e.g., Ekblad & Bäärnhielm, 2002; Kitzinger, 1995) suggest that participants from diverse groups are more likely to maximise the exploration of different perspectives. Further, Kitzinger (1994) also states that that the expression of different views is enhanced when pre-existing groups are used in focus group research because group members already have an established level of trust with each other. Therefore, samples drawn from pre-existing groups comprising a range of diverse cultures was regarded as the recruitment ideal.

**Recruitment Settings**

Seven organisations providing services to refugees resettled in Melbourne were invited to participate in this study via telephone and email. Three of these organisations agreed to participate. Consent was provided after representatives from the Napier Street Child and Family Resource Centre, MacKillop Family Services in Footscray, and Debney Meadows Primary School in Travancore Melbourne met with the researcher to discuss the study’s aims, proposed research methodology, and the potential benefits to the refugee communities they served. The plain language statement, evidence of RMIT ethics approval, and other relevant documents were also provided at this initial meeting.

In conducting ethical research with refugee communities, the cross-cultural literature suggests that researchers must be prepared to collaborate with the communities they are studying, share results that have practical value, and accept the conditions imposed by the community to gain access to participants and their information (Trimble & Fisher, 2006). Therefore, details about each recruitment
setting and how the researcher incorporated the aforementioned ethical considerations into the research process are described next.

**The Napier Street Child and Family Resource Centre (Napier Street).**

Napier Street is a service delivered under the auspices of the Brotherhood of St Laurence in Fitzroy. Napier Street offers services such as outreach, childcare, playgroups, and support for school children and their parents living in the surrounding area. Napier Street provided consent for the researcher to recruit participants from their playgroup, which is run once a week for two hours, during the school term. It is attended by a multi-cultural group of parents and their children, many of whom are of refugee background. Consent from Napier Street was provided on the condition that the researcher discuss the proposal with refugee community leaders, become a volunteer at the playgroup to establish rapport with the participants, share the findings with the organisation, and at the conclusion of the study provide the participants with any relevant parenting support or information they may request.

**MacKillop Family Services (MacKillop).**

MacKillop is one of Australia’s largest providers of welfare services to children and families. Through their Regional Parenting Service they provide training, information and resources for parents and professionals through playgroups, information sessions, consultations and seminars. MacKillop provided consent for the researcher to recruit participants from their playgroup in Footscray, which is attended by a multi-cultural group of parents and their children, many of whom are of refugee background. Consent from MacKillop was provided on the condition that the researcher also obtains ethics approval from the Quality Board & Advocacy Committee at MacKillop Family Services, discuss the proposal with refugee
community leaders, build rapport with the participants before conducting the focus
groups, and share the research findings with the organisation at the conclusion of the
study.

**Debney Meadows Primary School (Debney Meadows).**

Debney Meadows is a small, inner-city, public school in the suburb of Travencore in Melbourne. It is attended by a diverse and multi-cultural group of children, many of whom come from a refugee background. Debney Meadows values cultural diversity and is committed to promoting the well-being of all its students and their families. Consent from Debney Meadows was provided on the condition that the researcher obtains ethics approval from the Department of Education and Early Childhood Development (DEECD) and that the research proposal was discussed with a refugee community leader. No other conditions were requested by the school for their participation in this study.

**Design**

Qualitative data was collected via focus group interviews. Qualitative methods are appropriate when exploring a phenomenon, or when little is known about a groups’ attitude on an issue (Green & Thorogood, 2009). Focus groups are a type of group discussion that is focussed around a specific issue and utilises group interactions to stimulate thinking and verbal contributions for the collection of data (Asbury, 1995; Kitzinger, 1994). Focus groups are a particularly useful way to obtain insight into a groups’ opinion, attitude, vocabulary and reasoning about an issue (Ekblad & Bäärhnielm, 2002) and is a particularly useful tool for engaging culturally and linguistically diverse (CALD) populations because many CALD societies have strong oral cultural traditions (Halcomb et al., 2007; Huer & Saenz, 2003; Saint-
Germain, Bassford, & Montano, 1993). Given limited financial resources, it was anticipated that three focus groups was the logistical and practical limit for this study.

Owen (2001) describes five advantages of utilising the focus group format with vulnerable groups, which may be relevant to refugee participants. First, focus groups rely on verbal communication and therefore do not discriminate against people who cannot read or write. Second, because the focus group setting provides a friendly, comfortable and inviting environment, the focus group can encourage people to share their thoughts and experiences who would otherwise be reluctant to be interviewed on their own. Third, because the group interaction is promoted over interaction with the facilitator, this gives participants greater control over the direction of the discussion and allows for a richer exploration of the issues from the participants’ perspective. Fourth, the focus group promotes a respectful, non-condescending atmosphere by respecting the views brought forward by all group members. And finally, the focus group is generally an enjoyable experience because of its friendly atmosphere. Owen (2001) also notes that focus groups may be particularly suited for female participants because of their established tradition of sharing personal information with other women. Ekblad and Bäärnhielm (2002) also argue that focus groups are more conducive to stimulating discussions than individual interviews, and thus results obtained through focus groups have higher face validity.

However, as with any data collection method, focus groups also contain certain inherent disadvantages. For example, ethical issues related to privacy and confidentiality are raised because information disclosed is heard by all participants. The presence of dominant group participants may influence the level of disclosure by other participants and thus produce results that are not representative of the groups’ experiences and perspectives. Importantly however, the facilitator’s level of
experience can also influence results depending on how competently they direct the session, how effectively they monitor and respond to verbal and non-verbal responses, and how they manage any conflict that may arise (Halcomb et al., 2007). However, many of these limitations can be partially or wholly overcome by careful training and planning.

Procedure

Ethics approval.

Ethics approval for this study was obtained from RMIT University (Project No. 17/09; Appendix A), DEECD (RIS09103; Appendix B), and MacKillop Family Services (Appendix C). Ethics approval from The Brotherhood of St Laurence was not required as this organisation deemed ethics approval from RMIT and DEECD as sufficient assurance of the study’s ethical integrity.

Recruitment of participants and associated ethical considerations.

Recruitment of participants was initiated only after ethics approval from relevant bodies had been obtained, and written permission to conduct research was obtained from the managers/Principal from Napier Street, MacKillop and Debney Meadows (Appendix D). Recruitment procedures incorporated important ethical practices that must be followed when conducting research with refugee communities. These practices included finding out about the refugee communities being investigated (Guerin & Guerin, 2007), and consulting with community leaders about how best to conduct the recruitment procedure (Trimble & Mohatt, 2006). It is only by paying attention to protocols such as these that cross-cultural research can be responsive to cultural concerns (Castro, Rios, & Montoya, 2006).
Engaging with community leaders in the research process is also in the spirit of promoting participatory social action and also enables community leaders to act as gatekeepers to protect the rights of their community members (Castro et al., 2006; Ellis, Kia-Keating, Yusuf, Lincoln, & Nur, 2007). Additionally, when research is supported by community leaders, participants are usually more willing to participate in research (Chin, Mio, & Iwamasa, 2006; Goodkind & Deacon, 2004; Guerin & Guerin, 2007). Therefore, recruitment was preceded by meetings with the community leaders identified by the managers/Principal at each organisation. During these meetings, the study aims and research methodology were discussed, and copies of plain language statements, consent forms, and evidence of ethic approval documents were provided. Active recruitment of participants was initiated only after the researcher made amendments to the research methodology, as requested by community leaders. The recruitment strategies employed in each setting are described next.

**Napier Street.**

The researcher presented the research proposal to Napier Street’s Sudanese social worker and the playgroup facilitator, who were identified as trusted community leaders to their refugee clients. The community leaders granted their approval, but requested that the researcher make changes to informed consent procedures (as described in the section: “Informed consent and associated ethical considerations”) and requested that the researcher becomes a volunteer at the playgroup to build rapport with the participants and their children. This request is consistent with the cross-cultural research literature which emphasises the need for fostering trust and mutual respect with refugee community. Without trust and respect, conducting any sort of meaningful research with refugee populations is impossible (Miller, 2004).
Therefore, the researcher volunteered at the Napier Street playgroup every week for four months. During this time, relationships were developed and the research project was discussed with refugee mothers in attendance. All individuals who met the study’s inclusion criteria were invited to participate in the study. Flyers advertising the date, time, location, and basic information about the study were distributed in the three weeks preceding the focus group in order to allow participants sufficient time to decide on their participation, and to raise any queries they had about the study. Individuals were asked to register their interest with the researcher so that interpreters, child-minding, seating arrangements, and catering could be organised. Six mothers registered their interest to participate.

*MacKillop.*

The researcher presented the research proposal to the MacKillop play-group facilitator, an Eritrean female who was identified as a trusted community leader amongst their refugee clients. The community leader requested similar changes to the informed consent and recruitment procedures as stipulated by Napier Street’s community leaders. The researcher therefore attended the playgroup as a guest every fortnight for two months. In this way, the researcher was able to build rapport, meet the mothers attending playgroup, play with their children, and answer questions they had about the research. All parents meeting the study’s inclusion criteria were invited to participate in the study. A flyer advertising the date, time, location, and basic information about the focus group study was distributed during these visits, and the community leader also volunteered to speak with the playgroup attendees about the project. Individuals were asked to register their interest with the researcher so that interpreters, transport, child-minding, seating arrangements, and catering could be organised. Ten mothers registered their interest to participate.
Debney Meadows.

The recruitment of participants from Debney Meadows Primary School involved meetings with the Principal and the school’s multi-cultural education aide, a Somali female who was identified as a trusted community leader at the school. The researcher discussed the study’s aims and research methodology with the community leader who then approved the study. The community leader offered to take sole responsibility for the recruitment of participants because she knew many Somali mothers with children at the school whom she believed would like to participate. The researcher suggested that she aim to recruit between six to ten participants for one focus group only. The community leader also offered to organise two Somali interpreters to attend the focus group. A recruitment flyer was not distributed to participants at Debney Meadow Primary School because the community leader suggested that it would be better if she informed participants verbally about the research project. It is unknown how many individuals were approached, or how many registered their interest to participate from this setting.

Informed consent and associated ethical considerations.

When conducting research with refugees, informed consent procedures are made more complex due to issues such as vulnerability, compromised autonomy, mistrust and the complexities of representation, and therefore, traditional Western informed consent procedures are often inadequate and inappropriate (MacKenzie, McDowell, & Pittaway, 2007). Instead, MacKenzie et al. (2007) advocate for an iterative model of consent in which ethical relationships are established between researcher and participants, so that consent procedures may be more responsive to participants’ needs, concerns, and values. MacKenzie et al. (2007) and others (e.g., Bailes, Minas, & Klimidis, 2006; Barrett & Parker, 2003) state that iterative models
of consent begin when researchers consult with community leaders, representative bodies, or with non-government organisations (NGOs) where appropriate, about how best to proceed on matters of informed consent. These negotiations establish the research as a partnership, and encourage the refugee community to play an active role in setting the research agenda, thus ensuring the research shows respect for the values and concerns of the participants. This process also helps to build trust and to avert misunderstanding (MacKenzie et al., 2007).

Therefore, the consent process for this study began by meetings held with managers/Principal from the three consenting organisations, and the community leaders nominated by these organisations. At these meetings, the researcher described the study’s aims and methodology, and provided copies of the plain language statement (PLS; Appendix E), consent forms (Appendix F) and a list of the proposed focus group questions (Appendix G). The researcher made a verbal request for the community leaders to inform the researcher should any aspect of the proposed study or consent procedures appear contrary to cultural norms. The researcher also asked for any other feedback or input regarding the study proposal, and finally, asked permission for the research to proceed.

Community leaders from Napier Street and MacKillop advised the researcher to produce a flyer containing basic information about the study together with the list of potential focus group questions as an alternative to the PLS and consent forms based on the RMIT Human Research Ethics Committee (HREC) pro-formas. A request was also made for verbal information about the study to be communicated at the time of flyer distribution. The community leaders advised that this strategy would be a superior strategy in the pursuit of informed consent over the distribution of a formal PLS. This strategy was consistent with that employed by Bailes et al. (2006) who
reported that providing whole page explanations about a research project is not an effective way to communicate important information to refugee research candidates. Therefore, an information flyer (Appendix H) was developed for Napier Street and MacKillop following the suggestions made by the community leaders. The flyer was produced in English only as the community leaders did not request a translated version.

On the advice of all community leaders, consent for participation was also obtained verbally rather than in written format. This strategy is supported by research conducted with the Somali community in Melbourne which found that the collection of signatures on documents written in English was often associated with anxiety for refugees (Bailes et al., 2006). In addition, Barrett and Parker (2003) state that the notion of a written contract does not always have the same purchase in other cultures as it does in Western cultures.

Once the informed consent strategy had been finalised, the target sample was approached and the recruitment phase was carried out over four-months at Napier Street, and over two-months at MacKillop. The prolonged recruitment phase at these centres was essential to develop rapport and give participants time to reflect upon their participation. During recruitment, the researcher stressed that participation was voluntary, and that there would be no adverse consequences for refusing to participate in the study. The researcher and the community leaders also made themselves available to answer any questions or concerns that potential participants may have. In the spirit of promoting community participatory action (Ellis et al., 2007), the community leader at Debney Meadows was encouraged to take responsibility for the dissemination of information about the study, recruiting participants and organising interpreters for the focus group.
Focus group questions.

Three main questions were developed to provide the basis for the focus group discussion and obtain the data required to fulfil the aims of the study. The main questions were:

- What do you like/makes you happy about being a mother in Australia?
- What don’t you like/makes you unhappy about being a mother in Australia?
- What information/services do you wish were available/would be helpful/would make it easier for your families and other refugee parents in Australia?

These questions were selected because a review of the literature revealed that this basic information was missing from the refugee parenting literature. In addition, these questions were likely to generate ideas for mental health prevention and promotion initiatives that may improve the wellbeing of refugee parents and refugee families.

Questions were open-ended to promote the sharing of stories and experiences, thus allowing participants to determine the flow and direction of the conversation. Other questions were also used to build rapport, ascertain the participants’ demographic profile, learn more about the participants’ parenting practices, and draw out additional details about the main research questions. As previously indicated, a list of all possible questions that the participants could expect during the focus groups were distributed in the recruitment phase of the study (see Appendix G). Feedback received from community leaders and managers/Principal about these questions indicated that they found the questions interesting. Also, they did not raise any issues regarding any of the proposed questions.
Focus group procedure.

The location, date and time of the focus groups were set after negotiations between the researcher, the three organisations and their respective community leaders. The focus groups were conducted on the premises of each participating organisation, which was ideal because participants were familiar with the venues and could easily access them. Krueger and Casey (2000) suggest that the ideal number of participants falls between six and eight participants because it allows for a variety of perspectives to be obtained without the focus groups becoming too disorderly. Therefore, three focus groups were scheduled based upon the number of participants who registered their interest to participate in the focus groups.

On the day of the focus groups, child-care was offered free-of-charge for participants at Napier Street and MacKillop. Child-care was essential as this would remove the burden on participants to find alternative care arrangements, and would enable the mothers to contribute to the discussions unimpeded by demands from their young children. Child-care was not necessary for the Debney Meadows participants. Transport to the venue was also organised for the MacKillop participants as this is a usual service offered by MacKillop. At the suggestion of community leaders, food and refreshments were also made available. The physical environment of the interview room was arranged so that participants were seated in a circle, with a table in the middle where the food and refreshments were placed. Two interpreters were in attendance at each focus group.

Before the focus groups began, the interpreters were briefed about the study’s aims and were given a copy of the PLS to read. As participants arrived, they were welcomed and their children settled into childcare. When all participants were seated, the researcher described the reason for the gathering, explained how focus groups
generally work, and summarised the information in the PLS ensuring that participants were aware of their rights, and had all the information required to make an informed decision about their participation. The participants were reminded that the discussion would be recorded, and were instructed not to disclose family names so as to preserve their anonymity in the recordings. The researcher also advised the participants that personal information disclosed during the discussions should not be repeated outside of the group. Once all queries had been addressed, and verbal consent for participation had been obtained, the researcher turned on the digital recording device and officially began the focus group.

Each focus group ran for approximately 90 minutes. They were moderated by the researcher, who also made field notes during and after the focus groups. As recommended by Krueger (1998), field notes can provide auxiliary information, such as about non-verbal gestures, group dynamic and interactions between participants that cannot be derived from transcripts. Participants were not paid for their involvement. However, the researcher sent a thank you card to each organisation and requested that the researcher’s gratitude be communicated to all participants for their contribution. Focus groups were conducted in August and September, 2009.

Community and participant feedback.

Once the focus group data was analysed, a preliminary summary feedback report was generated in order for the participating organisations to review and provide comments. Debney Meadows elected not to provide feedback on this report. This summary report serves two functions. First, it helps to fulfil the researcher’s obligation of sharing the study findings with the participating organisations. And second, as the managers are well acquainted with the participants, their feedback could help reduce the risk of the researcher making biased, harmful or inaccurate
interpretations of the data (Elliot & Urquiza, 2006). All feedback received was taken into account and incorporated into the analysis and discussion of the data. The researcher has also made arrangement to visit the playgroups after this thesis is submitted to provide participants with the study findings.

Analyses.

Focus groups were audiotaped using a digital recorder and transcribed verbatim by the researcher. Field notes were also transposed onto the transcripts. These transcriptions formed the basis of data analysis. Where dialogue could not reliably be transcribed, it was not included in the transcripts as substitution or interpretation of words by the researcher could affect the validity and reliability of the data, especially when research is conducted across linguistic and cultural boundaries (Green & Thorogood, 2009; Wallin & Ahlström, 2005). Transcription proved to be a time-intensive process with each focus group recording taking at least twelve hours to transcribe.

Thematic content analysis was chosen as the analysis strategy to summarise and present the key ideas raised by the participants. The researcher consulted with Dr Paterson (i.e., Paterson & Britten, 2008; Paterson, Vindigni, Polus, Browell, & Edgecombe, 2008; Paterson, Zheng, Xue, & Wang, 2008), a prolific qualitative researcher who recommended thematic content analysis as a sound and appropriate method of analysis for the current study (personal communication, November 12, 2010).

Thematic content analysis is a common approach used in qualitative research to identify the typical responses and/or the salient issues confronting a particular group of individuals about a topic (Green & Thorogood, 2009). In thematic content analysis, data is categorised into recurrent or common themes by looking at each segment of
text within a transcript and asking “what is this text about?” and “how is it similar and/or dissimilar to other segments of text?” In this way, each segment of text is inductively coded into succinct themes that summarise the key elements within the respondents’ accounts (Green & Thorogood, 2009).

Therefore, when transcription was complete, the researcher read and re-read the transcripts in their entirety to obtain an overall picture of the focus group discussions and to develop a list of themes emerging from the transcripts. Using this list, a coding key (see Appendix I) was developed that contained a list of each theme and to describe how the transcribed text was to be assigned. Coding of the transcribed text was facilitated by the use of an electronic spreadsheet, in which each segment of text was categorised into themes, as per the coding key. A review of each coded theme and its associated text, both separately and in combination with the other themes, allowed the researcher to refine, expand or collapse the themes that emerged. Before analysis was complete, feedback about the emergent themes was also sought from staff at Napier Street and MacKillop (as described in the previous section, “community and participant feedback”).

Finally, by presenting extensive verbatim quotes in the result section of the current study, transparency of the analysis is provided (Yardley, 2000).

**Results**

The results are presented in different sections to reflect the various themes that emerged from the data. The first section examines the roles, duties, goals, joys and benefits that parenting brings. The second examines the difficulties and/or challenges associated with being a parent in Melbourne, while the third section presents other difficulties associated with life in Melbourne. Finally, the fourth section presents other results relevant to the study.
Section I: Roles, Duties, Goals, Joys, and Benefits of Parenting

This section presents the participant’s opinions, experiences, or salient issues relating to the roles and duties parents must perform, their goals and aspirations for their children, as well as the joys and benefits of being a parent.

A parent’s role and duty.

In African culture, the participants reported that it is traditional for the father to assume the role of breadwinner and not to actively participate in the day-to-day running of the household or the raising of children. In contrast, it is traditional for the mother to stay at home and look after the house and raise the children. The participants reported that it was a parent’s duty to provide children with a good upbringing. According to these participants, good parents protect their children and strive to meet their physical, emotional, and spiritual needs. They stated that parents are role models, and that they must set a good example for their children. Parents must also teach their children right from wrong and raise them as Muslims. They also stated that open communication with their children is a good strategy to stay in touch with what is going on in their children’s lives.

I have to look after my child very good. I have to look after his needs. I have to make him happy. And when he will be happy, also I will be happy (Napier Street, 3:45 mins).

To be a good parent, and a Muslim parent, I have to pass on my values and my belief to my child. So my child will be like me, or even better (Napier Street, 5:42 mins).

Importantly, most participants described some degree of success in providing for their children’s needs and wellbeing. However, two participants at MacKillop stated that in order to give their children the best upbringing they can, they would like
to take their families back to Africa so that their children can reconnect with their extended families and with their African culture, as well as to escape the negative influences found in Australian/Western culture (described in Part II).

**Aspirations and goals for children.**

Most of the following information was drawn from the Napier Street and MacKillop focus groups as these topics were not explored in great detail at Debney Meadows. All aspirations and goals expressed were generally endorsed by the other mothers present. Overall, participants hoped that their children would be happy, healthy, well-behaved, be good Muslims, obtain a good education, get married, and generally lead successful lives. It was also very important to them that their children maintain their African and Islamic heritage. Each goal is explored in turn.

**Behaviour and religion.**

The mothers stated that they want their children to be well-behaved, know right from wrong, respect and obey their elders, be polite and caring, and follow Islam. Specifically they would like their children to read and know the Qur’an, and importantly, abstain from using drugs and alcohol, and not engage in intimate or sexual relationships before marriage – both of which are strictly forbidden by the Qur’an.

Religion is very important because it is like you know, it tells the child, this good and this is bad, you know. Like if you see the drink we, we are not allowed, the drug we are not allowed, you know. ....And we would like them to obey the parents, to be nice to the neighbour you know, to be nice to everyone, you know to care for each other (Napier Street, 5:06 mins).
Education.

All participants agreed that educating their children was important. However, in terms of the professions they would like their children to pursue, the mothers at Napier Street and MacKillop revealed that they would like them to pursue professions like medicine, nursing, or engineering. However, the mothers at Napier Street also stated that this choice is best left to the children themselves. One participant also acknowledged that not all children have the desire or inclination to pursue these professional roles, while another acknowledged that money and prestige does not always bring happiness.

In terms of their choice [about vocation] when they grow up, it’s up to the child (Napier Street, 6:45mins).

Integration.

The participants at Napier Street explicitly stated that they were happy for their children to adopt positive aspects of Australian culture, but that it was important to maintain their African/Islamic culture. However, the positive aspects of Australian culture were not explicitly articulated by participants.

We want him to take the good things of Australia, and the good things of our Islam. We want him to be a human being, to respect everyone, and to appreciate Australia, where he lives, so this is what we want... (Napier Street, 26:09 mins).

Daughters – education, domestic duties, marriage and family planning.

Participants also expressed specific hopes and goals relating only to their daughters. The MacKillop participants also specifically stated that they wanted their daughters to complete their education before getting married. The participants reported that this goal is a departure from traditional Somali parenting practices.
However, they explained that once married, the pursuit of education must stop so that their daughters can meet the commitments associated with raising a family.

Interpretation: 

…Because marriage means, you cannot, you cannot continue the study, marriage means like a prison. You can’t do anything after marriage.

Participant: You can’t. You can’t. If you get married, you be a mum, you stay home, you have a baby, you see your husband coming back.

(MacKillop, 35:38 mins).

The Ethiopian participants at MacKillop also reported that mothers are particularly relieved when their daughters get married because it means that they can “keep their daughters”. This term was explained to mean that once married, mothers are relieved because they no longer have to be responsible for their daughters, and that marriage provides “safety” for their daughters. However, safety from what was not described. Another participant also stated that she would like her daughter to get married when she is a little older because this would enable her to start her family straight away, rather than use contraception. This mother stated that she is opposed to contraception.

**Parenting joys and benefits.**

Being a parent was also described as a positive and rewarding experience. Participants described the experience of motherhood as a blessing, and as a rewarding and positive experience. They described being very proud of their babies, that they enjoyed showing them off, and one participant believed that it was only by having children that a female truly becomes a woman.
First I was very happy in the world. I was young when I become a mum and I remember my mum. I was very excited. I didn’t believe God he give me this all. Thanks be to God. I am very happy (MacKillop, 14:18 mins).

Children were also commonly described as an asset which helped the mothers cope with loneliness and other difficulties in their lives. They reported that speaking with and playing with their children helped them to forget their problems, and also provided them with company.

Even if he is a child [i.e. her son], you speak with, you have fun with him. Too many things together you know, you don’t feel the hard time, you know. Happiness. There is a special happiness (Napier Street, 11:48 mins).

One mother also jokingly, but sincerely claimed that without the company of her children, she would have gone crazy with loneliness.

In general, participants with pre-school aged children (i.e. those at MacKillop and Napier Street) provided more positive, detailed and passionate responses when answering questions related to the joys of motherhood. In contrast, participants with school-aged children did not spend as much time talking about this aspect of parenting and instead, quickly moved the topic of conversation to the difficulties associated with raising adolescents and teenagers.

**Section II: Parenting Challenges**

This section presents the various parenting challenges that the participants experienced while raising their children in Melbourne. Three main parenting challenges and eleven other parenting challenges emerged from the data. The three main parenting challenges are examined first.
Main parenting challenges.

The three themes emerging as the most salient issues negatively impacting upon the participants’ experience of parenting in Melbourne were related to (a) the separation and loss of their families and support networks, (b) difficulties with discipline and fears about child protective services, and (c) Australian/Western influences and acculturation fears. These challenges were categorised as the participants’ main challenges as they were either identified as such by the participants, by the amount of time devoted to discussing these issues, and/or by the level of expressed emotion accompanying these discussions. The three main parenting challenges are examined in turn. A summary of the main challenges and the suggestions proposed by participants to overcome these difficulties are presented in Table 2.
Table 2

*Main Parenting Challenges, Associated Subthemes and Suggestions Provided to Address These Challenges*

<table>
<thead>
<tr>
<th>Main parenting challenges</th>
<th>Subthemes</th>
<th>Participants’ suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separation and loss of social supports</td>
<td>40-day post-natal support</td>
<td>Promotion of family reunification programs</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>Longer stays in hospital after giving birth.</td>
</tr>
<tr>
<td></td>
<td>Altered family roles</td>
<td>More medical and social supports after hospital discharge</td>
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<td></td>
<td></td>
<td>Increased social supports</td>
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<td></td>
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<td>Mental health support</td>
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<td></td>
<td></td>
<td>Religious coping</td>
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<tr>
<td>Discipline and child protective services</td>
<td>Family/community support</td>
<td>Promotion of family reunification programs</td>
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<tr>
<td></td>
<td>Smacking</td>
<td>Culturally appropriate and sensitive support and information about child behaviour, and effective discipline strategies</td>
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<td></td>
<td>Child Protection Fears</td>
<td>Information about child protection</td>
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<td></td>
<td>Family dynamics</td>
<td></td>
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<tr>
<td></td>
<td>School Teachers</td>
<td>Parenting programs</td>
</tr>
<tr>
<td>Australian/Western influences and acculturation fears</td>
<td>Assimilation</td>
<td>Increase cultural awareness about African culture and increase awareness about Islam. Promote and celebrate differences</td>
</tr>
<tr>
<td></td>
<td>Sexual relationships</td>
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<tr>
<td></td>
<td>Homosexuality</td>
<td>Support families resolve the cultural dilemmas they face.</td>
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<td></td>
<td>Drugs and alcohol</td>
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<td></td>
<td>Television</td>
<td>Encourage open and honest lines of communication between parents and children</td>
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<td></td>
<td>School</td>
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<tr>
<td></td>
<td>Teenage issues</td>
<td>Send children to Islamic schools</td>
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<tr>
<td></td>
<td></td>
<td>Return to Africa to raise children</td>
</tr>
</tbody>
</table>
Separation and loss of social supports.

The most prominent and overwhelming response provided by participants from each focus group about the difficulties associated with raising children in Melbourne was their separation from their family, friends, and community. They described missing their family’s love and support every day, and expressed intense feelings of grief and loss. Participants reported feelings of intense grief when their children asked about their grandparents, and lamented the fact that their children will never have the opportunities to develop meaningful relationships with grandparents, cousins and other extended family.

Plus also you feel lonely when you’ll be by yourself. Your mum, your sister, or you don’t have a neighbour here. You feel very lonely, not only helping you in your life and everything or and stuff. But you feel very lonely. You need always the culture, you need your sister, or with your mother, and you need that love (Napier Street, 15:20 mins).

The participants generally described child-rearing back in Africa as easier, more enjoyable and rewarding due to the community-wide approach to caring for and disciplining children. In contrast, child-rearing in Australia was described as an isolating and unsupported experience. The participants made it very clear that without their family, friends and community, parenting is considerably more difficult, and at times, extremely distressing for them.

I wish I had my kids back home before I came here with my family…Before, I had two kids back home with my family before I came, and I get a lot of help from mother, sister, and neighbour. And I have two kids in here after I came and it was a bit difficult for me….The two that I had back home before I came, I
never felt like I have. But the two that I had in here by myself...it was very hard
(Napier Street, 30:03 mins).

Even participants who were fortunate enough to have some family in Australia
revealed that the level of support and assistance they received was now compromised
because their families often lived very far away, or were too busy working, studying,
or running their own households.

You have someone here like home, not like back home. Because now, my sister
she’s loyal, very nice, but she go to school, she go to university, she go to
work…so she doesn’t have time, even if she tries to help me, she comes home
very tired, so it’s very difficult for her even if she wants to help me. It’s not like
back home. Back home, you have many people who can help you (Debney
Meadows, 23:57 mins).

40-day post-natal support.

Participants from all three focus groups also spent a considerable time telling
the researcher about the customary 40-day post-natal, intensive emotional and
practical support provided to mothers in Africa following the birth of a child. These
participants reported that after a birth, family and friends assume all responsibilities
for the house and baby, with the exception of breast-feeding. This enables the mother
to rest and recover while others take care of cooking, cleaning, washing, nappy
changing, and baby bathing. The mothers also explained that being involved in this
supportive process is an important way that young females learn the skills to care for
babies. However in Australia, this custom cannot be replicated due to the mother’s
diminished social networks. As a result, the post-natal period in particular was
described as a difficult and distressing experience.
I thinking about mum and my sister...and somebody you help you, you know.

You do everything by yourself. The time is going is breakfast, but you have to feed her before you eat breakfast. If somebody was [there for] you, they would bring it for you if you’re feeding. You can’t here. And I was crying, crying, crying (MacKillop, 18:13 mins).

*Maternal Depression.*

Experiences of depression may also be a common experience for refugee mothers after their arrival to Australia, as this issue was raised by several participants at Napier Street and Debney Meadows. The participants explained that depression for them was a consequence of their separation from family and friends. At Debney Meadows, one participant stated that the intensive, 40-day post-natal support traditionally received plays an important role in a mother’s well-being, and that without that support, Somali mothers in Australia are more likely to develop post-natal depression.

Participant A: Someone will do all the jobs for the baby. Someone will prepare the food, you just rest.

Participant B: You’re not allowed to do anything.

Researcher: This is a good custom!

Participant A: No post-natal depression in Somalia

Group: [Group agrees with previous statement].

Participant A: People have a lot of support, bringing a lot of gifts, visiting…

Participant B: The neighbours are always helping each other.

Researcher: Do you know mothers who have depression here in Australia after their baby?

Group: Yes… [Group discussion continues in Somali]
Two Napier Street participants from Eritrea also revealed that they had, or were currently struggling with depression. However, they reported that they had felt better after regularly attending social groups, such as playgroup, and after speaking with doctors.

I was very lonely, I didn’t know any people, and I was very stressed, and I wanted to leave. I was saying whenever someone comes, I am leaving next week. But people they would say no because I am just new, because the situation is different, a few months, a year you will be good. And then after that I am OK. Now I am OK. Playgroup coming, similar every week I come here, change (Napier Street, 48:52 mins).

The mothers attending Napier Street had openly discussed issues related to depression with the researcher on various occasions before the focus group was held. In one such discussion, one mother told the researcher that she had noticed that the one-year-old son of a depressed mother she knew very rarely smiled, and was often unresponsive to other people around him.

*Altered family roles.*

The participants reported that in Africa, a husband’s role is traditionally confined to being the family’s breadwinner. However, given the participant’s diminished social supports, their husbands now find themselves obliged to assist their wives, especially after the birth of a baby. Not only must they help tend to the new baby, but must also look after their other children and assist with the domestic chores. Although the participants reported that they are highly appreciative of their husband’s help, they also indicated that this support is not equivalent to the support they are used to from their mothers, sisters and other friends. Unfortunately, no information was
provided to illustrate how their husbands might view, or be coping with these altered roles and expectations upon them.

**Participant solutions/suggestions.**

As the participants generally considered separation from family as their number one difficulty, the participants suggested the government could help refugee parents by further promoting family reunification programs. Participants reported that travelling back to visit their families is a financial impossibility for most refugees. Therefore, the only other option available to them involves sponsoring family to migrate to Australia. However, as one participant explained, she had been trying unsuccessfully for years to bring her sister and six children to Australia. She reported that the process was stressful, extremely tedious, and very disappointing when the process ultimately failed.

To help combat the challenge that mothers face in the immediate aftermath of giving birth in Australia in the absence of their families, one participant from MacKillop suggested that it would be very beneficial to allow mothers to stay in hospital for at least five days after giving birth. This mother also suggested that extra medical and social supports after leaving hospital, such as more nurse visits, would be extremely helpful.

Although none of the participants reported that they had consulted with a mental health professional, one participant described the availability of psychological services as a valuable service, especially for those refugee mothers who do not have anyone else to talk to.

In the absence of family, the participants suggested that socialising with other people from their communities is a great way to combat loneliness, pass the time, and learn about what life in Australia can offer them. Participants also generally agreed
that playgroups, and other women’s social groups, were great ways to meet others and socialise. The Napier Street participants reported that word-of-mouth is the prime way that African mothers hear about these groups. When times are particularly difficult, participants also reported drawing strength from their religion, indicating the importance of religious affiliations with coping.

**Difficulties with discipline and fears about child protective services.**

The next most important parenting challenge related to difficulties with discipline, and fears about involvement from child protective services. While mothers with school-aged children were much more likely to report actual difficulties managing children’s behaviour, those with younger children were extremely worried about their children developing problem behaviour in the future. However, all participants reported holding fears about child protective service involvement. The participants described several factors which they believed contributed to bad behaviour and problems with discipline. These included: (a) reduced support from family, friends and the community in the supervision of and discipline of children; (b) not being allowed to smack their children; (c) fear of child protective services; (d) changes in family power dynamics; and (e) influences from school. Together, these issues decreased the joy in being a parent and contributed to a sense of failure in, or loss of confidence in their parenting abilities. Each theme is examined in turn.

**Lack of family/community support.**

The participants explained that in Africa, it is not uncommon for children to spend many hours playing outside while their parents attend to other responsibilities. As a result, extended family, neighbours, friends, and even strangers step-in to supervise and discipline children they see who are at risk of getting into mischief or
danger. As a result of the separation from these support networks, the amount of supervision and discipline that these parents must undertake is significantly increased. However, this burden now falls mostly upon mothers, who are the children’s main caregivers in Australia.

Adjusting to this change has been difficult. Mothers reported that parenting is very tiring. They are fearful of letting their children play unsupervised outside because no-one will step in to keep their children safe or out of trouble. As a result, their children are kept indoors much more than they would like them to be, but feel like they have no other choice. The mothers expressed much sorrow that their children are not able to enjoy the same kind of freedoms to play that they themselves experienced as children.

Our children, I mean, back home we have a lot of freedom. Children play outside freely, and sometimes, if they do something wrong you will expect anything, like strangers to discipline them, tell them to stop that and maybe smack them. And there is nothing wrong with that. I mean we don’t get upset about that. But here, it is totally different environment. Here [the children are] locked up in the house, and they don’t have as much freedom as we have. And sometimes we feel sorry for them (Debney Meadows, 48:23 mins).

**Smacking.**

Participants reported that smacking is a very common and widely accepted discipline strategy used in Africa to teach children right from wrong. They also reported that smacking is endorsed by the Qur’an, as long as parents use it in a responsible way. However, different norms about acceptable disciplinary practices are a source of much distress for African parents now living in Australia. Participants
reported that they have been told that smacking is against the law, and had been
warned that smacking will result in children being removed from their care.

…if my child do something, at least I can smack him, and it is normal back home. And it will scare him so he will not do something wrong … But in here, if you smack your child, straight away, he call authorities (Napier Street, 17:33 mins).

Indeed, participants from Debney Meadows personally knew families who have had children removed by protective services. Some participants reported that laws against smacking have left them only with limited and ineffective strategies, such as yelling, when their children require discipline. One participant reported that she feels like she yells all day and this significantly reduces her enjoyment in parenting. However, others revealed that they utilise a range of other punishment strategies, such as sending children to sit in corners, sending them to their rooms, and taking away privileges.

*Child protection fears.*

Participants reported that stories about families having their children removed have caused widespread fear and distress within their communities. Their fears about child protection are further compounded by the belief that social services do not care about the children they remove, and do not look after them – allowing them to get up to mischief or get involved with drugs.

… The police what he do? Me, I kinder than the police for the kids. The police no kind about children, yah! When he listen in the children court, the police he come and take the children. Where he put the children? Outside for the better? He make him good? He not make him good! Just he take him out of the house and leave him outside! Maybe he makes drugs, maybe he makes anything not
good. And the police after, they say “doesn’t matter, he's not my kid.” But if they're your kids, you can look after him, about you, not got drugs...

(MacKillop, 1:15:55 min).

