NEW PARADIGMS OF ENQUIRY INTO POSTTRAUMATIC STRESS DISORDER SYMPTOMS AND ADAPTATION IN ADOLESCENTS FROM REFUGEE BACKGROUNDS: A MIXED METHODS APPROACH

Lucy Sarah McGregor

BA/BSc(Hons)

Centre for Developmental Psychiatry & Psychology

Department of Psychiatry

School of Clinical Sciences

Faculty of Medicine Nursing & Health Sciences

And

School of Psychological Sciences

Faculty of Medicine Nursing & Health Sciences

Monash University

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This thesis includes three original papers submitted for publication. The core theme of the thesis is the role of familial and psychosocial factors in posttraumatic stress disorder symptoms and adaptive processes in resettled refugee adolescents. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the candidate, working within the School of Psychological Sciences under the supervision of Dr. Glenn Melvin and associate supervision of Professor Louise Newman. The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research.

In the case of Chapters Five, Six and Seven, my contribution to the work involved the following:

Project conceptualisation and design (in consultation with my supervisors), review of appropriate literature, securing of ethical approval, data collection, data analysis (in consultation with my supervisors and departmental statisticians and qualitative researchers) and manuscript preparation. My supervisors provided input into completed manuscript drafts.

Thesis chapter	**Publication title**	**Publication status**	**Nature and extent of candidate's contribution**
Five	Familial separations, coping styles, and PTSD symptomatology in resettled refugee youth	Submitted	As above
Six	Differential accounts of refugee and resettlement experiences in youth with high and low levels of posttraumatic stress disorder symptomatology: an interpretative phenomenological investigation	Submitted	As above
Seven	A qualitative exploration of the validity of the Adaptation and Development after Persecution and Trauma (ADAPT) model with resettled refugee adolescents in Australia	Under review	As above

I have renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

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Abstract

Historically, research with refugee populations has generally characterised the impact of the refugee experience in psychopathological terms, that is, by examining how particular aspects of people's experiences as refugees lead to specific psychiatric outcomes. Particular emphasis has been devoted to the examination of posttraumatic stress disorder (PTSD), with prevalence studies consistently finding that a small but significant proportion of refugees develop the disorder. Though the PTSD syndrome has been shown to be valid in ethnically diverse refugee populations, the emphasis on examining PTSD specifically, and psychopathology generally, has come under increased debate in recent years. Critics argue that research into PTSD has been reductive in focus, in its failure to examine how interrelationships between pre-migration, resettlement and psychosocial variables act in the aetiology of the disorder. Further critique has been directed toward the emphasis on examining PTSD and psychopathology as predominant outcomes of the refugee experience, when other important familial, psychosocial and adaptive processes are clearly implicated, yet understudied.

The overarching aim of this thesis, therefore, was to examine the impacts of the refugee experience in general, and PTSD symptomatology in particular, from broader conceptual and empirical perspectives. Three empirical studies utilising a mixed-methods research approach were undertaken, with a total of 50 young people from refugee backgrounds participating in the research. Participants completed quantitative measures assessing for PTSD symptomatology and use of coping styles, and partook in a semi-structured interview specifically designed for use in the present research and based on a proposed theoretical model of refugee adaptation.

The first study, comprised of the full sample of 50 participants, sought to jointly investigate how familial separations and the use of coping styles related to PTSD

symptomatology in youth. Young people who were residing with non-intact immediate families were found to have higher levels of PTSD symptomatology than those who did not have immediate familial separations, though there were no differences between groups in their use of coping styles. Hierarchical multiple regressions revealed a significant relationship between the use of avoidance coping and increased PTSD symptoms, however this diminished to non-significance once possible confounds were controlled for.

The second study aimed to explore, based on adolescents' accounts of their resettlement and refugee experiences, psychosocial and adaptive mechanisms that may play a role in PTSD symptomatology. This study was based on a sub-sample of 10 participants, and utilised interpretative phenomenological analysis to analyse the differences in qualitative accounts between participants with high and low levels of PTSD symptoms. The themes of *cultural belongingness and identification, psychological functioning, family unit functioning and relationships,* and *friendships and interpersonal processes,* were identified as having particular relevance for distinguishing between participants with high and low levels of PTSD symptomatology.

The third study was based on a sub-sample of 43 participants, all of whom completed the semi-structured interview and consented for it to be audio-recorded. This study was undertaken to examine the applicability of a theoretical model of psychosocial adaptation to adolescents' accounts of their refugee and resettlement experiences. Utilising thematic analysis, preliminary evidence for the model's validity was obtained.

Taken together, the results from the present thesis provide strong evidence for the need to conceptualise and examine the impacts of the refugee experience from broader psychosocial and ecological perspectives. Adolescents' familial systems were particularly implicated in the studies' findings, emphasising the need for future theory development and research to consider this central, yet understudied, aspect of the refugee experience.

Papers Submitted During Candidature

McGregor, L.S, Melvin, G.A., & Newman, L. (2014). Familial separations, coping styles, and PTSD symptomology in resettled refugee youth. Manuscript submitted to *The Journal of Nervous and Mental Disease.* July, 2014

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Chapter 1. Introduction and Thesis Outline

From the triggers that cause people to flee their homes, the uncertainty and challenges in seeking initial safety and asylum, to the difficulties associated with resettling in a third country, the refugee experience is one of loss, upheaval and new beginnings. For children and youth, who make up almost half of the world's population of people from refuge backgrounds (hereafter referred to as 'refugees'; United Nations High Commissioner for Refugees [UNHCR], 2014a), the impacts of such experiences may be profound, and have been shown to affect psychological and developmental processes alike (De Haene, Grietens & Verschueren, 2007; Fazel & Stein, 2002; Joshi & O'Donnell, 2003).

Research findings have provided important insights into the mental health impacts associated with the refugee experience, and have elucidated links between specific experiences endured by refugees and psychological outcomes (Davidson, Murray & Schweitzer, 2008; Ehntholt & Yule, 2006; Lustig et al., 2004). Particular attention has been devoted to examining posttraumatic stress disorder (PTSD) in refugee populations, and findings consistently demonstrate that it is one of the most common psychological conditions experienced by refugees (Drury & Williams, 2012; Fazel & Stein, 2002). Yet this research paradigm has been the subject of much debate and contention, with many arguing that it fails to account for broader factors that are both the cause, and outcomes, of people's experiences as refugees (De Haene, Grietens & Verschueren, 2007; Porter, 2007; Silove, 1999).

The current thesis' overarching aim was to add to the understandings of the impacts of the refugee experience on children and adolescents' mental health and adaptive processes. The specific aims of the project were twofold: firstly, to develop knowledge on PTSD symptoms as they are manifest in youth from refugee backgrounds by taking an ecological, holistic and multi-modal approach in examining the topic; and secondly, to broaden current

conceptualisations of the impact of the refugee experience by investigating how adaptive processes may be affected by youths' refugee and resettlement experiences.

This thesis was undertaken as a thesis by publication, as such it contains three empirical papers; two of which have been submitted for publication (Chapters 5 and 6) and one of which (Chapter 7), at the time of writing, has been submitted for publication and has been accepted to be reviewed by the editor. Due to the nature of a thesis by publication format, there is some unavoidable repetition throughout. The entire thesis comprises 8 chapters, which will be detailed herein.

Chapter 2 provides a brief overview of definitional issues, and refugee resettlement within a global and local context. A brief overview regarding the Australian political debate, legislation and policies pertaining to refugee and asylum seeker issues is provided in order to contextualise the thesis within the prevailing political climate.

Chapter 3 begins with an examination of the existing quantitative literature on PTSD in refugee populations, with particular emphasis on studies conducted with youth. Reflecting the literature's historic tendency to examine the impact of the refugee experience from a life-events framework (De Haene, Grietens & Verschueren, 2007), an overview of the pre-migration, migration and resettlement risk factors that have been found to act in the development and maintenance of PTSD is provided. Following this, there is a summary of research that has examined how intraindividual and familial factors act to confer risk and protection in the development of PTSD. A review of the predominant critiques of the literature is then provided, along with an overview of newly proposed theoretical paradigms of enquiry. The literature review concludes with a review of the qualitative research examining mental health and wellbeing in refugee youth populations.