Some participants also described feeling victimised by the Department of Human Services, because the authorities do not trust them to be good parents.

I remember one day when I was cooking and some oil spat out of the pot and hit the child and child protection questioned it (Debney Meadows, 1:05:00 mins).

One participant at MacKillop was very upset about what she considers interference from the State into her family’s private affairs. She believes that she should have the freedom to raise her children as she sees fit because she is the one who has the best interests of her children at heart. Others complained that the financial support given to children who are removed from families acts as an incentive for teenagers to lie to the authorities about abuse, in order to receive this money.

And sometimes you will see those children when they come here and get the information about child protection. They say “Ah, I get money. Centrelink will give me money, I am 16, I want my money”, and maybe most of them end up maybe outside of the house, I mean because they have that money and everything come from the clash (Debney Meadows, 1:20:33 mins).

Participants also explained that contributing to their fears about child protection is the lack of information given to refugee parents about the law and the role of child protection. However, others reported that the community is in fact bombarded with information about child protection, leaving them scared and confused.

Changes in family power dynamics.

Participants reported that refugee parents also experience intra-familial conflict caused by shifts in family power dynamics. They claimed that parents become
disempowered when children learn that threatening to call the authorities with complaints of abuse is an effective strategy to control their parents and avoid discipline. This has reportedly made some refugee parents too afraid to discipline their children at all.

Some people, he won’t tell big boys about something. He says, “No, no, I'm scared because when I tell him like that, he tell the police” (MacKillop, 1:30:06 mins).

However, attempts to exploit parents’ fear are not always successful. Some mothers described no problems calling their children’s bluff when they have threatened to call the police.

*School teachers.*

Some participants reported that Australian teachers are not strict enough with children and as a result, their children pick-up bad behaviour/manners at school which they then bring into the home.

He [the teacher in Sudan] not every day he hit, but the teacher he talk hard.

But here, the teacher not talk hard. He playing with the kids. And the kids think “this teacher not hit me, and not she talk with me hard, she is not cross with me, and me, I do anything I want”…And how the teacher let the kids! (MacKillop, 1:35:50 mins).

Participants also expressed disapproval about the way teachers instruct children to call 000 if their parents “do anything to them that they do not like” as they feel this undermines their authority at home.
Participant solution/suggestions.

The participants from Debney Meadows suggested that new-arrivals families could benefit from the provision of culturally appropriate and culturally-sensitive parenting support and information about child behaviour, and effective discipline strategies. Some of the participants at Debney Meadows reported that they had participated in and benefited from a parenting program run by their school and suggested that recently-arrived refugee parents would benefit from attending such programs. They also suggested that these programs could provide new families with clear and accurate information about child protection. One participant from MacKillop requested that authorities should recognise that she is a good person, and because she has her children’s best interests at heart, she should be allowed to raise her children as she sees fit.

Australian/Western influences and acculturation fears.

Participants across all three focus groups devoted considerable time discussing their worries and fears about some of the negative influences present in the Australian/Western environment. However, participants with the youngest children expressed a particularly strong fear that their children will reject their African culture and Islamic religion as they get older. Negative influences identified as particularly worrisome were associated with behaviours or lifestyles forbidden by the Qur’an, such as sex before marriage, homosexuality, and using drugs and alcohol. Participants stated that engaging in any of these activities would bring shame upon the family.

We are worried like, for our culture. And also, I am very worried because I want my child to follow part of my culture. Yes, I don’t mind if he follows the good part of Australian culture, but I want him to follow my culture, my religion. So I
am very worried about um, drug and alcohol and also a girlfriend (Napier Street, 20:54 min).

Inappropriate television content, as well as the aforementioned negative behaviour/manners picked up from school where also cited as particular Australian/Western influences that they did not approve of. However these mothers also recognised that negotiating day-to-day cultural differences must also be confusing and difficult for their children. They acknowledged that children must learn to reconcile a world in which very different expectations are placed upon them at home compared to school. To illustrate, a participant gave the example that African parents teach that it is rude for children to look an adult in the eye. However at school, teachers expect all children to make eye-contact and if they don’t, teachers believe that their children are being rude or that they must be lying.

Participants from Debney Meadows reported that families with refugee teenagers may also have a particularly difficult time adjusting to life in Australia. The participants explained that in Africa, teenagers generally enjoy more freedom, autonomy, and more responsibility than they do after their families move to their resettlement countries. In Australia, the participants reported that parents become more controlling than before, and in conjunction with the other resettlement challenges teenagers face (described in the “other parenting challenges” section), teenagers can become extremely unhappy. One participant at Napier Street reported that a friend of hers was forced to send her 14-year-old son back to Africa because he was unable to cope with the acculturation stressors he faced.

I have a friend she moved to Canada, and her son stay there for maybe two years… And after four months, he said I don’t want it, I want to go back [to Africa]. And they sent him, only him, older one, he was 13 or 14. Of course he
want the freedom. He doesn’t want to be controlled. Back there [in Africa] he feel like a man, you know. He was doing and he was helping, and he has responsibility. But here, the mother is controlling, "Where are you going?", "You have to come now!" (Napier Street, 57:20).

**Participant solutions/suggestions.**

A participant at Napier Street recommended that parents keep open and honest lines of communication with their children so that they can keep in touch with their children and the difficulties they may be facing while growing up in Australia. However, most participants requested that Australian organisations, in particular schools, increase their cultural awareness about African culture and about Islam, promote and celebrate these differences, and help children and their families resolve the cultural conflicts and dilemmas they may face. They also recommended that sending children to Islamic schools in Melbourne may help children keep in touch with their Islamic faith. However, concerns about the negative influences within the Australian environment were so great for one participant, that she had made plans to return to Sudan in order to raise her children where the environment is more acceptable to her (and maybe more accepting of her).

**Other parenting challenges.**

Other challenges and/or difficulties described by participants to impact negatively upon their parenting capacity and experiences, as well as some possible solutions are presented in Table 3.
Table 3

*Other Parenting Challenges, Associated Subthemes and Suggestions Provided to Address these Challenges*

<table>
<thead>
<tr>
<th>Other parenting challenges</th>
<th>Subtheme(s)</th>
<th>Participants’ suggestions</th>
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<tr>
<td>Activities for children</td>
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<td>Funding for safe community activities</td>
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<td>Toy libraries</td>
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<td>Parent-child interactions</td>
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<td>Education</td>
<td>Homework</td>
<td>More educational support funding</td>
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<td>Academic support</td>
<td>Home schooling</td>
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<td>Children not progressing at school</td>
<td>Increase the number of apprenticeships</td>
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<td>Life skills training</td>
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<td>Teenagers</td>
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<td>Interpreters</td>
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<td>Health nurses at school</td>
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<td>Fatigue</td>
<td>-</td>
<td>Family support</td>
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<tr>
<td>Childcare</td>
<td>-</td>
<td>Family support</td>
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<tr>
<td>Language problems</td>
<td>Homework</td>
<td>More support for learning English before arrival</td>
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<td></td>
<td>Reliance on children</td>
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<td>Government support</td>
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<td>More support that is culturally-sensitive</td>
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<td>Adjustment to motherhood</td>
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<td>Employment</td>
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<td>Family support</td>
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Activities and entertainment for children.

Problems associated with the provision of appropriate and stimulating activities and entertainment for children were raised by participants across all three focus group settings. Problems associated with the affordability of toys, and difficulties finding appropriate playmates were raised by participants with younger children. The MacKillop participants also described their children as being a lot fussier about toys than they ever were, and have found that their children not only demand expensive toys such as PlayStations and mobile phones, but that they also tire of them quickly.

Participants with older children raised challenges related to the lack of space indoors, as well as the difficulties they had coming up with ideas, other than television, for indoor entertainment. They also felt that their children were not safe playing outdoors in their community environment, and complained that there were no community-based activities for their children to participate in. The parents worried that their children were more likely to get into mischief if they played outdoors.

They are kind of left out, there's no youth activities around here usually. So if the children are not given the opportunity to do all that stuff, the freedom that we had back home, they will do something else. They will make their own activity... But they have nothing to do. They are at home, what are they going to do? It’s just you and them. Yeah there’s nothing to do, so it is hard (Debney Meadows, 49:41 min).

Participant solutions/suggestions.

The Debney Meadows participants requested that youth activities, such as soccer for boys and basketball for girls, be provided in the community so that the children will not only have something to do, but parents can feel comfortable in the knowledge that their children are safe and are being supervised. Although not raised
in the focus group, prior informal discussions with the Napier Street participants revealed that the mothers were regularly accessing the local toy library and valued the benefits that this service offered parents.

**Parent-child interactions.**

Participants at Debney Meadows reported that in Somalia, children generally spend a large part of their day away from their parents playing outside. However, in Australia refugees generally live in smaller homes with no private outside spaces. Therefore, these Somali families have found that they are spending much more time together than they are accustomed to, and some participants have found adjusting to the increased child-parent interactions particularly challenging. According to these participants, this is a bigger problem for new arrival families who have older children, whereas families who arrive with younger children have a much easier time adjusting and overcoming these challenges.

Like, in back home, we didn’t have like, to sit our parents and to talk to them. In here, it’s only you and the kids and you're locked in the house. And we don’t have experience for that communication…In here now, the kids are coming and talking to you. And you think, “Hey, what are they doing?” (Debney Meadows, 52:43 min).

**Education.**

Problems associated with education were raised only by participants at Debney Meadows. These issues related to problems associated with homework, resources for academic support, information about the Australian school system, and the school adjustment issues experienced by refugee teenagers. The participants reported that parents with school-aged children feel inadequate because they are unable to help
their children with homework or with any other school issues because of their limited English and unfamiliarity with the Australian school system. One participant was particularly anxious because she had recently received news that her child would not be progressing onto the next school level, and utilised time in the focus group to seek advice from the other participants about what she should do.

So the parents really struggle when they see their kids struggling. You can’t help. You don’t have the language, and you have just come to the country. That’s the thing (Debney Meadows, 1:27:26 mins).

The Debney Meadows participants were also unhappy about the level of educational support that schools generally offer refugee children.

There’s a lot of schools that don’t even have a teacher’s aide. The one my children go, they don’t have teacher aide. There’s no one there. They ask me to translate some of the newsletters (Debney Meadows, 1:33:49).

They complained that even though some schools do provide multicultural aides and community development workers, there is not enough funding or resources for these workers to meet the needs of all the refugee families at the school. They clearly stated that this lack of funding disadvantages refugee children and their families.

You can see that they are very disadvantaged. And they need this. It’s not their fault. I mean, they need this, they need that and the government is not supporting them. What do you do? …The only thing we can do is help them ourselves. (Debney Meadows, 1:30:55 mins).

The Debney Meadows participants also reported that refugee families who come to Australia with teenage children face particular parenting challenges. As education is one of the greatest aspirations refugee parents have for their children, parents do not cope well when their teenage children drop out of school.
The children will come like 17 or 16, and maybe not have enough schooling or never had any schooling back home or in the refugee camp. They come here and maybe six months or one year in the language centre and… [cannot decipher]… the children will get confused, the children will see themselves that they are not preforming well at school, they will drop out, then the mother or the parents will see that their children are not going to school, and that they are under-performing, that they are not doing well. They will say, they will think that they should be performing like the others who were at school from Prep. And they will blame that child. The child gets confused and drop out. So it’s hard for those children at that age… (Debney Meadows, 1:19:12 mins).

Participant solutions/suggestions.

The participants requested much more educational support such as more multicultural education aides and homework support. Participants suggested several ideas that may help ease the burden on refugee teenagers and their families. These included government resources that would enable them to be schooled at home, or programs to assist teenagers secure apprenticeships that will be more likely lead to future employment opportunities. Another participant suggested that teenagers should not be sent to school straight after their arrival, but should be given time to adjust and offered programs that teach teenagers and their families the basic, day-to-day survival skills required, such as how to use public transport and how/where to go shopping, before considering sending them to school to learn maths and science for example.

Healthcare.

Problems associated with the quality of medical treatment was also raised by a participant at Debney Meadows who reported that she did not receive sufficient
medical support and that doctors did not adequately communicate with her about what was causing her baby to cry non-stop for four months.

I took the baby to the hospital and I said “I can’t help this baby, so can you help me?” Then they told me back, and take him back and just feed him … But he didn’t stop and I used to cry a lot and I didn’t know what to do. And I couldn’t get any help (Debney Meadows, 37:36 min).

A similar problem was recounted in an informal discussion with an Eritrean mother from MacKillop. She claimed that medical staff in a hospital emergency ward ignored her and her sick child, and that staff failed to organise an interpreter for her. Her baby did not receive any treatment and this mother was still visibly upset by the experience.

Participant solutions/suggestions.

Participants stressed the importance of providing refugees with interpreters at hospital. At Debney Meadows, participants described the health nurse stationed at the school to specifically assist new arrival families with health issues as a fantastic initiative, and suggested that all schools would benefit from a school-based health service.

Fatigue.

Raising children was described as very tiring and demanding. One mother reported that she is constantly running around after her daughter and finds very little time to rest. Another reported that only when her children are asleep does she find time to relax, but overall there was not enough time to rest.

One day maybe, or one hour, you be nicely with the baby. Everybody they know if you be mum. Yeah. One hour, two hours [of quiet] you be happy with that. (MacKillop, 56:38 min).
However, the participants noted that being a parent gets easier with subsequent children because they learn about being a parent, and thus, there is less anxiety involved about the process. Complaints about fatigue were often made in the context of missing their families and support networks and thus indirectly suggested that problems with fatigue could be alleviated by promoting family reunion programs.

**Childcare problems.**

Only participants at Napier Street and MacKillop referred to difficulties associated with the cost and availability of childcare. They explained that because refugee families do not have extended family to mind children when they need to run errands, they often need childcare services. They also complained that childcare facilities do not always have spots available, especially at short notice.

Yeah it is hard. For example, yesterday I went to do the, to get, what is it called, the childcare. But, my husband he is outside, I am by myself, no one is near me, but there is no childcare…There is no childcare, but I like to go, like I have to go to CentreLink…It is a long process, you know. If you don’t have family, it's hard…if you have a child you have to deal with him…(Napier Street, 13:45 mins).

Although the participants were grateful for the childcare rebates available, the cost of childcare was still too expensive for them to utilise as often as they would like. Therefore, participants indirectly suggested that childcare availability and costs could be improved, and that childcare problems could be alleviated by having their families with them, and thus, again advocating for family reunion programs.
**Language problems.**

The participants at Debney Meadows were the only group to link problems with their English language proficiency to problems with parenting. These participants asserted that children take advantage of their limited English to manipulate and lie to them in order to get their way.

Participant A: And especially, a lot of parents don’t have the language. The kids play the role that they can tell what they want to their parents.

Participant B: The children are a little bit cheeky

Group: Yeah [laughter all around] (Debney Meadows, 1:18:40)

However, participants across all three settings described language as one of the main obstacles to adapting to life in Australia. Participants reported that learning English is difficult and that it takes much courage to speak in front of native English speakers. Participants suggested that refugees should be supported to learn as much English as they can before their arrival.

**Government support.**

Participants from Napier Street and MacKillop provided glowing reviews about the parenting assistance, services and facilities they had accessed and received in Australia. These included being happy with interpreting services, Health-Care cards, the Medicare system, baby-bonus payments, rebates for day-care and child-care services, courses offered at child and maternal health centres, visits from maternal child and health nurses, playgroups, financial assistance, supports for single working mothers, as well as breastfeeding and nappy changing facilities in shopping centres. The Napier Street participants also rated the assistance they received in Australia favourably compared with those offered in other countries. However, a participant
from Napier Street also stated that although there were sufficient services available
for refugees in Australia, many refugees did not access or utilise them. Unfortunately,
she did not provide details about possible barriers to access or offer any suggestions
about how access utilisation could be improved.

In contrast, participants from Debney Meadows were much more critical of the
government support they and other refugees received and described feeling
abandoned by the Australian Government.

…There is really no help at all. The government brings people here, but then
you are by yourself (Debney Meadows, 34:30 min).

While participants from Debney Meadows acknowledged that the support provided to
Somali refugees had improved significantly since they had arrived (on average about
twelve years ago), they also stated that support had steadily declined in recent years.
One participant who had previously lived in the Netherlands considered Australia’s
support as significantly inferior to the case-management support she had received
there.

Yes, for all refugees, you have a social worker who is going to lead you, show
you for the while you settle down in that country. For the schooling, for the
shopping, everything. I remember that girl took me everywhere. Even if I say I
want to take my sisters for a holiday, like to go the museum, she came and she
took me there. But here there is not that kind of help available. Not even for the
basic help, show them how to shop, how to go to hospital… (Debney Meadows,
35:25 mins).

Another participant at Debney Meadows reported that the sponsorship program
allowing refugees to bring family to Australia was also flawed. She explained:
My brother sponsored me from the humanitarian program. So my brother had to show us everything. But he was studying, he was working…[remainder of discussion obscured]… (Debney Meadows, 32:15 mins).

This participant went on to report that she felt that she had been left to fend for herself after her arrival because although sponsors are supposed to provide new arrivals with orientation, accommodation and financial assistance, sponsors are often so overwhelmed with their own problems and commitments that they do not adequately meet the needs of these new arrivals. Another participant was particularly vocal about the lack of support for new arrival refugee families. She explained that the settlement challenges refugee families must face are too immense for most, and unequivocally stated that it was the government’s lack of support for refugees that was the cause of refugee teenagers, for example, ending up on the wrong side of the law.

Participant solutions/suggestions.

The Debney Meadows participants insisted that more support was necessary for refugees. However, they did not provide specific examples of how they could be better supported other than stating that recently-arrived refugee families should be made a priority and implying that more comprehensive case-management support could be helpful. Participants at MacKillop expressed a wish for services to be delivered in more culturally-sensitive ways and stated that this could be achieved by gaining a better understanding Islam and African culture.

Adjusting to motherhood.

One participant at Napier Street reported that she thoroughly enjoyed life as a single woman. However, with the added responsibilities that becoming a wife and a mother entails, she lamented that she is no longer able to be carefree and socialise
with her friends as often as she would like. Other participants concurred and explained that this was a common complaint for mothers with young children.

**Employment.**

Only one participant at each of the playgroups identified themselves as working mothers. In contrast, most participants at Debney Meadows were involved in some form of paid employment or knew many mothers who were. Those not working reported that it was very difficult to juggle the demands of parenting and participate in the workforce at the same time. One could not comprehend how someone could juggle being a mother and a worker.

Yeah I think how they do it, some people that can explain to us they do job, and they have a baby, they study. And some people they work … and everything. I just want to know how they do it! (MacKillop, 37:09 mins).

However, one participant indicated that there may be a stigma attached to being a working mother in African culture. She stated that if a wife wants to work outside the home, it must mean that she is not happy in her marriage. Therefore, some refugee mothers may not actually want to be employed outside the home.

**Section III: General Settlement Challenges/Difficulties and Other Issues**

Other challenges and/or difficulties associated with life in Australia not directly related to parenting challenges, but may negatively impact their parenting capacity and experiences, were also raised.

**Unfamiliar environment.**

Challenges raised by participants at all three focus groups related to the difficulties associated with navigating and negotiating their new and unfamiliar environments. The participants described feeling scared and helpless upon their
arrival. A high level of distress was associated with not knowing where to go to buy food. Participants reported spending full, whole days sourcing the ingredients and equipment needed just to make one meal. Recognising food items was made impossible because they were unable to read packaging labels, or because the spices and food looked and smelt differently.

When I came to Australia, I was feeling like a new born baby...because everything was new...even the people looked scary to me...not like a normal human...I was scared because of the people. Because when you don’t speak the person’s language, it is different how you communicate. It was very difficult for me when I first came. I remember I used to cry a lot. Because in Australia, it was cold, raining all the time, we didn’t have Somali interpreters at that time when we came, and we didn’t have a lot of shops, a lot of people, so if you missed something, even we didn’t know what to buy (Debney Meadows, 26:11 min).

Unfamiliarity with the public transport system and with trains in particular, also placed some participants in near-fatal situations. One woman described a harrowing experience at a railway-crossing because she had never encountered boom-gates before. In addition, some participants reported that the transition from rural to urban or city living can be particularly difficult.

**Participant solutions/suggestions.**

The mothers at Debney Meadows advocated for government assistance in the form of an orientation-like program and case-management support for new arrivals to help them navigate their new world, including teaching families how to get to the places they need to go, where to buy essential items, and to provide them with the information they may need to settle successfully in a new country. A MacKillop
participant also suggested that it was important for new arrivals to try and take things slow in the beginning, and not to expect too much of themselves or their environment because adjusting takes time.

**Racism and discrimination.**

The participants provided various examples of discrimination and racism experienced while living in Australia. Participants described being spoken to disrespectfully, of people hanging up on them after hearing their strong accents on the telephone, and being ignored when they have asked for help. They also felt that they had been discriminated against by service agencies and believed that the Australian government was racist.

There is always racism and discrimination between communities, even in service, not only in the government or the people here. There is always, but it’s very little (Napier Street, 44:28).

However, this issue may be more widespread than alluded to in the focus groups because the African Community Support Worker at Debney Meadows reported that she receives many complaints about discrimination, and that advocacy makes up a large portion of her work. Participants at Napier Street also reported that they are deeply shocked upon learning that some Australians believe Muslim men have up to four wives, and that it is normal for Muslims to beat their wives and children. They also reported a strong concern about the growing public perception that Muslims are terrorists. Although distressing, the participants at Napier Street reported that they try to ignore instances of discrimination and try to correct incorrect beliefs about Islam.
Section IV: Other Results

Participant satisfaction and turnout.

All participants stated that they enjoyed participating in the focus groups. At the conclusion of the focus groups, participants lingered for up to 30 minutes to talk with the researcher, drinking coffee, and eat the remaining food. At Napier Street, the participants stated that they should bring coffee to playgroup every week. One of the interpreters also attempted to arrange an additional focus group with the researcher so that the Eritrean mother’s group she belongs to could also contribute to the current research.

However, not all reports were positive. One participant at the Napier Street focus group did not stay for the whole session, and the researcher heard indirectly through the playgroup facilitator that this participant felt that the participants were not being totally honest about the extent of their difficulties in Australia.

Five mothers from MacKillop who had informed the researcher that they would attend did not show up on the day of the focus group. However, discussions with the playgroup managers revealed that attendance at playgroup was often variable and is related to the weather, the health of their children, and other commitments that invariably emerge.

Community feedback on preliminary analysis results.

A summary feedback report with the study’s key findings was prepared for the community leaders and managers/Principal at the participating organisations for comment and review. The playgroup managers reported that the results showed good face validity, and were consistent with the stories and experiences they had observed or learned about from their refugee clients. The managers agreed that in their
experience, separation from family was the central issue causing distress for their refugee clients, and that family reunion is a major priority for them. The participants’ fears associated with child protection, the importance of safe outdoor activities, and more support for education were also endorsed as important issues.

The playgroup managers also reported that they felt that no other major issues, other than problems associated with domestic violence were missing from the report. The Napier Street manager explained that in her experience, it is culturally inappropriate to discuss problems about domestic violence in an open forum. However, she was surprised that the participants discussed depression because in her experience, the mothers always “put on their happy faces to attend playgroup”.

The feedback the managers/facilitators received from participants regarding their involvement in the focus groups was positive. They stated that participants enjoyed the experience and appreciated the free childcare, as it gave them the opportunity to talk without having their children present - which is a very rare occurrence for these mothers.

Discussion

Summary of Major Findings

The first aim of the current study was to obtain a greater understanding of both the positive and negative aspects to parenting experienced by refugee parents while raising their families in Melbourne. The second aim was to elicit participant suggestions about how they could be better supported to meet their parenting needs. Together, this information was used to better inform and generate ideas for service supports and mental health prevention and promotion initiatives to improve the mental health and wellbeing of refugee parents.
This study has demonstrated that qualitative methodology, using focus groups and thematic content analysis can be used to provide insight and identify salient issues relating to refugee parenting experiences in Melbourne. This approach was also useful in eliciting participant suggestions about how clinicians, agencies and policy makers can better assist refugee parents effectively negotiate the challenges they face, and thus improve their mental health and wellbeing.

**Positive aspects of parenting.**

Despite many difficulties, participants revealed much strength and much resilience in their parenting roles. Participants described competently carrying out their traditional parenting roles, and that they were also flexible enough to make adjustments to these roles when necessary. For example, participants reported that husbands now contribute, and take over the children’s care when necessary, and some wives have found employment outside of the home. Importantly, participants described successfully providing for their children’s physical, emotional, spiritual, and social needs, and providing them with opportunities to promote their wellbeing and success in life.

These results are important because to the researcher’s knowledge, this study represents the first instance in which the positive aspects of refugee parenting have been explored and documented, and represents the first instance in which parenting issues have been explored in recently-arrived refugee parents to Melbourne. Previous research with refugee parents has focussed mainly on parenting challenges and problems (e.g., Lewig et al., 2010), or with settlement problems in general (e.g., Casimiro et al., 2007; Valtonen, 1999). In addition, these findings highlight the notion that refugee parents, like most parents irrespective of their culture and experiences, also aim to promote the survival and health of their children, teach their children the
skills that are necessary to survive economically and to encourage the attributes that are valued by their culture (LeVine, 1988).

**Challenges associated with parenting.**

The second aim of the study was to learn about the parenting challenges that refugee parents experience while raising their families in Melbourne. Underpinning effective interventions for parents, and for indeed any target group, requires an understanding of the group’s experiences, strengths, challenges, and needs (DHAC, 2000). Therefore, this study goes some way into providing this information.

Participant responses indicated that refugee families face immense challenges in Australia. While the following three main challenges were reported; (a) the separation from their extended families and social supports; (b) difficulties with discipline and fears related to child protection; and (c) fears about Australian/Western influences and acculturation, there was also a significant number of other challenges reported touching upon almost all aspects of life. Interestingly, the main parenting challenges found in this study were also described by Lewig et al. (2010) in their sample of refugee parents who had been involved with child protective services in South Australia.

Regarding separation from extended family and social supports, these findings are consistent with other research reporting separation from family and friends as one of the greatest source of distress amongst refugees (e.g., Miller, Worthington, et al., 2002). Kamalkhani (2001) explains that refugees may not be able to relax or enjoy their freedom while knowing their loved ones continue to face danger and uncertainty. Moreover, the non-refugee parenting literature consistently reports that access to family support is an important protective factor. For example, it has been shown to support effective parenting (Crnic & Acevedo, 1995), to protect mothers against post-
natal depression (Lee et al., 2007), and that support from grandparents for example, can help protect children growing up in high-risk environments from adverse outcomes (Jack, 2000). It was also apparent that these participants conceptualised problems with depression and post-natal depression, in terms of their separation from family and community. This conceptualisation explaining mental distress has also been described by other refugee researchers (e.g., Guerin et al., 2004).

Regarding the difficulties associated with discipline and fears about child protection, these findings are also consistent with other refugee parenting studies (Israelite et al., July, 1999; Lewig et al., 2010). However, difficulties with discipline are not unique to refugee families. For example, in a national survey of the child-rearing needs of parents with young children in the United States, 42 per cent of the 2017 parents interviewed requested more information about discipline (Young, Davis, Schoen, & Parker, 1998). In addition, Dybdahl and Hundeide (1998) interviewed 20 Somali mothers living at home in Mogadishu and also reported that problems with child disobedience were common.

Importantly, participants in this study appear to be misinformed about Australia’s discipline laws. Although “reasonable” corporal punishment in the home is lawful throughout Australia (National Child Protection Clearinghouse, 2010), these refugee parents believe that all forms of physical discipline is against Australian law. This misunderstanding may have arisen from the ambiguity in the law about what constitutes reasonable punishment. Alternatively, for simplicity and maybe to err on the side of caution, family workers may have informed these refugee parents that physical discipline is unlawful, full-stop. However, the misunderstanding may have also arisen because family workers and parenting websites generally oppose all forms of physical discipline, stating that it is not effective, that it teaches children that
violence is an acceptable way to get what you want, and that it negatively impacts upon children’s behaviour and emotional development (e.g., Raising Children Network, 2009). However, further research is required to understand what refugee parents understand about the law and why.

In the context of discipline problems and misinformation about the law, fears about children being taken away by child protective services are understandable. However, this fear also seems to be a common problem for many refugee parents living other Western countries. For example, Israelite et al. (July, 1999) also found reports from refugee mothers living in Canada of being victimised by child protective services, and of children using threats to call authorities about abuse to control their parents. Therefore, it is also possible that as a consequence of their refugee experiences, these parents may be extremely sensitive to any threat that could separate them from their children. For example, they may have seen families separated during their stay in refugee camps, and some may have come from countries where children had been taken from parents to fight wars.

Fears about the negative Western influences on children have also been reported by other refugee and migrants parents. For example, Bouma and Brace-Govan (2000) reported that female Muslim immigrants to Australia also felt the need to protect their children from Western ideas, fearing for the moral safety of their children. In focus groups conducted with 21 Somali refugee women resettled in Canada, mothers revealed that they were also worried about the negative influence of Canadian culture, and were very uncomfortable with the behaviours their children had developed (i.e., swearing) since their arrival (Israelite et al., July, 1999). And finally, Lewig et al. (2010) reported that refugee parents were concerned about losing their influence over
their children, and that in some instances, this fear was great enough to consider returning to their country of origin - as was found in the current study.

Other important parenting challenges described by participants in this study involved difficulties related to the lack of affordable and appropriate toys, a lack of safe activities for their children, difficulties adjusting to increased child-parent interactions, education problems, healthcare problems, fatigue, affordability and availability of childcare, English language problems, adjustments to motherhood, difficulties with access to and other problems with support services, and employment challenges. Many of these challenges raised have also been reported by other recently-arrived refugee parents.

For example, Somali parents in Canada have also complained that their children have nowhere safe to play outside, and that the education system was not sensitive to their needs (Israelite et al., July, 1999). In addition, lack of English language competency has also found to be a major stressor for Muslim refugee women living in Perth (Casimiro et al., 2007), although these participants did not link their lack of English competency with parenting problems. However, some of these challenges are not unique to refugee mothers. For example, fatigue is a common problem reported by mothers across all strata of society (Esdaile & Greenwood, 1995).

General challenges to resettlement, such as negotiating one’s way in an unfamiliar environment and experiences of racism and discrimination, were also described by participants in this study. These are consistent with the refugee literature reporting on post-settlement stressors (e.g., Davidson, Murray, & Schweitzer, 2008). Although not directly related to parenting practices, these challenges may have an impact upon an individual’s ability to parent effectively because of the stress they cause. Parental stress in low SES families has been shown to affect interactions
between parent and child because it may lead to the over use of negative control strategies, low warmth, low responsiveness, and failure to adequately monitor children (McLoyd, 1990; cited in Bradley & Corwyn, 2002).

Importantly however, this study uncovered parenting difficulties that have not been reported in any other refugee parenting research. For example, to this author’s knowledge this is the first time that refugee mothers have described difficulties related to adjusting to a different way of interacting with their children because of the extra time that these families are now forced to spend with each other. Although this issue was only discussed briefly, it clearly warrants further attention in future research in order to ascertain the extent of this problem and whether refugee parents could benefit from some support in this area.

**Participant suggestions.**

The final aim was to elicit the participant’s ideas about how services could better meet their parenting needs. Asking refugee parents directly about what they consider helpful is a major strength of this study. It is crucial that input from the most important stakeholders is obtained because effective service delivery depends upon having a good fit between the needs of the client and how the client would like these needs to be met (Department of Human Services, 2009).

Given the gravity or the impact of the three main challenges to parenting identified, it was not unexpected that these areas attracted the greatest number of participant suggestions to address them. In addition, because the Debney Meadows participants generally described feelings of frustration with the level of support offered to refugees, it was also not unexpected that they would be the most vocal and enthusiastic to offer possible intervention/support suggestions for recently-arrived refugee families.
The stark differences in the number and intensity of participant suggestions offered by participants from the primary-school setting versus the playgroup settings may be explained by a number of factors. First, it may be related to the level of funding and availability of services for disadvantaged families found within the different settings. Indeed, according to the MacKillop and Napier Street managers, services for disadvantaged families in the Fitzroy and Footscray areas are much better resourced than those in the Travencore area. However, it is also possible that the different responses reflect the different parenting challenges facing these participants. For example, the Debney Meadows mothers generally had a greater number of children who were also generally older than the children of their playgroup counterparts. Therefore, the challenges experienced by mothers who have a greater number of children and who are old enough to go to school may be more stressful than the challenges facing mothers with fewer and younger children who are not yet attending school. However, in order to substantiate these theories, further research is required.

**Practical Implications**

The suggestions provided by participants in this study can be used as the basis to inform and generate a list for mental health prevention and promotion initiatives aimed at refugee families.

**Cultural awareness.**

It is important to highlight that for all interventions proposed in this section, particular attention must be paid to incorporating a culturally-sensitive and strengths-based approach. Many participants requested that government services and the education system, in particular, be more culturally-sensitive. Enhanced cultural
awareness is more likely to ensure that culturally-sensitive practices are implemented that improve access to health education, and human services by NESB and refugees (e.g., Hamden, 2002). In contrast, offering services that are not culturally-sensitive is likely to alienate refugee parents. Therefore, improving cultural awareness and supporting culturally-competent practice amongst school-teachers and other practitioners who provide services to refugee families should be prioritised.

**Intervention priorities.**

Given how strongly participants felt about the three main parenting challenges identified in the current study, interventions targeting these problem areas may have the greatest positive impact upon the wellbeing of refugee parents and their families. They are therefore described as intervention priorities and are presented first. Intervention ideas based on all other participant suggestions will follow.

**Enhancing social supports.**

Overwhelmingly, the most salient parenting challenge facing refugee mothers stems from their separation from families and other social supports. Without their families, parenting is made considerably more difficult, and at times, is extremely distressing for them. Therefore, a mental health promotion strategy could involve making family reunification programs a priority and altering Australia’s migration policy to prioritise family reunion for refugees and/or increase its humanitarian intake. Reuniting families would help put minds at ease about the fate of family left behind, help to alleviate loneliness and depression, and also go a long way in easing the challenges they experience as a result of raising children alone. Indeed, one could consider family reunification a panacea for these participants, not only for addressing
their many parenting challenges, but for improving their well-being in a more general sense.

The results of this study also highlight the role that friends, community, and social groups play in promoting the well-being of refugee parents. Participants suggested that a greater promotion of social networks could be an alternative to family reunion. Not only do social networks reduce loneliness and promote information sharing, it would provide refugee parents with a sense of community and connection to their new home. Playgroups appear to be particularly effective at achieving this. The researcher noted that playgroup attendees were a tightly-knit group who were supportive of one another, and who shared a great deal of practical and emotional support. Therefore these findings suggest that promoting and funding more social groups, such as community playgroups in areas with high refugee populations should become the focus of a greater number of mental health prevention and promotion initiatives.

To cope with the lack of family support after giving birth to a child, participants also suggested that longer stays in hospital, and extra maternal and child nursing support after leaving hospital would be extremely helpful. Therefore changes to health policy and increased funding to maternity care system are encouraged in order to reduce the risk of these mothers developing mental health problems such as post-natal depression. Looking to international maternity care models such as the Dutch system, in which “kraamverzorgende” (or post-partum caregivers) workers are made available to support mothers and families in the postpartum period (Benoit et al., 2005) could help to inform new health policy initiatives.

The study findings about the importance of social networks to refugee families may also have important implications for mental health promotion initiatives aimed at
housing. All new arrival families should be settled in locations that allow them to easily link in with other members of their community.

**Parenting support and child protection information.**

Information on effective ways to discipline children was requested by refugee mothers with older children. Participants reported that the parenting program they had attended at Debney Meadows Primary School were very helpful and advocated for similar programs to be offered to all recently-arrived refugee families. This is particularly important given that Lewig et al. (2010) reported that notifications of suspected abuse and neglect are increasingly being received by Australian child protection authorities for families from refugee backgrounds.

Therefore the culturally-sensitive parenting programs such as those delivered at Debney Meadows primary school should be delivered on a larger scale. In addition, resources that are written in various languages (and which are tailored towards different cultural groups) which contain information about effective ways to communicate with children, and information about alternative strategies to manage behaviour could be distributed to all refugee families. However, it should be remembered that these parents may need support over an extended period of time to allow them time to change habits and resolve the difficulties they encounter.

Fears about children being removed from their care were also compelling. It became apparent that refugee parents are misinformed about Australian law regarding discipline and participants reported feeling victimised by authorities. Therefore, accurate information about the role and function of child protective services, parent rights, and the law should be disseminated as a priority. However, further research may be needed to ascertain where refugee parents are getting their information about
the law and corporal punishment, and how this information may be better communicated to refugee parents.

**Tackling acculturation issues.**

In response to their fears about the influences of Australian/Western culture on their children’s behaviour and moral principles, participants requested support to help their families negotiate the challenges that acculturation may bring. Children often acculturate quicker than their parents, and this can be a major source of intergenerational conflict. Therefore, parenting programs could be used as a forum to tackle this, while agencies serving refugee parents could play a major role in educating new arrivals about the social and community services systems available to help refugee parents and their families integrate more harmoniously into their new surroundings.

Participants suggested that family/community agencies and schools in particular, are well-placed to assist them resolve their families’ cultural conflicts and dilemmas. Participants suggested that these organisations could help to achieve this by increasing their cultural awareness, and by promoting and celebrating diversity so that their children are not ashamed of being different from their mainstream Australian peers. As per participant suggestions, refugee parents could also be encouraged to find ways to keep open and honest lines of communication with their children – information about which could be included in the aforementioned parenting programs.

**Other potential interventions.**

Although the aforementioned parenting and family-focussed interventions could have a greater positive impact upon the wellbeing of refugee parents, all suggestions
provided by the participants should be considered and used to inform interventions to support these families. Again, incorporating culturally-sensitive and strengths-based approaches to these interventions is highly encouraged.