Chapter 4 provides an overview of the rationale for and details pertaining to the methodologies employed for this thesis. Given the limited detail of study methodology

afforded within the empirical papers, this Chapter provides more details on the research design and approaches to data analysis. The Chapter concludes with a discussion around the particular ethical considerations that applied to this research study.

Chapter 5 comprises the first empirical study, which used quantitative methods to examine familial separations and their relation to adolescents' use of coping styles and PTSD symptomatology. Differences in the use of coping styles and PTSD symptom levels were examined in participants who resided with intact immediate families versus those who had familial separations.

Chapter 6 comprises the second empirical study, which used Interpretative Phenomenological Analysis (IPA) to investigate whether data from the semi-structured interviews could be differentiated between two select groups of participants: those with high levels of PTSD symptomatology versus those with low levels of PTSD symptomatology.

Chapter 7 comprises the third and final empirical study. This study used thematic analysis to examine participants' responses to a semi-structured interview on their refugee and adaptational experiences. The study specifically sought to examine whether Silove's (1999) proposed theoretical model, the Adaptation and Development After Trauma model, could be applied to the self-described refugee and resettlement experiences of an adolescent sample.

Chapter 8 provides an integrated discussion of the results derived from the three empirical studies. The results are considered within the framework of the overarching aims of the thesis and the prevailing literature on the mental health of refugee populations. Implications for theory development, clinical practice and further research are discussed and the limitations of the research are addressed.

Chapter 2. Refugee Resettlement: Global and Local Contexts

This chapter contains a focused overview of the global and local contexts pertaining to refugee and asylum seeker issues. Particular definitional, legislative and political issues are overviewed, in order to contextualize the thesis in these important issues. Specific details regarding refugee resettlement in Melbourne and Hobart, where the data collection for the thesis was carried out, will be briefly discussed.

2.1 Background Information and Definitional Issues

2.1.1 Definition of refugees.

The United Nations (UN) Convention Relating to the Status of Refugees (1951) set forth the first legal framework for the protection of refugees. The definition put forth by the 1951 convention is still commonly used, where a refugee is defined as being anyone 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, or, owing to such fear, is unwilling to avail himself of the protection of that country. (Article 1A(2)).

Despite the definition availing legal recognition and protection to millions of people since its inception, it has been critiqued as being too narrow in its failure to account for other groups of people who are forced to flee their homes (Zetter, 2007). To illustrate this, at the end of 2012, there was a total population of 35.8 million people of concern (including asylum seekers, internally displaced and stateless peoples) to The Office of the High Commissioner for Refugees, but only 10.5 million were classified as refugees (UNHCR, 2014b). The issue of the definition and labelling of refugees and those in refugee-like situations will be considered in subsequent sections given the pertinence of the topic in the contemporary Australian political context.

2.1.2 The global context.

The core mandate of the UNHCR is to provide protection for refugees and those in refugee-like situations, with the first priority being to ensure their basic human rights are being met. For longer term solutions to the plight of refugees, the UNHCR works towards three "durable solutions": repatriation, local integration and resettlement (UNHCR, 2014c). Voluntary repatriation is the preferred option for the majority of refugees, wherein they voluntarily move back to their home country (UNHCR, 2014d). For other refugees, local integration into their country of asylum is the most viable option. This solution enables refugees to integrate into, and ideally become citizens of, their country of asylum (UNHCR, 2014e). In cases where refugees are unable to return to their homelands or find residence in their countries of asylum, the solution of resettlement into a third country is pursued (UNHCR, 2014f), an option only available to around one percent of all refugees worldwide at present (UNHCR, 2014f).

2.2 Refugee Resettlement in Present-Day Australia: Legislative, Policy and Political Context

2.2.1 Refugee resettlement program.

Australia is one of 27 countries worldwide to have a formalized refugee resettlement program under the auspices of the UNHCR (Department of Immigration and Border Protection, 2013). Australia's resettlement program, the *Humanitarian Programme*, has two major components: offshore resettlement and onshore protection. The offshore resettlement component accepts refugees, most of whom are referred by the UNHCR, from overseas countries and provides permanent resettlement in Australia. In the year 2013-14 the offshore resettlement program is set to accept 13,750 people (Department of Immigration and Border Protection, 2013). A minimum of 11,000 places are set to be granted through the offshore

component, and the balance through the onshore protection component, granted to people who arrived in Australia with valid visas (Department of Immigration and Border Protection, 2013). Since 2008, children aged under 18 years have made up the greatest proportion of applicants to the Humanitarian Programme (Department of Immigration and Citizenship, 2013b).

The onshore protection component of the Humanitarian Programme has seen radical changes in recent years, stemming from shifting political policies and changes in government. From September 2013, onshore protection has been afforded to people who are already in Australia, have come on valid visas and arrived in Australia by air (according to current Australian legislative context) and who wish to make an application for protection or asylum (Department of Immigration and Border Protection, 2014a).

2.2.2 Asylum seeker policies.

Asylum seekers (people who claim to be refugees but have not yet had their claim definitively evaluated (UNHCR, 2014g), enter into Australia in two ways: by air, either with or without a valid visa, or by sea. At the time of writing, asylum seekers who enter Australia on valid visas (such as tourist or student visas) are able to apply for Protection Visas under the abovementioned onshore protection component of the Humanitarian Programme (Department of Immigration and Border Protection, 2013a). For those who arrive in Australia without valid visas, Australia's policy of mandatory detention will be applied (Phillips & Spinks, 2013). Under this policy, asylum seekers will be detained in immigration detention centres while they make arrangements for valid visas, or until they depart the country (Phillips & Spinks, 2013).

Australia's mandatory detention policy particularly affects asylum seekers who arrive in Australia by boat (Commonwealth of Australia, 2013; Department of Immigration and Border Protection, 2014b). In July 2013, under the *Regional Resettlement Arrangement*, the

then Labor government announced that all asylum seekers arriving by boat to Australia would have their asylum claims processed in offshore detention centres and not be granted resettlement in Australia, even if found to be refugees (Amnesty International, 2013). The federal election in 2013 saw a change of government to the Liberal party, who have continued to enact border protection policies largely in keeping with those established by the previous Labor government, but have changed the ways in which people arriving by boat are managed and processed. Although precise details are sparse, the Liberal party, through their Operation Sovereign Borders policy, have upheld processing and resettling asylum seekers overseas, with no apparent prospect that they will ever be able to resettle in Australia (The Liberal Party, 2013). The government also attempted to reintroduce Temporary Protection Visas (TPVs; Amnesty International, 2013), which was met with much criticism from human rights groups due to the significant mental health impacts on asylum seekers when the visas were last in use prior to 2008 (Amnesty International, 2013; Steel, Brooks, Momartin, Alzuhairi & Susljik, 2006). The reintroduction of TPVs however, was blocked by the Senate in December 2013, and thus, at the time of writing, are not currently in use (Amnesty International, 2013).

As of May, 2014, there were a total of 4,016 people in immigration detention facilities, which included 1,237 people in immigration detention on Christmas Island and 1,883 in offshore processing centres. Children under 18 years of age make up a significant proportion of these populations, with 775 residing in immigration detention facilities and a further 1,507 in community detention (Department of Immigration and Border Protection, 2014b). The detrimental impacts on the mental health of asylum seekers, particularly children, in detention centres has been well-documented (Newman, Proctor & Dudley, 2013; Robjant, Hassan & Katona, 2009; Steel et al., 2006). Although people in community detention live in the community on bridging visas whilst they seek resolutions to their

immigration status (Department of Immigration and Border Protection, 2014c), the uncertainty associated with this process, and the conditions attached to the visas (such as prohibition to seek employment) can have detrimental impacts on mental health (Australian Human Rights Commission, 2013). In addition to this, there is evidence to suggest that such policies, and the associated political discourse that is put forth in the public forum, can be harmful to the wellbeing of asylum seekers and refugees who have already successfully resettled in Australia (Pedersen, Attwell & Heveli, 2005).