**Educational and vocational support.**

Providing their children with an education is a top priority for these refugee parents. Unfortunately, the participants reported that refugee children and families are not given enough support to succeed academically in Melbourne. Therefore, educational interventions are important avenues to pursue, especially given the well-established link between education and positive mental health (Ross & Mirowsky, 1999). The development of a national school policy to deal with refugee children’s complex and unique needs is therefore, urgently required.

In addition, it is also recommended that programs such as HIPPY (Home Interaction Program for Parents and Youngsters) should be developed and implemented. HIPPY is a home-based parenting and early-childhood enrichment program that supports early literacy development, pays close attention to parent-child interactions, and equips parents to support their children. It does not exclude parents with a low level of literacy, or those who have English as a second language (HIPPY Australia, 2010) and importantly, two evaluation studies indicate that it is an effective early educational intervention for refugee families (Dean & Lueng, 2010). Therefore, HIPPY programs may be a highly appropriate intervention for refugee parents who would like to provide homework support to their children.

The participants also requested more educational and vocational support specifically for refugee teenagers who have had little or no prior school experiences. Therefore, the education system could increase funding for education aides, run more homework groups, and extra classes specifically to cater to these children’s needs.
New programs informed by the HIPPY model could also be developed to cater to parents with older children. Alternatively, rather than placing refugee teenagers into mainstream education, participants requested a different pathway for these children, such as more funding for apprenticeship positions. Fortunately, the Changing Cultures Project (Bond et al., 2007) provides an excellent framework that could be used for addressing this issue. This project developed some excellent educational/vocational program interventions for refugee teenagers in Melbourne which resulted in very positive outcomes. It is therefore highly recommended that this project is expanded and continued.

Finally, given the limited education opportunities in refugee camps, Australia (and other governments) could also take a more pro-active approach by better addressing the educational needs of refugee children in camps, thereby increasing their chances of connecting successfully with the education system in resettlement.

Activities for children.

Young people require opportunities for socialising and playing for good mental health (Bond et al., 2007). However, participants complained of inadequate space for children to play in, both indoors and out, of limited organised youth activities, and described current community space as unsafe. Even though recreational facilities/activities are available in the wider community, it seems that more work could be done to make Australian sporting and other activity organisations more culturally-sensitive and inclusive. Therefore, it is recommended that more community-funded youth activities which are attractive to refugee children of all ages be organised as a priority.

Examples offered by participants included more soccer clubs and basketball groups to be funded and run by the local community. Expanding and/or promoting
local toy libraries for these families may also be beneficial. However, schools could also disseminate ideas to refugee parents about low-cost community-run activities/events for families and children, as well as ideas about home-based activities that children can play.

**Orientation programs.**

Although the Integrated Humanitarian Settlement Strategy (IHSS) provide settlement support to recently-arrived humanitarian entrants for six months (DIAC, 2010c) and the Complex Case Support (CCS) services provides intensive case management services to humanitarian entrants with exceptional needs for five years (DIAC, 2010b), the participants from Debney Meadows requested more assistance for recently-arrived refugee families. Therefore, the eligibility criteria, as well as the duration and effectiveness of services provided through the IHSS and CCS should be reviewed to establish how the Government may better meet the needs of refugee families. The CCS program could also be compared with programs in which individual case-workers are assigned to all refugee families, not just those with “exceptional” needs. In addition, settlement services could be made available to all individuals from a refugee-like background, not just those who arrive on a humanitarian visa.

**Healthcare.**

The findings from this study highlight the importance of offering interpreting services to all refugees seeking medical care. Although interpreting services are available at hospitals, two individuals complained that interpreters were not made available to them. As a result of communication failures, their sick children did not receive appropriate medical support. Therefore, research is needed to check whether
interpreting services are routinely being offered to refugees presenting for care at hospitals and other medical facilities. In addition, the provision of a school-based health service for new arrival families may also ensure that refugee families receive the health care they need.

The experience of giving birth to children in Australia was described as extremely difficult for these mothers. Participants requested more support from government in the post-natal period. As discussed previously, health policies could be amended to enable refugee mothers to stay longer in hospital, and funding for more home visits by post-partum caregivers, as occurs in the Netherlands, could be considered.

**Mental health and wellbeing.**

Problems associated with loneliness and depression were reported to the researcher, and by virtue of the number of participant fears and worries described, anxiety issues may also be relevant in this sample. Taken together with the reported prevalence of mental health problems in refugee populations, it could be deemed appropriate and beneficial for multi-cultural mental health workers to visit social groups, such as playgroups, to discuss and normalise feelings of loneliness, depression, and anxiety. Discussions about the negative impact that these mental health challenges can have on parenting, and the provision of information about where and how to seek help if they, or someone they know are struggling with these issues may also be helpful. Consultation with the refugee community is of course strongly advised when designing such a program.
English classes.

Problems with learning English were reported by participants even though free English language classes that provide childcare free of charge are offered through the Adult Migrant English Language Program (DIAC, 2010a). English language proficiency is a critical component of environmental mastery for refugee resettlement (Miller, Weine, et al., 2002). Therefore, research is needed to understand if and how refugee parents are utilising this service, and ways that may better enhance English competency in this group. The merits of other community programs that could teach English to refugees in more informal ways should also be investigated.

Childcare.

Government funding for childcare could be increased so as to allow refugee parents to carry out their day-to-day task more efficiently and to seek employment, should they desire. Increased availability of affordable childcare may be particularly important to refugee women without husbands.

Discrimination and racism.

Participants reported experiences of discrimination and racism in their daily lives, not only from the Australian public, but also from within service agencies. Experiences of discrimination and racism are strongly and positively associated with depression and anxiety in refugees (Gorst-Unsworth & Goldenberg, 1998; Pernice & Brook, 1996). Therefore, it is critical that all agencies audit and review their service delivery models to address any problems with racial and religious discrimination.

Religion.

Participants reported drawing strength from their religion during difficult times, and that it provides them with guidance in their parenting tasks. With more and more
Islamic refugees being resettled in Australia, providing space for prayer and places of worship will be important to this group’s wellbeing. Establishing more Islamic schools may also be beneficial for Islamic refugees. However, given the participant’s reported experiences with religious discrimination, it may also be helpful for the Government to concurrently develop community initiatives aimed at the Australian public to embrace and support religious diversity.

**Research method implications.**

This study is innovative in that using focus groups, it effectively explored the parenting experiences of refugee mothers living in Melbourne. Therefore, this study supports the use of focus group inquiry as an exploratory tool to better understand the factors influencing refugee parenting experiences.

**Theoretical Implications**

The current research is the first to examine the parenting strengths and challenges in a community sample of recently-arrived, refugee mothers in Melbourne. This is an area of important implications for the wellbeing of refugee families, and has largely been neglected in the parenting literature. Without an understanding of the parenting strengths and stressors experienced by refugee parents in Melbourne, it is impossible to adequately respond to their parenting needs.

Importantly, this study represents the first explicit examination of the parenting strengths in recently-arrived refugee mothers to Australia. The findings add further support to the notion that refugees are highly resilient. The participants revealed that they have been generally successful in meeting their children’s needs and were competently carrying out their traditional parenting roles despite adversities experienced. They also demonstrated an ability to adapt their parenting to local
demands. For example, fathers were also contributing to childcare, and some mothers have secured employment outside of the home. These findings also support theoretical models of parenting which posit that all parents, irrespective of culture, aim to promote the health and survival of their children, teach the skills necessary to survive economically, and to encourage the attributes that are valued by a particular culture (LeVine, 1988).

The findings also provide support for the notion that refugee parenting in resettlement countries is fraught with many difficulties. The main parenting difficulties reported related to separation from family, disciplinary practices, fears about child protective services involvement, and problems associated with acculturation. These difficulties are consistent with those reported by other refugee parents in Finnish and Canadian community samples (e.g., Degni et al., 2006; Israelite et al., 1999) and in one South Australian sample (e.g., Lewig et al., 2010). However, this focus group study also uncovered parenting challenges that have never before been reported in the refugee parenting literature. For example, the participants revealed that because of the extra time that these families are now forced to spend with each other, it has been a challenge for parents to learn different ways of interacting with their children.

**Limitations of the Study**

The results from this study can be considered to be reliable, as common issues were raised by participants in all three focus groups of the current study. The results can also be considered to be valid, as many of the findings are consistent with previous refugee research, and the findings were judged by the participating organisation’s managers and playgroup facilitators to have face validity. However,
this study has several limitations which should be considered when interpreting the results.

**Resources, research design and research method.**

Unfortunately, conducting research as part of a university doctoral program means that limited resources are available to student researchers. As data saturation was not achieved, it was clear that more focus groups were necessary to obtain data to reflect the breadth of this research topic, and therefore, conducting a greater number of focus groups would have enhanced the reliability and validity of the findings.

It also became apparent that due to the number of participants wanting to share their views and experiences and the extra time required for interpreters to relay this information, covering all research questions adequately proved ambitious. In addition, because the researcher was a novice focus group facilitator, this may have affected the quantity and quality of the discussions. It has been reported that novice moderators tend to ask questions that are confusing, complex, and difficult to analyse, and vary in their ability to direct discussion, and monitor verbal and non-verbal responses (Halcomb et al., 2007; Krueger, 1998).

As with any self-report measure, the focus group interview is also subject to self-report bias. Some research participants may intentionally or unintentionally “fake good”, or present themselves in a good light (Cohen & Swerdlik, 2004). Therefore some participants may not have reported challenges or difficulties they perceived to be embarrassing or socially unacceptable. This may have occurred in the current study, as one participant from Napier Street focus complained precisely about this problem. In addition, problems associated with domestic violence reported in other refugee studies (e.g., Lewig et al., 2010) were not raised in this study. However, it is
impossible to ascertain whether participants withheld information, and if so, to what degree.

**Sample size and sample characteristics.**

Twenty-one refugee mothers represent only a small sample of the total refugee parent population in Melbourne and therefore, this limits the generalisability of the findings. However, qualitative methods place less emphasis on generalisability, and instead aim for richness and depth of information by exploring the quality of participant experiences through meaning and process (Ambert, Adler, Adler, & Detiner, 1995; Barbour, 2000). Nevertheless, it is recognised that the characteristics of the sample were narrow, as only refugee mothers from four African countries took part in this study. It would have also been interesting to hear the perspectives from refugee fathers. Even though the researcher hoped to include fathers with a refugee background in this study, as refugee fathers did not attend the play-groups, it is clear that the recruitment strategies used in this study did not adequately reach out to fathers. Unfortunately, the mother’s perspective is often over-represented in parenting research as they are generally the main caregivers (Kolar & Soriano, 2000) and this study was no exception. The perspectives from refugee parents from other African nations and other regions of the world such as Asia, and the Middle-East would also enhance the validity of findings.

**Sample bias.**

The views and experiences of participants who volunteered in the study may also be different from those who did not participate. Non-participants may be experiencing greater difficulties, be too embarrassed to discuss difficulties in public, or talk about problems with a white, middle-class university researcher. Finally, the
sample was drawn from a community sample, and therefore, different results might be obtained from parents drawn from a clinical sample.

**Conclusions and Future Research**

This study aimed and succeeded in obtaining first-hand accounts about the parenting strengths, challenges, and suggestions for mental health promotion and prevention interventions for refugee parents living in Melbourne. Given the absence of this information from the parenting literature, these findings have significantly contributed to the cross-cultural and refugee parenting knowledge base. As a result, the information gleaned from this study can be used to inform the development of mental health promotion initiatives, as well as to inform policy and service provision reform by incorporating these perspectives and ideas into planning.

However, it must be recognised that these findings do not represent a complete account of the strengths, challenges and suggestions through which refugee parents and families can be better supported. Therefore, further investigations are encouraged. Investigations exploring the perspective of refugee fathers, refugee parents from other cultural groups and living in other locations across Australia are strongly recommended. In light of the new insights raised by the current study, further attention could also be directed towards exploring whether refugee parents are experiencing difficulties in their parent-child interactions, now that they are forced to spend significantly more time together than they are accustomed to. In addition, more detailed explorations about the way services and policy could be changed to better meet their needs would also be useful as some of the difficulties raised by participants were not always accompanied by corresponding suggestions for support or improvement. Interviews with practitioners who provide direct services to refugees
may also produce useful information about the ways service providers can make their programs more relevant, culturally-sensitive, and effective for refugee parents.

In summary, participants reported that they were happy to be living in Melbourne but that everyday life is made stressful by a multitude of challenges they must face. A mother’s well-being is integral to her families’ successful adjustment and overall well-being in resettlement (Goodkind & Deacon, 2004). Therefore, the parenting strengths and challenges and suggestions provided by these refugee mothers should be taken seriously and should be used to inform mental health promotion and prevention strategies, social and migration policy reform, and the way services and supports are delivered to recently-arrived refugee families in Melbourne.
Chapter 5: Literature Review - Interventions for Refugees

As highlighted in Chapter 2 and Chapter 3, research has shown that many refugees continue to report distress and mental health problems even after they have resettled to safer countries. A range of interventions have therefore been developed to alleviate this distress and to promote more successful resettlement experiences. Therefore, the aim of this chapter is to review the various mental health treatments, promotion and prevention initiatives utilised in resettlement countries to promote the wellbeing of refugees. It will be shown that currently there is very little evidence demonstrating that these interventions are effective with refugee populations. It will also be clear that the majority of refugee intervention research has focused on treatment interventions. Given the promise that mental health prevention programs have shown for other at-risk children, a strong argument will be presented for the urgent evaluation of mental health prevention program for refugee children who have recently resettled to Australia.

Mental Health Treatment for Refugees in Resettlement Countries

The extreme losses, stressors and traumatic experiences which are commonly endured by refugees unfortunately places their mental health at risk. As a result, clinicians have tried to develop treatments in order to relieve the psychological distress that some refugees experience. Therefore, this section presents a review of the various treatments for PTSD described in the literature. This will be followed by a review of treatments targeting other mental health disorders found in refugee populations. Randomised controlled trials (RCTs) which are generally accepted to be the gold standard test of an intervention’s effectiveness (Bisson, 2003; Rosen, Manor, Engelhard, & Zucker, 2006) will be reviewed where possible. However, since very
few RCTs have been conducted with refugees, other research designs such as non-randomised trials, uncontrolled pre-post trials, and case studies will be included. While these studies offer less-rigorous evidence of effectiveness, they do provide valuable information about the applicability and effectiveness of Western-oriented clinical approaches in the treatment of mental health disorders in refugee populations.

**Treatment of PTSD.**

A systematic review conducted by Crumlish and O’Rourke (2010) of RCTs involving treatments for PTSD clearly demonstrates that a solid evidence base for the effective treatment of PTSD in refugee and asylum seeker populations does not exist. This review also indicated that the majority of PTSD treatment interventions used with refugees include: trauma-focussed cognitive behaviour therapy, eye-movement desensitisation reprocessing, pharmacotherapy and narrative exposure therapy. The evidence behind each treatment modality is briefly described in turn

**Trauma-focussed cognitive behaviour therapy.**

Currently, trauma-focussed cognitive behaviour therapy (TF-CBT) is one of only two interventions recommended for the treatment of PTSD in the general population (National Institute for Clinical Excellence [NICE], 2005a). While CBT generally comprises a range of behavioural and cognitive strategies to help individuals recognise that behavioural and/or thinking patterns impact upon feeling states, thus encouraging people to develop alternative cognitive and/or behavioural coping skills to reduce the severity of symptoms and problems (NICE, 2005b), the focus of treatment in TF-CBT is placed on the memories and meanings of traumatic events. However, Crumlish and O’Rourke (2010) confer only cautious support for the use of TF-CBT in refugees with PTSD.
Only one RCT conducted by Hinton, et al. (2005) was rated to be of high enough quality to show support for the treatment efficacy of TF-CBT in refugee populations. Although three other RCTs utilising TF-CBT (i.e., Hinton et al., 2004; Otto et al., 2003; Paunovic & Ost, 2001) reported positive results in the treatment of PTSD among refugees, Crumlish and O’Rourke (2010) stated that because of methodological limitations which introduced significant bias into the outcomes of these studies, they were not of high enough quality to add support for this treatment modality.

Other TF-CBT refugee studies not included in the Crumlish and O’Rourke (2010) review because they involved case-studies (e.g., Basoglu, Ekblad, Baarnhielm, & Livanou, 2004; Schulz, Marovic-Johnson, & Huber, 2006) and small cohort studies without control groups (e.g., d’Ardenne, Ruaro, Cestari, Fakhoury, & Priebe, 2007; Schwarz-Langer, Deighton, Jerg-Bretzke, Weisker, & Traue, 2006) have also produced encouraging results. Although these studies add further support for the application of TF-CBT to adult refugees with PTSD, because of their uncontrolled designs, they cannot provide definitive evidence towards the relative efficiency of these interventions (Carlsson, Mortensen, & Kastrup, 2005).

To this author’s knowledge, only two studies showing promising but limited support for TF-CBT with refugee children have been published. These include a controlled study by Ehntholt, Smith, and Yule (2005) evaluating a group, school-based CBT program, and a detailed case-study describing the use of individual TF-CBT with a young refugee girl (Vickers, 2005).

**Eye-movement desensitisation reprocessing.**

Eye-movement desensitisation reprocessing (EMDR) is the second of two interventions recommended for the treatment PTSD (NICE, 2005a). EMDR is a form
of exposure therapy that utilises rhythmic eye-movements and other bilateral stimulation to help people suffering from traumatic stress restructure their cognitions and/or reprocess information (Corey, 2005).

Despite the extensive evidence base for EMDR in traumatised people of non-refugee background (NICE, 2005a), only one empirical study conducted by Oras, Cancela de Ezpeleta, and Ahmad (2004) has evaluated the effectiveness of EMDR with refugee children suffering with PTSD. Significant improvements in functioning and significant symptom reduction relating to PTSD, stress, and depression were reported. However, the lack of a control group, small sample size, use of mixed therapeutic methods, and the receipt of permanent residency for the families of seven children involved in this study limit the interpretation of these results. More research is required before the efficacy of EMDR can be established in refugee populations.

**Pharmacotherapy.**

NICE guidelines state that healthcare professionals should consider the pharmacological treatment for PTSD only after treatment with TF-CBT or EMDR shows no, or limited improvement (NICE, 2005a). Nevertheless, some researchers have suggested that there may be a place for pharmacological interventions with refugees. This includes instances when psychological interventions are unavailable, or when individuals are not prepared to initiate a talk therapy because of the severity of their symptoms (e.g., Crumlish & O’Rourke, 2010; Smajkic et al., 2001).

According to Crumlish and O’Rourke (2010), only two RCTs involving drug therapy in refugee populations have been conducted. The first study by Smajkic et al. (2001) indicated that pharmacological treatment with sertraline and paroxetine reduced the severity of PTSD and depression symptoms, and improved functioning in Bosnian refugees, but all participants still met criteria for PTSD at the end of the
study. The second study by Otto et al. (2003) reported that sertraline alone did not reduce PTSD symptoms in a group of 10 Cambodian women. Two further pharmacotherapy studies not included in the Crumlish and O’Rourke (2010) review have also been described (i.e., Boehnlein, Kinzie, Ben, & Fleck, 1985; Kinzie & Leung, 1989). Although the results of these studies indicated that symptoms of PTSD and depression were reduced, the studies were uncontrolled and pharmacological treatment involved concurrent psychosocial therapy. More trials are obviously needed in refugee populations to ascertain the effectiveness of pharmacological treatment of PTSD. No empirical studies investigating pharmacological treatment in refugee children could be located and therefore, no evidence for the pharmacological treatment of PTSD in young refugees currently exists (Ehntholt & Yule, 2006).

**Narrative exposure therapy.**

According to Crumlish and O’Rourke (2010), Narrative Exposure Therapy (NET) currently has the best empirical support of all the treatment modalities for refugees. NICE guidelines also state that NET is an encouraging therapy option for traumatised refugees (NICE, 2005a). NET is a psychological treatment that was specifically developed for the victims of organised violence living in insecure settings and who have limited access to resources and trained professionals to manage their care. NET is based on giving testimony, and exposure. During NET, all the stressful life events that a person has experienced are documented in chronological order from birth to the present day. However, during this process, NET incorporates a strong emphasis on graded exposure whereby individuals in the process of documenting their trauma are emotionally exposed to their traumatic memories for a sufficient amount of time to enable habituation to occur. Over the course of therapy, NET aims to reduce emotional responses to traumatic memories and at the end of the therapy, the
individual receives a copy of the completed testimony for their own private records (Gorman, 2001; Robjant & Fazel, in press).

Crumlish and O’Rourke identified four RCTs that demonstrate the superiority of NET over other non-active control groups and/or active treatment comparators such as supportive and trauma counselling, psychoeducation, and treatment as usual (i.e., Hensel-Dittman et al., submitted; Neuner et al., 2008; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004; Ruf et al., 2010). One further uncontrolled trial of NET which reported significant decreases in PTSD and depression scores between pre, post, and 6-month follow-up in adult refugee and asylum seekers living in Norway was also identified (Halvorsen & Stenmark, 2010).

In terms of NET treatment in refugee children, the aforementioned study by Ruf et al. (2010) constitutes the only RCT utilising KidNET, an adapted version of NET for children. This study demonstrated that KidNET can be an effective treatment for asylum seeking children with PTSD. Onyut et al. (2005) also provide further, albeit limited support for the effectiveness of KidNET. In their uncontrolled study, PTSD and depression symptoms decreased significantly at post-test and at 9-month follow-up in six Somali refugee children living in a refugee camp (Onyut et al., 2005).

It is interesting to note that NET shares many of the same components of TF-CBT including: (a) the use of exposure to habituate an individual to their traumatic memories; and (b) the techniques used to construct the traumatic narrative reflects a technique used in some CBT interventions (Crumlish & O’Rourke, 2010). However, there have been no trials directly comparing the effectiveness of NET and TF-CBT. This would make a very important and interesting research study.

Even with the limited number of NET trials conducted so far, NET has been shown to be a useful treatment modality with adult and child refugee and asylum-
seekers living in high income countries like Germany and Norway (Halvorsen & Stenmark, 2010; Hensel-Dittman et al., submitted; Neuner et al., 2010; Ruf et al., 2010), and in refugee camps (Neuner et al., 2008; Neuner et al., 2004; Onyut et al., 2005). Furthermore, NET has also been shown to be effective when it is administered by lay counsellors with limited mental health training. Together, these results indicate that NET is a promising psychological treatment for refugees with PTSD living in unsafe and poorly equipped conditions. This is particularly important, given that the majority of the world’s refugees live in such areas (Robjant & Fazel, in press).

However, all NET studies published to date have been led by the same research group and therefore, more research is needed to establish whether NET can be effectively disseminated by other groups.

**Treatment of depression and other disorders.**

Only a very limited number of empirical treatment studies specifically targeting mental health disorders other than PTSD in refugees have been published. For example, to this author’s knowledge, only one RCT has evaluated the efficacy of interpersonal psychotherapy (IPT) in the treatment of depression (e.g., Bolton et al., 2007). Furthermore, only one efficacy trial of a group-based group anxiety intervention could be located (e.g., Barrett, Moore, & Sonderegger, 2000).

In the study by Bolton et al. (2007), a group-based IPT program was compared with a creative play program and a wait-list control group in a sample of 314 adolescents living in two refugee camps in northern Uganda. The results of this study suggests that group IPT was more effective compared with creative play in reducing the symptoms of a local depression-like syndrome, but only in girls. It was not effective in reducing local anxiety-like syndrome or conduct problems in girls or boys.
In a pilot study with 20 clinically anxious teenage female refugees from the former-Yugoslavia, Barrett, Moore, et al. (2000) evaluated the efficacy of the FRIENDS program. The FRIENDS program is a ten-week CBT group-based anxiety intervention focusing on coping strategies for anxiety. In this non-randomised control trial, those receiving the intervention \((n = 9)\) reported significantly lower levels of anxiety at post treatment than those in the wait-list control condition \((n = 11)\). Although these findings are limited by the small sample size, participants rated the intervention as culturally acceptable.

Although empirical studies focusing on the treatment of GAD, simple phobia, conduct disorder, or somatisation disorder could not be located, the majority of PTSD treatment evaluations have also investigated secondary outcome gains related to depression, anxiety, panic, and somatisation. This approach has merit given the high level of co-morbidity found in refugee populations (e.g., Favaro et al., 1999; Marshall et al., 2005).

Of the aforementioned NET and pharmacological PTSD interventions which also investigated secondary outcomes related to depression, significant decreases in depressive symptoms have been reported in all studies (e.g., Halvorsen & Stenmark, 2010; Kinzie & Leung, 1989; Neuner et al., 2004; Otto et al., 2003; Smajkic et al., 2001).

TF-CBT interventions directed at PTSD have also reported promising secondary outcome gains on symptoms of depression, anxiety and somatisation. For example, Basoglu et al. (2004), Hinton et al. (2004; 2005), and Paunovic and Ost (2001) reported significant decreases in concurrent depressive and anxiety symptoms. In addition, Hinton and colleagues (2004; 2005) demonstrated that TF-CBT can also be effective in treating panic disorder, while Kruse et al. (2009) and Otto et al. (2003)
demonstrated that TF-CBT may have a positive effect on co-morbid somatoform disorders. In contrast, one study found no changes in levels of depression or anxiety in a six week school-based group TF-CBT intervention for children with PTSD (i.e., Ehntholt et al., 2005).

However, the Western-oriented, clinical treatment approaches described so far is only one way that clinicians in resettlement countries treat mental health problems in refugee populations. Specialised refugee service agencies for example, rarely offer the aforementioned treatment interventions in isolation, and instead offer a multi-disciplinary, community-based treatment approach that cater to the wide ranging psychosocial needs that many refugees require upon resettlement. School-based mental health services have also been established in an attempt to overcome some of the barriers to refugee children receiving treatment for mental health difficulties. These two different approaches are reviewed in turn.

Community-based models of intervention in resettlement countries.

Specialised agencies that incorporate treatment, promotion and prevention of mental health problems in traumatised refugees have been set up in Western nations to address the wide ranging needs of traumatised refugees. These include for example, the Rehabilitation and Research Centre for Torture Victims (RCTV) in Denmark, the Medical Foundation (MF) located in the United Kingdom, the Advocates for Survivors of Torture and Trauma (ASTT) in the United States, and the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) in Australia. These agencies specialise in working with survivors of torture and trauma to help them recover from their experiences and rebuild their lives in their resettlement countries.
A review of these agencies’ websites (e.g., ASTT, 2010; Foundation House, 2010; MF, 2010; RCTV, 2010) reveal that their approach to mental health involve addressing the physical, mental, emotional, and spiritual needs of refugees in culturally-sensitive ways through the provision of psychological support, medical consultation, case management, advocacy, and other programs for individuals, families and groups. Part of their work also involves training and educating the community and service providers, and providing advocacy to ensure that government policies are sensitive to the needs of refugees. Through the broad range of services that these agencies offer, it is clear that they recognise a diverse set of needs for traumatised refugees.

Agencies such as these that have a long history of providing services to traumatised refugees, have accumulated and disseminated a vast amount of clinical wisdom through publications and training, and are much respected for the services they provide (National Child Traumatic Stress Network [NCTSN], 2005). However, very little research on the effectiveness of community-based models of interventions have been reported. Only one evaluation study conducted by the RCTV in Denmark could be located. The RCTV reported that after eight months of multidisciplinary treatment, the mental health symptoms and health-related quality of life did not change in a group of 55 Middle-Eastern traumatised refugees (Carlsson et al., 2005). Although eight months might be too short a time to expect any changes in the mental health in this sample, it highlights the necessity for outcome evaluation research, so that more effective interventions can be identified.

The paucity of outcome evaluation research from these specialist agencies has been widely criticised (e.g., Basoglu, 2006; Birman, et al., 2008). However, it is encouraging to see that these agencies are attempting to address this issue by
gathering and operationalising their practice-based evidence. This is to be encouraged because it can objectively document the mental health care that has been delivered to refugees in these settings. For example, Foundation House, the Victoria branch of FASSTT, has announced on its website that it is currently undertaking a major project to produce evidence about its service delivery outcomes (Foundation House, 2010). The NCTSN has also announced plans to do the same and will initiate a data collection protocol across all of its agencies providing services to refugee children (NCTSN, 2005).

Despite the lack of empirical evidence of the efficacy of their work, it is likely that these specialist organisations do produce some effective outcomes as they have accumulated a great deal of wisdom with respect to their work. Nevertheless, the steps now being taken to better describe, identify, and understand which intervention components and approaches are the most effective will undoubtedly serve the long term goal of developing evidence-based interventions for traumatised refugees (NCTSN, 2005).

**School-based mental health services.**

Recognising that many psychologically distressed refugee children do not obtain appropriate mental health interventions, O’Shea, Hodes, Down, & Bramley (2000) established a mental health service within a primary school in London. Teachers at the school identified and referred 14 refugee pupils with psychological difficulties to a child and adolescent mental health service (CAMHS) worker who visited the school one afternoon per week. A range of psychological and family interventions addressing issues of loss were offered and a CAMHS worker also liaised with the school staff and other professionals such as the family’s GP.
This service was evaluated using an uncontrolled pre-post test design, and although some children showed dramatic benefits and that most families engaged in the program quickly and found the service useful, the overall reduction in the children’s symptoms, as assessed by the Strengths and Difficulties Questionnaire (SDQ) was not statistically significant. Nonetheless, school-based mental health services such as the one described show promise in that they appear to be acceptable to refugee families, and thus may improve access for refugee children.

In a further attempt to support refugee children and to obtain evidence for the utility of mental health services located in schools, Fazel, Doll, & Stein (2009) established another school-based mental health service in Oxford, London. Using indigenous white children and children from non-refugee ethnic minority groups as controls, the service was also evaluated to determine whether such a service could address the psychological needs of refugee children. Results from the SDQ completed by the children’s teachers revealed that refugees had poorer overall adjustment at baseline but at post-test, their hyperactivity scores had decreased significantly more than those in the control groups. In addition, refugee children who had received a direct clinical intervention from the mental health service also showed an improvement in their peer problems scores.

The studies by O’Shea et al. (2000) and Fazel et al. (2009) are the only published study investigating school-based mental health service designed specifically for refugees. Nevertheless, they indicate that mental health services located in alternative locations such as schools may benefit vulnerable refugee children. School-based mental health service may improve access to these services because many refugee families do not follow up with referrals to traditional mental health service settings, possibly because of the stigma associated with these services, and possibly
because they are reluctant for their children to miss educational opportunities if they must remove them from school to attend (Hodes, 2000). However, further studies are necessary to establish the efficacy of school-based mental health services for refugee children, especially in countries other than the United Kingdom.

**Mental Health Promotion and Refugees in Resettlement Countries**

Interest in mental health promotion initiatives aimed at refugee populations is also attracting attention. Rather than preventing illness or treating current symptoms of illness, mental health promotion is concerned with promoting well-being and fostering those conditions or environments which support good mental health (WHO, 2010). Mental health promotion is applied to entire populations and tries to reach all people, including those who are currently well, at risk, and experiencing illness. Therefore, mental health promotion initiatives are relevant before, during and after the onset of mental health problems (DHAC, 2000).

A strong link between good mental health and physical health, peace, stability, and success has been strongly established in the general population (Keleher & Armstrong, 2005; WHO, 2005) and therefore mental health promotion initiatives tend to target these domains. As a result, organisations other than those in the traditional mental health sectors are required to be involved in such programs (DHAC, 2000) and often include strategies such as advocacy, policy, project development, legislative reform, and communications (Keleher & Armstrong, 2005; WHO, 2005).

Promotion efforts aimed at supporting and improving the mental health of refugees have been developed at both the international and national level. Arguably, one of the most important international mental health policy initiatives, in which Australia played an integral role in developing, was the drafting of the Universal Declaration of Human Rights (UDHR; United Nations General Assembly, 1948). The
UDHR is an international agreement whereby signatories agree to respect, fulfil and protect basic human rights at all times (WHO, 2005). These rights include the right to life, liberty, free speech, equality, privacy, and health, as well as education, economic, social, and cultural rights. Freedom from fear, torture, and persecution, as well as the right to seek asylum are also included in the UDHR. These human rights support health, peace, stability, and success, all of which underpin good mental health (Keleher & Armstrong, 2005; WHO, 2005). The UDHR is a powerful mental health promotion tool because it can encourage international diplomatic action when Governments or States violate any of its articles (Joyce, 1978). In matters relating directly to the status of refugees, the UDHR has been used by the UN to urge its State members to improve the legal status of refugees residing in their countries (Joyce, 1978).

On a more local level, VicHealth has developed a mental health promotion framework to address the following key socioeconomic determinants of mental health (a) social inclusion, (b) freedom from discrimination and violence, and (c) access to economic resources will lead to improved mental health (Keleher & Armstrong, 2005). This framework has been recognised both nationally and internationally, and has been adopted by WHO as part of its general framework for mental health promotion (Woodhouse, 2010). Importantly, it has also been used to promote the mental health of refugees living in Australia.

For example, mental health promotion efforts aimed at promoting social inclusion for refugees include the development of “The Ambassador”, an African community newspaper established in 2004 by the Horn of Africa Community Network. This newspaper is published in six different languages including Arabic, Amharic, Oromo, Somali, English and Tigrinya. The Ambassador not only provides
information about current events for African community such as concerts, exhibitions and festivals, but it also provides a platform where people from these cultures can share their views about various issues. In addition, the newspaper provides information about how to access services such as Centrelink, opportunities for work experience, and helps to train community members in various skills (Anonymous, 2008). Although no quantitative evaluations of the newspaper’s effect on social inclusion could be located, qualitative reports indicate that the newspaper has helped to build a positive African-Australian community identity (WHO, 2005).

Mental health promotion efforts in Victoria aimed at reducing discrimination and violence against all individuals, including refugees, involve a range of legislative initiatives such as The Multicultural Victoria Act 2004, The Equal Opportunity Act 1995, The Racial and Religious Tolerance Act 2001, and The Charter of Human Rights and Responsibilities 2007 (McDonald, Gifford, Webster, Wiseman, & Casey, 2008). Although the effects that these legislative changes have had on refugee mental health have not been evaluated, McDonald et al. (2008) importantly highlight that initiatives that address discrimination and racism are especially important in rural regions of Australia, where local populations are generally less likely to embrace diversity.

Other mental health promotion efforts aimed at improving access to economic resources include three rural refugee relocation programmes to Shepparton, Ballarat, and Mt Gambier. Unlike the other promotion initiatives reviewed here, these efforts have undergone some evaluation. Unfortunately, evaluations conducted 12-months after the commencement of each project have produced mixed results. While the Shepparton and Mt Gambier regional humanitarian settlement evaluations revealed positive indicators of settlement success for relocated Congolese and Burmese
refugees (Piper, 2007, 2008), the 12-month evaluation in Ballarat revealed some negative outcomes for the relocated Togolese refugees.

Various difficulties in the delivery of crucial settlement services were cited as the most significant factor in the program’s inability to meet the needs of these refugees (Piper, 2009). However, Ballarat’s high unemployment rate combined with the refugee’s limited vocational skills may have been the reason why many were unable to secure employment within their first year. These evaluations clearly highlight that to be successful, relocation settings must have the capacity and funding to deliver crucial settlement services, have staff with the appropriate training to work with traumatised refugees, and ensure that the locations selected have good employment opportunities.

Even though a range of mental health promotions initiatives targeting refugees in Australia have been conducted, many lack a sufficient evidence base of effectiveness. The evidence often lags behind because resources, in terms of funding and training, are not usually allocated for such evaluations to be conducted (Keleher & Armstrong, 2005). However, the strengthening of the evidence base for mental health promotion initiatives is urgently required so that policy and practice can be better informed (WHO, 2005).

**Mental Health Prevention and Refugees in Resettlement Countries**

While mental health promotion strategies focus on promoting healthier environments and encouraging healthier lifestyles, mental health prevention programs focus on reducing the risk factors and enhancing the protective factors that have been associated with mental ill-health (WHO, 2004). Despite these subtle, but important differences, mental health promotion and prevention strategies are complementary, often adopt similar approaches and produce similar outcomes (DHAC, 2000;
Herrman, 2001). Preventive interventions offer several advantages over treatment interventions. They can often be carried out by paraprofessionals in consultation with mental health professionals, and can be structured so they reach a large number of individuals (NCTSN, 2005). As a result, they also typically cost less than clinical treatment services, but unfortunately, they are often a lower funding priority for governments (Weine et al., 2003).

Nevertheless, many preventive programs have been developed to target a wide range of problems in the general population including for example, depression (Cardemil, Reivich, & Seligman, 2002), anxiety (Barrett & Turner, 2001; Feldner, Zvolensky, & Schmidt, 2004), alcohol misuse in young people (Foxcroft, Ireland, Lister-Sharp, Lowe, & Breen, 2002), and conduct disorder (Barlow & Parsons, 2004). However, very few of these programs have been validated for use with refugees. Nevertheless, some prevention interventions for refugee families and children have been described and these will be presented in turn with evidence for effectiveness, where available.

Preventive family interventions.

In the spirit of mental health prevention in which protective factors are enhanced, Weine et al. (2003) developed and evaluated an intervention called TAFES (Tea and Family Education and Support) for recently-arrived Kosovar refugee community in Chicago. This intervention was designed to encourage families draw upon their strengths and resources to cope under the stresses of displacement and to improve the families’ ability to obtain appropriate care for possible mental health problems. The TAFES intervention is a six-session, multi-family, group intervention covering salient family issues and dilemmas relating to mental health. In the TAFES evaluation, forty-two families engaged in the program and completed surveys. Results
indicated that participation in TAFES was associated with increases in reported psychiatric service use, as well as increases in perceived social support, trauma mental health knowledge, and family hardiness. Positive changes related to mental health attitudes were also reported.