Research findings demonstrate that some members of the Australian public hold negative, false, and hostile, beliefs towards asylum seekers (Pederson et al., 2005a; Pedersen, Clarke, Dudgeon & Griffiths, 2005). Governmental policies towards asylum seekers as well as negative media coverage have been postulated as, among other things, some of the reasons behind these beliefs (Pederson et al., 2005a; Pedersen et al., 2005b). The flow on effect from such widely held public attitudes, namely racism and discrimination, may act as significant barriers to successful adaptation to life in Australia for many refugees. While it is beyond the scope of this project to examine this topic in any further detail, it is an important contextual issue to consider given the premise of this thesis, and particularly considering some participants in this study arrived in Australia as asylum seekers themselves.

2.3 Refugee Resettlement in Melbourne and Hobart

2.3.1 Refugee resettlement in Melbourne, Victoria.

Settlement statistics.

In the financial year 2013-14, Victoria accepted a total of 2,154 persons under the Humanitarian programme, which represented 8.6% of the state's permanent settler (defined by the Australian Department of Immigration and Border Protection, 2013b, as people who are granted permanent residence status while in Australia on a temporary visa; people who

arrive from overseas and are entitled to stay in Australia permanently; people granted permanent humanitarian and migration visas both offshore and onshore) arrivals for that year (Department of Immigration and Border Protection, 2013b).

Educational programs.

In greater Melbourne, there are four English language schools (ELSs) which are stand-alone facilities, and five English Language Centres (ELCs) which are attached to mainstream schools (State Government of Victoria, 2011). A recent report by the Victorian government noted that the majority (70%) of secondary school age youth from refugee backgrounds enter the educational system via the ELS/Cs in Victoria (State Government of Victoria, 2011).

2.3.2 Refugee resettlement in Hobart, Tasmania.

Resettlement statistics.

In the financial year 2013-14 Tasmania accepted a total of 288 persons under the Humanitarian programme. Notably, these new arrivals made up 50.1% of Tasmania's permanent settler arrivals for that year (Department of Immigration and Border Protection, 2013b). More than half of entrants to Tasmania under the Humanitarian programme are less than 20 years of age (Department of Health and Human Services, 2010).

Educational programs.

Unlike Victoria, Tasmania does not have any specialized English Language Schools that youth from refugee backgrounds can attend prior to commencing mainstream schooling. As a result, young people of school age enter generally enter straight into the mainstream schooling system upon arriving in Tasmania, regardless of English language abilities. For 18 to 24 year olds, there is a specific English language program at TasTAFE (Tasmania's post-compulsory vocational education and training provider) which youth are entitled to attend.

Chapter 3. Posttraumatic Stress Disorder and Adaptation in Refugee Populations: A Literature Review

3.1 Introduction

Since its inception in the Diagnostic and Statistical Manual for Mental Disorders III (DSM-III; American Psychiatric Association, 1980) in 1980, and the first studies into the condition as it was manifest in refugee populations following the Vietnamese war (Kinzie et al.,1990), posttraumatic stress disorder (PTSD) has been one of the main focal points in research examining the mental health of people from refugee backgrounds (Schweitzer & Steel, 2008). Although characterized by methodological, sampling and diagnostic variances, this research paradigm has found that a sizeable portion of refugees develop PTSD as a result of their traumatic pre-migration and associated resettlement experiences (Fazel & Stein, 2002), with the trajectory of the disorder often continuing many years into resettlement (Ehntholt & Yule, 2006). Numerous studies have demonstrated that a range of factors inherent to the refugee experience (i.e., , those endured before migration, during migration and through the process of asylum and resettlement) have causal or correlational relationships to PTSD development and maintenance (Fazel, Reed, Panter-Brick & Stein, 2012; Murray, Davidson & Schweitzer, 2008; Reed, Fazel, Jones, Panter-Brick & Stein, 2012). Further research demonstrates that conceptually broader factors (including intraindividual processes, such as coping styles, familial make-up and aspects of the socio-demographic environment) play notable roles in the manifestation of PTSD (Fazel et al., 2012; Lustig et al., 2004). Despite the contribution this line of research has made to the understandings of the condition as it is manifest in refugee populations, and the undoubted positive impact the resultant provision of tailored mental-health services across resettlement countries have had on mental health outcomes of resettled refugees (Cunningham & Silove,1993; Schweitzer & Steel,

2008), it has recently come under extensive critique and debate (Porter, 2007; Silove, 1999). Many have argued that the prevailing western-based nosology of PTSD is reductionistic, in its emphasis on PTSD as the predominant outcome of the refugee experience and its failure to account for other manifestations, including indigenous forms, of distress (Hollifield et al., 2002; Porter, 2007; Porter & Haslam, 2005; Summerfield, 2012). Many further posit that it is exclusionary, in failing to examine how phenomenon, including societal, familial and resettlement factors, may contribute to psychopathology (Bracken, Giller & Summerfield, 2005; Porter, 2007; Porter & Haslam, 2005).

The following chapter provides an overview of the extant literature on PTSD in refugee and war-exposed populations, with particular emphasis on child and adolescent refugees. A review of the current state of knowledge regarding the risk and protective factors for the development and maintenance of PTSD in refugee populations is provided, with a summary of studies that have examined how intraindividual factors, such as coping styles, and elements of the family unit relate to PTSD symptomatology, to follow. Following this, a critique of the refugee mental health literature and an overview of proposed new paradigms of enquiry in mental health research within refugee populations is provided. Finally, a review of qualitative research with refugee populations is undertaken, with particular emphasis on studies that have examined coping and adaptive processes in resettled refugee populations.

3.2 Prevalence of PTSD in Resettled Youth Refugee Populations

Given the vast heterogeneity that characterizes research with refugee populations, making generalizations regarding prevalence rates of psychopathology is difficult (Fazel, Wheeler & Danesh, 2005). Much of the variance between findings is likely attributable to the inherent diversity of individuals' refugee experiences, as well as likely differences in cultural manifestations of distress (Mghir & Raskin, 1999; Steel et al., 2009). Variances in

methodologies, including the use of diagnostic tools and the nature of sampling techniques, further add to the heterogeneity of the literature (Drury & Williams, 2012; Ehntholt & Yule, 2006).

In line with the variability between populations studied and methodologies used, findings regarding prevalence rates of PTSD in refugee youth are varied. Studies that have used self-report measures to examine PTSD symptoms, and to estimate rates of likely PTSD have reported widely differing results. A study with resettled Somalian adolescents in the United States for example, found rates of 19% (Bronstein & Montgomery, 2011; Ellis, MacDonald, Lincoln & Cabral, 2008), whilst 28% in a sample of Bosnian resettled youth met clinical cut-off scores (Papageorgiou et al., 2000). Further self-report studies with clinic (e.g., Betancourt et al., 2012; Hepinstall, Sethna & Taylor, 2004) and unaccompanied refugee minors (e.g., Bean, Derluyn, Eurelings-Bontekoe, Broekaert & Spinhoven, 2007; Bean, Eurelings-Bontekoe & Spinhoven, 2007; Bronstein, Montgomery & Dobrowolski, 2012) have found clinically elevated self-report scores in populations to be as high as 73% (Hodes, Jagdev, Chandra & Cunnif, 2008), with these sub-populations apparently demonstrating higher rates of PTSD than community-based refugee samples (Bean et al., 2007a).

Interview-based diagnostic studies have generally found comparably lower prevalence rates of PTSD (e.g., Berthold, 1999; Sack, Clarke & Seeley, 1996). It is likely that this is due, at least partly, to the added diagnostic accuracy of having a trained clinician make such judgements (Ehntholt & Yule, 2006), in contrast with the use of self-report measures, which are not diagnostic (Drury & Williams, 2012). In their study of Tibetan adolescent refugees residing in India, for example, Servan-Schreiber, Lin and Birmaher (1998) found an 11.5% prevalence rate of PTSD using diagnostic interview. In a meta-analysis of studies using interview-based psychopathological diagnoses with refugees resettled in Western countries,

Fazel, Wheeler and Danesh (2005) found that overall, 11% (7-17% range) of refugee children and adolescents were diagnosed with PTSD.

Prevalence rates of PTSD in child and adolescent resettled refugee populations are generally significantly higher than those of age-matched native-born populations (Ehntholt & Yule, 2006; Fazel et al., 2005). On the other hand, prevalence rates are largely comparable, and in some cases lower, to rates found in other trauma exposed populations (Bronstein & Montgomery, 2011; Dyregrov & Yule, 2006). In a study with University students who attended Virginia Tech University at the time of the worst campus shooting event in American history (Hughes et al., 2011), for example, high levels of PTSD symptomatology (above clinical cut-off scores on self-report PTSD measure) was experienced in 15.4% of the 4,639 participants three to four months after the shooting (Hughes et al., 2011). In another study with youth (N = 325) who survived the Utøya Island massacre in Norway, Dyb et al. (2014) assessed PTSD symptomatology using the University of California at Los Angeles PTSD Reaction Index (PTSD-RI), a self-report measure corresponding with the Diagnostic and Statistical Manual for Mental Disorders (DSM) criteria for PTSD. In total, 47% of participants endorsed clinical levels of PTSD symptoms; 11% had clinical levels of posttraumatic stress reactions that met all of the PTSD-RI's PTSD symptom criteria (criteria B, C and D), and 36% of participants fulfilled partial criteria for PTSD by meeting symptom criteria for two of the three PTSD symptom criteria. Unlike participants in Hughes et al.'s (2011) study, many of whom had not directly witnessed the campus shooting, 100% of participants exposed to the Norwegian shooting heard gun shots and 73.1% saw the terrorist or heard his voice (Dyb et al., 2014), which may have explained the particularly high levels of PTSD symptoms in this sample. In comparison, Famularo, Fenton, Kinscherff and Augustyn (1996) found a 35% of children and adolescents who had been removed from their parents' care due to maltreatment and psychological trauma met formal criteria for PTSD

using structured clinical interviews. Similarly, Ackerman, Newton, McPherson, Jones and Dykman (1998), who also used structured clinical interviews, found a 36% rate of PTSD in a sample of children and adolescent victims of interpersonal abuse. Finally, a recent meta-analysis of studies examining psychopathology in youth survivors of disasters found prevalence rates of diagnosable PTSD to range from two to 32% following floods, and 10 to 57% following exposure to tsunamis (Wang, Chan & Ho, 2013).

3.3 Risks, Correlates and Protective Factors for PTSD in Refugee Populations

While prevalence rates of PTSD in populations are highly variable across studies, when considered in their totality, results demonstrate that PTSD is a condition that only a minority, albeit a substantial one, experience (Drury & Williams, 2012; Fazel et al., 2005; Nickerson, Priebe, Bryant & Morina, 2014; Silove, 1999). Although the literature on child and adolescent refugees is sparse compared to studies with adult populations (Lustig et al., 2004) research has tended to focus, at least until recently, on how stressors experienced during people's refugee experiences act as risk factors for the development of the condition (Lustig, 2004; Porter, 2007). While cross-sectional studies have found evidence for exposure to violence and severity of exposure to war-related trauma to be particularly implicated in the development of PTSD (Drury & Williams, 2012; Ehntholt & Yule, 2006), longitudinal findings with adults (Carlsson, Olsen, Mortensen & Kastrup, 2006; Hermansson et al., 2002; Lie, 2002) and children (Almqvist & Broberg, 1999) point to the importance of resettlement factors in the maintenance of PTSD symptomatology. Studies pertaining to familial and intraindividul factors, such as personality attributes, psychological functioning and coping styles, and how they act to confer risk or protection in the development and maintenance of PTSD are few (Lustig et al., 2004; Nickerson et al., 2014; Porter & Haslam, 2005), yet they present important avenues for future enquiry.

Findings from the broader literature base on PTSD demonstrate that it is a condition developed through interacting inter and intrapersonal variables, present both before and after the index trauma, as well as factors associated with trauma exposure itself (Brewin, Andrews & Valentine, 2000; Ozer, Best, Lipsey & Weiss, 2008). A recent comprehensive meta-analysis of predictors of PTSD symptomatology in adults found that individual and familial factors were important predictors in a range of trauma-exposed populations (Ozer et al., 2008). Psychological difficulties prior to people's experiences of index trauma, for instance, related to increased PTSD symptoms; amongst these results were two prospective studies of war veterans which found that personality variables (in the form of elevated pre-combat Minnesota Multiphasic Personality Inventory scores and neuroticism) were positively related to the later development of increased PTSD symptoms (Schnurr, Friedman & Rosenberg, 1993; Lee, Vallant, Schnurr & Elder, 1995). Perceived social support, particularly in the form of emotional support, was also found to be a strong protective factor against the development of PTSD, and familial history of psychopathology was shown to be a risk factor (though this finding did not stand up to post-hoc tests of robustness; Ozer et al., 2008). These findings are illustrative of the fact that the historic predominance of examining PTSD in refugee populations through life-events models alone (wherein PTSD is examined solely in relation to war and violent events endured in the pre-migration and migration phases of the refugee experience, whilst neglecting how broader psychosocial processes may also impact upon symptomatology; De Haene, Grietens & Verschueren, 2007; Porter, 2007) is too narrow an approach (De Haene, Grietens & Verschueren, 2007; Porter, 2007; Porter & Haslam, 2005). This will be discussed in detail in subsequent sections.

3.3.1 Pre-migration risk factors.

Refugee youth endure a raft of cumulative, and often prolonged, pre-migration traumas and stressors (Lustig et al., 2004). In research examining the nature and impact of

war trauma on Bosnian children's psychopathology, authors found that participants endured numerous traumatic experiences, including being forced to leave their villages and towns, being separated from family members, experiencing artillery fire at close distance, being witness to people's recent injuries and having family members injured during the war (Papageorgiou et al., 2000). Similar studies with refugee youth from Iran (Almqvist & Brandell-Forsberg, 1997), Cambodia (Rousseau, Drapeau & Platt, 1999), and other African and Middle-Eastern countries (Betancourt et al., 2012; Neugebauer et al., 2009), have found youth to endure other forms of trauma including the witnessing of mass burials, their parents being tortured or killed, and being forced to partake in the combat experience.

Factors associated with the nature, duration and intensity of pre-migration traumas are associated with PTSD symptomatology in young refugee populations (Al-Krenawi, Graham & Kanat-Maymon, 2009; Davidson, Murray & Schweitzer, 2008; Ehntholt & Yule, 2006). Cumulative trauma exposure has been demonstrated to relate to a range of negative mental health impacts (Fazel et al., 2012), and in PTSD in particular. A dose-response relationship between increased pre-migratory trauma exposure and heightened PTSD symptoms has been a common finding in the literature (e.g., Bronstein et al., 2012; Neugebauer et al., 2009). However further findings also attest to the importance of considering lifetime trauma exposure (Fazel et al., 2012). A study conducted with resettled Khmer youth for instance, demonstrated that cumulative exposures to trauma across participants' lifetimes (particularly exposure to community violence in their country of resettlement) was predictive of PTSD symptomatology, while pre-migratory traumas were not (Berthold, 1999). Such results attest to the importance of considering young people's life experiences, not only those they endured as refugees, when considering how events may impact upon mental health outcomes (Fazel et al., 2012).