Following these encouraging results, Weine et al. (2008) developed and evaluated the CAFES (Coffee and Family Education and Support) intervention in an effort to improve access to mental health service for Bosnian refugees with PTSD living in Chicago. Trained Bosnian refugee facilitators provided education and support to 110 Bosnian refugees suffering with PTSD and their families, over nine sessions. The results of the study indicated that CAFES significantly increased the level of access to mental health services compared with the control group families (n = 87) who did not participate in the intervention.

Two important lessons can be learned from the CAFE/TAFE interventions. First, multiple family group interventions show promise in encouraging those who would benefit from but would otherwise be unlikely to seek mental health services. Second, utilising multiple-family group interventions with refugee groups from collectivist and family-orientated cultures may be more effective than individual approaches because their formats may resonate more with the population (American Psychological Association, 2010; Murray, Davidson, & Schweitzer, 2008). However, randomised control trials with larger sample sizes and with different cultural groups are needed before firm conclusions can be made about the effectiveness of multiple-family group prevention interventions with refugees.

**School-based prevention programs.**

School-based interventions are popular because they provide a highly accessible environment where refugee children can be easily reached before mental health
problems develop or worsen (American Psychological Association, 2010; Betancourt, 2005; Fazel et al., 2009). In a review of the prevention programs that have been developed for refugee children, Rousseau and Guzder (2008) describe three categories of school-based prevention programs. The first category involves those providing professional development to teachers to improve their cultural competency and educate them about the unique needs of refugee children. Rousseau and Guzder assert that only qualitative reports about these interventions are available, and that these reports provide mixed results. For example, Rousseau and Guzder report that while some teachers become passionate advocates for refugee children and their families following professional development training, others can become overwhelmed by the information and by their limited skills in trying to meet these demands.

The second category of school-based prevention interventions described by Rousseau and Guzder (2008) focus on interventions that build relationships between the home and school. These interventions aim to empower parents, provide them with an opportunity to learn about their children’s settlement experience, and share any concerns they might have about their children with the school (VFST, 2002). Although likely to impact upon the children’s home/school environment in a positive way, no empirical evidence has been collected to support the efficacy of these approaches.

Finally, the third type of prevention intervention reviewed by Rousseau and Guzder (2008) involve school-based prevention programs intended for the refugee children themselves. Of these programs, the most prolifically mentioned in the refugee literature include the Pharos Schools Programs and various creative expression programs. The evidence for these and other school-based refugee prevention interventions identified by this author will be briefly described in turn.
Two school based programs for refugee youth have been developed by The Pharos Foundation for Refugees and Health (Pharos) in the Netherlands (Pharos, 1997). Each program was developed to cater to the developmental level of elementary, and high-school aged children. Both Pharos programs consist of eight sessions which explore issues and themes pertaining to the children’s past and present, identity, daily life in the Netherlands, family, school, social relations, and values. According to Ingleby and Watters (2002), qualitative feedback about the programs has been positive. They also claim that in as yet unpublished studies, quantitative evaluations of the Pharos program indicate that the programs have a positive effect on children’s sense of belonging and on the number of health complaints they report. In addition, another research project is currently underway to develop and test this program with refugee students in the United Kingdom (Ingleby & Watters, 2002). However, outcome results of this study are also pending.

Creative arts therapies are considered by many to be a useful way of working with refugee children to help them construct meaning and identity (Rousseau & Guzder, 2008) – especially for those who are too embarrassed, resistant, or do not have the necessary language skills to talk about their past. In addition, some believe that creative therapy techniques such as storytelling may be especially appropriate for children from cultures with strong storytelling traditions (NCTSN, 2005). As a result, prevention interventions utilising art and other expressive therapies are widely implemented with refugee children however, as a general rule, their efficacy has rarely been evaluated (NCTSN, 2005). An exception to this general trend is the creative therapy programs led by Cecil Rousseau, who has conducted and evaluated several creative programs with refugee students in Canada.
For example, Rousseau, Drapeau, Lacroix Bagilishya, and Heusch (2005) evaluated a 12-session, creative expression workshop program run by an art therapist, psychologist, and teacher involving 138 refugee children (aged 7-13 years) in two separate primary schools. The program combined verbal and non-verbal means of expression (drawing, painting, storytelling or writing) to encourage children to make sense of their pre-migration and migration experience; to foster reciprocal respect about cultural differences; and to bridge the gap between home and school. Pre-test and post-test data were collected from the children and from their teachers. At the program’s end, significant increases in self-esteem and reductions in emotional and behavioural problems were detected in children who had participated in the program, compared with controls.

Rousseau et al. (2007) also evaluated a 9-week drama therapy program with 136 adolescent refugees (aged 12-18 years) attending high school. The program uses playback theatre, a type of improvisation, which aims to achieve personal and social transformation through the sharing of a theatre experience. Pre-test and post-test data from participants and teachers revealed no improvements in self-esteem or emotional and behavioural symptoms. However, participants reported lower levels of impairment and improved school performance compared with the control group. The researchers concluded that drama therapy is a promising way of working with refugee adolescents in a non-stigmatising manner.

Rousseau, Benoit, Lacroix, and Gauthier (2009) more recently evaluated a 10-session sand-play workshop run by three art therapists of diverse cultural backgrounds, with the help of the classroom teachers. The sand-play program aimed to help children express the challenges they faced and to develop a sense of agency through the playful transformation of their world. In the evaluation, 105 immigrant
and refugee pre-schoolers, predominantly from a South-Asian population and aged 4 to 6 years, were randomly assigned to an experimental or control group. Pre-test and post-test data collected from parents and teachers using the Strengths and Difficulties Questionnaire revealed a moderate positive effect for those who had participated in the program. Qualitative reports from teachers also indicated that those in the control group displayed more emotional and behavioural symptoms by the program’s end.

However, Rousseau and her colleagues are not the only researchers to have evaluated creative expression programs with refugee students. Baker and Jones (2006) used a short-term music therapy program to evaluate its effect on the classroom behaviours of 31 recently-arrived refugee students attending an English Language School in Queensland. Using a cross-over design, two five-week intervention periods were employed with group music therapy sessions being conducted twice a week. In this way, all refugee children attending the school were able to participate. The first music intervention period typically involved instrumental improvisations, dancing, song learning and singing, as well as students sharing pre-recorded music from their cultures or from current popular music charts. The second intervention period involved song writing workshops which entailed discussions related to adjustment, acculturation, racism and feelings of failure in the classroom. This content was then incorporated into song, which was then rehearsed, recorded, and finally, CD copies were given to the students to keep. The results of this evaluation suggested that music therapy significantly reduces the severity of externalising behaviours, and may also reduce internalising behaviours. However, no effect on adaptive skills was detected.

With creative techniques designed for various developmental levels, Rousseau and colleagues (2005, 2007, 2009) and Baker and Jones (2006) have demonstrated that these programs may have a positive impact on the wellbeing of refugee children
in Canada and Australia. However, given the popularity of these interventions and the relatively limited number of evaluations these programs have attracted, there is an urgent need to systematically study their effectiveness. This is especially important given that many interventions, including CBT interventions often use creative activities to help children process and explore their emotions and thoughts (NCTSN, 2005).

A CBT intervention developed to prevent anxiety and depression in Australian youths is the FRIENDS program (Barrett, Lowry-Webster, & Turner, 2000a, 2000b, 2000c, 2000d) which was recently conducted and evaluated with youth from a non-English speaking background (NESB). Barrett, Sonderegger, and Xenos (2003) evaluated the capacity of the CBT-based FRIENDS program to reduce psychological distress and prevent the development of mental health problems in 320 NESB youth. Although not explicitly stated, many of the NESB youth who participated in the study are very likely to have been refugees, or at least from a refugee-like background given the cultural identity of the participants (former-Yugoslavian, South-East Asian, and African). The researchers found that the NESB youth who participated in the FRIENDS program reported significantly greater self-esteem, fewer internalising symptoms, and a less pessimistic outlook for the future than their wait-list control counterparts at both the post-test and six-month follow-up assessment intervals. These results indicate that the FRIENDS program may not only be effective in treating anxiety problems in adolescent refugees (as indicated by Barrett, Moore, et al., 2000), but it may also be effective in preventing mental health problems from developing in refugee children.

Interestingly however, the former-Yugoslavian adolescents in the FRIENDS evaluation conducted by Barrett et al. (2003) reported a significantly greater reduction
in anxiety symptoms than the Chinese and “non-specific NESB” cultural groups (comprised mainly of African and South-East Asian children). The researchers theorised that strategies taught in the FRIENDS program may have been more culturally appropriate and acceptable to the former-Yugoslavian children because of the greater cultural similarities between children of European background and their Australian peers, for whom the program was initially developed. Therefore, this study highlights the importance of evaluating the efficacy of mental health prevention programs in a range of different cultural groups and exploring ways to increase their cultural relevance and appropriateness, especially in those cultures that are very different from Western cultures.

Chapter Summary

The review conducted in this chapter clearly highlighted that the vast majority of empirical studies evaluating the efficacy of mental health interventions pertain to the treatment of PTSD in refugee adult groups. So far, results indicate that NET and possibly TF-CBT may be the most effective treatment modalities. That the literature does not adequately address the treatment of other disorders or of mental health issues in refugee children highlights a critical gap in the mental health literature. However, specialised refugee trauma agencies and school-based mental health services have also been providing comprehensive and culturally-sensitive services and interventions to refugees. Although these initiatives are highly valued and respected, evidence for their effectiveness is also lacking. Unfortunately, without a strong evidence base for effective treatments, making appropriate mental health care decisions for our refugee clients is made much more difficult. However, the provision of clinical treatment is only one way that clinicians can improve the wellbeing of refugees in resettlement countries.
Mental health promotion and prevention strategies have also shown to be effective in improving the mental health and well-being of individuals in the general population. However, very few promotion and prevention initiatives have been specifically developed for refugee populations. Of the few which have been developed, only a very limited number have been systematically evaluated for their effectiveness. Although interventions look promising, without hard empirical evidence, there is no way of knowing if these interventions are helpful or harmful. Policy and mental health decision makers are also less likely to allocate the funds required to deliver interventions that have no empirical support.

Therefore, there is an urgent need for psychologists - in their roles as clinicians, researchers, educators, and advocates - to strengthen the evidence base by undertaking evaluations of mental health prevention efforts targeting our refugee populations. Given that many refugee children are at an increased risk for developing mental health problems, a strong rationale can be provided for the evaluation of the mental health prevention program, *The Rainbow Program for Children in Refugee Families* (VFST, 2002). This evaluation forms the basis for Study Two of this thesis.
Chapter 6: Study Two - Evaluation of the Rainbow Program

As reviewed in Chapter 3, the refugee experience can have serious short-term and long-term consequences for children and adolescents. Further, as established in Chapter 5, current literature in the area highlights the need for more effective mental health prevention programs for refugee children. In this context, an evaluation of the Rainbow Program for Children in Refugee Families (VFST, 2002) was conducted. The Rainbow Program for Children in Refugee Families (referred to hereafter as the Rainbow program) was developed by VFST, or ‘Foundation House’, which is one of eight specialist torture and trauma rehabilitation agencies in Australia that specialises in helping refugee survivors of torture and trauma recover from their experiences and build new lives (Foundation House, 2010).

The Rainbow program (VFST, 2002) is a structured, school-based intervention designed for delivery to children and families soon after their arrival in Australia. It is designed as a small group intervention (i.e. 8–10 participants) for refugee children aged between 9 and 12 years of age who have been in Australia for at least six months. The program was developed by the VFST in collaboration with school communities and the Victorian Department of Education and Training. This program was selected for evaluation for several reasons. Firstly, it is one of very few mental health prevention program designed specifically to make a positive contribution to the settlement experience of children from a refugee background. Second, it is a freely available program and as such, is a popular intervention that has been implemented in many schools and centres nationwide (e.g., Maleluka Refugee Centre, 2007). Third, the Rainbow program has the potential to make a significant contribution to the wellbeing of refugee children as its components are based on evidence-informed
intervention principles, are practical and easy to deliver in a school setting, are
developmentally appropriate, and can be delivered in a culturally-sensitive manner.
As it has yet to be formally evaluated, an evaluation may reveal information about the
Rainbow’s effectiveness, reveal opportunities for improvement, and ultimately make
assessments about the Rainbow program’s merit and worth.

While there are a number of approaches to program/intervention evaluation, this
study utilises the CIPP model of program evaluation (Stufflebeam, 2000). The CIPP
model is particularly relevant for those who work from the perspective of the
scientist-practitioner (Matthews & Hudson, 2001). It has been used to evaluate
programs and projects from a range of disciplines, and has also been used in the
evaluation of clinical interventions (e.g., Gavidia-Payne, Littlefield, Hallgren, Jenkins,
& Coventry, 2003) and non-clinical interventions for children at risk (e.g., Van
Kannel-Ray, Lacefield, & Zelle, 2008). Corresponding to the letters in the CIPP
acronym, the model is made up of four core concepts; context, input, process, and
product evaluation.

The “context” component of the CIPP model assesses problem areas and the
need for interventions. The “input” component of the CIPP model assesses alternative
approaches (or strategies) that could be undertaken to meet the needs identified in the
context evaluation (Stufflebeam, 2000). However, context and input evaluations are
not the focus of this study as these components would have been addressed during the
development of the Rainbow program (although these components could be revisited
again after a process and product evaluation has been conducted). Therefore, the
“process” and “product” components of the CIPP model are the most relevant to the
present study.
The objective of a process evaluation is to assess the quality of program’s implementation and how participants judge the program, and how much they accept and carry out their roles. Therefore, a process evaluation of the Rainbow program would therefore involve implementing the program and documenting how closely instructions in the manual are adhered to (i.e. program integrity), as well as evaluating its social validity, level of attendance and participation. Process evaluations are a vital methodological requirement in any intervention evaluation because any changes, key omissions and/or poor execution of procedures could affect the program’s outcomes (Dumas, Lynch, Laughlin, Phillips Smith, & Prinz, 2001). Unfortunately, Durlak and Wells (1997) note that in a review of 177 studies of mental health prevention programs for children, very few provided information about program integrity and social validity.

The objective of a product evaluation is to measure, interpret and judge the extent to which a program has met its intended goals. Product evaluations are enriched by assessments conducted from several vantage points. For example, by using quantitative and qualitative instruments completed by various informant types. Product evaluations should also include reports on immediate effects (i.e. pre-post differences), as well as longer-term effects (i.e. follow-up evaluations). As indicated previously, it is important to ground product evaluations in the context of process evaluations (Stufflebeam, 2000). However, conducting a product evaluation of the Rainbow program first requires one to identify the program’s intended goals.

The Rainbow program was developed to make a positive contribution to the settlement of children from refugee backgrounds (VFST, 2002). Therefore, the current study should assess whether the Rainbow program achieves this goal. In addition, because prevention programs aim to enhance mental health protective factors and
reducing risk factors (DHAC, 2000), an evaluation study should also measure the Rainbow program’s effect on relevant protective and risk factors.

Important protective factors for mental health include good self-esteem and adaptive functioning. Both are consistently associated with positive mental health (Catalano, Haggerty, Oseterle, Fleming, & Hawkins, 2004; Crocker, Luhtanen, Blaine, & Broadnax, 1994; World Health Organization, 2004), and adaptive functioning in the school environment has also been associated with better coping skills (Karver & Bickman, 2002). In contrast, low self-esteem is associated with acculturative stress (e.g., Roebers & Schnieder, 1999) and is a risk factor for the development of PTSD and depression in refugee children (Geltman et al., 2005; Nguyen, Messe, & Stollak, 1999). Similarly, there is a significant association between poor adaptive functioning with depressive symptoms (Haavisto et al., 2004) and hospitalisations for psychiatric disturbances (Sholle-Martin & Alessi, 1988). Therefore, an evaluation of the Rainbow program’s effect on self-esteem and adaptive functioning is highly relevant in this study.

Important risk factors for mental health problems include the presence of internalising symptoms (emotional problems that are mainly within the self usually associated with depression and anxiety) and externalising symptoms (behavioural problems that involve conflicts with other people, usually associated with conduct problems). A large body of research shows that internalising and externalising symptoms in childhood and early adolescence is associated with the future development of psychopathology (Colman, Wadsworth, Croudace, & Jones, 2007; Oland & Shaw, 2005; Sourander et al., 2007), and with an increased risk of suicide (Lewinsohn, Rohde, & Seeley, 1993). Furthermore, internalising symptoms have also been associated with perceived discrimination among young refugees from the Middle
East (Montgomery & Foldspang, 2007). Therefore, an evaluation of the Rainbow program’s effect on internalising and externalising symptoms is also pertinent to this study.

And finally, because mental health prevention programs ultimately attempt to reduce the burden associated with mental health issues (WHO, 2004), the Rainbow program’s effect on symptoms of anxiety and depression is particularly important, given the prevalence of these disorders in refugee children.

**Study Aims**

The overall aim of the current study is to make a much needed contribution to the promotion of wellbeing in refugee children by evaluating a mental health prevention program. Therefore, this study aims to:

1. Implement Rainbow program as directed by the Rainbow program manual.
2. Conduct qualitative and quantitative evaluations of social validity through evaluations of participant satisfaction, level of participation, and attendance.
3. Conduct a qualitative evaluation of the Rainbow program’s mental health prevention effects by examining the extent to which the program contributes to the settlement experiences of recently-arrived refugee children.
4. Conduct a quantitative evaluation of the Rainbow program’s mental health prevention effects by examining its immediate (pre-post) and longer-term effects (at 12-month follow-up) on protective factors (self-esteem and adaptive functioning), risk factors (internalising and externalising symptoms) and on symptoms of depression and anxiety in recently-arrived refugee children.
Study Hypotheses

1. Regarding program integrity, it was hypothesised that the Rainbow program would be implemented with sound program fidelity (as measured by the Session Summary Worksheet).

2. In regards to the social validity of the Rainbow program, it is hypothesised that the Rainbow program would demonstrate high social validity as reflected by: (a) high satisfaction (as measured by the Social Validity Questionnaire, Rainbow Session Feedback Questionnaire, and the Letters to the Researchers), (b) high attendance rates, and (c) high participation rates.

3. Regarding the contribution that the Rainbow program makes to the settlement experience of recently-arrived refugee children, it was hypothesised that:
   
a. The participants would describe the Rainbow program as a highly enjoyable and valuable experience (as measured by Letters to the Researchers).

b. The researcher would observe participants enjoying their experiences in the program, and would observe improvements in confidence and the level of social, behavioural and emotional strengths displayed by each participant over time (as measured by the Participant Progress Notes).

4. In regard to the Rainbow program’s pre-post and 12-month follow-up effects on mental health, it was hypothesised that:
   
a. Levels of self-esteem and adaptive functioning would increase between pre- and post-testing for participants in the Rainbow group while these levels would stay the same or decrease for participants in the control group.

b. Levels of internalising and externalising behaviours would decrease between pre- and post-testing for participants in the Rainbow group while these levels would stay the same or increase for participants in the control group.
c. Levels of depression and anxiety would decrease between pre- and post-testing for participants in the Rainbow group, while these symptoms would stay the same or increase for participants in the control group.

d. All the abovementioned changes would be maintained at 12-month follow-up.

Method

Participants

A total of 21 recently-arrived refugee children participated in this study (12 males and 9 females) ranging in ages from 7 to 12 years ($M = 10.6$ years, $SD = 1.4$). Students were recruited from the Western English Language School (WELS) in Braybrook, Melbourne. WELS is a transitional school for children from non-English speaking backgrounds and has a high percentage of children from a refugee background and it routinely offers the Rainbow program to its students. The school’s welfare co-ordinator requested that 11 refugee students participate in the Rainbow program as they were displaying coping difficulties at school, or because of other factors placing their wellbeing at risk. The reasons provided for their referral to the program are presented in Table 4.

Table 4

<table>
<thead>
<tr>
<th>Participant</th>
<th>Reason cited on student list for referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.1</td>
<td>Preliterate</td>
</tr>
<tr>
<td>No.2</td>
<td>Social skills, behaviour issues, possible history of trauma</td>
</tr>
<tr>
<td>No.3</td>
<td>Interrupted schooling history</td>
</tr>
<tr>
<td>No.4</td>
<td>Orphan, slow reader</td>
</tr>
<tr>
<td>No.5</td>
<td>Likes to be on her own</td>
</tr>
<tr>
<td>No.6</td>
<td>Low self-confidence</td>
</tr>
<tr>
<td>No.7</td>
<td>Only just beginning to communicate</td>
</tr>
<tr>
<td>No.8</td>
<td>Resistant speaker</td>
</tr>
<tr>
<td>No.9</td>
<td>Slow learner</td>
</tr>
<tr>
<td>No.10</td>
<td>Preliterate</td>
</tr>
<tr>
<td>No.11</td>
<td>Sibling recently died</td>
</tr>
</tbody>
</table>
The control group \( n = 10 \) were selected by the researcher from the remaining pool of students enrolled at WELS to match the intervention group as closely as possible in terms of age, gender, and culture. More detailed descriptions of participant demographic details can be found in Table 6 and Table 7 in the results section of this study.

**Design**

A mixed qualitative and quantitative approach was adopted to evaluate the Rainbow program. The study’s quantitative evaluation component was initially designed as a randomised control trial with a wait-list control group and 12-month follow-up. However, methodological issues required that the study design be amended to a quasi-experimental pre-post design with a non-randomised experimental and control group. Specifically, randomisation was not possible because the welfare co-ordinator at WELS requested that certain students be included in the Rainbow intervention group. As MacKenzie et al. (2007) point out, it is unethical to deny a request for intervention in the name of ‘objective’ research. In addition, this is the usual process of selection used by WELS when running the Rainbow program, as the school does not have the necessary resources to offer the program to all refugee students aged 9 to 12 years at the same time.

In addition, it was not possible to conduct the 12-month follow-up assessments as planned because WELS students generally stay at the school for six to nine months before moving into various mainstream schools around Melbourne. Even if the follow-up assessments were conducted three months later, all but two of the intervention participants and four of the control participants would have still been enrolled at WELS. As a result, tracing all the participants at follow-up would prove to
be beyond the resources available for this study. For this same reason, it was also impossible to offer the Rainbow program to the wait-list control group in the following school term.

Materials and Measures

Intervention.

The Rainbow program is composed of three components: (a) the teacher component, (b) the parent component, and (c) the children’s component. Although these components are designed to be offered together, the children and teacher components can be delivered as stand-alone initiatives.

The teacher component is comprised of a 30-minute briefing session followed by two, 90-minute professional development sessions to educate teachers about the impact that the refugee experience and resettlement issues can have on children and their families. The teacher component also explores some strategies that teachers can employ in order to promote supportive environments for refugee children, as well as strategies to look after their own wellbeing when working with this group.

The parent component comprises three sessions, and aims to inform parents about the Rainbow program, as well as to provide opportunities for parents to establish links with their children’s school, to learn about their children’s settlement experiences, and to enable parents to share any concerns they may have.

The children’s component comprises seven structured sessions (with an optional eighth session), and each session is structured to last two hours. Participants engage in group discussions, as well as individual and team activities. The activities are based on evidence-informed intervention principles and thus, provide participants with psychoeducation about emotions to help normalise their feelings. It also provides
participants with an opportunity to share their resettlement experiences so as to help reduce feelings of isolation. Several activities in the children’s component are also based on cognitive–behavioural principals. For example, participants explore and learn about emotions, and explore the thoughts, behaviours and sensations associated with these emotions. The coping skills participants use to deal with emotions are also discussed. In addition, participants are encouraged to focus on and express their hopes and dreams for the future, providing them with an opportunity to develop more positive thoughts and hopes about their present and future lives in Australia.

The children’s component also aims to help build self-esteem and a positive self-concept by building connections with peers, fostering a sense of trust and belonging, celebrating and affirming cultural identity, and assisting refugee children to appreciate the experience of living in two cultures. Other activities in the children’s component also aim to assist refugee children integrate past experiences and acknowledge the challenges of settlement. The Rainbow program’s aims are achieved by focusing on two key themes, identity and emotions, and by promoting trust, shared goals and cohesion within the group.

The Rainbow program manual (available for free download from the VFST website) provides background information about refugee issues, detailed information about how to plan and implement the program, and provides session outlines, descriptions of activity and their objectives, as well as administration instructions and the skills required to facilitate the program. However, a session by session description of the Rainbow program’s children’s component and objectives are outlined in Appendix J.

The researcher delivered the Rainbow program as outlined in the program manual; however limited changes were made to support the intervention evaluation.
For example, the Social Validity Questionnaire and the Rainbow Session Feedback Questionnaire were administered at the end of every session. In addition, letters written by participants to the researcher were also read out by participants in the final session as part of the “acknowledgment of end of group” to ensure that these letters were completed and received.

**Treatment integrity.**

**Session summary worksheet (SSW).**

To assess the integrity of the program delivery, the SSW (adapted from Barrett, Moore, et al., 2000) was completed by the researcher and her co-facilitator at the end of each session. The SSW (Appendix K) provides a session-by-session checklist of activities with a space to record whether activities were delivered. The SSW also includes a rating scale to assess the quality of the following group process dimensions; listening, inclusion of participants, use of positive reinforcement, group tasks, and completion of activities. Ratings were made on a 4-point Likert scale, ranging from ‘1’ = ‘not at all’ to ‘4’ = ‘extremely well’.

**Social validity measures.**

**Social validity questionnaire (SVQ).**

To evaluate the social validity of the program, the SVQ (adapted from Stallard et al., 2005) was used to determine the extent to which participants found the program understandable, enjoyable and useful. The SVQ (Appendix L) was completed by every participant at the end of session 1 through 6. Participants rated the Rainbow program on a 3-point scale (Yes, A little, No) on each of the following nine items; Did you understand most of the work? Did you feel safe talking about yourself? Were
you listened to? Was it fun? Do you think it has helped you? Did you learn anything new? Would you recommend it to a friend?

**Rainbow session feedback questionnaire (RSFQ).**

To evaluate the social validity of the program, the RSFQ (VFST, 2002) was used to collect qualitative data about the group’s experiences of the Rainbow program and to elicit ideas from the group about how the program may be improved. The RSFQ (Appendix M) forms part of the Rainbow program’s in-built social validity evaluation and continual improvement strategy. Although the manual directs facilitators to administer this questionnaire during the final session, for the purpose of this evaluation, the RSFQ was administered to the group at the end of every session. The RSFQ contains the following items: What do children remember most about the group session? What did they learn? What did they like best? What didn’t they like? What would they have liked to have done more of? Is there anything they would want to change?

**Letter to the researchers.**

The Rainbow program directs participants to submit a letter to the Rainbow program facilitator describing their most important memory of the program. Therefore, the Letter to the Researchers was used for this purpose (Appendix N). Although this letter is designed to be part of the program’s in-built evaluation to determine its effect on participant resettlement experiences. Thematic content analysis was used to analyse the contents in the letters order to provide a qualitative measure of social validity at the individual level. The letters submitted were not anonymous.
Program effectiveness: Qualitative evaluations.

Letter to the researchers.

As discussed in the previous section, the Letter to the Researchers (Appendix N) forms part of the Rainbow program’s in-built evaluation to determine its effect on participant resettlement experiences. Participants write a letter describing their most important memory of the program to the facilitator. Thematic content analysis was used to analyse the content of the letters in order to provide a qualitative measure of program effectiveness. The letters submitted were not anonymous.

Participation progress notes.

Progress notes for each Rainbow participant were written at the end of each session in order to document any changes in participant wellbeing and functioning over time. In these notes, the researcher recorded observations about each participant in terms of their demonstrated emotional and behavioural strengths and/or difficulties. In this way, a qualitative measure of the Rainbow program’s effect on personal outcome experiences could be obtained. Level of participation in session was also recorded in these notes to provide data for the social validity participation component.

Program effectiveness: Quantitative evaluation.

A questionnaire package was created to examine self-reported levels of self-esteem, depression, and anxiety (Appendix O). The questionnaire package was made up of three measures: The Coopersmith Self-Esteem Inventory (Coopersmith, 2002), The Child Depression Inventory-Short Version (Kovacs, 1999), and the Revised Children’s Manifest Anxiety Scale (Reynolds & Richmond, 1985). As each measure requires participants to answer items in a slightly different format, a practice item was added at the beginning of each measure. The package was made child-friendly by
presenting each question in large print and with each item clearly delineated from the next.

Coopersmith Self-Esteem Inventory-School Form (CSEI).

The CSEI (Coopersmith, 2002) was used to provide a measure of self-esteem. The CSEI is designed for administration with school children (ages 8-15) and assesses attitudes towards the general self, as well as self-esteem in the specific contexts of peers, parents and school. Thus it is made up of four subscales: General-Self, Social-Self/Peers, Home/Parents, and School/Academic. In order to limit the number of questions the participants were required to answer, only the Social-Self/Peers and School/Academic subscales were included in this study. The CSEI has been used in this truncated manner in previous cross-cultural and refugee studies (Barrett et al., 2001; Barrett, Sonderegger, & Sonderegger, 2002; Barrett et al., 2003). Participants report whether items are “like me” or “unlike me” with higher scores indicating higher self-esteem. Higher scores on the CSEI equate to higher levels of self-esteem, and with a maximum score of eight on each subscale, the CSEI in this study yields a total score ranging from 0–16.

The CSEI manual states that internal consistency reliability ranges between .80 and .92, the 5-week test-retest reliability is .88, and that concurrent validity has been demonstrated with correlations of .44 with a behavioural rating of self-esteem and .45 with the Californian Psychological Inventory for children. However, it has not been validated or normed using refugee populations.

Child Depression Inventory-Short Version (CDI-S).

The CDI-S (Kovacs, 1999), is a commonly used self-report instrument to measure depression symptoms in 7-17 year-old children. The scale consists of 10
items relating to sadness, self-blame and interpersonal relationships. Each item includes three statements (e.g., “I am sad once in a while,” “I am sad many times,” “I am sad all the time”), with each statement attracting scores of 0 to 2. Respondents endorse the statement that best describes him/her during the past two weeks. A total CDI-S score is calculated by summing all item scores, and ranges between 0 (no depression symptoms) to 20 (all depression symptoms clearly present), with higher total scores indicate a higher level of depression. As recommended by Yu, et al. (2006), a cut-off score of 8 can be used to identify individuals who are likely to be depressed on the CDI-S.

This CDI manual states that the alpha coefficients of reliability range from .71 to .89, and that 2 to 4-week test-retest reliability coefficients range between .41 and .83 in non-clinical populations. Good discriminant validity has been reported (Kovacs, 1999) and convergent validity has been demonstrated between the CDI and the Reynolds Adolescent Depression Scale (correlations between .56 and .78), and the Reynolds Child Depression Scale (between .70 and .73) (Masip, Amador-Campos, Gómez-Benito, & del Barrio Gándara, 2010). While the full scale version of CDI has been used in previous refugee studies (e.g., Ajdukovic & Ajdukovic, 1998; Thabet, Vostanis, & Karim, 2005), the CDI-S has not. The CDI has not been validated or normed using refugee populations.

**Revised Children’s Manifest Anxiety Scale (RCMAS).**

The RCMAS (Reynolds & Richmond, 1985) assesses levels of general anxiety in 6-19 year-old children. It consists of 28 dichotomous (yes/no) items and contains sample items such as “I am afraid of a lot of things”, “I am nervous”, and “I often worry about something bad happening to me”. Yes responses are scored in the positive direction and are summed to yield a total anxiety score. Three factor scores of
general anxiety can be obtained; physiological anxiety, worry/oversensitivity, and social concerns/concentration. The lie scale from this questionnaire was omitted in the current study to limit the number of questions the participants were required to answer. However, one lie scale item, “I am always good” was used as the practice item for the measure.

Internal consistency reliability estimates of the RCMAS total score is reported at .83 and test-rest reliability at .98 with a 3-week interval and .68 after a 9-month interval (Reynolds & Richmond, 1985). Concurrent and convergent validity has been demonstrated between the RCMAS and the Minnesota Multiphasic Personality Inventory anxiety scales (e.g., Lee, Piersel, Friedlander, & Collamer, 1988). The RCMAS has been used in previous cross-cultural investigations (e.g., Barrett et al., 2003; Papageorgiou et al., 2000). A cut-off total score of 18 has been found to predict the presence of anxiety disorder (Montgomery & Finch, 1974; cited in Papageorgiou et al., 2000).

The Teacher Report Form for Ages 6-18 (TRF).

The TRF (Achenbach, 2001) was used to obtain a measure of each participant’s adaptive functioning and problem behaviour in the classroom. Adaptive functioning is measured in terms of how hard the child is working, how much they are learning, how happy they are and how appropriately they are behaving. A raw score of 13 and 12 for 6-11 year-olds and 12-18 year-olds respectively indicates normal functioning in comparison to their same aged peers (Achenbach, 2001). Problem behaviour is measured across three broad scales; Internalising, Externalising, and Total Problems. The Internalising scale comprises problems that are mainly within the self and is made up of the Social Anxious/Depressed, Withdrawn/Depressed and Somatic Complaints subscales. The Externalising scale comprises problems that involve conflicts with
other people and is made up of the Rule-Breaking Behaviour and Aggressive Behaviour subscales. The Total Problems scale includes the Internalising and Externalising problem subscales, plus the Social Problems, Thought Problems, Attention Problems and Other Problem subscales.

Teachers describe problem behaviours from a list of 113 items using a 3-point Likert scale in terms of how true the item is (0 = Not True, 1 = Somewhat True or Sometimes True, 2 = Very True or Often True) now or within the past 2 months. Example items include; “Cries a lot”, “Destroys property belonging to others”, and “Bites fingernails”. High scores on the behaviour problems section of the TRF are indicative of more severe behaviour problems. The TRF also requests information about a pupil’s academic performance. However, in order to reduce the burden on teachers involved in the study, information about academic performance was not requested.

The TRF has well established reliability and validity (Achenbach & Rescola, 2001). The test-retest reliability after 16 days is .93 for Adaptive Functioning scale and .95 for the Total Problems scale. Cronbach’s alpha coefficients for the TRF scales range from $r = .72$ (Somatic Complaints and Thought Problems) to $r = .97$ (Total Problems). The TRF’s content validity has been supported by four decades of research, and because every scale on the TRF discriminates significantly between referred and non-referred children, criterion-related validity has also been demonstrated. Finally, construct validity has been supported through the significant associations found between the TRF scales and DSM criteria, as well as analogous scales on other instruments (Achenbach & Rescola, 2001). The TRF has also been used with many cross-cultural populations including refugee children (e.g., Habir, Marriage, Littlefield, & Pratt, 1994; Rothe et al., 2002).
Procedure

Ethics approval and organisation consent.

Ethics approval for this study was obtained from RMIT University (Project No. 24/08; see Appendix P) and from the Department of Education and Early Childhood Development (SOS003894; see Appendix Q). The Principal at WELS and the Regional Manager from VFST also provided consent for the proposed research to be undertaken (see Appendix R and Appendix S respectively).

Consent and associated ethical considerations.

When conducting research with refugee communities, traditional Western consent procedures (i.e. providing participants with a detailed written information statement to inform them about the purpose, methods, risks, benefits, and the voluntary nature of participation, and obtaining their signed consent) are often inappropriate (MacKenzie et al., 2007). In order to be more responsive to refugee participants’ needs, concerns, and values, cross-cultural researchers suggest that refugee community leaders, representative bodies, or NGOs where appropriate, should be consulted to determine the best way to proceed on matters of informed consent (Bailes et al., 2006; Barrett & Parker, 2003; MacKenzie et al., 2007).

Therefore, the researcher met with school’s welfare co-ordinator and multicultural education aides (MEAs) to discuss the study aims, research methodology and review the plain language statement (PLS) (see Appendix T). As a result of these discussions, it was advised that the most appropriate way to obtain informed consent from the student’s parents was for the MEAs to telephone each parent/guardian individually to relay information about the Rainbow program and the RMIT research project. It was determined that the MEAs were the most appropriate
individuals to inform the parent/guardians about the study because; (a) most parents were already acquainted with the MEAs, (b) the MEAs were already heavily involved in dealing with parents, especially at parent teacher evenings, and often liaised with parents when day-to-day issues arose at the school, and (c) because they were able to speak all the languages spoken by the WELS sample. However, one MEA suggested that the researcher should be present during their conversations with the parents, to enable parents to speak directly with the researchers if they so requested. The principal researcher spoke directly with only one parent during the informed consent procedures.

The MEAs also advised that obtaining both written and verbal consent for their children’s participation was appropriate. Although the process of obtaining written consent from refugee research participants has been associated with anxiety for refugees (e.g., Bailes et al., 2006), the MEAs and the welfare co-ordinator at WELS assured the researcher that the refugee parent/guardians at the school were accustomed to providing written consent for school-related matters. Parent/guardians were also informed that a photograph of their child would be taken as part the Rainbow program and that their children would bring home a consent form (Appendix U) for parents to sign and return to the school. Verbal and written consent was provided by all parent/guardians approached.

**Crisis care.**

An element of risk always exists when working with refugee children who may have experienced traumatic events. Therefore, crisis care provisions were arranged in the event that students emotionally decompensate during the program. However, there was no need to make use of these arrangements.
Implementation of Rainbow intervention.

The Children’s component of the Rainbow program was implemented during school hours in Term 3 of the 2008 school year. The program was facilitated by the researcher, who was assisted by another postgraduate psychology student. An ESL teacher and two interpreters also attended each session.

Although the researchers initially planned to implement and evaluate all components of the program concurrently, this was not possible. The teacher’s component was not implemented as WELS staff had already participated in the Teacher components as part of their usual professional development requirements. However, the Parent component was not implemented because the school was unable to cover the costs for transporting parents or for childcare arrangements. The welfare co-ordinator stated that the Parent component had never been successfully implemented by the school because of the lack of available resources to offer free transport and childcare that would enable parents to attend.