Specific trauma events are also important risk factors for PTSD (Bronstein & Montgomery, 2011; Ehntholt & Yule, 2006). Separation from parents (Geltman et al., 2005; Halcon et al., 2004), direct personal injury (Geltman et al., 2005), violent death of a family member (Hepinstall et al., 2004), witnessing the death or injury to a family member or friend (Jones & Kafetsios, 2005) and the perception of threat to life during trauma exposure (Dyregrov, Gupta, Gjestad & Mukanoheli, 2000) have all been shown to be risk factors and correlates for the development of PTSD symptomatology in child and adolescent populations. It is important to note that these factors are not necessarily unique to refugees' pre-migratory experiences, and may occur in the flight stage, and even in the resettlement period (Berthold, 1999).

3.3.2 Flight.

In likeness to the refugee experience more broadly, flight experiences are heterogeneous both at the population (i.e., those fleeing from the same country) and the individual level (Lustig et al., 2004). Despite this, many refugees' flight experiences are characterized by uncertainty, loss, and, in many cases, traumatic experiences (Fazel & Stein, 2002; Lustig et al., 2004). Tibetan refugee children who fled to India, for example, endured imprisonment, witnessing travelling companions die and seeing dead bodies of other travellers in their journeys (Servan-Schreiber et al., 1998). Whilst Cuban children and adolescents who fled to America by boat witnessed drownings, travelling companions dying from thirst and starvation and boat sinkings (Rothe et al., 2002). Separation from parents, caregivers and family members during the flight phase is common (Lustig et al., 2004), and has been consistently found to be a significant risk factor for the later development of a range of psychological difficulties, including PTSD (Huemer et al., 2009).

For many refugees, journeys may involve often long periods of time spent in refugee camps (Ahmad, Sofi, Sundelin-Wahlsten & Von Knorring, 2000; Lustig et al., 2004). At the

end of 2012, approximately 3.5 million people were residing in various refugee camps across the world, and more than half of the residents were estimated to be children (UNHCR, 2014a). Even in providing inhabitants with relative safety, although this is not always a given (Kumssa, Herbert Williams, Jones & Des Marais, 2014; Rothe et al., 2002), life in refugee camps remains difficult and uncertain and thus imposes unique psychosocial stressors on their inhabitants (Khamis, 2005; Morgos, Worden & Gupta, 2008). Indeed, Khamis (2005) found that living in a refugee camp was one of the most salient predictors for PTSD in Palestinian children. Others, however, found no such evidence for the impact of refugee camp internment on young refugees' mental health (Loughry & Flouri, 2001; Tousignant et al., 1999). These results may be explicated by the fact that Khamis' study was conducted with adolescents during their camp internment, while youth partook in the other studies in the years following their camp experiences. These results may therefore indicate that the psychological burden associated with living in refugee camps dissipates in the years following time spent in a camp, but that mental health is negatively impacted during the time in residence, although this would need to be ascertained through prospective studies. Alternatively, these results may be reflective of the fact that conditions and their associated psychological impacts differ between refugee camps (Reed et al., 2012; Thabet, Abed, Vostanis, 2004). Future studies that use comparison groups, and matched methodological and procedural approaches to compare psychological profiles of different camps' residents would go some way in providing initial evidence on this topic.

3.3.3 Resettlement factors and stressors endured after the pre-migration and flight period.

For young refugees who resettle into a host country there are challenges as well as opportunities. Whilst the majority of young people adapt and resettle successfully to their host countries (Gifford, Correa-Velez & Sampson, 2009), some continue to experience

psychosocial difficulties many years into resettlement (Lie, 2002; Montgomery, 2010). Some of these difficulties have been shown to be attributable to factors in the resettlement environment (Fazel & Stein, 2002; Porter & Haslam, 2005); including, among other things, discrimination (Ellis et al., 2008), school difficulties (Montgomery, 2008) and relationships with peers (Geltman et al., 2005; Liebkind, 1996).

The initial years of resettling into life in a host country pose particular challenges to refugee youth. For most, they are tasked with integrating into a new schooling system, with many also having to learn a new language concurrently (Gifford, Correa-Velez & Sampson, 2009). Cultural values of host countries can be markedly different to that of refugees' homelands, and as such may pose adaptational challenges to youth and their family members alike (Weine et al., 2004). Further, refugee youth may find themselves straddled between cultures of their homeland and their newly adopted host country, with difficult choices to be made as to how much of each to integrate into their daily lives (Sam & Berry, 1995), a process that has been found to cause stress to the family unit in some refugees (Fazel et al., 2012; Liebkind, 1996). Experiences including racism and discrimination, financial hardships and frequent changes in residential abodes are further common resettlement stressors (Gifford et al., 2009; Hepinstall et al., 2004; Silove, Sinnerbrink, Field, Manicavasagar & Steel, 1997).

As reported earlier, research findings attest to the need to consider traumata refugees have experienced across their lifetime (including in the resettlement period) in addition to their premigratory experiences, in the manifestation of PTSD symptomatology (Berthold,, 1999; Fazel et al., 2012). Research findings have also convincingly shown that factors, which could arguably be conceptualised as being non-traumatic, also play a significant role in PTSD symptomatology in refugees (Ellis et al., 2008; Geltman et al., 2005; Hepinstall et al., 2004). In a large (N = 393) and comprehensive study with war-exposed adolescents from Sarajevo, Durakovic-Belko, Kulenovic and Dapic (2003) found that while traumatic war experiences

explained 20% of the variance in PTSD symptoms, socioenvironmental and individual factors explained a further 17%. It is important to note, however, that only 19% of the sample in this study were refugees. Therefore, the nature of the socioenvironmental stressors that the majority of the sample were experiencing may not be comparable to those that a population of refugee youth would experience in a resettlement environment. These findings are nonetheless illustrative, and are echoed in the findings below, in studies with resettled refugee youth.

Perceived discrimination (Ellis et al., 2008), and stressors (including social isolation, acculturative stress, insecure asylum status, and reduced ability to speak the resettlement country's language) encountered in the resettlement environment have been found in a range of resettled refugee populations to relate to increased PTSD symptomatology (Geltman et al., 2005; Halcon et al., 2004; Hepinstall et al., 2004; Sack et al., 1996). Social relations in the resettlement environment appear to have particular salience in their relation to emotional wellbeing in resettled refugee youth (Fazel et al., 2012), and have been found to specifically influence PTSD symptomatology also. Increased PTSD symptomatology in unaccompanied Sudanese minors resettled in the United States, for instance, was associated with feelings of loneliness and isolation, and difficulties in adjusting to cultural practices of US society (Geltman et al., 2005). These findings echoed those of Ellis and colleagues' study, in which perceived discrimination was the most significant correlate of PTSD symptoms, aside from pre-migration factors.

It is important to note that the abovementioned findings are drawn from studies employing cross-sectional research designs. Results therefore may be due to participants with higher PTSD scores being prone to reporting higher resettlement stressors, due possibly to the impact on their functioning. Indeed, in a population-based study of 338 Somali and Oromo refugee youth who had been resettled in the United States, findings revealed that participants

with the highest PTSD symptom scores self-reported experiencing more social, physical and psychological problems than those in the sample with PTSD scores in the lowest quartile (Halcon et al., 2004). While in a study with adolescent Khmer refugees, those who had a PTSD diagnosis reported higher levels of resettlement stress compared to those with no mental illness, and those with depression (although it was not clear if these differences were statistically significant; Sack et al., 1996). A further possibility is that people with PTSD may actually experience more resettlement stressors, a finding consistent with reported clinical evidence (Sack et al., 1996). Despite uncertainties pertaining to the direction of relationships, this evidence demonstrates that resettled refugees with PTSD are a vulnerable group, not only due to their PTSD symptomatology but also in their possible vulnerability and potential susceptibility to resettlement stressors (Halcon et al., 2004; Sack et al., 1996). More longitudinal and follow-up studies are required to elucidate these important relationships, given their potential implications for preventative interventions.

3.4 Longitudinal Course, and Differential Impacts of the Three Phases of the Refugee Experience on PTSD Symptomatology

There is a marked lack of longitudinal and follow-up studies with populations of resettled youth (Lie, 2002; Sack, Him & Dickason, 1999), and thus relatively little is known about the longitudinal course of psychological disorders, including PTSD, in these populations (Lie, 2002; Montgomery, 2010). As such, findings reported herein are largely from studies with adult resettled refugees, as well as one from one study with refugee children. Perhaps due to the dearth in longitudinal and follow-up studies, findings from this line of research are mixed. While some studies attest to the chronicity of a PTSD response (Almqvist & Broberg, 1999; Lie, 2002; Sack et al., 1999), this was not found in other studies (Becker, Weine, Vojvoda & McGlashan, 1999; Carlsson, Olsen, Mortensen & Kastrup, 2006). The continuing impact of

index-trauma exposure on long-term PTSD symptomatology is also equivocal. One commonality, however, is the finding that resettlement stressors play an important role in the maintenance of PTSD symptomatology (Almqvist & Broberg, 1999; Lie, 2002). Finally, two studies have demonstrated that intraindividual factors also play an important role in the manifestation of PTSD symptomatology in adult (Lie, 2002) and child (Almqvist & Broberg, 1999) refugee populations.

Kinzie, Sack and their colleagues (Kinzie, Sack, Angell, Manson & Rath, 1986; Kinzie, Sack, Angell, Clarke & Ben, 1989; Sack et al., 1993; Sack et al., 1999) commenced a pioneering series of studies into the mental health of resettled refugees in the 1980s in their work with Cambodian youth who had resettled in the United States (US) following the Pol Pot regime. The authors studied participants from adolescence through to adulthood, and examined the longitudinal course and correlates of PTSD and depression symptoms using interview-based diagnostic techniques. Youth partook in the research early into their resettlement in the US (Kinzie et al., 1986), and in the subsequent three (Kinzie et al., 1989), six (Sack et al., 1993), and 12 years following (Sack et al., 1999). Findings from this series of studies are notable for a number of reasons. Firstly, they demonstrated that the PTSD diagnosis was chronic and persistent. From year six to year 12, the rates of PTSD diagnosis remained relatively high (38% and 35% respectively). Secondly, the PTSD diagnosis was variable across individuals over time. Some youth evidenced PTSD early in the study period but later became diagnosis-free, for others there was a delayed onset of PTSD, with 18% of the 40 participants who were exposed to the Pol Pot regime exhibiting PTSD later in data collection, at least five to eight years after fleeing Cambodia. In the 12 year follow-up study, Sack, Him and Dickason (1999) postulated that specific conscious memory of a traumatic event was associated with PTSD symptoms.

Despite having numerous strengths, including a long follow-up time, their high retention and participation rates and in their use of interview-based diagnostic procedures, the aforementioned studies do have a number of important caveats that must be considered in their interpretation. Firstly, Sack, Him and Dickason (1999) did not use statistical means to explicate the nature of the association between traumatic memories and PTSD diagnoses in their 12 year follow up study of Cambodian refugees. Furthermore, the authors did not assess for traumata or stressors experienced in the resettlement environment, nor did they control for past levels of PTSD symptomatology. While their findings as to the longitudinal course of PTSD in this population group are enlightening, it is not clear from this study what factors may be contributing to this pathology. A further point to consider from these studies is that the participants are not necessarily representative of other groups of refugees. The majority of the participants were exposed to particularly distressing trauma events, and thus their experiences may have been more extreme than other refugees'. For example, in a nine year-follow up of young Middle Eastern refugees resettled in Denmark, Montgomery (2010), found 16% of participants experienced the torture, killing or intimidation of family members, whilst 63% of Sack et al.'s (1993) sample had parents that were either killed or missing. Although this is arguably a point that applies to all research with refugee populations, it is important to factor in the extreme trauma and hardships (83.8% of the studies' pre-test sample experienced malnutrition, for example; Sack et al., 1993) that participants in Sack and Kinzie and colleagues' studies experienced, factors which may partly account for their longitudinal symptom profile.

Compared to findings in Sack et al. (1993) and Sack Him and Dickason's (1999) aforementioned studies, further research regarding the chronicity of PTSD in refugee populations is mixed. While a chronic PTSD response was evidenced in resettled Iranian children (Almqvist & Broberg, 1999) and in adult refugees from a range of countries resettled

in Norway (Lie, 2002), PTSD rates diminished in a one year follow-up study Bosnian adolescents (Becker et al., 1999), and in a ten year follow up of severely traumatised Iranian and Iraqi refugees in Denmark (Carlsson et al., 2006). It is important to consider that the study by Becker, Weine, Vojvoda and McGlashan (1999) had a considerably small sample size (N = 10), and 77% of the participants of Carlsson, Olsen, Mortensen and Kastrup's (2006) study had been involved in a psychological treatment program between the initial screening and follow-up period of the study. Both of these factors could have contributed to the findings of reduced PTSD symptomatology at follow-up.

The evidence pertaining to the predictors of PTSD symptomatology is likewise mixed, although not extensively studied in longitudinal and follow-up research. In adult refugees, unemployment status has been demonstrated in a number of studies as a particular risk factor for increased PTSD symptomatology (Carlsson et al., 2006; Hermansson, Timpka & Thyberg, 2002; Lie, 2002). Whilst other factors, including poor physical health (Hermansson et al., 2002) and absence of social contacts (Carlsson et al., 2006; Lie, 2002), were also found to relate to increased rates of the condition and its symptoms in adult refugees. Regarding the relationship between pre-migration trauma and PTSD symptomatology, Lie (2002) found a significant positive relationship, while Hermansson, Timpka and Thyberg (2002) found no such relationship and Carlsson Olsen, Mortensen and Kastrup (2006) did not investigate their role. An examination of the predictors and correlates of PTSD symptoms in children has only been conducted in one study, to the writer's knowledge, in the aforementioned three and a half year follow up study of a sample of Iranian children by Almqvist and Broberg (1999). Pre-migration traumas remained predictive, although diminished in importance of PTSD symptomatology, as did children's pre-existing vulnerabilities of poor health and propensity to experience temper tantrums.

Given the differential follow-up periods, methodologies and populations studied, findings from longitudinal and follow-up studies with refugee populations are difficult to generalise from. There is clearly a major dearth of such research with refugee populations, and in order to better understand the development and multifaceted processes of causation, more studies are needed (Fazel et al., 2012). While traumas experienced prior to migration remained of predictive importance in PTSD symptomatology in two studies (Almqvist & Broberg, 1999; Lie, 2002), intraindividual and resettlement factors were also found to have important relationships to PTSD symptom levels (Almqvist & Broberg, 1999; Carlsson et al., 2006; Hermansson et al., 2002). Clearly the relationships between these factors are interactive and complex (Almqvist & Broberg, 1999). It may be that the interactive effects of pre-existing vulnerabilities, PTSD symptomatology and resettlement stressors act in concert to compound symptomatology in refugee youth (in a study with internally displaced Congolese adolescents, for example, there were interactive relationships between trauma exposure and daily stressors on externalizing symptoms; Mels, Derluyn, Broekaert & Rosseel, 2010) (Almqvist & Broberg,1999; Ellis et al., 2008). Alternatively, resettlement stressors may act to hinder recovery from PTSD symptoms caused by exposure to pre-migration stressors (Mels et al., 2010; Miller, Omidian, Rasmussen, Yaqubi & Daudzai, 2008).

3.4.1 Intraindividual factors.

In contrast to the comparatively extensive research on the influence of contextual variables on PTSD outcomes following trauma, little research attention has been paid to examining how intraindividual characteristics may operate in the manifestation of PTSD symptomatology in refugee populations (Khawaja, White, Schweitzer & Greenslade, 2008; Lustig et al., 2004). Findings from the wider literature with adult civilian and war-exposed populations attest to the role of intraindividual factors (Ozer et al., 2008), including

neuroticism and interpersonal sensitivity, in PTSD outcomes following trauma (McNally, 2003; Nickerson et al., 2014), indicating that it may be a pertinent line of enquiry to pursue to develop a better understanding of the condition as it is manifest in young refugee populations.