The implementation and evaluation of the program was carried out over nine weeks as outlined in Table 5 with the assistance of an RMIT Psychology Honours student, who acted as the program’s co-facilitator.
Table 5

*Rainbow Program Implementation and Evaluation Schedule*

<table>
<thead>
<tr>
<th>Week</th>
<th>Activity Undertaken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>Collection of pre-intervention data ((n = 11))</td>
</tr>
<tr>
<td></td>
<td>Collection of pre-intervention data ((n = 10))</td>
</tr>
<tr>
<td>Weeks 2, 3, and 4</td>
<td>Sessions 1, 2, and 3 of the Rainbow program</td>
</tr>
<tr>
<td>Week 5</td>
<td>One week break – due to school curriculum day</td>
</tr>
<tr>
<td>Weeks 6 and 7</td>
<td>Sessions 4 and 5 of the Rainbow program</td>
</tr>
<tr>
<td>Week 8</td>
<td>Sessions 6 of the Rainbow program</td>
</tr>
<tr>
<td></td>
<td>Collection of post-intervention data for two Rainbow participants(^a)</td>
</tr>
<tr>
<td>Week 9</td>
<td>Collection of post-intervention data for remaining participants followed by Sessions 7 of the Rainbow program</td>
</tr>
<tr>
<td></td>
<td>Collection of post-intervention data</td>
</tr>
</tbody>
</table>

\(^a\)Post-intervention data was also collected during week 8 for two Rainbow participants who would not be present in week 9 as they were going to be away on school camp.

**Collection of pre and post-intervention evaluation material.**

The questionnaire package was administered to all participants at the same time using a group format before and after implementation of the Rainbow program. The MEAs translated each questionnaire item for the participants in turn. Administration of the questionnaire package took approximately 100 minutes to complete. ESL teachers, school aids, and the researchers also provided assistance where necessary, paying particular attention to the two pre-literate individuals in the intervention group. However, as two intervention participants were away on school camp for the
scheduled post-intervention data collection, this data was collected immediately after session 6 for these participants only. MEAs assisted these youths to complete the questionnaire package. The TRF was also completed for each participant before and after the implementation of the Rainbow program.

**Data Analysis.**

**Qualitative data.**

Qualitative data from the Letters to the Researchers and participant progress notes were analysed using thematic content analysis, in which data is categorised into recurrent or common “themes” (Green & Thorogood, 2009). Qualitative data from the RSFQ were simply summarised.

**Quantitative data.**

*Program integrity.*

Adherence to program agenda items was calculated by dividing the number of agenda items planned by the total number of items implemented, and multiplying this value by 100. Ratings for group process effectiveness were graphically represented.

*Social validity.*

Percentage attendance at each session of the Rainbow program was calculated by dividing the number of participants in attendance by the total number of participants, and multiplying this value by 100. Participation in the Rainbow program was calculated by dividing the number of participants by the total number of students approached to participate, and multiplying this value by 100. Participant satisfaction ratings from the SVQ were also converted to percentages.
**Rainbow program effects.**

Quantitative data were analysed using Predictive Analytics SoftWare (PASW) Statistics (Version 17). Descriptive statistics (\( n, \) mean, \( SD \)) were used to summarise data comparing participant characteristics in each group.

In this study, raw scores rather than standard scores derived were used in all statistical analyses. Achenbach and Rescorla (2001) state that using raw scores in statistical analyses is especially useful because raw scores “directly reflect all variation that is possible on each scale” (p. 89). In addition, the norms and standard scores of the questionnaires used in this study were not developed using refugee children in their normative and standardisation samples. Previous cross-cultural studies utilising these questionnaires have also utilised raw scores in statistical analyses (e.g., Ajdukovic & Ajdukovic, 1998; Barrett et al., 2003; Papageorgiou et al., 2000).

Between-group differences on categorical variables were analysed using chi-square analyses which evaluate whether a statistical relationship exists between two categorical variables (Green & Salkind, 2003). Between-group differences on continuous variables were analysed using paired-samples \( t \)-tests which evaluates whether the means on a dependent variable between two groups differ significantly from each other (Green & Salkind, 2003).

In order to investigate the mental health prevention effects of the Rainbow program, separate 2 x 2 split-plot (i.e., mixed-design) factorial analysis of variance (ANOVA) were conducted for adaptive functioning and depression. The 2 x 2 split-plot factorial ANOVA involves one dependant variable (DV) and two independent variables (IVs), where one IV is a within-subject or repeated measure, and the other is a between-subjects IV. In this study, the within-subjects IV is phase, and has two
levels (pre-test and post-test). The between-subjects IV is group, and also has two levels (intervention and control).

In order to reduce the likelihood of committing a Type I errors, separate 2 x 2 split-plot factorial multivariate analysis of variance (MANOVA) were conducted for the subscales within the self-esteem (CSEI), anxiety (RCMAS), and problem behaviour (TRF) measures because two or more related dependent variables DV were tested in these analyses.

Factorial designs, such as 2 x 2 split-plot factorial ANOVA and MANOVA procedures, produce three main tests of significance. Firstly, the interaction effect, which tests whether changes in scores for the two groups are significantly different from one another. The interaction effect is the most important significance test produced by factorial ANOVA and MANOVA procedures. In this study, the interaction tests whether the Rainbow group scores change at a different rate compared with the control group scores. However, if the interaction is not significant, the focus of the analysis shifts to analysing whether the following main effects for group and phase are significant.

Secondly, the main effect for group assesses whether the marginal mean pooled across pre-test and post-test for one group is considered statistically different from the marginal mean pooled across pre-test and post-test for the other group.

Thirdly, the main effect for phase assesses whether the marginal means pooled across intervention and control groups at pre-test is statistically different from the marginal means pooled across the intervention and control groups at post-test.

In the study, if either the interaction or main effects are significant in the factorial ANOVA analyses, additional follow-up tests are not necessary because each IV has
only two levels. Thus, examination of marginal means is sufficient to interpret significant results. However, if either the interaction or main effects are significant in the factorial MANOVA analyses, separate univariate ANOVAs must be performed for each dependent variable. Examination of marginal means is then sufficient to interpret any significant follow-up ANOVA results because each factor has only two levels. Green and Salkind (2003) suggest controlling for Type I error when using multiple ANOVAs in follow-up analyses with the Bonferroni correction procedure. Bonferroni adjustments are made by dividing the significance level of the test set at $p = .05$, by the number of dependent variables being compared in the analysis. For example, if three dependent variables are being compared in the factorial MANOVA, $p = .05$ is divided by the three, to obtain the adjusted $p$ value of $p = .017$, which is set as the new criterion for significance.

ANOVA and MANOVA analyses are the most appropriate test to use when treatment and control groups are not randomly allocated to groups, and differences at pre-test are not likely to be due to chance (Howell, 2010). Lord explains, “there simply is no logical or statistical procedure that can be counted on to make proper allowances for uncontrolled pre-existing differences between groups” (Lord, 1967, p.305; cited in Howell, 2010).

Data preparation and assumption testing for parametric procedures.

Exploratory data analysis was conducted on all quantitative data in accordance with Howell (2010) to check for data entry errors and to ensure that statistic assumptions underlying parametric procedures were met. This analysis revealed that no major violations in the normality and linearity assumptions were found in the data for self-esteem, adaptive functioning, and anxiety. In contrast, data for depression and problem behaviours from the TRF were positively skewed, and violated the
assumption of normality and homogeneity. Transformations of these variables did not improve normality sufficiently and therefore, data was left untransformed for analyses.

Despite these departures from normality and homogeneity, parametric procedures were used for all continuous variable analyses following Norman (2010) who states that “many studies, dating back to the 1930s consistently show that parametric statistics are robust with respect to violations of these assumptions” (Norman, 2010, p. 625). Norman further states that “parametric statistics can be used with Likert data, with small sample sizes, data with unequal variances, and with non-normal distributions” (Norman, 2010, p. 631). Further, Norman states that “parametric methods examining differences between means, for sample sizes greater than 5, do not require the assumption of normality, and will yield nearly correct answers even for manifestly non-normal and asymmetric distributions like exponentials” (Norman, 2010, p. 628).

Nevertheless, Box's $M$ statistic, which evaluates the assumption of homogeneity of the variance-covariance matrices in MANOVA analyses, was not significant. This indicates that this assumption was met. However, Green and Salkind (2003) report that the Box $M$ index should be interpreted with caution as non-significant results may be due to small sample size and a lack of power.

Meeting the sphericity assumption was not required in this study as this assumption is only meaningful in univariate tests when there are more than two levels of a within-subjects factor (Green & Salkind, 2003). In this study there were only two levels (pre-test and post-test) on the within-subject factor.

The final assumption of ANOVA and MANOVA analyses involved the assumption that scores of any one subject are independent of the scores for any other
subject (Green & Salkind, 2003). This assumption was met as there was no dependency of scores between the participants.

**Effect size.**

Effect sizes were computed to complement the analyses of significance testing. For *t*-test comparisons, effect sizes were reported as Cohen’s *d* statistic, which can range from negative infinity to positive infinity, and are interpreted according to Cohen’s convention of .2, .5, and .8 being a small, moderate, and large effect respectively (Howell, 2010). For 2 x 2 split-plot factorial ANOVA and MANOVA analyses, effect sizes were reported as partial eta squared ($\eta_p^2$), which can range in value from 0 to 1. According to Cohen (1988), $\eta_p^2$ is interpreted using the following convention whereby,.01 = small, .06 = medium, and .15 = large. Ninety-five per cent confidence intervals were computed around each Cohen’s *d* and $\eta_p^2$ effect size using scripts for use with PASW Statistics package downloaded from http://psychology3.anu.edu.au/people/smithson/details/CIstuff/CI.html (Smithson, 2003).

**Missing values.**

Two randomly missing values in the Teacher Report Form were detected in the post-test data collection phase only. Missing values were assessed using Missing Values Analysis in the PASW Statistics software package, and were replaced using the Expectation Maximization function. Expectation Maximisation has been reported to provide missing value estimates closest to the original value of deliberately removed data (e.g., Musil, Warner, Yobas, & Jones, 2002). It estimates missing values by creating a missing data correlation matrix and making inferences about the
missing values on the likelihood that they fall under that distribution (Tabachnick & Fidell, 2001, p. 63).

**Reliable indicators of change and clinical significance.**

The Jacobson and Truax (1991) method was used for determining the clinical significance of the Rainbow program’s effect on anxiety levels for one participant only. This is because one participant scored within the clinical range on the RCMAS at pre-test. Although one participant’s TRF scores fell in the borderline range at pre-test, there was no change in this score by post-test, and thus examination of this result using the Jacobson and Truax (1991) method was not necessary.

The Jacobson and Truax (1991) method uses two criteria for assessing clinically significant change of a psychological intervention (Ogles, Lunnen, & Bonesteel, 2001). The first criteria is that individuals receiving the intervention must move from a theoretical dysfunctional population to a functional population. The second criteria is that the changes in scores must be reliable (Ogles et al., 2001). To determine reliability of the change scores, Jacobson and Truax (1991) calculate the Reliability Change Index (RCI), which is determined by calculating the difference between the pre-treatment and post-treatment scores, and dividing this value by the standard error of difference ($S_{\text{diff}}$). The $S_{\text{diff}}$ is calculated using the standard error of measurement ($SEM$) of the instrument/questionnaire using the following formula: $S_{\text{diff}} = \sqrt{2(SEM)^2}$. If the RCI is greater than 1.96, the change is considered reliable. If both criteria are met, one can be 95% confident that a clinically significant and reliable change has occurred.

The Jacobson and Truax (1991) method can also be represented graphically with pre-intervention scores on the x-axis, and post-intervention scores on the y-axis. Four additional lines are superimposed upon this graph. The first is a horizontal line
that represents the post-intervention cut-off score necessary to be considered part of the functioning population. A centre diagonal line running from corner to corner represents the line of no change. Individuals who have the same pre- and post-intervention scores will be plotted on this line. Dashed lines on either side of the centre diagonal line represent the change scores necessary to result in a reliable change index (RCI) greater than 1.96. Results between the dashed diagonal lines are not considered to have changed sufficiently to rule out random fluctuations or test unreliability. However, any results falling outside this range can be considered clinically significant, and reliable, at a 95% confidence level.

Results

Demographics

The demographic characteristics comparing the intervention and control groups on categorical and continuous variables are presented in Table 6 and Table 7 respectively. To detect differences between groups on categorical variables, a series of Chi-Square analyses were performed. As shown in Table 6, none of the Chi-Square analyses were significant. This indicates that both the intervention and control groups were comparable in terms of gender, first language, country of birth, and the number of parents still alive. These non-significant results are not unexpected as the control group were deliberately chosen to match the intervention group.
Table 6

*Demographic Characteristics on Categorical Variables with Corresponding Chi-square Analysis of Differences*

<table>
<thead>
<tr>
<th>Demographic Information</th>
<th>Intervention ($n$)</th>
<th>Control ($n$)</th>
<th>$df$</th>
<th>$\chi^2$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>7</td>
<td>1</td>
<td>1.29</td>
<td>.26</td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First language</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karen</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>4.72</td>
<td>.58</td>
</tr>
<tr>
<td>Chin</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burmese</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tigrinya</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dinka</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amharic</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kiswahili</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>3.38</td>
<td>.64</td>
</tr>
<tr>
<td>Burma</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudan</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of parents alive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td>8</td>
<td>9</td>
<td>2</td>
<td>2.02</td>
<td>.37</td>
</tr>
<tr>
<td>One</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To detect demographic differences between groups on quantitative demographic variables, a series of independent $t$-tests were performed. As shown in Table 7, none of the independent $t$-test analyses were significant. This indicates that both the intervention and Control groups were comparable in terms of age, the amount of time spent in Australia and at WELS, as well as the number of years of previous education in total, and internationally. These non-significant results are not unexpected as the control group were deliberately chosen to match the intervention group.
### Table 7

*Demographic Characteristics on Quantitative Variables with Corresponding Independent Sample t-test Analysis of Differences*

<table>
<thead>
<tr>
<th>Demographic Information</th>
<th>Intervention M</th>
<th>SD</th>
<th>Control M</th>
<th>SD</th>
<th>df</th>
<th>t</th>
<th>P</th>
<th>d</th>
<th>95% CI for d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>10.99</td>
<td>1.32</td>
<td>10.19</td>
<td>1.42</td>
<td>19</td>
<td>1.34</td>
<td>.20</td>
<td>0.59</td>
<td>-0.30 - 1.46</td>
</tr>
<tr>
<td>Months in Australia</td>
<td>8.94</td>
<td>4.25</td>
<td>6.41</td>
<td>4.92</td>
<td>19</td>
<td>1.27</td>
<td>.22</td>
<td>0.55</td>
<td>-0.33 - 1.42</td>
</tr>
<tr>
<td>Months enrolled at WELS</td>
<td>7.02</td>
<td>4.37</td>
<td>4.50</td>
<td>3.67</td>
<td>19</td>
<td>1.42</td>
<td>.17</td>
<td>0.62</td>
<td>-0.27 - 1.49</td>
</tr>
<tr>
<td>Total previous education (years)*</td>
<td>3.10</td>
<td>1.20</td>
<td>3.67</td>
<td>1.58</td>
<td>17</td>
<td>-.89</td>
<td>.39</td>
<td>-0.41</td>
<td>0.00 - 1.28</td>
</tr>
<tr>
<td>Previous international education (years)*</td>
<td>1.70</td>
<td>1.49</td>
<td>0.67</td>
<td>0.71</td>
<td>17</td>
<td>1.89</td>
<td>.08</td>
<td>0.87</td>
<td>-0.09 - 1.80</td>
</tr>
</tbody>
</table>

*Data missing from one participant from each group because these students were newly enrolled and this information was not available at time of data collection.*
Program integrity

As depicted in Table 8, analysis of the Session Summary Worksheet (SSW) indicated that adherence to program agenda items was high. The only agenda item to be missed was the closing exercise.

Table 8

<table>
<thead>
<tr>
<th>Session</th>
<th>No. of agenda items</th>
<th>% Implemented</th>
<th>Missed item</th>
<th>Reason missed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>6</td>
<td>100</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Session 2</td>
<td>4</td>
<td>100</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Session 3</td>
<td>4</td>
<td>75</td>
<td>Closing exercise</td>
<td>No Time Left</td>
</tr>
<tr>
<td>Session 4</td>
<td>5</td>
<td>100</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Session 5</td>
<td>3</td>
<td>67</td>
<td>Closing exercise</td>
<td>No Time Left</td>
</tr>
<tr>
<td>Session 6</td>
<td>6</td>
<td>83</td>
<td>Closing exercise</td>
<td>No Time Left</td>
</tr>
<tr>
<td>Session 7</td>
<td>3</td>
<td>100</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Average</td>
<td>4.4</td>
<td>96.4</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Note. SSW = Session Summary Worksheet

Analysis of the SSW further revealed that the agenda items were effectively implemented and that the group process over the course of the program was high. As depicted in Figure 1, it is clear that agenda item implementation and group process improved over time. Note, a rating of ‘4.0” was the target level for the program implementation as group process was rated using the following scale; 1 = not at all, 2 = not very well, 3 = moderately well, 4 = extremely well.
Figure 1. Average results from the SSW depicting the level of: (a) effectiveness of implementation of agenda items, (b) levels of listening within the group, (c) level that facilitators included children, (d) level of positive reinforcement provided, (e) level of participation in group tasks, and (f) level that participants were able to complete activities.
Social Validity

Social validity was evaluated using data from the SVQ, RSFQ, and Letters to the Researchers. Results from each of these measures are presented in turn.

Social validity questionnaire (SVQ).

In general, participant responses about the Rainbow program were positive, with an overall 98.2% satisfaction rating. However, several participants endorsed the “a little” and “no” categories over the duration of the Rainbow program. Participant No. 11 reported that she did not understand the work, and that the session was only “a little” fun in the first session. This participant was one of two participants who did not have access to an interpreter. Only five other participants endorsed the “a little” category once each, over the duration of the Rainbow program. Participant responses from the SVQ are summarised in Table 9. All participants present completed the SVQ at the end of every session.

Table 9

<table>
<thead>
<tr>
<th>Items on Satisfaction Questionnaire</th>
<th>% Endorsed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1. Did you understand most of the work?</td>
<td>95.5</td>
</tr>
<tr>
<td>2. Did you feel safe talking about yourself?</td>
<td>100.0</td>
</tr>
<tr>
<td>3. Were you listened to?</td>
<td>98.5</td>
</tr>
<tr>
<td>4. Was it fun?</td>
<td>98.5</td>
</tr>
<tr>
<td>5. Do you think it has helped you?</td>
<td>98.3</td>
</tr>
<tr>
<td>6. Did you learn anything new?</td>
<td>100.0</td>
</tr>
<tr>
<td>7. Would you recommend Rainbow to a friend?</td>
<td>96.8</td>
</tr>
<tr>
<td>Overall endorsements</td>
<td>98.2</td>
</tr>
</tbody>
</table>

<sup>Note.</sup> SVQ = Social Validity Questionnaire. <sup>a</sup>Responses provided in session one. <sup>b</sup>One participant provided this response in session two. <sup>c</sup>Two different participants provided this response in session one and session five.
Rainbow session feedback questionnaire (RSFQ).

Overall, feedback obtained about the Rainbow program from the RSFQ was consistent and overwhelmingly positive. Participant feedback for questions pertaining to positive experiences (i.e. RSFQ questions 1 – 3) are summarised in Table 10. These responses clearly indicate that participants enjoyed all activities undertaken, and could recall what they did and learned in each session.
<table>
<thead>
<tr>
<th>Question</th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Session 6</th>
<th>Session 7(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1: What do children most remember about the group session?</td>
<td>Games</td>
<td>Play games, laugh, funny together</td>
<td>Decorating poster</td>
<td>Body game</td>
<td>Country clothes</td>
<td>Body tangle</td>
<td>Country and dancing</td>
</tr>
<tr>
<td></td>
<td>Guidelines</td>
<td>Share our story</td>
<td>Colouring in</td>
<td>Cultural object</td>
<td>Sharing and learning about different countries</td>
<td>Dancing</td>
<td>Dancing and games</td>
</tr>
<tr>
<td></td>
<td>Rainbow map</td>
<td>Drawing pictures</td>
<td>Pictures</td>
<td>Making masks putting hair on masks</td>
<td>Happy and sad</td>
<td>Happy</td>
<td>Rainbow beautiful, drawing missing people</td>
</tr>
<tr>
<td></td>
<td>Talking about where we are from</td>
<td>Photos on the poster</td>
<td>Talking</td>
<td>Body</td>
<td>Photos</td>
<td>Lying down to draw pictures</td>
<td>Rainbow colours and dancing</td>
</tr>
<tr>
<td></td>
<td>Photos</td>
<td>Talking</td>
<td>Colouring in</td>
<td>Mask</td>
<td>Laughing</td>
<td>Talked about love</td>
<td>Dancing</td>
</tr>
<tr>
<td>Question 2: What did they learn?</td>
<td>About rainbows</td>
<td>About rainbows</td>
<td>About happy and sad</td>
<td>Learnt about games</td>
<td>Dancing, English,</td>
<td>Dancing, Body parts</td>
<td>Shows and tell, Body parts</td>
</tr>
<tr>
<td></td>
<td>Where everyone comes from</td>
<td>Favourite foods</td>
<td>Drawing</td>
<td>How to say hello</td>
<td>Laughing,</td>
<td>Dress from your country</td>
<td></td>
</tr>
<tr>
<td></td>
<td>About different countries</td>
<td>Different countries</td>
<td>Colour</td>
<td>Rainbow</td>
<td>Rainbow,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speaking English</td>
<td>Where we were born</td>
<td>Masks</td>
<td>Learnt about happy, sad and love,</td>
<td>Cultural objects,</td>
<td>Asking questions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>What we speak at home</td>
<td>About rainbows</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Speaking English</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question 3: What did they like best?</td>
<td>Games</td>
<td>Feet game</td>
<td>Body parts</td>
<td>Showing the cultural object,</td>
<td>Dancing,</td>
<td>Answers the same as Question 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rainbow maps</td>
<td>Drawing</td>
<td>Sharing,</td>
<td>Drawing</td>
<td>Body tangle</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Photos</td>
<td>Learning to talk</td>
<td>Cultural objects,</td>
<td></td>
<td>Body tangle</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Learning to talk</td>
<td>Colouring pictures</td>
<td>Masks</td>
<td></td>
<td>Drawing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. \(^a\) participant feedback based on overall Rainbow program experience.
Examination of responses provided for questions 4 to 6, which aimed to elicit participant feedback pertaining to any negative experiences they may have experienced, revealed that there was nothing about the Rainbow program that participants did not like. However, some suggestions for improvement were put forward. For example, some participants would have liked more activities such as playing more games, dancing, singing, and more creative activities such as drawing, writing and colouring. Participants also suggested that they would like to talk more about the countries that the other participants had come from, and to have the opportunity to show the masks they made to their friends. The researcher also noted that the questions on the RSFQ were always answered with much enthusiasm, and that participants enjoyed the opportunity to reflect at the end of each session.

**Letters to the researchers.**

In order to obtain a qualitative measure of program satisfaction from each individual participant, the Letters to the Researchers were reviewed for themes of program acceptability. The feedback in these letters was overwhelmingly positive. It was evident that participants enjoyed the program thoroughly and were extremely sad to see it end. The content of these letters are published in Appendix V to provide a richer understanding of the participant’s positive sentiments about the program and what the Rainbow program meant to them.

**Attendance rate.**

Over the seven week program, there was an average attendance rate of 93.5%. Of the 11 participants who completed the program, only four participants missed one session each. Where participants could not attend, it was due to illness or because they were away at camp. Data was not collected about the number of children in the control group who
missed out on school or the reasons for their absence. Therefore a comparison cannot be made about their attendance at school.

**Participation rates.**

The percentage of children participating in the Rainbow program was high, with 100% of parents consenting to their child’s participation, and no subsequent withdrawals from the Rainbow program. These results indicate that parent were supportive of the evaluation study, and were enthusiastic for their children to participate in the intervention. Qualitative analysis of the progress notes revealed that each participant’s level of participation and sharing either improved, or remained the same if they were already participating at a high level.

**Researcher’s reflection on social validity.**

It was evident to this researcher that the participants thoroughly enjoyed the Rainbow program experience. Participants were eager to attend every session, and were sad to see it end. The researchers also noted that the participants were very respectful of one another and followed the group rules that they themselves had developed in session. Participants worked well on, enjoyed, and completed all individual and group-based activities. However, some participants were shy, and found speaking in front of the group or presenting their cultural object difficult, although no-one refused to carry out any of these tasks. In the final session, every female participant hugged the facilitators, and talked about how sad they were that the program was ending, some of whom ended up in tears. The ESL teacher and the interpreters who attended the sessions (and who were refugees themselves) also reported that they liked the program and believed the program would be of benefit to the participating refugee children.
Program effectiveness: Qualitative Evaluations

Letters to the researchers.

The feedback in the Letters to the Researchers (Appendix V) indicated that the Rainbow program was an overwhelmingly positive experience for participants. Thematic content analysis of the letters clearly indicated that the Rainbow program was special and valued by the participants.

Several participants wrote that they would miss the group and did not want the facilitators to forget them. They described the program as a place where they had fun and enjoyed interacting with their Rainbow teachers (i.e. the researchers). Participants reported that the program had given them a fun way to learn English – a skill that they very much wanted to master. Participants found the games and activities extremely enjoyable. Participants also reported that they liked learning about emotions, were pleased with the opportunity to develop their social skills, and build their self-confidence. One participant also reported that her family were impressed with the program however, it was not possible to ascertain exactly what the family liked about the program. The content of the letters also illustrated that learning and talking about rainbows in the group was a particularly poignant experience for these participants, with six participants making comments about how much they liked rainbows. Thus, the contribution of the Rainbow program to the settlement experience of recently-arrived refugee children was overwhelmingly positive. The results of this analysis are presented in Table 11.
Table 11

*Themes, Subthemes and Participant Quotes from the Letters to the Researchers*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
<th>Example Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptability of the program</td>
<td>Enjoyment</td>
<td>“I really enjoyed being in the Rainbow group”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I like to do rainbow playgroup every week”</td>
</tr>
<tr>
<td></td>
<td>Sadness about the</td>
<td>“I was cry when you go”</td>
</tr>
<tr>
<td>end of the program</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Important</td>
<td>“Please remember me. I am remember you too. I never forget you. Thank you so much”</td>
</tr>
<tr>
<td></td>
<td>experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Content</td>
<td>“What you teach us is so interesting”</td>
</tr>
<tr>
<td>Aspects Enjoyed</td>
<td>Activities</td>
<td>“What I enjoyed most was the dancing”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Thank you for draw picture”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I like to play game with you”</td>
</tr>
<tr>
<td></td>
<td>Content</td>
<td>“Drawing a picture of a person who is sad and happy”</td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td>“Thank you for help me…thank you for reading and writing with me”</td>
</tr>
<tr>
<td></td>
<td>Rainbow</td>
<td>“I like rainbow because the rainbow is beautiful”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Thank you for teach me about rainbow”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“There were three different types of rainbows, but one was the most important for me. The rainbow that stop the rain was my best…”</td>
</tr>
<tr>
<td></td>
<td>Facilitators</td>
<td>“You two are the best teachers ever”</td>
</tr>
<tr>
<td>Personal</td>
<td>Building</td>
<td>“I have been doing well with this program”</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Confidence</td>
<td>“[I] learnt many things…We learnt English and dancing”</td>
</tr>
<tr>
<td></td>
<td>Learning and Skill</td>
<td>“Thank you for teach me no fighting with your friend. Thank you for teach me about play together with your friend. Thank you for teach me about someone was speaking you quiet or you listen to them”</td>
</tr>
<tr>
<td>development</td>
<td></td>
<td>“In this school you will be a good student if you speak and write English so much… I like to learn to speak English in the class”</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>“My parents say Rainbow is very good”</td>
</tr>
<tr>
<td></td>
<td>Mastery</td>
<td>“I did not [know how] to draw a rainbow and you help me”</td>
</tr>
</tbody>
</table>

Participant progress.

Thematic content analysis of the participant progress notes revealed that participants underwent three different types of “change” over the course of the intervention. These categories were; (a) slow-to-warm-up, (b) continual improvement, and (c) maintainers.
The slow-to-warm up participants were difficult to engage from the outset of the intervention. They were observed to be shy, and spoke only when directly addressed. When they did speak, their voices were usually inaudible and activities involving speaking, dancing or singing in front of others were only attempted if they could blend in and not be the centre of attention. Participants in this group had varying abilities in describing or depicting the different emotions discussed during the Rainbow program. However, these participants displayed an improvement in their level of participation, enjoyment, confidence, and sharing of stories between the fourth and sixth session. Only children with a Karen background were identified as slow to warm up.

The continual improvement group were classified as shy to begin with, but did engage and interact well with others from the outset of the program. However, their enjoyment, participation, confidence and sharing was noted to continually improve throughout the duration of the program. Participants in this group also had varying abilities in describing or depicting the different emotions discussed. This group was composed of various cultures, gender and ages, and had varied histories in terms of deaths in the family. Thus a grouping variable cannot be put forth to explain their presentation.

The participants in the maintainers group were placed into this category because they participated fully, displayed confidence, and shared stories from the outset. These participants continued in this manner throughout the duration of the program. The maintainers group had no difficulty describing or depicting the different emotions discussed. The participants in this group were also from various backgrounds, had varied histories in terms of deaths in the family, but were generally the oldest participants in the group.

The participants categorised into each group, as well as progress note summaries for each participant in each of these groups are presented in Table 12.
## Table 12

**Summary of Changes Observed in Participant Behaviour over the Duration of the Rainbow Program**

<table>
<thead>
<tr>
<th>Progress Type and Participant Details</th>
<th>Progress Note Summaries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Slow to warm up</strong></td>
<td></td>
</tr>
<tr>
<td>9-year-old Karen male (Participant No. 9)</td>
<td>Generally very shy and quiet throughout first four sessions. Increased display of enjoyment, sharing, confidence and participation in final two sessions.</td>
</tr>
<tr>
<td>12-year-old Karen male (Participant No. 7)</td>
<td>Generally shy and quiet throughout first five sessions, but participated when focus was not on him, and when directly addressed. Increased confidence evident in final session. Displayed difficulties depicting emotions.</td>
</tr>
<tr>
<td>11-year-old Karen female (Participant No. 8)</td>
<td>Extremely shy and quiet throughout first six sessions. Struggled to contribute and answer questions when directly addressed. Trouble depicting “angry” emotions. In final session, increased display of enjoyment, sharing, confidence and participation.</td>
</tr>
<tr>
<td><strong>Continual improvement</strong></td>
<td></td>
</tr>
<tr>
<td>9-year-old Congolese female (Participant No. 11)</td>
<td>Irritable in first session, but displays of enjoyment, confidence, participation and sharing generally increased over the course of the program. Attention seeking and disruptive at times (may have been the result of language barrier or problems with concentration) but this behaviour reduced considerably by the end of program. Trouble depicting angry, fear, sad.</td>
</tr>
<tr>
<td>11-year-old Sudanese male (Participant No. 1)</td>
<td>Increasing displays of confidence, participation and sharing of stories. Good emotion depiction, some difficulty talking about “anger”. Socially conscious when talking about “love” in front of group.</td>
</tr>
<tr>
<td>8-year-old Ethiopian female (Participant No. 3)</td>
<td>Increasing displays of confidence, participation and sharing. Concurrent increase in seeking the facilitator’s attention. Good emotion depiction.</td>
</tr>
<tr>
<td>12-year-old Karen female (Participant No. 5)</td>
<td>Increasing displays of enjoyment, confidence, participation and sharing. Good emotion depiction, but some difficulty depicting “anger” initially. Was sometimes bossy towards other children.</td>
</tr>
<tr>
<td>9-year-old Karen male (Participant No. 6)</td>
<td>Increasing displays of enjoyment, confidence, participation and sharing. Socially conscious when discussing “sad” and “love” emotions in front of group, more comfortable exploring “angry”</td>
</tr>
<tr>
<td><strong>Maintainers</strong></td>
<td></td>
</tr>
<tr>
<td>12-year-old Ethiopian male (Participant No. 2)</td>
<td>Level of confidence, participation and sharing generally high throughout program. Comparatively mature responses to questions and behaviour. However at times, sensitive to being perceived as different and withdrew in response. Emotion depiction good.</td>
</tr>
<tr>
<td>12-year-old Burmese female (Participant No. 4)</td>
<td>Level of confidence, participation and sharing generally high throughout. Comparatively mature responses to questions and behaviour, played leader role, good emotion depiction.</td>
</tr>
<tr>
<td>11-year-old Chin female (Participant No. 10)</td>
<td>Level of self-confidence, participation and sharing generally high throughout program. Comparatively mature responses to questions and behaviour. Proud of her work and enjoyed receiving praise. Good emotion depiction.</td>
</tr>
</tbody>
</table>
Program effectiveness: Quantitative Evaluations

Effect on self-esteem.

Descriptive statistics comparing the results of the intervention and control groups at pre-test and post-test on the CSEI are presented in Table 13. With a maximum total score of 16 on the CSEI, participants in both the intervention and control groups positively endorsed most of the self-esteem items on this scale, thus rating their self-esteem highly.

Table 13

Comparison of CSEI Scores by Group at Pre-test and Post-test

<table>
<thead>
<tr>
<th>Group/CSEI Subscale</th>
<th>Pre-Test</th>
<th>Post-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Intervention (n = 11)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School-Academic</td>
<td>7.18</td>
<td>1.08</td>
</tr>
<tr>
<td>Social-Self/Peers</td>
<td>6.09</td>
<td>1.14</td>
</tr>
<tr>
<td>Total</td>
<td>13.27</td>
<td>1.68</td>
</tr>
<tr>
<td>Control (n = 10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School-Academic</td>
<td>7.60</td>
<td>0.70</td>
</tr>
<tr>
<td>Social-Self/Peers</td>
<td>6.00</td>
<td>0.67</td>
</tr>
<tr>
<td>Total</td>
<td>13.60</td>
<td>1.26</td>
</tr>
</tbody>
</table>

Note. CSEI = Coppersmith Self-Esteem Inventory

To test the hypothesis that participants exposed to the Rainbow program will show a statistically significant increase in self-esteem scores compared with the control group, the CSEI data was analysed using a 2 x 2 split-plot factorial MANOVA with an alpha level of .05 ($p = .05$). The first factor consisted of group (intervention, control) and the second factor was phase (pre-test, post-test). The DVs were scores from the two CSEI subscales, ‘school–academic’ and ‘social/self–peers’. No significant multivariate interaction was found, Wilks’ $\Lambda = .90$, $F(2, 18) = 1.06$, $p = .37$, $\eta^2_p = .11$, 95% CI [0.00, 0.33]. This indicates that the two factors (phase and group) are operating independently, and that overall, both groups
displayed similar changes on the dependent variables and thus, the research hypothesis was rejected. As the interaction effect was not significant, the multivariate main effects for group and phase were considered next.

The main effect for group was not significant, Wilks’ $\Lambda = .89 \ F(2,18) = 1.13, \ p = .35$, $\eta^2_p = .11, \ 95\% \ CI [0.00, 0.34]$. This indicates that there is no overall significant difference between the intervention and control groups’ total CSEI self-esteem scores when they are pooled across pre-test and post-test. However, the main effect for phase was significant, Wilks’ $\Lambda = .52, \ F(2,18) = 8.47, \ p = .003, \ \eta^2_p = .49, \ 95\% \ CI [0.09, 0.66]$. This indicates that the marginal mean self-esteem scores pooled across intervention and control groups at pre-test are statistically different from the marginal mean self-esteem scores pooled across the intervention and control groups at post-test, and that this effect was large.

Having established a significant multivariate main effect for phase, univariate ANOVA tests were conducted as a follow-up to the MANOVA on each dependent variable using the Bonferroni adjusted $p$ value of $p = .025$. These analyses revealed a significant phase main effect on the School-Academic subscale, $F(1, 19) = 16.09, \ p = .001, \ \eta^2_p = .46, \ 95\% \ CI [0.11, 0.65]$, but not on Social-Self subscale, $F(1, 19) = 0.35, \ p = .56, \ \eta^2_p = .02, \ 95\% \ CI [0.00, 0.23]$. Examination of the marginal means of School-Academic scores demonstrates a significant overall reduction in self-esteem scores from pre-test ($M = 7.38, SD = 0.92$) to post-test ($M = 6.29, SD = 1.15$) across both groups.

However, at a descriptive level there is some support for the research hypothesis. A visual inspection of the Social-Self/Peers subscale scores in Figure 2a reveals that self-esteem scores on this subscale increased for the intervention group. In comparison, the self-esteem scores on this subscale in the control group decreased. In addition, although both groups showed a decrease in the School/Academic subscale, Figure 2b shows that the control group displayed a sharper decrease on this subscale than that observed for the intervention group.
Figure 2. Mean scores for the CSEI subscales and CSEI Total score across time for the intervention and control groups.
This pattern of results is further supported by comparing the magnitude of the effects sizes using Cohen’s $d$ for self-esteem between the two groups over time, which are presented in Table 14. The larger effect sizes for the control group indicate that the decrease in self-esteem was greater in magnitude that the decrease seen in the intervention group.

Table 14

Cohen’s $d$ and the 95%CI for Self-Esteem Representing the Amount of Change between Pre-test and Post-test for the Rainbow and Control Groups

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>Intervention ($n = 11$)</th>
<th>Control ($n = 10$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$d$ Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>CSEI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School/Academic</td>
<td>0.66</td>
<td>-0.01</td>
</tr>
<tr>
<td>Social-self/Peers</td>
<td>-0.12</td>
<td>0.00</td>
</tr>
<tr>
<td>Total</td>
<td>0.26</td>
<td>-0.35</td>
</tr>
</tbody>
</table>

Although the MANOVA results indicate that these differences were not large enough to generate a significant interaction in the analysis, had sample number in each group been larger, a significant interaction may have been found.