Pre-existing intraindividual vulnerabilities have been shown to relate to increased PTSD symptomatology (Ozer et al., 2008), and are hypothesised to impact on children's abilities to recover from posttraumatic stress symptoms associated with the refugee experience (Almqvist & Broberg, 1999). While having the ability to express emotions and pro-sociality are characteristics which have been found to be protective against the development PTSD symptoms in young refugees (Daud, Klintenberg & Rydelius, 2008b). Coping is a further intraindividual factor that has been demonstrated to relate to PTSD symptomatology in adult refugees. While coping has been studied in populations of refugee youth, there has been minimal research into the relationship between coping factors and PTSD symptoms in child and adolescent refugees (Bronstein & Montgomery, 2011).

Coping.

Research on the nature, structure and function of coping in childhood and adolescence may be particularly implicated in young people's mental health, given its role in self-regulatory and stress management processes (Compas, Connor-Smith, Saltzman, Harding Thomsen & Wadsworth, 2001). That such factors are linked to psychopathology (Braun-Lewensohn et al., 2009; Lazarus & Folkman, 1984) makes coping a potentially fruitful line of enquiry in refugee research, particularly in studies seeking to elucidate reasons for individual variation in psychiatric morbidity (Ghazinour, Richter & Eisemann, 2003; Hooberman, Rosenfeld, Rasmussen & Keller, 2010). While there is a broad literature base on coping in (largely Western) children and adolescents, it is coloured by varying and non-developmentally appropriate definitions, and emerging theoretical constructs regarding the nature and structure of coping (Compas et al., 2001; Hooberman et al., 2010). This has

resulted in the proliferation of publications with disparate methodologies and theoretical orientations, leading to a "…lack of clarity and consensus regarding the nature of coping during childhood and adolescence" (Compas et al., 2001, pp. 87). Consequently, there is a lack of consensus as to what specifically constitutes coping (Hooberman et al., 2010), and thus how it can be defined. In detailing what they argue to be one of the few developmentally appropriate definitions of coping, Compas Connor-Smith, Saltzman, Harding Thomsen and Wadsworth (2001, pp. 88) define coping as, "conscious volitional efforts to regulate emotion, cognition, behavior, physiology, and the environment in response to stressful events or circumstances". That this definition is a developmentally-sensitive one though is arguable.

Perhaps due to the lack of consensus regarding the nature of coping, there are a number of proposed theoretical models of coping in the literature. Such models posit that coping is a multidimensional construct, with specific coping strategies (*first-order* strategies) being subsumed under overarching higher order coping dimensions (Compas et al., 2001). In their widely cited early work, Lazarus and Folkman (1984), posit a two-factor coping model, in which coping responses are subsumed under the two hierarchical categories of *emotion-focused* and *problem-focused* coping. More recent research has found that such two-part models are too simplistic, and have thus proposed, and found empirical evidence to support, more complex models of coping in children and adolescents (Ayers, Sandler, West & Roosa, 1996; Compas et al., 2001; Connor-Smith, Compas, Wadsworth, Thomsen & Saltzman, 2000). Connor-Smith, Compas, Wadsworth, Thomsen and Saltzman (2000), for example, propose that stress responses can be distinguished as either *voluntary* or *involuntary*, with voluntary responses being further distinguished by engagement versus disengagement coping. Another model by Ayers, Sandler, West and Roosa (1996) found empirical evidence for their four-factor model of coping, which comprises of *active*, *distraction*, *avoidance* and *support-seeking* coping strategies. This latter model by Ayers, Sandler, West and Roosa has been

demonstrated as being better fitted to data than comparable two-factor models in confirmatory factor analysis studies (Compas et al., 2001). Yet despite evidence attesting to the comparable better fit of more complex coping models to youth's coping behaviours and styles, there are still studies being published with measures based on less robust two-factor models (e.g., Durakovic-Belko, Kulenovic & Dapic, 2003; Hooberman et al., 2010).

Notwithstanding the problems with the literature base, important findings pertaining to the direct, correlational and moderating role coping strategies play between psychosocial stressors and psychopathology have been demonstrated (Braun-Lewensohn et al., 2009; Compas et al., 2001; Hooberman et al., 2010). Though such results have predominantly been found in adult refugee populations, they nonetheless shed important light on the role that coping processes play in the manifestation of distress in refugees and thus present important future avenues of enquiry in studies with young refugees.

Coping in refugee populations.

Studies into the linkages between coping and PTSD symptomatology in refugee populations are relatively few. While there are findings purporting links between the two constructs (Ai, Tice, Whitsett, Ishisaka & Chim, 2007; Finklestein, Laufer & Solomon, 2012; Matheson, Jorden & Anisman, 2008), studies are characterised by methodological variances making generalisations from the findings difficult. The majority of research has examined coping styles and PTSD symptomatology using cross-sectional designs, with findings therefore only being largely correlational in nature. Positive correlations have been found between refugees' use of avoidance (e.g., Ai et al., 2007; Finklestein et al., 2012) and cognitive coping styles and increased PTSD symptoms (Ai et al., 2007), while problem-focussed coping styles (Ghazinour et al., 2003) and use of particular forms of religious coping (Leaman & Gee, 2012) have been found to relate to diminished PTSD symptomatology.

Further research has demonstrated that coping styles act in a more complex way than only through direct effects, and may play a moderating role in PTSD symptomatology (Hooberman et al., 2010; Hujits, Kleijn, Van Emmerik, Noordhof & Smith, 2012). In their study with resettled refugees in the Netherlands, Hujits, Kleijn, Van Emmerik, Noordhof and Smith (2012) used path analysis to examine the relationships between coping styles, PTSD and quality of life. Though the direction of relationships between coping and PTSD was not able to be ascertained, the authors found that avoidant and problem-focused coping was interlinked with PTSD symptomatology (through either the coping styles influencing PTSD symptom severity, or PTSD influencing the use of the coping styles). Hooberman, Rosenfeld, Rasmussen and Keller (2010) argue that there is a need to examine possible overlaps and interactions between protective processes, such as coping styles, and pathological outcomes. These authors examined how coping styles impacted upon processes of resilience in refugee survivors of torture and found that emotion focused coping styles significantly moderated the relationship between cognitive appraisal variables (particularly social comparison) and in doing so usually increased the likelihood of increased PTSD symptomatology (Hooberman et al., 2010).

Despite their potential implications, particularly around tailoring clinical interventions towards promoting adaptive coping styles in refugees with high levels of symptomatology (Hooberman et al., 2010), results from coping studies must be interpreted with some caution. A vast range of assessment measures have been utilised to assess coping styles, with questionable cross-cultural validity, and, in some cases, low internal consistency of measures (e.g., Finklestein et al., 2012, Ghazinour et al., 2003; Leaman & Gee, 2010). Further, though there is likely to be a degree of overlap between PTSD symptomatology and coping behaviours (for example, with avoidance-based PTSD symptomatology and the use of

avoidance coping styles), these possible confounds between measures have not been controlled for (Finklestein et al., 2012; Hooberman et al., 2010).

Studies on coping in resettled refugee youth, in comparison, have largely been exploratory, and have predominantly examined what coping strategies are used by young refugees, without analysing how they are related to psychopathological or resilience outcomes. Findings demonstrate that young refugees use a wide variety of coping strategies, including distraction, suppression of thoughts, emotion and problem-focused strategies, finding meaning through religious beliefs, and the use of exercise and social support (Brough, Gorman, Ramirez & Westoby, 2003; Halcon et al., 2004; Luster, Qin, Bates, Johnson & Rana, 2009).