**Effect on adaptive functioning.**

Descriptive statistics comparing the results of the intervention and control groups at pre-test and post-test on the adaptive functioning scale of the TRF are presented in Table 15. An adaptive function score between 12 and 13 indicates average functioning in comparison to other children their age (Achenbach, 2001). Therefore, the results indicate that all participants in both groups are adapting well in their school environment compared with typical pupils of the same age.
To test the hypothesis that participants exposed to the Rainbow program will show a statistically significant increase in adaptive functioning scores compared with the control group, the data was analysed using a 2 x 2 split-plot factorial ANOVA. The first factor consisted of the group (intervention, control), the second factor was phase (pre-test, post-test), and the DV was adaptive functioning scores. No significant multivariate interaction was found, Wilks’ Λ = .98, $F(1,19) = 0.33$, $p = .57$, $\eta_p^2 = .02$, 95% CI [0.00, 0.21]. Furthermore, no significant univariate main effects for group, $F(1,19) = 2.16$, $p = .16$, $\eta_p^2 = .10$, 95% CI [0.00, 0.40] or phase were found, Wilks’ Λ = .96, $F(1,19) = 0.80$, $p = .38$, $\eta_p^2 = .04$, 95% CI [0.00, 0.24]. The non-significant interaction and main effect results suggest that each group’s adaptive functioning scores are not significantly different from one other at either time point, and that there is no significant change in either group’s adaptive functioning scores over time. Importantly however, the results indicate that the Rainbow program did not have a statistically significant impact on the participant’s adaptive functioning, and thus the research hypothesis must be rejected.

Even at a descriptive level, the research hypothesis was not supported as the control group’s adaptive functioning scores increased more than the intervention’s scores on adaptive functioning. This is further corroborated by inspection of the calculated effect size $d$ for adaptive functioning, which are presented in Table 16.
Table 16

*Cohen’s d and the 95%CI for Adaptive Functioning Representing the Amount of Change between Pre-test and Post-test for the Rainbow and Control Groups*

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>Intervention 95% CI</th>
<th>Control 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>d</td>
<td>Lower</td>
</tr>
<tr>
<td>Adaptive Functioning</td>
<td>-0.08</td>
<td>0.00</td>
</tr>
</tbody>
</table>

The effect size $d$ is larger for the control group than for the intervention group, indicating that the increase effect was greater in the control group.

**Effect on internalising, externalising and total problem behaviours.**

Descriptive statistics comparing the results of the intervention and control groups at pre-test and post-test on the problem behaviour subscales from the TRF are presented in Table 17. Compared with a normative sample, TRF scores on the internalising, externalising, and total TRF subscales were in the non-clinical range for all participants, except for one participant in the intervention group whose externalising score was in the borderline-clinical range.
Table 17

Comparison of TRF Problem Behaviour Scores by Group at Pre-test and Post-test

| Group/Subscale | Pre-Test | Post-Test | |
|---------------|----------|-----------|
|               | M        | SD        | range | M        | SD        | range |
| Internalising | 1.82     | 1.72      | 0-4   | 1.50<sup>a</sup> | 1.96      | 0-7   |
| Externalising | 1.27     | 3.90      | 0-13<sup>b</sup> | 1.80<sup>a</sup> | 3.92      | 0-13<sup>b</sup> |
| Total         | 7.09     | 7.23      | 0-24  | 9.10<sup>a</sup> | 8.86      | 0-26  |
| Control (<i>n</i> = 10) |          |           |       |          |           |       |
| Internalising | 0.10     | 0.32      | 0-1   | 0.10     | 0.32      | 0-1   |
| Externalising | 0.00     | 0.00      | 0-0   | 0.00     | 0.00      | 0-0   |
| Total         | 0.90     | 2.23      | 0-7   | 0.70     | 1.34      | 0-4   |

Note: <sup>a</sup>The teacher missed completing the TRF details for one participant in the intervention group in the post-testing phase only. Missing data was estimated using EM methods. <sup>b</sup>One participant’s score falling within the borderline-clinical range on the externalising subscale.

To test the hypothesis that participants exposed to the Rainbow program will show a statistically significant decrease in problem behaviours compared with the control group, the TRF data was analysed using a 2 x 2 split-plot factorial MANOVA with an alpha level of .05 (<i>p</i> = .05). The first factor consisted of the group (intervention, control) and the second factor was phase (pre-test, post-test). The DVs were scores from the three TRF subscales, Internalising, Externalising, and Total problem behaviours.

No significant multivariate interaction was found, Wilks’ Λ = .84, <i>F</i>(3, 17) = 1.11, <i>p</i> = .37, η<sup>p</sup><sup>2</sup> = .16, 95% CI [0.00, 0.36]. This indicates that the two factors (phase and group) are operating independently, and that overall, both groups displayed similar changes on the dependent variables and thus, the research hypothesis must be rejected. As the interaction effect was not significant, the multivariate main effects for group and phase were considered next.

The multivariate main effect for phase was not significant, Wilks’ Λ = .86, <i>F</i>(3, 17) = 0.91, <i>p</i> = .46, η<sup>p</sup><sup>2</sup> = .14, 95% CI [0.00, 0.33]. This indicates that the marginal mean TRF
scores pooled across the intervention and control groups at pre-test are not statistically different from the marginal mean TRF scores pooled across the intervention and control groups at post-test. However, the multivariate main effect for group was significant, Wilks’ $\Lambda = .59$, $F(3, 17) = 3.94$, $p = .03$, $\eta_p^2 = .41$, 95% CI [0.00, 0.59]. This indicates that there is an significant difference between the groups’ TRF problem behaviour scores when they are pooled across pre-test and post-test.

Having established a significant multivariate main effect for group, univariate ANOVA tests were conducted as a follow-up to the MANOVA on each dependent variable using the Bonferroni adjusted $p$ value of $p = .017$. These analyses revealed a significant univariate main effect for group on the total problem behaviour subscale, $F(1, 19) = 9.00$, $p = .007$, $\eta_p^2 = .32$, 95% CI [0.03, 0.56], and a significant univariate main effects for group on the internalising subscale, $F(1, 19) = 10.03$, $p = .005$, $\eta_p^2 = .35$, 95% CI [0.04, 0.57]. Examination of the marginal means demonstrates that the intervention’s total problem behaviour scores ($M = 8.10$, $SD = 7.96$) and internalising scores ($M = 1.66$, $SD = 1.81$) were significantly higher than the control group’s total problem behaviour ($M = 0.80$, $SD = 1.79$) and internalised scores ($M = 0.10$, $SD = 0.31$) when each group’s scores were pooled across pre-test and post-test. The externalising subscale results were not significant between groups, $F(1, 19) = 1.58$, $p = .22$, $\eta_p^2 = .08$, 95% CI [0.00, 0.33].

At a descriptive level however, there is partial support for the research hypothesis. As can be seen in Figure 3, scores on the internalising subscale for the intervention group decreased, while the corresponding scores from the control group stayed the same. However, in direct contrast to the research hypothesis, scores on the externalising and total problem behaviour subscales increased sharply for the intervention group, while the corresponding scores from the control group stayed the same or decreased.
Figure 3. Mean scores for the TRF problem behaviour subscales across time for the intervention and control groups.
This pattern of results is confirmed when comparing the magnitude of the effects sizes for the TRF subscales between the two groups. The effect sizes $d$ are shown in Table 18.

Table 18

*Cohen’s $d$ and the 95% Confidence Interval for the Teacher Report Form Representing the Amount of Change between Pre-test and Post-test for the Intervention and Control Groups*

<table>
<thead>
<tr>
<th>TRF subscale</th>
<th>Intervention</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$d$</td>
<td>95% CI</td>
</tr>
<tr>
<td></td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>Internalising</td>
<td>0.16</td>
<td>-0.44</td>
</tr>
<tr>
<td>Externalising</td>
<td>-0.39</td>
<td>0.00</td>
</tr>
<tr>
<td>Total</td>
<td>-0.33</td>
<td>0.00</td>
</tr>
</tbody>
</table>

*Note.* $^a$ Cohen’s $d$ and associated CI could not be computed due to the standard error of the difference being zero for this variable.

Even at the case-study level, the results indicate that the Rainbow program is not effective in reducing externalising behaviours. For example, a score of 13 on the externalising subscale was ascribed to participant No.2 at both pre-test and post-test (a score of 13 on this subscale falls in the borderline-clinical range when compared with other boys his age). Thus, there was no change in this participant’s externalising behaviours despite his participation in the Rainbow program.

However, examination of the TRF questionnaires completed for this individual also reveals a possible validity problem with this participant’s data. It was noted that the teacher used the same examples of problem behaviour on items 40 and 73 to describe participant No.2 at both pre-test and post-test. However, the TRF directs teachers to describe a pupil as they are “now or in the past 2 months”. For these results to be valid, the incidences described would have had to have occurred one week prior to pre-test (as there was a seven week delay between pre- and post-testing). Although this is possible, it is also possible that the teacher did not follow the TRF instructions and instead, provided answers about this pupil in general rather than keeping descriptions about him within a two-month time-frame. Although this may throw the validity of all other TRF results into question, this it is impossible to ascertain
because extra descriptive comments about behaviour were only provided for Participant No.2 on the TRF.

An additional point to note about the TRF was the level of teacher dissatisfaction reported about the TRF. The school-teachers involved in the research complained that this questionnaire was too time-consuming and added a significant burden to their already heavy workload. The researcher suspects that the high number of zeroes circled on the TRF forms may have been influenced by teacher fatigue, although this assertion cannot be verified.

Nevertheless, the 2 x 2 split-plot factorial MANOVA results indicated that the observed differences were not great enough to generate a significant interaction in the analysis.

However, had the groups been larger and the power of the study stronger, it may well have indicated that the Rainbow program was helpful in reducing levels of reported internalising behaviours, but not externalising behaviours.

**Effect on depression.**

Descriptive statistics comparing the results of the intervention and control groups at pre-test and post-test on the CDI-S are presented in Table 19. As presented in this table, very few items were endorsed by participants, with the average score being well below 8, which is the cut-off used in this study to indicate possible depression on the CDI-S.

Table 19

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-Test</th>
<th>Post-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>Intervention ($n = 11$)</td>
<td>0.82</td>
<td>1.08</td>
</tr>
<tr>
<td>Control ($n = 10$)</td>
<td>0.80</td>
<td>0.79</td>
</tr>
</tbody>
</table>

To test the hypothesis that participants exposed to the Rainbow program will show a statistically significant decrease in depression scores compared with the control group, the
CDI-S data was analysed using a 2 x 2 split-plot factorial ANOVA. The first factor consisted of group (intervention, control) and the second factor was phase (Pre-test, Post-test). The DV was CDI-S scores.

No significant multivariate interaction was found, Wilks’ $\Lambda = .995$, $F(1,19) = 0.10$, $p = .75$, $\eta^2_p = .01$, 95% CI [0.00, 0.17]. Furthermore, no significant univariate main effects for group, $F(1,19) = 0.04$, $p = .85$, $\eta^2_p = .002$, 95% CI [0.00, 0.08] or phase were found, Wilks’ $\Lambda = 1.000$, $F(1,19) = 0.000$, $p = .99$, $\eta^2_p = .000$, 95% CI [0.00, 0.00]. The non-significant interaction results suggest that the pattern of change for depression scores over time is not different for the intervention and control groups and thus, the research hypothesis must be rejected as the Rainbow program did not have a statistically significant impact on the children’s level of depression. The non-significant main effect results indicate that that each group’s depression scores are not significantly different from one other at either time point, and that there is no significant change in either group’s depression scores over time.

However, at a descriptive level, there is some support for the research hypothesis. Inspection of the CDI-S results in Table 19 reveal that depression scores decreased over time for the intervention group, while depression scores increased for the control group. Analysis of the effect size $d$ for both groups presented in Table 20, reveal that although the magnitude of change for the intervention and control groups was the same, the direction of that change was in the hypothesised direction – with depression scores decreasing in the intervention group, while they increased for the control group.
Table 20

*Cohen’s d and the 95%CI for the Children’s Depression Inventory Representing the Amount of Change between Pre-test and Post-test for the Rainbow and Control Groups*

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>Intervention d 95% CI</th>
<th>Control d 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDI-S</td>
<td>0.07 -0.53 0.66</td>
<td>-0.07 0.00 0.48</td>
</tr>
</tbody>
</table>

Importantly, as the 2 x 2 split-plot factorial ANOVA results indicated, the observed differences were not great enough to generate a significant statistical interaction. However, had the groups been larger and the power of the study stronger, it may well have indicated that the Rainbow program was helpful in reducing levels of reported levels of depression.

**Effect on anxiety.**

Descriptive statistics comparing the results of the intervention and control groups at pre-test and post-test on the RCMAS are presented in Table 21. Previous studies have reported that a cut-off total raw score of 18 on the RCMAS may be predictive of an anxiety disorder (Montgomery & Finch, 1974; cited in Papageorgiou et al., 2000). As can be seen in Table 21, at pre-test the mean intervention scores fell at this cut-off.
Table 21

Comparison of Mean, Standard Deviation and Range Scores by Group at Pre-test and Post-test for the Revised Children’s Manifest Anxiety Scale

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-Test</th>
<th>Post-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Intervention (n = 11)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiological</td>
<td>1.91</td>
<td>1.64</td>
</tr>
<tr>
<td>Worry/Oversensitivity</td>
<td>4.55</td>
<td>2.91</td>
</tr>
<tr>
<td>Social concerns</td>
<td>2.73</td>
<td>1.56</td>
</tr>
<tr>
<td>Total</td>
<td>9.18</td>
<td>5.42</td>
</tr>
<tr>
<td>Control (n = 10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiological</td>
<td>1.00</td>
<td>0.82</td>
</tr>
<tr>
<td>Worry/Oversensitivity</td>
<td>2.10</td>
<td>1.45</td>
</tr>
<tr>
<td>Social concerns</td>
<td>2.30</td>
<td>1.34</td>
</tr>
<tr>
<td>Total</td>
<td>5.40</td>
<td>2.55</td>
</tr>
</tbody>
</table>

To test the hypothesis that participants exposed to the Rainbow program will show a statistically significant decrease in anxiety scores compared with the control group, the RCMAS data was analysed using a 2 x 2 split-plot factorial MANOVA with an alpha level of .05 (p = .05). The first factor consisted of group (intervention, control) and the second factor was phase (pre-test, post-test). The DVs were scores from the three RCMAS subscales; ‘physiological anxiety’, ‘worry/oversensitivity’, and ‘social concerns’. No significant multivariate interaction was found, Wilks’ $\Lambda = .92$ $F(3, 17) = 0.51$, $p = .68$, $\eta_p^2 = .08$, 95% CI [0.00, 0.25]. This indicates that the two factors (phase and group) are operating independently and that overall, both groups displayed similar changes on the dependent variables. Thus, the research hypothesis must be rejected as the pattern of change in anxiety scores over time is not different for the intervention and control groups. As the interaction effect was not significant, the multivariate main effects for group and phase were considered next.
The multivariate main effect for group was not significant, Wilks’ $\Lambda = .69$, $F(3, 17) = 2.57, p = .09, \eta^2_p = .31, 95\% \text{ CI}[0.00 - 0.51]$. This indicates that there is no overall significant difference between the intervention and control groups’ total RCMAS anxiety scores when they are pooled across pre-test and post-test. However, the multivariate main effect for phase was significant, Wilks’ $\Lambda = .33$ $F(3, 17) = 11.57, p < .001, \eta^2_p = .67, 95\% \text{ CI}[0.27 - 0.77]$. This indicates that the marginal mean anxiety scores pooled across intervention and control groups at pre-test are statistically different from the marginal mean anxiety scores pooled across the intervention and control groups at post-test, and that this effect was large.

Having established a significant multivariate main effect for phase, separate univariate ANOVA tests were conducted as a follow-up to the MANOVA on each dependent variable using the Bonferroni adjusted $p$ value of $p = .017$. These analyses revealed a significant phase main effects on the social concerns subscale, $F(1, 19) = 23.24, p < .001, \eta^2_p = .55, 95\% \text{ CI}[0.20 - 0.72]$, and that this effect was large. Examination of the marginal means for the social concerns subscales demonstrates a significant overall reduction in scores from pre-test ($M = 2.52, SD = 1.44$) to post-test ($M = 1.24, SD = 1.04$) across both groups. The phase main effects for the physiological subscale, $F(1, 19) = 0.01, p = .92, \eta^2_p = .00, 95\% \text{ CI}[0.00 - 0.02]$ and the worry/oversensitivity subscale, $F(1, 19) = 5.13, p = .04, \eta^2_p = .21, 95\% \text{ CI}[0.00 - 0.47]$ were not significant.

However, at the descriptive level, there is some support for the research hypothesis. For example, Figure 4a clearly shows that the control group displayed a rise in reported physiological anxiety between pre-test and post-test, while the intervention group reported a corresponding decrease in physiological anxiety. In addition, the intervention anxiety scores decreased at a sharper rate compared with the control group on the worry/oversensitivity subscale (Figure 4b) and on total RCMAS anxiety overall (Figure 4d).
Figure 4. Mean scores for the RCMAS subscales and RCMAS Total score across time for the intervention and control groups.
The patterns are corroborated by comparing the magnitude of the effects sizes for anxiety between the two groups over time. The effect sizes $d$ for the RCMAS subscales were calculated, and are shown in Table 22.

Table 22

<table>
<thead>
<tr>
<th>RCMAS Subscale</th>
<th>Intervention</th>
<th></th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$d$</td>
<td>95% CI</td>
<td>$d$</td>
</tr>
<tr>
<td>Physiological</td>
<td>0.22</td>
<td>-0.38 - 0.82</td>
<td>-0.32</td>
</tr>
<tr>
<td>Worry/Oversensitivity</td>
<td>0.56</td>
<td>-0.09 - 1.19</td>
<td>0.42</td>
</tr>
<tr>
<td>Social concerns</td>
<td>1.00</td>
<td>0.25 - 1.72</td>
<td>1.16</td>
</tr>
<tr>
<td>Total</td>
<td>0.69</td>
<td>0.02 - 1.34</td>
<td>0.52</td>
</tr>
</tbody>
</table>

Further support for the Rainbow program’s effectiveness for reducing anxiety symptoms comes from analysis of its clinical effects using the Jacobson and Truax (1991) method of clinical significance. Inspection of pre-test RCMAS scores revealed that one participant in the intervention group returned a total RCMAS score at the cut-off of 18, which has been previously shown to predict the presence of anxiety disorders (Montgomery & Finch, 1974; cited in Papageorgiou et al., 2000). In addition, two further intervention participants scored very close to this cut-off. The change in scores reported between pre- and post-intervention for these participants are presented in Table 23, and all reveal decreases in reported anxiety levels to a level well below the cut-off after their participation in the Rainbow program. Therefore, the Rainbow program appears to fulfil Jacobson and Truax’s (1991) first criteria for clinical significance for at least one participant (and potentially two other participants) because participant No. 8 moved from the “dysfunctional” range into the “functional” range on RCMAS scores. Participants 4 and 2 also moved deeper into the functional range.
Table 23

*Examination of Pre- and Post-Test Results of High Scoring Intervention Participants on the RCMAS*

<table>
<thead>
<tr>
<th>Participant</th>
<th>RCMAS Pre-Total</th>
<th>RCMAS Post-Total</th>
<th>Change in scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. 8</td>
<td>18</td>
<td>8</td>
<td>-10</td>
</tr>
<tr>
<td>No. 4</td>
<td>16</td>
<td>2</td>
<td>-14</td>
</tr>
<tr>
<td>No. 2</td>
<td>16</td>
<td>10</td>
<td>-6</td>
</tr>
</tbody>
</table>

The reliability of these changes were evaluated next using a Jacobson and Truax (1991) reliable change graph, which is presented in Figure 5. The horizontal line represents the cut-off score of 18, which has been found to predict the presence of anxiety disorders. As can be seen in Figure 5, the majority of participant results fall between the dashed diagonal lines, and are considered not to have changed sufficiently to rule out random fluctuations or test unreliability as the source of the change. However, of the three participants identified in Table 23, two participants (No. 8 and No. 4) fall outside this range, while one participant (No. 2) falls right on the dashed line. Therefore, participants No. 8 and No. 4 are considered to have made reliable changes for the better because their RCMAS scores dropped. Although RCMAS results for participant No. 2 also dropped, the change in scores observed for this participant were not reliable.
Figure 5. Scatter plot of pre-test and post-test scores from the RCMAS total anxiety scale with a band showing the reliable change index based on the 95% confidence interval of the $S_{\text{diff}}$ (i.e. 1.96 $S_{\text{diff}}$) to determine the reliability of change scores.

At the case-study level, these results suggest that the Rainbow program had a clinically significant effect for participant No. 8, who was identified as being at risk of having an anxiety disorder, and potentially for participant No. 4, whose scores came very close to the cut-off at pre-test. However, as the 2 x 2 split-plot factorial MANOVA results indicated, the observed differences were not great enough to generate a significant statistical interaction in the analysis. Had the groups been larger and the power of the study stronger, it may well have indicated that the Rainbow program was helpful in reducing levels of reported anxiety compared with the control group.

Anxiety-lie item.

Results from the single lie item included in the RCMAS indicated that at pre-test 82% and 60% of participants in the intervention and control groups respectively endorsed the lie
item “I am always good”. High levels of item endorsement on the RCMAS lie scale may indicate acquiescence, social desirability, or deliberate faking of responses. However, as only one of the nine lie items were administered in this study, this cannot conclusively be used to bring the validity of the results from the RCMAS and indeed the other self-report measures into question.

Interestingly, at post-test, the percentage of participants endorsing the lie item dropped to 36% and 50% for intervention and control groups respectively. Reasons for this change is unknown. Chi-square analyses presented in Table 24 reveal no differences between groups in the pattern of responding to this item in either phase of the study.

Table 24

<table>
<thead>
<tr>
<th>Phase</th>
<th>Number of participants endorsing Lie item</th>
<th>df</th>
<th>( \chi^2 )</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-test</td>
<td>9</td>
<td>6</td>
<td>1</td>
<td>1.22</td>
</tr>
<tr>
<td>Post-test</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>0.40</td>
</tr>
</tbody>
</table>

Note. RCMAS = Revised Children’s Manifest Anxiety Scale.

12-Month Follow-Up Data

As the 12-month follow-up assessment data were not collected, the program’s prevention effects (i.e. longer term effects based on follow-up evaluations) could not be evaluated.

Discussion

The overall aim of this study was to implement and evaluate the effectiveness of the Rainbow Program for Children in Refugee Families, a mental health prevention program for recently-arrived refugee children. This is the first time that the Rainbow program has been formally evaluated. However, this study contained four specific aims, centred around a process and product evaluation of the Rainbow program. The first aim was to implement the
Rainbow program as directed by the program manual. The second aim was to conduct both qualitative and quantitative evaluations of social validity by examining level of participant satisfaction, and level of participation and attendance. The third aim was to conduct qualitative evaluations of the program’s effect on the settlement experiences of recently-arrived refugee children. And the final aim was to conduct quantitative evaluations of the Rainbow program’s mental health prevention effects by examining its immediate (pre-post) and longer-term effects (at 12-month follow-up) on protective factors (self-esteem and adaptive functioning), risk factors (internalising and externalising symptoms) and on symptoms of depression and anxiety.

Summary of Results

Program integrity.

It was hypothesised that the Rainbow program would be implemented at WELS with sound program fidelity however, this hypothesis was only partially supported as the teacher and parent components of the Rainbow program were not implemented. Staff from WELS had already undertaken this component as part of their professional development requirements, and because WELS was unable to contribute to the cost of providing transport and childcare for parents, implementation of the parent component was placed beyond the means of the current study’s budget. However, the children’s component was successfully implemented.

The overall program integrity for the children’s component was high, with a 96% adherence rate to the agenda items specified in the program manual. In addition, analysis of the Session Summary Worksheet (SSW) revealed that the agenda items were implemented effectively and that all aspects of the group process were rated very positively. However, a threat to the reliability and validity of these results exists because the SSW is essentially a
self-assessment, in which the researcher rated herself on the quality of her own delivery of the program. However, the researcher completed the SSW in collaboration with the co-facilitator, which helped to reduce the threat of biased reporting on this measure.

Examination of the SSW also revealed that only the closing exercises were omitted from the program on three occasions due to time constraints. However, it is unlikely that omitting the closing exercises would have made a significant impact on the program outcomes. This is because delivering the Rainbow Session Feedback Questionnaire and the Social Validity Questionnaire at the end of each session could be considered a suitable substitute for the closing exercises.

As previously discussed, program integrity evaluations are a vital methodological requirement for intervention effectiveness evaluation because any changes, key omissions and/or poor execution of procedures could affect the program’s outcomes (Dumas et al., 2001). Given that the program integrity ratings for the children’s component were very positive, it is extremely likely that the study’s findings on intervention effectiveness of the children’s component are valid.

**Social validity.**

It was hypothesised that the Rainbow program would demonstrate high social validity as reflected by: (a) high satisfaction rates, (b) high attendance rates, and (c) high participation rates. This hypothesis was supported at all three levels.

Satisfaction ratings were determined using the Social Validity Questionnaire (SVQ), the Rainbow Session Feedback Questionnaire (RSFQ) and the Letters to the Researchers. The results across all three measures were consistent and overwhelmingly positive. An overall 98.2% satisfaction rating was obtained from the SVQ however, a couple of negative ratings obtained highlight the importance of employing interpreters for all participants. The findings from the RSFQ clearly indicated that participants enjoyed all activities undertaken, and could
recall what they did and learned in each session. These findings suggest that agenda items resonated with the participants. Perhaps activities were novel, enjoyable, interesting, and/or used skills that the participants have become proficient in (e.g. drawing, colouring), giving them a sense of mastery. These results also suggest that the exercises used to explore identity, emotions and similarities were engaging.

Although the social validity measures were not anonymous, participants still provided some suggestions for how the program could be improved. This indicates that the participants felt safe enough to provide constructive criticism, and that the participants were not necessarily providing only positive responses just to please the facilitators. The value of completing the RSFQ at the end of every session was also demonstrated in this study. By administering the RSFQ at the end of every session, detailed and rich feedback can be collected about each session, rather than about the program overall. Information collected from the RSFQ could then be used to inform any future changes to the Rainbow program.

The high rates of attendance (93.5% overall) and level of participation (100% consent rate for participation in the study, as well as high or improved levels of participation in program activities) adds further weight to the social validity of the Rainbow program. The high level of consent for children participation in both control and intervention groups suggests that parents may see the value in evaluating programs designed for their children’s benefit. The overwhelming positive experiences by everyone involved in running the Rainbow program at WELS, including the participants, researchers, ESL teachers and interpreters (who were also refugees) provides evidence for the social validity of the program.

**Program effectiveness: Qualitative evaluations.**

Regarding the contribution the Rainbow program makes to the settlement experience of recently-arrived refugee children, it was hypothesised that the participants would describe the Rainbow program as a highly enjoyable and valuable experience (as measured by Letters to
the Researchers). It was also hypothesised that the researcher would observe participants enjoying their experiences in the program, and would observe improvements in confidence and the level of social, behavioural and emotional strengths displayed by each participant over time (as measured by the participant progress notes). Both of these research hypotheses were supported.

In the Letters to the Researchers, participants indicated that their experiences in the program were special and highly valuable to them. They described the program as a place where they had fun and could learn English in an enjoyable way. Participants also reported that they liked learning about emotions, were pleased with the opportunity to develop their social skills, and build their self-confidence. The content of participant letters also illustrate that learning and talking about rainbows in the group was a particularly poignant experience for them. Thus, incorporation of the rainbow theme into many of the program’s activities most definitely caught the attention and imagination of the participants.

The researchers also observed positive changes in the Rainbow participants over time. Overall, each participant’s level of enjoyment, participation, sharing and confidence improved, or remained at the same high level if these aspects well developed to begin with. This may be due to the predictable structure of each Rainbow session, the safe environment created by virtue of the program rules and the constant positive reinforcement provided by the facilitators and group participants whenever a contribution was made. Although similar observations were not conducted with the control group to compare their social, behavioural and emotional strengths in their usual class settings, taken together, these findings support the Rainbow program’s effectiveness in making a positive contribution to the experiences at school for recently-arrived refugee children.
Program effectiveness: Quantitative evaluations.

Self-esteem.

Being a protective factor, it was hypothesised that levels of self-esteem would increase between pre- and post-testing for participants in the Rainbow group while the self-esteem would stay the same or decrease for participants in the control group. This hypothesis was not supported as the 2 x 2 split-plot factorial MANOVA interaction was not significant. However, at the descriptive level, the pattern of results on the Social-self/peers subscale occurred in the hypothesised direction. Scores on the Social-self/peers subscale increased between pre- and post-testing for the intervention group while they decreased in the control group. In addition, the control group displayed a decrease in School/Academic scores that was sharper over time than that observed for the intervention group. Had the sample number in each group been larger and the power of the study stronger, a significant statistical result may have been observed.

Participants in both groups endorsed most of the self-esteem items on the CSEI positively, thus rating their self-esteem highly. However, as self-esteem scores were high to begin with in both groups, it was not unexpected that improvements by post-test were not observed in the intervention group. Interestingly, the self-esteem scores reported in the current study are generally higher than those reported by Barrett and colleagues (2001, 2002, 2003), who also utilised the same two CSEI subscales in their study with primary-school aged refugee children from the former-Yugoslavia. However, it is important to note the self-esteem scores in the studies by Barrett and colleagues were also high. Together, these results indicate that refugee children in Australia may enjoy healthy levels of self-esteem, at least in their first year after arrival.

While the finding in this study may accurately reflect the participant’s current level of self-esteem, follow-up studies utilising all subscales of the CSEI may help to illuminate
whether these findings reflect the “honey-moon period” found to accompany the early phases of resettlement, or whether they reflect enduring levels of high self-esteem in refugee children. Barrett et al. (2001) contend that in the early phases of resettlement, young migrants experience idealisation of their new environments. However, as disillusionment sets in after repeated confrontations with foreign cultural norms and difficulties, self-esteem begins to suffer. Indeed, Gifford, Correa-Velez, and Sampson (2009) also reported that the transition to mainstream schools after positive experiences at English Language School is fraught with difficulties for recently-arrived refugee children, and that as a result, their self-esteem may begin to suffer. After their transition to mainstream schools, Gifford and colleagues found that refugee children described being unable to meet their own educational expectations, felt less safe, less supported by teachers, and had been subjected to discrimination. Therefore follow-up evaluations could help to determine whether participation in the Rainbow program helps to protect individuals when acculturative stressors at mainstream schools begin to take their toll.

Adaptive functioning.

Being a protective factor, it was hypothesised that levels of adaptive behaviour would increase between pre- and post-testing for participants in the Rainbow program, while levels of adaptive behaviours would stay the same or decrease for participants in the control group. This hypothesis was not supported as the 2 x 2 split-plot factorial ANOVA interaction was not statistically significant. Even at a descriptive level, the research hypothesis was not supported as the control group’s adaptive functioning scores were shown to increase by more points than the intervention group. However, adaptive functioning for participants in both groups was good, and rated at a level that was typical of other pupils the same age. Therefore, it was not unexpected that improvements at post-test were not observed for the intervention group. However, follow-up analyses are necessary to help determine whether the Rainbow
program is better able to sustain adaptive functioning in refugee children compared with the control group when acculturative stressors begin to take their toll.

Comparison of the current study’s adaptive functioning results with other refugee studies is made difficult by virtue of the fact that the majority of refugee studies utilising the TRF have not reported results from its adaptive functioning subscale (e.g., Bean, Eurelings-Bontekoe, & Spinhoven, 2007; Rothe et al., 2002). However, Habir et al. (1994) reported that all 59 Lebanese refugee children aged between five and 11-years living in Melbourne scored within the non-clinical range on adaptive functioning. Furthermore, a report by O'Regan (1998), documenting the social and academic adaptation of 31 Vietnamese and Bosnian refugee children living in Ireland, found that only two out of 31 children had scores in the clinical range. Taken together, these results indicate that many refugee children can adapt well to their school environment in resettlement countries. These findings therefore highlight the importance for researchers to investigate refugee strengths, not just perceived deficits.

Internalising and externalising problem behaviours.

Being risk factors for mental health, it was hypothesised that levels of internalising and externalising behaviours would decrease between pre- and post-testing for participants in the Rainbow group, while levels of internalising and externalising behaviours would stay the same or increase for participants in the control group. This hypothesis was not supported as the 2 x 2 split-plot factorial MANOVA interaction was not statistically significant. However, at the descriptive level, the pattern of results on the internalising subscale occurred in the hypothesised direction. Scores on the internalising subscale for the intervention group decreased, while the corresponding scores from the control group stayed the same. Had the sample number in each group been larger, the Rainbow program may have shown a significant statistical effect on the internalising subscale of the TRF. The literature indicates that refugee children are at particular risk of developing anxiety and depression. Given that
the internalising subscale reflects many of the symptoms of these two disorders, the results are highly encouraging of the Rainbow program’s potential as a mental health prevention program.

However, in direct contrast to the research hypothesis, scores on the externalising and total problem behaviour subscales increased sharply for the intervention group, while the corresponding scores from the control group stayed the same or decreased. In addition, the borderline-clinical results for participant No. 2 on the externalising subscale did not change after his involvement in the Rainbow program. Therefore, these results indicate that Rainbow program may have no effect and potentially, may have a detrimental effect on externalising behaviours. However, this is unlikely given that the increase in scores on the externalising subscale for the intervention group were generally very small, and all other scores were well within the non-clinical range for these behaviours. In addition, because problems with anxiety and depression are more commonly reported in refugee populations than are conduct problems, effects on internalising symptoms may be more relevant to the Rainbow program’s effectiveness for promoting wellbeing.

The TRF results in the current study are generally concordant with the few refugee studies also utilising the TRF. For example, O'Regan (1998) reported that the TRF Total scores of 31 Vietnamese and Bosnian refugee children living in Ireland scored within the non-clinical range (data from the internalising and externalising subscales were not provided in this report). Erol, Sqimsek, Öner, and Munir (2005) also reported that mean TRF Total scores fell well within the non-clinical range in a sample of Turkish children who had experienced internal displacement. Taken together, these results indicate that many refugee children are resilient, and can adjust despite experiences of hardship.
Depression.

It was hypothesised that levels of depression would decrease between pre- and post-testing for participants in the Rainbow group, while levels of depression would stay the same or increase for participants in the control group. This hypothesis was not supported as the 2 x 2 split-plot factorial ANOVA interaction was not statistically significant. The lack of change between pre-test and post-test on the CDI-S were not surprising given that scores fell within the healthy range to begin with. However, at a descriptive level, the pattern of results occurred in the hypothesised direction with decreasing CDI-S scores for the intervention group and increasing CDI-S scores for the control group. Had sample number in each group been larger and the power of the study stronger, a significant statistical result may have been observed.

To the researcher’s knowledge, this is the first refugee study that has utilised the short version of the CDI, and therefore direct comparisons of the results to other refugee studies cannot be made. However, the depression results reported in this study are significantly lower than the prevalence rate of depression varying between 15% and 47% in refugee children who have resettled in the United States (Crowley, 2009). Reasons for the low level of depressive symptoms may relate to the age of the participants. The average age of the participants in this study was 10.6 years. However, the literature indicates that the incidence of depression is generally low in this age group, and that if depression is present in young children, it is difficult to diagnose (Servan-Schreiber et al., 1998). Therefore, in order to properly evaluate the Rainbow program’s effect on depressive symptoms and on incidence of depression, follow-up evaluations are recommended and culturally-sensitive clinical interviews may be necessary to overcome difficulties with diagnosis of depression in young refugee children.
Anxiety.

It was hypothesised that levels of anxiety would decrease between pre- and post-testing for participants in the Rainbow group, while levels of anxiety would stay the same or increase for participants in the control group. This hypothesis was not supported, as the 2 x 2 split-plot factorial MANOVA interaction was not statistically significant. However, at the descriptive level, the pattern of results on the physiological subscale occurred in the hypothesised direction. The intervention group reported a decrease in physiological anxiety, while the control group displayed a corresponding rise in reported physiological anxiety between pre-test and post-test. In addition, the anxiety scores for the intervention group decreased at a sharper rate compared with the control group on the worry/oversensitivity subscale and on total RCMAS anxiety.

Further support for the Rainbow program’s effectiveness in reducing anxiety symptoms comes from the data of at least one (and possibly a second) intervention participant. This participant returned a pre-test RCMAS score at the cut-off which is predictive of an anxiety disorder. Although this cut-off was not established using refugee children, it was clear to the researcher that this participant was suffering from the effects of psychological difficulties throughout her involvement in the program. At post-test, RCMAS results were reliably and clinically significant reduced for two participants. Had the groups been larger and the power of the study stronger, it may well have indicated that the Rainbow program was effective in reducing levels of reported anxiety compared with the control group.

However, the lack of significant change between pre-test and post-test on the RCMAS were not surprising given that the majority of RCMAS scores fell within the healthy range to begin with. The RCMAS results reported in this study were similar to the RCMAS scores reported by Barrett et al., (2002) for former-Yugoslavian refugee primary-school children resettled in Australia (mean RCMAS Total = 9.18). However, the RCMAS scores reported in
this study were much lower than those reported by Barrett et al. (2003) for former-Yugoslavian refugee children resettled in Australia (RCMAS Total = 12.89), by Ehntholt et al. (2005) for refugee children from Kosovo, Sierra Leone, and Turkey resettled in London (RCMAS Total = 16.87), and by Papageourgiou et al. (2000) for 95 Bosnian refugee children living in Greece (RCMAS Total = 14.3). Reasons why RCMAS scores in this study were much lower than those reported in other studies could be related to lower levels of trauma and fewer settlement stressors experienced by participants. However this cannot be verified as the number and type of traumatic events and stressful experiences were not collected in the current study.

12-month follow-up.

The final research hypothesis in this study stated that the aforementioned hypothesised changes would be maintained at 12-month follow-up. Unfortunately, follow-up assessments were not conducted due to the financial constraints of the study. Therefore, the final hypothesis relating to the Rainbow program’s prevention effects (i.e. longer term effects based on follow-up evaluations) could not be assessed. The lack of a follow-up period is a major limitation of the study. At least a 12-month follow-up period is required if the Rainbow program’s effect on the wellbeing in refugee children is to be examined.

Overall discussion of quantitative results.

Taken together, the results of the current study highlight the importance for clinicians not to presume that recently-arrived refugee children will present with psychopathology. However, the findings from the single RCMAS lie item included in the questionnaire package, indicate that some participants may have displayed acquiescence, social desirability, or deliberate faked their responses. Thus, participants may have inadvertently underreported their distress. Alternatively, it also possible that one lie item is not sufficient to make this
assertion, or that the lie item chosen was not culturally-appropriate to use in this group of
children. Nevertheless, the quantitative data results were generally consistent with the
researcher’s observation that the majority of participants were not significantly emotionally
or behaviourally disturbed.

The finding that the majority of participants reported healthy self-esteem, adaptive
functioning, low levels of internalising and externalising problems, and low levels of anxiety
and depression may reflect that life in Australian society has been a positive experience for
these participants so far. Consequently, the result may indicate that Melbourne has
successfully provided the conditions necessary to allow refugees, especially for refugee
children, to recover from trauma and successfully integrate into their new environment
(McKelvey et al., 2002). Importantly, the support provided to students and their families by
the Western English Language School may also be a major contributor to their current
reported wellbeing.

However, as found by Barrett et al. (2001) and Gifford et al. (2009), young migrants and
refugees often experience disillusionment upon their transition to mainstream schools and are
confronted with foreign cultural norms, discrimination and other difficulties. Therefore
follow-up evaluations are essential before a determination can be made about the Rainbow
program’s ability to protect these individuals when acculturative stressors at mainstream
schools begin to take effect.

**Strengths and Limitations**

There were a number of strengths in this study that warrant discussion. First, this study
adds to the very limited number of controlled, empirical evaluations of prevention
interventions designed to improve the well-being of refugee children in the context of
resettlement. The dissemination of the study findings will help to improve mental health
literacy, and support the promotion, prevention and early intervention for recently-arrived
refugee children. Second, this study’s evaluation methodology was significantly informed by the CIPP model of program evaluation. Therefore, this study provides details about the program’s implementation and integrity – vital information that many evaluation studies fail to report. Third, this study evaluated an early-intervention programs that is popular and easily disseminated in a regular school settings. Thus, the evaluation enjoyed support from teachers, multicultural aides, and administrative staff which enormously helped the researcher to implement and evaluate the program. And finally, the high attendance and participation rates, as well as zero attrition rates were also a major strength of this study. Clearly, these strengths support the feasibility of conducting evaluations of intervention programs for refugee children.

However, it is important to consider the study’s limitations when interpreting the results. The design of this study was quasi-experimental, with the allocation to the experimental group based upon the needs of the children as determined by the school’s welfare co-ordinator. While this process is ecologically valid, this selection bias presents a threat to the internal validity of the study because there is no way of knowing whether the two groups were equivalent to start with (Salkind, 2003). In addition, as the participants were a convenience sample who were recruited from an inner-city language school, the external validity of the study is compromised as the findings cannot be generalised to other recently-arrived refugee children living in other locations, or to other groups from different cultural backgrounds. Furthermore, the small sample size allows for only cautious conclusions to be drawn. Although differences existed between the intervention and control groups, with a sample size of 21, the study lacked the statistical power necessary to detect whether statistically significant effects were present. The small sample size in the current study resulted from a lack of resources to pay interpreters for any other additional groups at different schools.
Other study limitations stemming from limited financial resources included; lack of a follow-up period, inability to provide interpreters for all participants, and the inability to run the parent’s component concurrently with the children’s component. The absence of a follow-up period means that this study cannot comment on the Rainbow program’s long-term effects on protective and risk factors for mental health, or on symptoms of depression and anxiety. As the effects of mental health promotion and prevention efforts often take some time to become evident (DHAC, 2000), a follow-up period of at least 12-months would be required to provide information about any long-term differences between the intervention and control groups. However, epidemiological studies also indicate that depression levels in young people begin to rise at around 13 to 15 years of age. Therefore, a follow-up period of at least 6-years may be necessary to sufficiently investigate whether the Rainbow program had an effect on depression. Unfortunately, the researchers did not have resources to trace this cohort upon their imminent departure from the institution they were recruited from. The few studies, which have successfully carried out longer follow-up investigations with refugee children have had larger research budgets, more resources, and used large sample sizes to insure against attrition rates (e.g., Bean et al., 2007; Horowitz & Garber, 2006; Rousseau, Drapeau, & Rahimi, 2003; Sack et al., 1999).

In addition, the researcher was unable to employ interpreters for two participants who were not proficient in English (one Sudanese and one Congolese participant), and this may have negatively influenced the results. Indeed, one of these participants reported that she did not understand the work in first session and that session was only “a little” fun. The limited resources also prevented the researchers from running the parent’s component, which aims to promotes social inclusion by “building links between parents and the school and provides a forum for parents to receive information about resources and initiatives in the school and wider communities to assist them in supporting their children’s settlement” (VFST, 2002, p.242).
As previously indicated, promotion of social inclusion has been shown to improve mental health (Keleher & Armstrong, 2005). As the emotional wellbeing of refugee parents has been shown to predict the emotional well-being of their children (Almqvist & Broberg, 1999), the parent component may also have a positive, but indirect effect on the wellbeing of refugee children. However, this research question could not be explored in this study.

An important limitation of the current study involved the use of measures with psychometric properties that have not yet been demonstrated with refugee populations. Thus, it is not clear whether the conclusions drawn from these measures are valid. However, the results from these measures were consistent with the researcher’s observations of the participant’s level of well-being. In particular, the RCMAS result for participant No. 8 was above the clinical cut-off and was consistent with the researcher’s impressions that this participant was significantly more anxious compared with her peers. However, due to lack of clinical interviews, inferences about individual cases are limited.

Unfortunately, there is a lack of culturally or linguistically sensitive, valid and reliable assessment measures for refugee children’s mental health (Davidson, Murray, & Schweitzer, 2010). Therefore, until such measures are developed, or until further validity, reliability and norming studies using refugee populations are conducted, all refugee mental health research will be limited by this issue. The reliance on self-report measures and their associated weaknesses such as response styles and response sets (Cohen & Swerdlik, 2004; Lanyon & Goodstein, 1997) are another general limitation in this study.

Finally, methodological limitations relating to how the measures were administered may have also impacted the validity of the results. Although group administration of the self-report measures is permitted according to the administration instruction, the researchers noted that in translating the items for the participants, the multi-cultural aides (MCA) spent a considerable amount of time talking about the items. Thus the researchers cannot verify the
equivocality of the items on the scales and the items administered. In addition, during the post-intervention data collection phase, the researcher overheard one MCA tell a participant how to answer at least one of the questions in the package, further bringing the validity of the results into question. Although brief training was provided to the MCAs about questionnaire administration and translation, these issues highlight the importance of providing better training to interpreters used in research. Finally, the time between pre- and post-testing was seven weeks, which meant that results from the TRF (which inquired about children’s behavioural, emotional and social problems over the previous 8 weeks) may have been confounded by a one-week overlap. The TRF was also very time consuming for the teachers to complete, and thus a different measure, such as the teacher version of the Strengths and Difficulty Questionnaire (Goodman, 1997) may have been a more acceptable to the teachers.

**Practical Implications and Recommendations**

Although the findings are highly encouraging, this evaluation produced insufficient evidence for the researcher to recommend the widespread introduction of the Rainbow program as a mental health prevention strategy for recently-arrived refugee children. More empirical support of the program’s effectiveness is required before such a recommendation can be definitively made. As a result, several practical implications are provided.

First, the resourcing difficulties associated with running the parenting component are noted. It is recommended that schools be provided with special government funding to cover the costs of transport, child care, and interpreting services to maximise parental attendance and participant experience in the Rainbow program. Second, although encouraging, the statistically insignificant findings suggest that the Rainbow program could be modified. One suggestion offered by the researcher involves increasing the number of sessions, so that sessions span at least one full school-term, if not for the full school year. Classroom-based mental health promotion interventions adopted continuously over a long time (e.g. more than
a year) have been found to be more effective (Green, Howes, Walters, Maher, & Oberklaid, 2005; Wells, Stewart-Brown, & Barlow, 2001).

The researcher recommends that the VFST commission a working group to develop extra sessions that could include more psychoeducation about the relationship between thoughts, emotions, behaviour, and body sensations, and the development of cognitive and social problem-solving skills. This may be especially important in light of the anticipated problems refugee children may face when they leave their English Language School for mainstream schools (Gifford et al., 2009). Further sessions could also discuss issues related to intergenerational conflict that has been reported in the refugee literature (e.g., Brough, Gorman, Ramirez, & Westoby, 2003; Lipson & Omidian, 1997; Poppitt & Frey, 2007).

The final recommendation relates to the Rainbow Session Feedback Questionnaire. The RSFQ should be administered at the end of each Rainbow session so that the information can be used to improve the program experience for participants by promoting agency, and by exploring topics that participants would like to further discuss. For example, in this study, participants revealed they would have liked to explore participant country of origin in further detail. However, there was not enough time to honour this request in subsequent sessions. Time could be set aside in the “extra” sessions developed by VFST to address these types of participant requests.

Further Research and Recommendations

Many mental health prevention programs have been found to be effective for children in the general population (e.g., Barlow & Parsons, 2004; Barrett & Turner, 2001; Cardemil et al., 2002; Feldner et al., 2004; Foxcroft et al., 2002). However, very few effective mental health promotion interventions targeting refugee children have been established. These findings reinforce the significance of conducting further evaluations of programs, like the Rainbow program to address this gap.
Therefore, based on the current findings there are several implications for future evaluations of the Rainbow program. First, although the Children’s component can be delivered as a stand-alone initiate, evaluation of the Rainbow program with the parent and children component run concurrently is highly encouraged. If, as recommended, extra sessions are developed for the Rainbow program, future studies may also consider running a comparison between the current version of the Rainbow program with the “updated” version. However, as previously mentioned, funding to cover transport, child-care, and interpreting services are required. An evaluation that includes the parent component may also open opportunities for researchers to conduct interviews with parents rather than solely relying on self-report measures from participants and teachers.

Second, conducting follow-up evaluations are necessary to determine the Rainbow program’s longer-term effects on the well-being of refugee children. Follow-up periods of at least 12-months, and ideally, up until participants turn 15 years of age is recommended. However, the most efficient, cost effective and sustainable means by which participants can be followed up would need to be resolved.

Third, future evaluations should also include larger sample sizes, random allocation to groups, and the evaluation of the program at multiple schools around Australia with different facilitators. In this way, studies that compare the effectiveness of the Rainbow program with refugees from various ethnic groups, as well as investigating separate outcomes for culture, sex, and age may also be possible. Unfortunately, the small sample size of this study did not permit the researcher to examine if program effects varied for different ethnic groups, younger versus older children, or for boys versus girls.

Fourth, it is acknowledged that involving teachers in research studies places extra burdens upon already busy individuals. Therefore, researchers should consider this in the selection of outcome measures. Careful training of interpreters assisting in the administration
of these measures is also highly recommended. Finally, this study supports the call for the development of culturally and linguistically sensitive, valid and reliable assessment measures for use with refugee children.

Conclusion

Although the results of the Rainbow program evaluation were inconclusive, the researcher is highly encouraged by the results. Not only was the Rainbow program shown to display very high social validity, qualitative results also indicated that the program does indeed make a positive contribution to the settlement experiences of recently-arrived refugee children. To date, very few randomised control trial prevention work has been conducted with refugee children and thus, the results from this study show that mental health prevention work is feasible and valuable. As stated in the Australian Government’s mental health action plan, if a program is shown to be effective, then there is an ethical obligation on the part of governments to provide that intervention in an ongoing way (DHAC, 2000, p. 25). This presents clinicians and researchers in the refugee field with a compelling reason to continue this line of work.
Chapter 7: General Discussion

In this chapter, the aims and major findings from Studies One and Two are briefly summarised. The methodological issues pertinent to conducting research with individuals from a refugee background are then discussed. Finally, the theoretical and practical implications of the findings are considered.

Summary of Findings

Study One.

Families can play a central role in helping its members cope with the stressors of displacement and past trauma (Weine et al., 2008). Unfortunately, research indicates that when parents are distressed and under stress, their parenting practices may become impaired and the wellbeing of their children is often negatively affected (Ajdukovic, 1996). However, very little research has examined the challenges facing recently-arrived refugee parents in Australia. Therefore the aim of Study One was to extend the current parenting literature and in doing so, generate possible intervention ideas for the development of mental health prevention and promotion initiatives that improve the wellbeing of refugee parents.

Supporting refugee parents to be healthier and happier should place them in a better position to positively influence their children’s wellbeing, by helping their children to cope, adjust, and succeed in their new environment.

In the current research, three focus groups were conducted in Melbourne with 21 refugee mothers representing four African refugee communities. The findings revealed that refugee mothers regarded parenting as a joyful and rewarding experience. In general, they reported that they had been relatively successful in meeting their children’s needs and that they were competently carrying out their parenting roles. They also depicted themselves as being flexible in their traditional parenting roles. For example, in the absence of extended
family and lack of economic resources, fathers have been contributing to childcare and some mothers have sought employment outside of the home. Overall, these findings are important because they provide evidence to highlight their resilience, strength, and commitment to meeting their children’s needs and providing a secure future for their families.

However, three main challenges negatively impacting upon their parenting experiences were also reported. These included: (a) the separation from their families and social supports; (b) difficulties with discipline and fears related to child protection; and (c) fears and difficulties related to Australian/Western influences and acculturation. These same challenges have previously been reported by Somali refugees in Finland and in Canada (Degni et al., 2006; Israelite et al., July, 1999) and by refugee parents from eight different cultural groups in Australia (Lewig et al., 2010). Given the consistency by which these findings have appeared in the literature, they strongly indicate that family and community-based interventions aimed at addressing these areas may have a significant positive impact upon the wellbeing of refugee families.

Indeed, the third aim of Study One was to elicit ideas from the participants themselves about how they could be better supported in their roles as parents. Participants generated several suggestions that would target these areas of difficulty including; for the Government to expand family reunification programs, the provision of parenting programs, more information about discipline and the law, and organisations (such as schools) to be more understanding and supportive of them through their family’s various acculturation challenges. However, reflecting their diverse needs and challenges, other requests such as educational support, the development of community activities for their children, the provision of case-management, and greater cultural sensitivity in government and other agency support services were also raised.
Importantly, many of these requests for support are consistent with the three major socioeconomic determinants of mental health – social inclusion, freedom from discrimination and violence, and access to economic resources (Keleher & Armstrong, 2005). If developed into mental health promotion and prevention initiatives, these suggestions therefore have the potential to significantly improve the wellbeing of recently-arrived refugee families. However, as highlighted in Chapter 5, very few refugee mental health promotion and prevention initiatives have been evaluated and therefore, a rigorous evaluation component must be built into any program developed in the future. Importantly, because these ideas were generated by refugee mothers themselves and are based upon their unique experiences and needs, they are more likely to be acceptable and relevant to refugee families. However, as highlighted by these participants, the initiatives must also be sensitive to their cultural needs and must be delivered by workers who are well informed about the communities they are supporting. Failure to address these cultural concerns would most likely render these efforts ineffective as refugees would simply not engage with these services.

Although more research exploring the perspectives of refugee fathers and of parents from other cultural groups is highly encouraged, the information gleaned from this study has made a valuable contribution in generating goals for mental health promotion and prevention initiatives. In addition, because this is the first time that the parenting challenges and strengths of refugee mothers resettled in Melbourne have been recorded, this information can be used to assist practitioners and service providers, who currently support refugee families, to better understand their clients, and thus incorporate their perspectives and ideas into service provision.

Study Two.

Although a range of mental health prevention initiatives have been developed and shown to be effective for children in the general population, there is currently a dearth of
mental health prevention programs that have been shown to be effective for refugee children. This is particularly unfortunate given the potential risk of serious mental health consequences for refugee children. In this context, Study Two involved a process and product evaluation of The Rainbow Program for Children in Refugee Families (VFST, 2002) to determine the program’s effectiveness in making a positive contribution to the wellbeing of refugee children recently resettled in Melbourne.

The evaluation involved several components which produced interesting results. First, an assessment of program integrity and social validity were vitally important in order to ground the evaluation outcomes to the program delivery. Program integrity and social validity were exceptionally high. However, as the parent component of the Rainbow program was not delivered, the evaluation outcomes can only be applied to the children’s component of the Rainbow program. Qualitative assessments of the program’s effect on wellbeing revealed that the Rainbow program was highly effective. Participants indicated that the Rainbow program was a special and valuable experience. The researcher also observed positive changes in all Rainbow participants related to their level of enjoyment, participation, sharing, and confidence they displayed. However, quantitative evaluations revealed no statistically significant improvements on measures of self-esteem or adaptive functioning, and no statistically significant decreases in internalising or externalising problems, or on symptoms of depression and anxiety. However, one Rainbow participant who reported high levels of anxiety symptoms at pre-test showed a clinically significant and reliable improvement by post-test. Furthermore, at the descriptive level, changes were observed in the hypothesised direction for self-esteem, internalising problems, depression, and anxiety. Had sample numbers in each group been larger and the power of the study stronger, significant effects may have been detected.
Although the results of this evaluation of the Rainbow program were inconclusive due a range of study limitations such as low power and problems with validity, the researcher is highly encouraged by the results. The findings indicate that mental health prevention work and program evaluation is not only feasible, it has the potential to improve the wellbeing of refugee children. However, further evaluations that include the Rainbow program’s parent component, a significantly larger sample size, and at least a 12-month follow up period is required to better ascertain the mental health prevention effects of the Rainbow program.

**Methodological Challenges**

**Sample size, characteristics, and selection bias.**

The samples utilised in both studies were limited by their small size and by the very few cultural groups who were represented. In addition, the samples used cannot be considered to be representative of the refugee population in Melbourne because participants were not randomly selected from the community. In addition, the views and experiences of participants who volunteered in Study One may also be different from those who did not participate. Non-participants may be experiencing greater difficulties, be too embarrassed to discuss difficulties in public, or talk about problems with a white, middle-class university researcher. In order to enhance the validity of findings, future research would benefit from obtaining data from a greater number of participants, from a greater range of cultural groups, and from a wider variety of settings.

**Quantitative and qualitative research measures.**

A limitation shared by all quantitative research conducted with refugee populations is the lack of valid and reliable measures for refugee mental health and wellbeing (Davidson et al., 2008). Therefore, the development of new measures, and/or studies of existing measures to establish the validity, reliability, and the development of norms for refugee populations is
strongly encouraged. Until then, all quantitative refugee studies will continue to be limited by this issue.

However, Study One provides support for focus groups as an appropriate and useful exploratory tool with refugee populations. The participants enjoyed the format and felt comfortable sharing difficult and intimate details about their lives and thus, focus group research has the potential to produce rich and detailed information. Qualitative research using focus groups can extend the research literature in a way that is empowering and respectful to refugee participants. Indeed, in the absence of validated quantitative measures for refugees, the use of mixed quantitative and qualitative research approaches is recommended to better identify and understand cultural variations in well-being, distress, and healing (Betancourt & Williams, 2008).

**Cultural validity of mental health constructs.**

The diagnosis, treatment and prevention of Western-oriented mental health constructs across different cultural groups is a major challenge and has proved to be quite controversial in the refugee field. Although most researchers now accept that PTSD, depression, and other mental health issues do affect refugees, the literature indicates that the expression and course of these illnesses may be culturally determined. As a result, clinicians must develop a sound knowledge of the concepts of mental health and illness across cultures; adopt an open, interested, and respectful attitude towards the non-Western individual’s expression of distress; and consider this expression within their own social and cultural context (Kirmayer, 2001; Phan & Silove, 1997). This could be achieved by management ensuring that staff working with culturally diverse populations attend regular professional development sessions which focus on culturally-sensitive practice.
Resourcing issues.

Unfortunately, conducting research as part of a university doctoral program means limited financial and time constraints are placed upon the research process. This is especially true for cross-cultural research endeavours. In particular, the high cost of interpreters placed an enormous strain on the current research budget and therefore placed a limit on the number of intervention groups and the number of focus groups that could be conducted. In addition, because resources required to conduct longitudinal assessments with refugee populations are vast, long-term follow-up assessment were made impossible in the current research. These methodological issues could be overcome by a greater commitment towards better mental health in refugee populations by the Australian and State Governments, and by Higher Education institutions. For example, special research grants should be provided as an incentive for investigators conducting research with refugee populations.

However, financial constraints are not the only issues preventing follow-up assessments with refugee populations. It is extremely difficult to conduct follow-up assessments with refugee participants because refugee families tend to move around a lot, children tend to change schools, and registers of refugees living in the community are not kept, or if they are, contact details are not up to date (Silove & Ekblad, 2002). Unfortunately, as was the case in the current research, most studies with refugee populations are cross-sectional in nature.

Theoretical Implications and Recommendations for Future Research

The focus group study (Study One) represents the first specific and detailed exploration into both the parenting strengths and challenges in a community sample of recently-arrived refugee mothers in Melbourne. Therefore, this study has extended the current parenting literature by highlighting that separation from family, problems related to discipline, fears about child protective service involvement, and problems associated with acculturation are among the most salient challenges facing refugee families in Melbourne.
Importantly, the focus group study findings also represent the first time that potential intervention goals for mental health prevention/promotion initiatives generated by refugee parents themselves have been reported in the literature. However, further investigations are encouraged to explore the parenting challenges and possible avenues for interventions from the perspective of refugee fathers, parents from other cultural groups, and parents living in other locations across Australia.

The Rainbow intervention evaluation (Study Two) represented the first time that this program has been formally evaluated. Indeed the findings contribute significantly to the extremely limited body of empirical evidence regarding the effectiveness of refugee-focussed mental health prevention interventions. Although the results of the Rainbow program evaluation are inconclusive, the findings are highly encouraging. The study also demonstrated that implementing a mental health prevention program and concurrently conducting an evaluation is highly feasible. Thus, in order to build the empirical evidence base, the researcher highly recommends that an evaluation component be carried out with every implementation of this program in the future.

Importantly, the findings from both studies in the current research are consistent with recent conceptualisation of refugees as survivors rather than victims, and thus further contributes to the emerging literature highlighting the strengths and resilience of refugees. Thus, the current research clearly underscores the need for clinicians not to presume that all refugees will have psychopathology.

Practical Implications and Recommendations for Future Research

Ethical considerations.

The use of traditional Western research practices and protocols are often inappropriate and unethical when used with refugee populations (MacKenzie et al., 2007). Although ethical
guidelines for conducting research and providing interventions to refugee communities do not currently exist, the cross-cultural research literature offers several important ethical considerations to help researchers address complex issues related to vulnerability, compromised autonomy, and mistrust.

This literature strongly advocates for researchers to first learn about the refugee communities they are investigating. It is also imperative that researchers are prepared to collaborate with the communities they are studying, accept the conditions imposed by the community to gain access to participants and their information, and to share results that have practical value (Guerin & Guerin, 2007; MacKenzie et al., 2007; Trimble & Fisher, 2006). They must also ensure that they consult with community leaders or cultural brokers about how best to conduct recruitment, obtain informed consent, collect data, and disseminate the information collected. It is only by paying attention to protocols such as these that cross-cultural research can be responsive to cultural concerns (Castro et al., 2006).

By incorporating these suggestions in the current study, the researcher firmly acknowledges the positive contribution they made to level of engagement achieved with the individuals and organisations participating in this research. Without this level of engagement, the success and outcomes of the current research would have been severely compromised.

The researcher also acknowledges that these ethical considerations are consistent with standard ethical practice principals related to the respect for the rights and dignity of people and peoples, propriety, and integrity, principals that all psychologists are expected to upheld at all times (Australian Psychological Society, 2007).

**Recruitment issues.**

Recruitment of refugee participants was not difficult to achieve once the aforementioned ethical recommendations were implemented. However, it is important to note that considerable time was initially required to establish contacts within the refugee area, to...
arrange meetings with the various organisations involved in the project, and to build and develop trust and rapport with the organisations and the refugee participants. However, it was also clear that when greater involvement was afforded to community leaders in the research process (as was the case at Debney Meadows Primary School), the recruitment processes ran significantly quicker and smoother, at least from the perspective of the researcher. This finding is consistent with the literature which indicates that when research is supported by community leaders, participants are also more willing to participate in research (Chin et al., 2006; Goodkind & Deacon, 2004; Guerin & Guerin, 2007).

**Other issues to consider.**

Other resourcing and pragmatic factors must also be considered if parents are to be involved in school-based intervention programs, or to successfully recruit refugee parents as research participants. It is imperative that interpreting services, child-care, and in many cases, transport be offered free of charge to participants. This was especially true of the refugee mothers who participated in the current research, as they did not drive and did not have family they could rely on to provide childcare while attending the groups. Without these resources, participation from refugee parents is likely to be limited. In addition, research must be conducted at times and in locations that are convenient to the participants, and must not be scheduled to coincide with important religious or cultural events.

Another important issue to consider when conducting research with mothers from refugee communities relates to accommodating their busy lifestyles and possibly, their different perceptions about time. For example, most focus group participants arrived up to one hour after the agreed upon and scheduled time. Although these mothers are undoubtedly busy trying to raise children and run households, the cross-cultural literature also indicates that some cultures have a different perception of time and therefore appear less concerned about being prompt for appointments (Ethnic Communities' Council of Victoria, 2006). As a
result, the researcher was not only required to be flexible with start and finish times for focus groups, but had to ensure interpreters were booked for a significantly longer period of time than the focus groups were scheduled to run. This obviously added to the cost of conducting the research, but was a necessary consideration.

Concluding Remarks

Given that many refugees, and in particular, refugee children are at an increased risk for developing mental health problems after their resettlement to countries like Australia, there is an urgent need for psychologists, in their roles as clinicians, researchers, educators, and advocates, to help design deliver and strengthen the evidence base not only for the treatment of mental health disorders, but also for mental health prevention and promotion initiatives. Mental health prevention and promotion work is particularly appealing because it has the potential to be highly effective, to reach a large number of individuals, and be delivered economically. Importantly mental health promotion and prevention interventions designed by or in consultation with the target communities, that pay close attention to issues of cultural sensitivity, which celebrate and respect diversity, and acknowledge the strength and resilience of refugees have the potential to make a significant and positive impact upon the wellbeing of Australia’s refugee population.

In bringing refugees to Australia, Australians have a responsibility to respect and understand their strengths and challenges so that we can support a smoother resettlement process, and to promote the health and wellbeing amongst our recently-arrived refugee children and their families. Although the current research was fraught with challenges, many of these difficulties were overcome with careful planning, consultation, and good will. Ultimately, it was a very successful and rewarding experience and although the research goals were met, there is still much more work to do. This presents clinicians and researchers in the refugee field with a compelling reason to continue this line of work.
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Appendix A: Ethics Approval from RMIT HREC – Focus Group Study

19 May 2009

Jenny Tsopas

Dear Jenny

Project No 17/09: “There’s no rainbow without rain”: Parenting in Australia after resettlement – Study 2

I am pleased to advise that this project was approved by the Human Research Ethics Committee at its meeting on 29 April for the period from 19 May 2009 until 31 December 2009. The project has been classified as level 3 as it involves higher risks to the participants than discomfort or inconvenience.

Responsibilities of primary investigator

It is important to emphasise that primary investigators are responsible for ensuring that the project proceeds according to the proposal approved by the Human Research Ethics Committee. The Committee’s approval of the project is not absolute. New and unforeseen ethical issues may arise. A researcher should continue to consider the ethical dimensions of the research as the project progresses.

Adverse events or unexpected outcomes

As the primary investigator you have a significant responsibility to monitor the research and to take prompt steps to deal with any unexpected outcomes. You must notify the Committee immediately of any serious or unexpected adverse effects on participants, or unforeseen events, which may affect the ethical acceptability of your project. Any complaints about the project received by the researcher must be referred immediately to the Ethics Officer.

Reporting

Approval to continue a project is conditional on the submission of annual reports (see attached sample form). A final report should also be provided at the conclusion of the project. If your work is completed within twelve months a final report only is required. Report forms are available from the Human Research Ethics Committee website: (http://www.rmit.edu.au/research/hrecc). Please note that failure to submit reports will mean that a project is no longer approved, and/or that approval will be withheld from future projects.
Conditions of approval
The Human Research Ethics Committee may apply additional conditions of approval beyond the submission of annual/final reports.

Conflicts of interest
When reporting the research, the researcher should again disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation that bears on the research. Conflicts of interest can arise after a project has been approved, and where they do they must be reported as soon as possible.

Amendments
If, as you proceed with your investigation you find reason to amend your research method, you should advise the Human Research Ethics Committee and seek approval for the proposed changes. If you decide to discontinue your research before its planned completion you must also advise the Committee of this and of the circumstances. Depending on the type of amendment — whether it is minor or major — will determine how long the review process for an amendment will take.

Storage of Data
All data should normally be stored on University Network systems. These systems provide high levels of manageable security and data integrity, can provide secure remote access, are backed on a regular basis and can provide Disaster Recovery processes should a large scale incident occur. The use of portable devices such as CDs and memory sticks is valid for archiving, data transport where necessary and some works in progress. The authoritative copy of all current data should reside on appropriate network systems; and the principal investigator is responsible for the retention and storage of the original data pertaining to the project for a minimum period of five years.

If you anticipate any problems in meeting this requirement please contact me to discuss an alternative secure data storage arrangement.

All reports or communication regarding this project is to be forwarded to the Ethics Officer.

On behalf of the Human Research Ethics Committee I wish you well with your research.

Yours sincerely

Peter Burke
Ethics Officer
RMIT Human Research Ethics Committee

cc: Dr Sophia Xenos
Appendix B: Ethics Approval from DEECD - Focus Group Study

Department of Education and
Early Childhood Development

Office for Policy, Research and Innovation

2 Treasury Place
East Melbourne, Victoria 3002
Telephone: +61 3 9637 2000
FAX 21083
GPO Box 4367
Melbourne, Victoria 3001

RIS09103

Ms Jenny Tsoupas

Dear Ms Tsoupas

Thank you for your application of 21 April 2009 in which you request permission to conduct a research study in government schools titled: There’s no rainbow without rain: Parenting in Australia after Resettlement.

I am pleased to advise that on the basis of the information you have provided your research proposal is approved in principle subject to the conditions detailed below.

1. Should your institution’s ethics committee require changes or you decide to make changes, these changes must be submitted to the Department of Education and Early Childhood Development for its consideration before you proceed.

2. You obtain approval for the research to be conducted in each school directly from the principal. Details of your research, copies of this letter of approval and the letter of approval from the relevant ethics committee are to be provided to the principal. The final decision as to whether or not your research can proceed in a school rests with the principal.

3. No student is to participate in this research study unless they are willing to do so and parental permission is received. Sufficient information must be provided to enable parents to make an informed decision and their consent must be obtained in writing.

4. As a matter of courtesy, you should advise the relevant Regional Director of the schools you intend to approach. An outline of your research and a copy of this letter should be provided to the Regional Director.

5. Any extensions or variations to the research proposal, additional research involving use of the data collected, or publication of the data beyond that normally associated with academic studies will require a further research approval submission.

6. At the conclusion of your study, a copy or summary of the research findings should be forwarded to Education Policy and Research Division, Department of Education and Early Childhood Development, Level 2, 33 St Andrews Place, GPO Box 4367, Melbourne, 3001.
I wish you well with your research study. Should you have further enquiries on this matter, please contact Chris Warne, Senior Policy and Research Officer, Education Policy and Research, by telephone on (03) 9637 2272 or by email at <warne.chrisline.petedumell.wf.gov.au>.

Yours sincerely

[Signature]

Dr Elizabeth Hartnell-Young
Group Manager
Education Policy and Research

15/1/2009

enc
Appendix C: Ethics approval from MacKillop Family Services – Focus Group Study

Dear Jenny,

Your application to conduct research at MacKillop Family Services was considered at the meeting of our Board Quality & Advocacy Committee last night. The application has received support with the qualification that you must demonstrate that you have received full Ethics Approval to proceed from the RMIT Human Research Ethics Committee. If you could forward this to Nick halfpenny@mackillop.org.au when you receive it, he will then authorise the research to commence.

The committee also noted that another similar project is being conducted with the Parentlink team and encouraged you to discuss this with Judy Cain to ensure this does not affect the validity of your own project.

We hope it goes well and look forward to hearing how the outcomes of your work may assist us in our work with families in our programs.

All the best,
Merrilee Cox

General Manager, Quality & Service Development
MacKillop Family Services

***********************************************
This e-mail and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you are not the intended recipient, you must not disclose or use the information contained within it. If you have received this e-mail in error please notify the sender by return e-mail and delete the message. The Organisation is not responsible for any changes made to the document other than those made by a staff member, or for the effect of those changes on the document's meaning.
***********************************************

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http://www.mailguard.com.au
Appendix D: Permission to Conduct Research Forms – Focus Group Study

Permission to Conduct Research

I, Nick Halfpenny

of, Mackillop Family Services

Being an appropriate authority, give permission for Jenny Tsoucas to recruit research participants and collect research data for his/her research project titled, "There's No Rainbow Without Rain": Parenting in Australia After Resettlement.

I understand that this research has been approved by the RMIT University Human Research Ethics Committee and any other relevant body, and that the research forms part of the degree of the Doctor of degree at RMIT University.

I have been offered the opportunity to examine the research materials before giving permission, including the plain language information statement and the informed consent form.

Please note: Any further conditions associated with this permission should be appended to this form.

Signed: [Signature]

Name: Nick Halfpenny

Position: Manager, Quality & Review

Date: 21/7/09
PERMISSION TO CONDUCT RESEARCH

1. Carolyn Pickett

of, Napier Street, Child & Family Resource Centre,
Brotherhood of St. Laurence

Being an appropriate authority, give permission for Jenny Tsoupas to recruit research participants and collect research data for his/her research project titled, "There's No Rainbow Without Rain": Parenting in Australia After Resettlement.

I understand that this research has been approved by the RMIT University Human Research Ethics Committee and any other relevant body, and that the research forms part of the degree of the Doctor of degree at RMIT University.

I have been offered the opportunity to examine the research materials before giving permission, including the plain language information statement and the informed consent form.

Please note: Any further conditions associated with this permission should be appended to this form.

Signed: Carolyn Pickett

Name: Carolyn Pickett

Position: Manager

Date: 11/6/2007
PERMISSION TO CONDUCT RESEARCH

1. Christine Nash

of, Debney Meadows PS

Being an appropriate authority, give permission for Jenny Tsoukas to recruit research participants and collect research data for his/her research project titled, "There's No Rainbow Without Rain": Parenting in Australia After Resettlement.

I understand that this research has been approved by the RMIT University Human Research Ethics Committee and any other relevant body, and that the research forms part of the degree of the Doctor of degree at RMIT University.

I have been offered the opportunity to examine the research materials before giving permission, including the plain language information statement and the informed consent form.

Please note: Any further conditions associated with this permission should be appended to this form.

Signed: Christine Nash

Name: CHRISTINE NASH

Position: Principal

Date: 9/6/09.
Appendix E: Original RMIT HREC Plain Language Statement – Focus Group Study

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT
PROJECT INFORMATION STATEMENT

Project Title:
- “There’s no rainbow without rain”: Parenting in Australia after Resettlement.

Investigators:
- Ms Jenny Tsoupas (Psychology Doctorate degree student)
- Dr Sophia Xenos (Project Supervisor: Senior Lecturer, Psychology, RMIT University sophia.xenos@rmit.edu.au, 9925 1081)

Dear Parents

You have been invited to take part in a research project being conducted by RMIT University. This sheet describes what the project is about in ‘plain English’. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?
Jenny Tsoupas is conducting this research as part of her Psychology Doctorate degree. Dr. Sophia Xenos from RMIT University will supervise this research. The RMIT Human Research Ethics Committee has approved this project. Debney Meadows Primary School and the Department of Education and Early Childhood Development has also given permission for this research to be conducted.

Why have you been approached?
We are inviting all refugee parents from Debney Meadows Primary School to participate in a study investigating what it is like to be a parent in Australia.

What is the project about? What are the questions being addressed?
Parents play a crucial role in their children’s development and well-being. However, the Australian parenting literature has largely ignored refugee parenting practices and their parenting needs after resettlement. The researcher will ask refugee parents about what parenting means to them and to talk about their parenting triumphs and the parenting challenges they face once settled in Melbourne. With this information, it is hoped that service providers and practitioners will be able to support refugee families in more culturally appropriate ways. Some of the questions you can expect to talk about may include:
- “What worries you as a parent?”
- “What advice would you give new refugee parents about raising a family in Australia?”

If I agree to participate, what will I be required to do?
If you agree to participate, you will be invited to attend a group with other refugee parents from Debney Meadows Primary School to talk about what it is like being a parent in Australia. This group will meet at the following times:

Day Month Date - at TIME
Day Month Date - at TIME

What are the benefits associated with participation?
The information that participants provide in these discussions will help prepare and aid service providers and practitioners to serve and support refugee families in Melbourne in more culturally appropriate ways.

What are the risks or disadvantages associated with participation?
It is unlikely that you will be exposed to any physical or social risk beyond the everyday norm. However, there is some risk to participants should they choose to disclose information about past traumatic experiences. It is important to note that eliciting painful details from the past is not the purpose of the focus groups. Rather the focus will be on the triumphs, challenges and concerns about their children, and
parenting in general. Every effort will be made to ensure that participants feel safe and at ease. Should participants require further assistance, the investigator can make recommendations. Alternatively, the participants may like to contact the following organisations for further information or support:

- Victorian Foundation for Survivors of Torture  ph: 9388 0022
- Lifeline  ph: 13 11 14

**What will happen to the information I provide?**
All information collected throughout the project will remain confidential. Any information that is collected can be disclosed only if (1) it is to protect you or others from harm; (2) a court order is produced; or (3) you provide the researchers with written permission. For the purposes of data analyses, a code will be assigned to each person so that the data is de-identified. Only the study investigators and supervisor will have access to the participant codes or other information that potentially identifies you. Information pertaining to participant codes will be destroyed after the completion of the study.

While the results may be published at a future date, these results will be presented as group data and will not include any personally identifying information. All information will be kept in a locked filing cabinet in the Division of Psychology at RMIT University for 5 years. Participants are eligible to access the information we hold them during this time.

**What are my rights as a participant?**
Participation in this research project allows you to have:
- The right to refuse participation in the focus groups at any time, without prejudice
- The right to withdraw participation at any time, without prejudice
- The right not to respond to every question, without prejudice
- The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified
- The right to have questions about the research answered at any time.

**Whom should I contact if I have any questions?**
If you require further information or if you have any concerns please contact Dr Sophia Xenos as soon as convenient. Dr Sophia Xenos will discuss your concerns with you confidentially and suggest appropriate follow-up, if necessary. Dr. Sophia Xenos can be contacted on 9925 1081 or via email at sophia.xenos@rmit.edu.au

**What other issues should I be aware of before deciding whether to participate?**
Occasionally people who have experienced trauma in their past can become very distressed. Should the researchers identify anyone who could benefit from extra support, the researchers can make recommendations for further support.

Thank you for taking part in this research project.

Jenny Tsoupas  
Psychology Doctorate Student  
Division of Psychology  
RMIT University, Bundoora Campus

Dr. Sophia Xenos  
Clinical Psychologist & Senior Lecturer  
Division of Psychology  
RMIT University, City Campus

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 8625 1748. Details of the complaints procedure are available from the above address.
Appendix F: Original RMIT HREC Consent Form – Focus Group Study

RMIT Human Research Ethics Committee

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

Portfolio
Science, Engineering and Technology

School of
Health Sciences

Project Title:
“There’s No Rainbow Without Rain”: Parenting in Australia after Resettlement

Name of participant:

Name(s) of investigators: (1) Jenny Tsoupas Phone: 9925 7376
(2) Dr Sophie Xenos Phone: 9925 1081

1. I have received a statement explaining the interview/questionnaire involved in this project.

2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.

3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.

4. I acknowledge that:
   (a) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
   (d) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
   (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to Debney Meadows Primary School. Any information which will identify me will not be used.

Participant’s Consent

Participant: ______________________________ Date: ________________
(Signature)

Witness: ______________________________ Date: ________________
(Signature)

Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 2251. Details of the complaints procedure are available from the above address.

Human Research Ethics Committee, June 2005
Appendix G: List of the Proposed Focus Group Questions

**Demographic information**
- Age, country, who lives at home, number of children, marital status, length of time in Australia, languages spoken

**Questions about parenting:**
- What makes you happy about being a parent?
- What makes you unhappy about being a parent?
- What do good parents do?
- What do good child do?
- What things does a child need from a parent?
- What are the children’s responsibilities to their parents/family?
- How do you define success for your children?
- What sorts of things do you do that are similar to your own mother and father?
- What sorts of things do you do that are different to your own mother and father?
- Do you have any idioms/stories in your culture about good/bad parents and children?

**Questions about parenting back home**
- How are children raised and disciplined back home?
- What roles/responsibilities do different family members have?
- What did you worry about as a parent back home?
- Thinking back to before you came to Australia, what were your hopes and expectations for your family’s future?
- To what extent have these hopes and expectations been realised?

**Questions about being a parent in Australia**
- Is Melbourne a good place to raise a family?
- What is it like to be a __eg Somali/Sudanese/Afghani/Eritrean__ family in Australia?
- What are the most positive things about your family?
- As a parent, what types of things do you do well?
- As a parent, what types of things do you do not so well?
- What is the best/worst thing about raising a family in Australia?
- What things make it easier/harder for others to be a good parent in Melbourne?
- What things make it easier/harder for you to be a good parent in Melbourne?
- What worries you as a parent now?
- What worries do other parents have about their children?
- What advice would you give new refugee parents about how to raise their families in Australia?
- What advice would you give to Australians about helping refugee families to live in Australia?
- What supports do you have as a parent?
- What supports do you want as a parent?
- What do you think gets in the way of you being a good parent?
- What is the impact of the refugee experience on your children?
- What would help you to raise your children to meet your goals for them?
- Where have you turned to for advice and support with your parenting, and why did you choose to go to those sources?
- What things did you find most difficult when you first arrived? Is this still a problem? How did you solve these difficulties?
- How do you view yourself and your children (eg as Somali, Australian, or both)
- How have your parenting practices changed as a result of living in a different country?
- How do you think other Australians view your parenting?
Appendix H: Information Flyer for Focus Group Participants

Parents from the Atherton Gardens Playgroup are invited to take part in a research project being conducted by Jenny Tsoukas, as part of her Psychology Doctorate degree at RMIT University.

Jenny would like to hear your stories and learn what it is like for you to be a parent in Australia.

There is very little information about being a refugee parent in Australia, but with this valuable information, it is hoped that better services can be provided to you and other refugee families. You are the best people to tell us what services are needed.

We will meet August 6th & August 13th at 10am

As a group, we will discuss what it is like to be a refugee parent, while we share a cup of tea or coffee and some biscuits.

We will meet 2-times, for 1-hour in the room next to the playgroup.

Jenny will ask the group some of the questions on the attached list but...
- You don’t have to join the group if you do not want to
- You don’t have to answer every question
- If you have better questions, please tell them to Jenny

Jenny will need to tape the conversation so that she can remember what the group spoke about. However, no-one’s name will be recorded and whatever you say will remain confidential. No-one else will know who said what.

If you will feel more comfortable speaking in your own language, Jenny will try to book your favourite interpreters.

If you need more information please call Jenny or Dr Sophie Xenos at RMIT University on 9925 1081

The Napier Street Child & Family Resource Centre and RMIT have approved this project. But if you have a complaint, please call 9925 1746.
### Appendix I: Coding Key Used to Develop Themes and Associated Subthemes

<table>
<thead>
<tr>
<th>Thematic categories and subthemes</th>
<th>Rules used to assign text into categories and subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of parents</td>
<td>Coded if the discussion covered issues related to: What a good parent does? What they or others expect a parent must do? What children need from their parents? What the role of a parent is?</td>
</tr>
<tr>
<td>Goals or aspirations for their children</td>
<td>Coded if the discussion covered issues related to: descriptions of positive or negative attributes of children, goals, wishes, or desired outcomes for their children, including future outcomes that they would like their children to avoid.</td>
</tr>
<tr>
<td>Joys and benefits of parenting</td>
<td>Coded if the discussion related to: aspects of parenting participants described in a positive light, made them happy, enjoyable, amusing, pleasurable, gave them a sense of accomplishment, was rewarding, or protected them from feeling down, lonely, isolated, depressed.</td>
</tr>
<tr>
<td>Parenting challenges</td>
<td>Coded if the discussion related to: The challenges or worries raised were coded if the discussion covered aspects of parenting or motherhood that the participants found particularly challenging, difficult, were unable to find solutions to, as well as any aspects of parenting or motherhood which contributed to or caused worry and mental anguish. In addition, discussion that pointed to feelings of incompetence, being judged, discriminated against, or being unable to find the resources necessary to succeed, or to be happy in their parenting role were also coded under this category.</td>
</tr>
<tr>
<td>Separation from support networks</td>
<td>This was coded if the discussion covered aspects directly related to separation from social networks, diminished levels of social support, and the difficulties or challenges that this presented in relation to parenting.</td>
</tr>
<tr>
<td>Discipline &amp; Child Protection</td>
<td>Coded if the discussion related to: difficulties, challenges, or fears related to their children’s behaviour, their efforts to manage that behaviour, and issues that contribute to difficult behaviour and discipline problems</td>
</tr>
<tr>
<td>Australian/Western influences &amp; acculturation fears</td>
<td>Coded if the discussion related to: difficulties, challenges, or fears related to parenting as a result of influences encountered in Australian/Western culture, and associated acculturation fears.</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Thematic categories and subthemes</th>
<th>Rules used to assign text into categories and subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities &amp; entertainment</td>
<td>Coded if the discussion related to: difficulties, challenges, or fears related to the provision of activities and entertainment opportunities for their children.</td>
</tr>
<tr>
<td>Parent-child interactions</td>
<td>Coded if the discussion related to: difficulties, challenges, or fears related to the parent-child interaction.</td>
</tr>
<tr>
<td>Education</td>
<td>This was coded if the discussion covered difficulties, challenges, or fears related to their children’s education.</td>
</tr>
<tr>
<td>Healthcare</td>
<td>This was coded if the discussion covered difficulties, challenges, or fears related to their children’s health and/or their efforts to obtain medical assistance.</td>
</tr>
<tr>
<td>Fatigue</td>
<td>This was coded if the discussion covered difficulties, challenges, or fears related to fatigue caused by raising children.</td>
</tr>
<tr>
<td>Childcare</td>
<td>This was coded if the discussion covered difficulties, challenges, or fears related to childcare services.</td>
</tr>
<tr>
<td>Language barrier</td>
<td>This was coded if the discussion covered difficulties or challenges related to raising children as a result of language barriers.</td>
</tr>
<tr>
<td>Government support</td>
<td>This was coded if the discussion covered difficulties, challenges, problems or fears related to the lack of Government’s assistance for refugee families.</td>
</tr>
<tr>
<td>Adjusting to motherhood</td>
<td>This was coded if the discussion covered difficulties, challenges, or fears related to the transition of becoming a married woman with children.</td>
</tr>
<tr>
<td>Employment</td>
<td>This was coded if the discussion covered difficulties, challenges, or fears related to employment.</td>
</tr>
<tr>
<td>Other Settlement Challenges</td>
<td>The challenges and/or difficulties associated with aspects of life not directly related to parenting (but could impact on the parenting) were coded under this category if the discussion revealed that the participants found these aspects challenging, difficult, or were unable to find solutions to their problems.</td>
</tr>
<tr>
<td>Unfamiliar environment</td>
<td>This was coded if the discussion covered aspects directly related to settlement difficulties and challenges associated with living in an unfamiliar environment.</td>
</tr>
<tr>
<td>Racism &amp; discrimination</td>
<td>This was coded if the discussion covered aspects directly related to settlement difficulties and challenges, as well as fears associated with racism and discrimination</td>
</tr>
</tbody>
</table>
### Appendix J: Session by Session Description of the Rainbow Program and Activity Objectives

<table>
<thead>
<tr>
<th>Session</th>
<th>Activity</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>Introductory exercise – “clapping rhythm game”</td>
<td>To help participants engage with each other, with the facilitators and teachers as a group.</td>
</tr>
<tr>
<td></td>
<td>Explanation of the Rainbow program and its purpose</td>
<td>Explaining the purpose of the group, placing it in a positive context and to cover housekeeping matters.</td>
</tr>
<tr>
<td></td>
<td>Participants set-up group conduct guidelines</td>
<td>For participants to feel comfortable and safe in the group and to engender a sense of ownership about the group.</td>
</tr>
<tr>
<td></td>
<td>World map exercise</td>
<td>Familiarises participants with one another, helps to consolidate group identity and cohesion.</td>
</tr>
<tr>
<td></td>
<td>Introduction to the polaroid exercise and ‘About me’ poster</td>
<td>To encourage self-reflection and provides a focus for exploring identity, promoting discussion around past and present experiences, and aspirations for the future.</td>
</tr>
<tr>
<td></td>
<td>Social Validity Questionnaire &amp; Rainbow feedback*</td>
<td>Process evaluation.</td>
</tr>
<tr>
<td></td>
<td>Closing exercise - “How I am feeling right now?”</td>
<td>Signals the end of the session, and helps children identify their emotions and how they are experienced.</td>
</tr>
<tr>
<td>Two</td>
<td>Introduction and revisiting rules</td>
<td>For participants to feel comfortable and safe in the group.</td>
</tr>
<tr>
<td></td>
<td>Focusing exercise – “stamping rhythm game”</td>
<td>To help participants engage with each other, with the facilitators and teachers as a group.</td>
</tr>
<tr>
<td></td>
<td>‘About me’ poster</td>
<td>To encourage self-reflection and provides a focus for exploring identity, promoting discussion around past and present experiences, and aspirations for the future.</td>
</tr>
<tr>
<td></td>
<td>Social Validity Questionnaire &amp; Rainbow feedback*</td>
<td>Process evaluation.</td>
</tr>
<tr>
<td></td>
<td>Closing exercise - “How I am feeling right now”</td>
<td>Signals the end of the session, and helps children identify their emotions and how they are experienced.</td>
</tr>
<tr>
<td>Session</td>
<td>Activity</td>
<td>Objective</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Three</td>
<td>Focusing exercise – “Greetings in own language”</td>
<td>Demonstrates both the similarities and differences between cultures and to help participants engage with each other, with the facilitators and teachers as a group.</td>
</tr>
<tr>
<td></td>
<td>‘About me’ exercise (continued)</td>
<td>To encourage self-reflection and provides a focus for exploring identity, promoting discussion around past and present experiences and aspirations for the future.</td>
</tr>
<tr>
<td></td>
<td>Introduction to the cultural objects exercise</td>
<td>To celebrate and reaffirm the importance of the children’s culture and provides a tangible link between the program and home.</td>
</tr>
<tr>
<td></td>
<td>Social Validity Questionnaire &amp; Rainbow feedback</td>
<td>Process evaluation.</td>
</tr>
<tr>
<td></td>
<td>Closing exercise – “Goodbye in own language”</td>
<td>Signals the end of the session, and helps to consolidate both the similarities and differences between cultures.</td>
</tr>
<tr>
<td>Four</td>
<td>Focusing exercise – “Dancing game”</td>
<td>To help participants engage with each other, with the facilitators and teachers as a group.</td>
</tr>
<tr>
<td></td>
<td>Introduction and revisit group rules</td>
<td>For participants to feel comfortable and safe in the group.</td>
</tr>
<tr>
<td></td>
<td>Cultural objects</td>
<td>To celebrate and reaffirm the importance of the children’s culture and provides a tangible link between the program and home.</td>
</tr>
<tr>
<td></td>
<td>Emotions exercise (Part 1, happy and sad poster)</td>
<td>To help children to identify emotions and the thoughts, feelings and behaviours associated with these emotions.</td>
</tr>
<tr>
<td></td>
<td>Happy and sad masks</td>
<td>To normalise emotions and to assist children to understand that others share similar emotions and that there are times when they may experience a number of emotions simultaneously.</td>
</tr>
<tr>
<td></td>
<td>Social Validity Questionnaire &amp; Rainbow feedback*</td>
<td>Process evaluation.</td>
</tr>
<tr>
<td></td>
<td>Closing exercise - “How I am feeling right now”</td>
<td>Signals the end of the session, and helps children identify their emotions and how they are experienced.</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Session</th>
<th>Activity</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five</td>
<td>Focusing exercise – “Voice pattern game”</td>
<td>To help participants engage with each other, with the facilitators and teachers as a group.</td>
</tr>
<tr>
<td></td>
<td>Welcome and cultural objects (continued)</td>
<td>To celebrate and reaffirm the importance of the children’s culture and provides a tangible link between the program and home.</td>
</tr>
<tr>
<td></td>
<td>Emotions exercise (Part 2, anger, fear, love, &amp; shyness)</td>
<td>To encourage children to reflect on when they experience certain emotions and on the thoughts, feelings and behaviours associated with these emotions. To normalise emotions, and assist children to understand that others share similar emotions.</td>
</tr>
<tr>
<td></td>
<td>Social Validity Questionnaire &amp; Rainbow feedback*</td>
<td>Process evaluation.</td>
</tr>
<tr>
<td></td>
<td>Closing exercise - “How I am feeling right now”</td>
<td>Signals the end of the session, and helps children identify emotions and how they are experienced.</td>
</tr>
<tr>
<td>Six</td>
<td>Focusing exercise – “Body tangle game”</td>
<td>To help participants engage with each other, with the facilitators and teachers as a group.</td>
</tr>
<tr>
<td></td>
<td>Cultural objects (continued)</td>
<td>To celebrate and reaffirm the importance of the children’s culture and provides a tangible link between the program and home.</td>
</tr>
<tr>
<td></td>
<td>Body poster</td>
<td>To assist children to identify how emotions affect the body and where they feel them. To illustrate similarities and differences between people in the way in which emotions are experienced.</td>
</tr>
<tr>
<td></td>
<td>Statues exercise</td>
<td>To illustrate how emotions can be evoked and expressed through other sensory stimuli - in this case music.</td>
</tr>
<tr>
<td></td>
<td>Planning for the party</td>
<td>To get ideas about what participants would like to celebrate the group and say goodbye to one another.</td>
</tr>
<tr>
<td></td>
<td>Social Validity Questionnaire &amp; Rainbow feedback*</td>
<td>Process evaluation.</td>
</tr>
<tr>
<td></td>
<td>Closing exercise - “How I am feeling right now”</td>
<td>Signals the end of the session, and helps children identify their emotions and how they are experienced.</td>
</tr>
<tr>
<td>Session</td>
<td>Activity</td>
<td>Objective</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Seven</td>
<td>Reflection on group experience</td>
<td>To prepare children for the ending of the group.</td>
</tr>
<tr>
<td></td>
<td>Acknowledgment of end of group and closure</td>
<td>To formally acknowledge the ending of the program and that feelings of sadness is a normal part of finishing something that has been fun. Letters to the researchers also serve as a means to assess the social validity and the contribution that the program has made to the settlement experience of participants*</td>
</tr>
<tr>
<td></td>
<td>Social Validity Questionnaire* &amp; Rainbow feedback</td>
<td>Process evaluation.</td>
</tr>
<tr>
<td></td>
<td>Party</td>
<td>To celebrate the group and say goodbye to one another.</td>
</tr>
</tbody>
</table>

## Appendix K: Session Summary Worksheet (SSW)

1= not at all, 2= not very well, 3= moderately well, 4= extremely well

<table>
<thead>
<tr>
<th>Session 1</th>
<th>Implemented (Y/N)</th>
<th>Effectiveness of their implementation</th>
<th>Group Process</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Listening</td>
<td>Including Children</td>
</tr>
<tr>
<td>Introductory exercise</td>
<td>Y/N</td>
<td>1 2 3 4</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Explanation of the Rainbow Program and its purpose</td>
<td>Y/N</td>
<td>1 2 3 4</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Setting group conduct guidelines</td>
<td>Y/N</td>
<td>1 2 3 4</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>World map exercise</td>
<td>Y/N</td>
<td>1 2 3 4</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Introduction to the Polaroid exercise and ‘About me’ poster</td>
<td>Y/N</td>
<td>1 2 3 4</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Closure</td>
<td>Y/N</td>
<td>1 2 3 4</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>

*Note*. SSW adapted from Barrett, Moore, et al., 2000

**Notes:**
Appendix L: Social Validity Questionnaire (SVQ)

Name: ____________________________________________________________

Please tell us what you thought about the RAINBOW program today.
Circle the answer that best describes how you feel about today's session.
There are no right or wrong answers.

<table>
<thead>
<tr>
<th>Session x</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you understand most of the work?</td>
</tr>
<tr>
<td>Did you feel safe talking about yourself?</td>
</tr>
<tr>
<td>Were you listened to?</td>
</tr>
<tr>
<td>Was it fun?</td>
</tr>
<tr>
<td>Do you think it has helped you?</td>
</tr>
<tr>
<td>Did you learn anything new?</td>
</tr>
<tr>
<td>Have you helped anyone with your new skills?</td>
</tr>
<tr>
<td>Would you recommend it to a friend?</td>
</tr>
</tbody>
</table>

Note. SVQ adapted from Stallard et al., 2005
### Appendix M: Rainbow Session Feedback Questionnaire (RSFQ)

**Session x**

*Date:*

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do children most remember about the group session?</td>
<td></td>
</tr>
<tr>
<td>What did they learn?</td>
<td></td>
</tr>
<tr>
<td>What did they like best</td>
<td></td>
</tr>
<tr>
<td>What didn’t they like</td>
<td></td>
</tr>
<tr>
<td>What would they have liked to have done more of?</td>
<td></td>
</tr>
<tr>
<td>Is there anything they would want to change?</td>
<td></td>
</tr>
</tbody>
</table>
Appendix N: Letter to the Researchers

Name:________________________________________

Please write a letter to Miss Sally and Miss Jenny.

Describe your most important memory of the Rainbow Group for them.

Dear Miss Sally and Miss Jenny,

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Appendix O: Questionnaire Package

Appendix O - Page 1
(not included in electronic version due to copyright restrictions)
Appendix O - Page 2
(not included in electronic version due to copyright restrictions)
Appendix P: Ethics Approval from RMIT HREC – Rainbow Study

14 July 2008

Jenny Tsoupas and Sally Beattie

Dear Jenny and Sally

Project No 24/08: ‘There’s no rainbow without rain’: Evaluation of the rainbow program for children in refugee families

I am pleased to advise that this project is now approved by the Human Research Ethics Committee for the period from the date of this letter until 30 June 2009. The project has been classified as level 3 as it involves higher risks to the participants than discomfort or inconvenience.

Responsible for the primary investigator
It is important to emphasise that primary investigators are responsible for ensuring that the project proceeds according to the proposal approved by the Human Research Ethics Committee. The Committee’s approval of the project is not absolute. New and unforeseen ethical issues may arise. A researcher should continue to consider the ethical dimensions of the research as the project progresses.

Adverse events or unexpected outcomes
As the primary investigator you have a significant responsibility to monitor the research and to take prompt steps to deal with any unexpected outcomes. You must notify the Committee immediately of any serious or unexpected adverse effects on participants, or unforeseen events, which may affect the ethical acceptability of your project. Any complaints about the project received by the researcher must be referred immediately to the Ethics Executive Officer.

Reporting
Approval to continue a project is conditional on the submission of annual reports (see attached sample form). A final report should also be provided at the conclusion of the project. If your work is completed within twelve months a final report only is required. Report forms are available from the Human Research Ethics Committee’s web site: (http://www.rmit.edu.au/ed/hrecapply)
Please note that failure to submit reports will mean that a project is no longer approved, and/or that approval will be withheld from future projects.

Conditions of approval
The Human Research Ethics Committee may apply additional conditions of approval beyond the submission of annual/final reports.

Conflicts of interest
When reporting the research, the researcher should again disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation that bears on the research. Conflicts of interest can arise after a project has been approved, and where they do they must be reported as soon as possible.

Amendments
If, as you proceed with your investigation you find reason to amend your research method, you should advise the Human Research Ethics Committee and seek approval for the proposed changes. If you decide to discontinue your research before its planned completion you must also advise the Committee of this and of the circumstances. Depending on the type of amendment — whether it is minor or major — will determine how long the review process for an amendment will take.

Storage of Data
All data should normally be stored on University Network systems. These systems provide high levels of manageable security and data integrity, can provide secure remote access, are backed on a regular basis and can provide Disaster Recover processes should a large scale incident occur. The use of portable devices such as CDs and memory sticks is valid for archiving, data transport where necessary and some works in progress. The authoritative copy of all current data should reside on appropriate network systems; and the principal investigator is responsible for the retention and storage of the original data pertaining to the project for a minimum period of five years.

If you anticipate any problems in meeting this requirement please contact me to discuss an alternative secure data storage arrangement.

All reports or communication regarding this project is to be forwarded to the Ethics Executive Officer.

On behalf of the Human Research Ethics Committee I wish you well with your research.

Yours sincerely

Peter Burke
Ethics Executive Officer
RMIT Human Research Ethics Committee

cc: Sophia Xenos
Appendix Q: Ethics Approval from the DEECD - Rainbow Study

Department of Education and Early Childhood Development
Office for Policy, Research and Innovation

SOS003894

Ms Jenny Tsoucas and Ms Sally Beattie

Dear Ms Tsoucas and Ms Beattie

Thank you for your application of 18 May 2008 in which you request permission to conduct a research study in government schools titled: "There's No Rainbow Without Rain": Evaluation of the Rainbow Program for Children in Refugee Families.

I am pleased to advise that on the basis of the information you have provided your research proposal is approved in principle subject to the conditions detailed below.

1. Should your institution's ethics committee require changes or you decide to make changes, these changes must be submitted to the Department of Education and Early Childhood Development for its consideration before you proceed.

2. You obtain approval for the research to be conducted in each school directly from the principal. Details of your research, copies of this letter of approval and the letter of approval from the relevant ethics committee are to be provided to the principal. The final decision as to whether or not your research can proceed in a school rests with the principal.

3. No student is to participate in this research study unless they are willing to do so and parental permission is received. Sufficient information must be provided to enable parents to make an informed decision and their consent must be obtained in writing.

4. As a matter of courtesy, you should advise the relevant Regional Director of the schools you intend to approach. An outline of your research and a copy of this letter should be provided to the Regional Director.

5. Any extensions or variations to the research proposal, additional research involving use of the data collected, or publication of the data beyond that normally associated with academic studies will require a further research approval submission.
6. At the conclusion of your study, a copy or summary of the research findings should be forwarded to Education Policy and Research Division, Department of Education and Early Childhood Development, Level 2, 33 St Andrews Place, GPO Box 4357, Melbourne, 3001.

I wish you well with your research study. Should you have further enquiries on this matter, please contact Chris Warne, Project Officer, Education Policy and Research, by phone on (03) 9637 2272 or by email at <warne.christine.p@edumail.vic.gov.au>.

Yours sincerely

Dr Jim Tangas
A/Assistant General Manager
Education Policy and Research

07/01/2008

cnc
Appendix R: Consent for Research - Principal from WELS

PERMISSION TO CONDUCT RESEARCH

I, Yolande De Zwaan
of, Western English Language School

Being an appropriate authority, give permission for Jenny Tsoupas and Sally Beattie to recruit research participants and collect research data for her research project titled, "There's No Rainbow Without Rain": Evaluation of the Rainbow Program.

I understand that this research will be approved by the RMIT University Human Research Ethics Committee and any other relevant body, and that the research forms part of the degree of the Doctor of Psychology, and the Bachelor of Applied Science (Psychology) (Honours) degrees at RMIT University.

I have been offered the opportunity to examine the research materials before giving permission, including the plain language information statement and the informed consent form (if relevant).

Please note: Any further conditions associated with this permission should be appended to this form.

Signed: Yolande De Zwaan
Name: Yolande De Zwaan
Position: Principal
Date: 21-7-08

Page 1 of 1
Appendix S: Consent for Research - VFST

21.4.2008

Division of Psychology
School of Health Sciences
RMIT University

Ethics Committee

Dear Madam / Sir

Re Evaluation of Rainbow Group Work Program

My name is Ieow Hess. I manage the western regional program at the Victorian Foundation for Survivors of Torture (Foundation House). Oversight of the agency's group work program comes within my purview.

I am very pleased to have the opportunity for the Rainbow Group Work Program to be evaluated through the involvement of RMIT doctoral student, Ms Jenny Thompsa. I have met with Jenny on a couple of occasions and am satisfied that Jenny's proposed approach to the evaluation addresses all relevant ethical considerations. I thus have no hesitation in supporting her application for RMIT ethics approval. I am happy to provide further information if required.

Yours faithfully,

Ieow Hess
Regional Manager

The Victorian Foundation for Survivors of Torture Inc.
President: Prof. David Jackson, OAM, Governor of Victoria, and Mrs Jan de Klerk
Patrons: Sir Henry Chalmers, Bt, Prof Max Wodak, AM, Ms Jane Dorey, Mrs Andrew Harman.
Visiting Professors: Michael Lacey and Prof David Pennington, AM, David McPartland
ABN: 79 045 093 0089
Appendix T: Plain Language Statement – Rainbow Study

RMIT University

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT
PROJECT INFORMATION STATEMENT


Investigators:
- Ms Jenny Tsoupas (Psychology Doctorate degree student)
- Ms Sally Beattie (Psychology Honours degree student)
- Dr Sophie Xenos (Project Supervisor: Senior Lecturer, Psychology, RMIT University, sophia.xenos@rmit.edu.au, 9925 1081)

Dear Parent/Guardian

Your child has been invited to take part in a research project being conducted by RMIT University. This sheet describes what the project is about in ‘plain English’. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?
Jenny Tsoupas and Sally Beattie are conducting this research as part of their Doctorate and Honours Psychology programs. Dr. Sophie Xenos from the Division of Psychology, RMIT University will supervise this research. The RMIT Human Research Ethics Committee has approved this project. The principal at your child’s school has also given permission for this research to be conducted.

Why have you been approached?
We are inviting all newly arrived refugee children from the Western English Language School (WELS) aged 9 to 12 years to participate in a study to evaluate the effectiveness of “The Rainbow Program for Children from Refugee Families”. However, in order for your child to participate, it is required that you (as parent/legal guardian) and your child provide informed consent.

What is the project about? What are the questions being addressed?
The Western English Language School is going to run a special program called the Rainbow Program for Children in Refugee Families. Foundation House has developed this program in order to help refugee children settle into Australia better. As part of this project, the researchers will determine whether this program has been helpful to your child. The researchers will do this by observing your child in the classroom, asking your child questions about how much they liked the program and how they feel about themselves. The researchers will also ask your child’s teacher questions about how your child interacts in the classroom. The researchers will ask these questions three times; before, directly after, and three months after the program finishes. It is expected that between 8-10 children will participate in each group. Some children will participate in the program in Term 3, and some in term 4. Your child will not be graded on their participation or their responses.

If I agree to participate, what will I be required to do?
If you and your child give your consent, your child will participate in the Rainbow Program. The program is held at the school during class time and runs for about 2 hours a week for seven weeks. As part of the Rainbow Program, each child will be asked to bring in something that reminds them of their home country to talk about with the other children. They will have their photograph taken, which they will be able to take home. Your child will also be asked to answer some questions about how much they liked the program and how they feel about themselves. Parents are also invited to the school three times to meet with the other parents and the group leaders. In these meetings, you will be told about the Rainbow Program and about what your child is doing in the group. You will also be able to ask questions and you will be invited to examine all program materials and questionnaires before deciding whether to give consent for your child to participate. If you have other children, you are welcome to bring them to the parents’ groups. Interpreters in your language will also be present. We will let you know when and where these meetings will be held.
What are the risks or disadvantages associated with participation?
Your child is unlikely to be exposed to any physical or social risk beyond the everyday norm. However, there is some risk that your child will experience distress if your child chooses to disclose information about traumatic experiences they have had. However, every effort will be made to ensure your child feels safe and at ease. The investigator will monitor each child’s behaviour and respond quickly to any questions, concerns or distress your child may experience.

What are the benefits associated with participation?
Informal feedback from organizations that have conducted the Rainbow program has been positive and it is expected that your child will also benefit from participating in the program. Strong research evidence suggests that a positive resettlement environment can help to protect refugee children from suffering long-term ill effects as a consequence of their refugee experiences.

What will happen to the information I provide?
All information collected throughout the project will remain confidential. Any information that is collected can be disclosed only if (1) it is to protect you or others from harm, (2) a court order is produced, or (3) the parent’s provide the researchers with written permission. For the purposes of data analyses, a code will be assigned to each child’s data so that results are de-identified. Only the study investigators and supervisor will have access to the participant codes or other information that potentially identifies your child. Information pertaining to participant codes will be destroyed after the completion of the study.

While the results may be published at a future date, these results will be presented as group data and will not include any personally identifying information. All information will be kept in a locked filing cabinet in the Division of Psychology at RMIT University for 5 years. Parents are eligible to access the information we hold about their child during this time.

What are my rights as a participant?
Participation in this research project allows you and your child to have:
✓ The right to withdraw participation at any time, without prejudice
✓ The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified
✓ The right to have any questions answered at any time.

Whom should I contact if I have any questions?
If you require further information, have concerns about your child’s participation in the Rainbow program, or if you have any concerns about your child’s responses to any of the questionnaire items, you should contact Dr. Sophia Xenos as soon as convenient. Dr. Sophia Xenos will discuss your concerns with you confidentially and suggest appropriate follow-up, if necessary.
Dr. Sophie Xenos can be contacted on 9925 1081 or via email at Sophia.xenos@rmit.edu.au

What other issues should I be aware of before deciding whether to participate?
Sometimes refugee children can become very distressed by their past experiences. As such, the researchers may identify children who could benefit from extra support. In these circumstances, the researchers can make recommendations to help your child.

Thank you for taking part in this research project.

Jenny Tsoupas  Sally Beattie  Dr. Sophia Xenos
Psychology Doctorate Student  Psychology Honours Student  Psychologist & Senior Lecturer
Division of Psychology  Division of Psychology  Division of Psychology
RMIT University, Bundoora Campus  RMIT University, Bundoora Campus  RMIT University, City Campus

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2479, Melbourne, 3001. The telephone number is (03) 9925 1745. Details of the complaints procedure are available from the above address.
Appendix U: Consent Form – Rainbow Study

RMIT Human Research Ethics Committee

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

Portfolio: Science, Engineering and Technology
School of: Health Sciences

"There’s No Rainbow Without Rain": Evaluation of the Rainbow Program for Children in Refugee Families

Name(s) of investigator(s): (1) Jenny Tsoupidis
(2) Sally Beattie
(3) Dr Sophie Xenos

1. I have received a statement explaining the interview/questionnaire involved in this project.
2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.
3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.
4. I acknowledge that:
   (f) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   (g) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   (h) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
   (i) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
   (j) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to The Western English Language School. Any information which will identify me will not be used.

Participant’s Consent

Participant: ___________________________ Date: ________________
(Signature)

Witness: ___________________________ Date: ________________
(Signature)

Where participant is under 18 years of age:

I consent to the participation of ___________________________ in the above project.

Signature: (1) ___________________________ (2) ___________________________ Date: ________________
(Signatures of parents or guardians)

Witness: ___________________________ Date: ________________
(Witness to signature)

Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 2251. Details of the complaints procedure are available from the above address.

Human Research Ethics Committee, June 2005
### Appendix V: Letters to the Researchers

<table>
<thead>
<tr>
<th>Participant</th>
<th>Contents of Letters</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-year-old Ethiopian female</td>
<td>I really enjoyed being in rainbow group. You two are the best teacher ever. You two teachers have been working so hard. What you teach us is so interesting and I learn new thing from you. Also what I most enjoyed doing was the dancing. Drawing a picture of a person he is sad and happy. I love you Miss Sally and Miss Jenny.</td>
</tr>
<tr>
<td>9-year-old Karen male</td>
<td>How are you? I'm good. I want to tell you about the Rainbow group. Every Friday I went to rainbow group and learnt many things. I had been doing well with this program. In the rainbow group, we learnt English, dancing, drawing and sometimes we played games.</td>
</tr>
<tr>
<td>9-year-old Karen male</td>
<td>Thank you for help me. Thank you for everything. Please remember me I will miss you. Thank you for draw picture. Thank you for play games. Thank you for reading and writing with me.</td>
</tr>
<tr>
<td>9-year-old Congolese female</td>
<td>I like rainbow because is many colour. There is yellow. There is red. There is blue. There is green. There is orange. There is pink. I like rainbow because it is well and I'm learn to draw pictures from rainbow.</td>
</tr>
<tr>
<td>11-year-old Karen female</td>
<td>Good bye to Miss Sally and Miss Jenny. I love rainbow playgroup and we played game every week and we grow the picture and I like to do every week. I like to do rainbow playgroup every week and I like to dack (sic) and I like to draw the rainbow and I like to see the rainbow and I like to play more game. I like you two you are a good teacher and I like to paint a picture and my friend at the rainbow playgroup. Goodbye to Miss Sally and Miss Jenny you two good teachers.</td>
</tr>
<tr>
<td>11-year-old Chin female</td>
<td>Thank you so much Miss Sally and Miss Jenny. I like dance and draw picture. I miss you a lot. I am very sad because I am going to a new school. I like rainbow group. My parents say rainbow is very good. Miss Jenny and Miss Sally you are very kind I like you. God bless you always. Please remember me. I am remember you too. I never forget you. Thank you so much Miss Jenny and Miss Sally. Goodbye.</td>
</tr>
<tr>
<td>11-year-old Sudanese male</td>
<td>I would like to describe my important memory of the rainbow group to you. There were three different types of rainbows, but one was the most important for me. The rainbow that stop the rain was my best because I don’t like rain. I hated rain and I like sun. Sun is my best and rainbow too.</td>
</tr>
<tr>
<td>12-year-old Ethiopian male</td>
<td>Thank you for teach me about rainbow. Thank you for learn me how do you draw picture. I will miss you when I change school. Thank you for teach me no fighting with your friend. Thank you for teach me about play together with your friend. Thank you for teach me about someone was speaking you quiet or you listen to them. Please remember me. I will remember you. Goodbye. I was cry when you go.</td>
</tr>
<tr>
<td>12-year-old Burmese female</td>
<td>I like rainbow because I like to dance. I like rainbow because the rainbow is beautiful. I like drawing. I like playing games. I like Miss Sally and Miss Jenn because Miss Sally and Miss Jenn is very funny.</td>
</tr>
<tr>
<td>12-year-old Karen female</td>
<td>How are you? Good luck to you and I hope you happy. Thank you for play with us. In rainbow group I like to do to play game. Miss Sally and Miss Jenny I like to play with you. Please remember we are played in Rainbow group. Goodbye miss Sally and Miss Jenny. Thank you.</td>
</tr>
<tr>
<td>12-year-old Karen male</td>
<td>Good luck to Miss Sally and Miss Jenny. In this school you will be a good student if you speak and write English so much and I like to draw picture and I like to play game with you and I did not to draw a rainbow and you help me and I like to learn to speak English in the class. Thank you Miss Jenny and Miss Sally.</td>
</tr>
</tbody>
</table>