Studies pertaining to coping in children who are exposed to war stressors, but have not fled from their countries of origin as refugees, is comparably more extensive. Findings from this line of research also demonstrate that war-exposed children use a variety of coping strategies to deal with stressors. Further, and in likeness to the wider literature on coping in western children (Skinner & Zimmer-Gembeck, 2007), studies have demonstrated that coping is multi-faceted and complex, with positive psychological correlates of coping relating to many factors including the nature and timing of the trauma (Punamäki, 2001), the gender of the young person (Punamäki , 1997), and broader familial, political and societal factors (Elbedour, ten Bensel & Bastien, 1993; Montgomery, Krogh, Jacobsen & Lukman, 1992; Punamäki , 1997). Whilst this literature base has made important contributions to elucidating some of the coping mechanisms used by child and adolescent refugees and those exposed to war traumas, it is difficult to make overarching conclusions from the studies because of their varying methodologies, theoretical bents and definitions (or lack of) of what constitutes coping. A further problem with this line of research is the lack of validated coping questionnaires with non-western populations (Gaylord-Harden, Gipson, Mance & Grant,

2008). Coping is a highly individualised process, and one that is also characterised by cross-cultural differences (Compas et al., 2001; Gaylord-Harden et al., 2008). Given this, and the lack of validated coping questionnaires with non-western populations (Compas et al., 2001; Gaylord-Harden et al., 2008), the use of qualitative methods to examine coping styles and strategies in refugee populations is highly warranted (Leaman & Gee, 2012).

3.4.2 Familial factors.

The post-migration family environment is of central importance to young refugees (De Haene et al., 2007; Gifford et al., 2009), and there are vast range of familial factors that may act to confer either risk or protection in young refugees' mental health outcomes (Gifford et al., 2009; McMichael, Gifford & Correa-Velez, 2011). Though the study of familial processes in refugee populations is in its relative infancy (De Haene et al., 2007; Weine et al., 2013), findings indicate that it is a particularly salient line of enquiry, given the conceptual and empirical interconnections between familial factors and psychopathological processes.

Residing with family members appears to be a protective factor against the development of psychopathology in young refugees in particular. Kinzie, Sack, Angell, Manson and Rath (1986), for example, found that psychiatric morbidity and poor functional outcomes were more pronounced in Cambodian adolescent refugees who did not reside with family members in their resettlement homes. While Tousignant et al. (1999) demonstrated that the rate of diagnosable psychological conditions (according to DSM-III criteria) was 5 times lower in refugee boys resettled in Canada who were residing with both biological parents compared with other living arrangements. Interestingly, girls' mental health was not associated with post-exile family structure in this study. The authors postulated that the impact of familial separations on boys may have been more pronounced due single mothers' inability to assert authority over boys because of their traditional cultural backgrounds

(Tousignant et al., 1999). While the authors did not elaborate on this, it may be that they were alluding to culturally-shaped notions of gender roles (McSpadden & Moussa, 1993; Nghe, Mahalik & Lowe, 2003), wherein males are considered to hold a higher social status than females, and men are the dominant members of the household (Franz, 2003; McSpadden & Moussa, 1993; Nghe et al., 2003). Indeed, while many refugee families attempt to maintain traditional gendered roles and hierarchies once resettled (Franz, 2003; Nghe et al., 2003), there are often new factors in the resettlement environment that may challenge the traditional family makeup (including female household members finding employment and children identifying with westernised cultural values and rebelling against parental authority; De Haene et al., 2007; Franz, 2003; Weine et al., 2004). Thus, as findings from Tousignant's study demonstrate, changes to familial structures and roles that arise from the refugee experience may result in flow-on impacts to family members' mental health outcomes (De Haene et al., 2007; Gifford et al., 2009; Nickerson, Bryant, Steel, Silove & Brooks, 2010; Weine et al., 2004). Another reason for this finding may be due to negative mental health impacts of father absence on the adolescent boys, in concert with broader literature on this topic (Flourie & Buchanan, 2003).

Posttraumatic stress and depressive symptoms have also shown to be higher amongst unaccompanied refugee minors who reside in independent and semi-independent living arrangements, compared to their counterparts who resided with parents or in foster care upon resettlement in London (Hodes et al., 2008). Whilst a study with resettled adult refugees found that there were significant mental health impacts resulting from being separated from family members remaining in countries of origin (Nickerson et al., 2010).

While the relationships between familial functioning and youth from refugee backgrounds' mental health are undoubtedly complex, they can be conceptualised as operating on a spectrum. That is, there are factors inherent to the familial environment that

have been found to impart risk for the development of psychopathology and adaptational difficulties upon resettlement (McMichael et al., 2011), yet there are also many familial factors that are protective (Fazel et al., 2012). In a follow-up study of resettled refugee youth in Sweden, for instance, stress in the family unit led to children's increased mental health symptoms (Hjern, Anders & Jeppson, 1998). There is further established evidence for the intergenerational transmission of psychopathology, including PTSD, implicating biopsychosocial processes in the manifestation of distress across generations (Ajdukovic & Ajdukovic, 1993; Panter-Brick, Grimon & Eggerman, 2013; Sack et al., 1995). On the other hand, several other studies have found that factors including family cohesion and adaptability (Laor et al., 1996; Rousseau, Drapeau & Platt, 2004), parental support (Berthold, 2000; Kovacev & Shute, 2004), and open communication between children and mothers (Montgomery, 2010) are protective. Despite these findings, on the whole, familial processes in refugee families remain understudied (De Haene et al., 2007; Weine et al., 2004). More research is needed in order to better understand how the refugee experience impacts upon specific familial processes and how they affect youth's psychological functioning (De Haene et al., 2007; Fazel et al., 2012; Weine et al., 2004).

3.5 Summary

The extant literature on risks, correlates and the longitudinal trajectory of PTSD in populations of young refugees is characterised by methodological variances and heterogeneous findings (Schweitzer & Steel, 2008; Silove, 1999). Whilst there is evidence, largely from cross-sectional studies, attesting to the importance of pre-migratory traumas in the manifestation of PTSD, further findings also point to the need to consider resettlement stressors, familial and intraindividual factors in the condition's manifestation (Almqvist & Broberg, 1999; Fazel et al., 2012; Porter, 2005). Further research is needed, particularly in the

form of longitudinal studies, in order to explicate the potentially complex and multifaceted interrelationships between such factors and PTSD symptoms (Almqvist & Broberg, 1999; Fazel et al., 2012).

While it is established that a significant subset of refugees experience a posttraumatic response as a result of their refugee and resettlement experiences (Miller et al., 2009; Porter, 2007), the extant literature has come under scrutiny for its emphasis on studying PTSD as a predominant outcome of the refugee experience (Bracken et al., 1995; Porter, 2007; Summerfield, 1999). As Schweitzer and Steel (2008, pp. 8) write, "the process of becoming a refugee is not at essence a psychological phenomenon, but results from socio-political circumstances that may have psychological implications". A range of processes, at numerous micro and ecological levels, are implicated in the refugee experience; yet the research base has tended to take an individualised approach in examining how the refugee experience impacts upon mental health outcomes (De Haene et al., 2007; Porter, 2007; Schweitzer & Steel, 2008; Silove et al., 2010). That the concept of PTSD further fails to encapsulate the broad range of psychological reactions (including understudied concepts such as posttraumatic growth (Papadopoulous, 2007) and cultural bereavement (Eisenbruch, 1991) that may arise from the refugee experience is another important reason for the current paradigm of enquiry into refugee mental health to shift direction (Porter, 2007; Schweitzer & Steel, 2008).

3.6 A Paradigm Shift in Refugee Mental Health Research and Proposed New Theoretical and Empirical Directions

3.6.1 Cross cultural validity of research with populations from refugee backgrounds.

Historically, research into the effects of war and refugee experiences has been dominated by studies that have examined PTSD as a primary outcome (Drury & Williams, 2012; Schweitzer & Steel, 2008; Summerfield, 1999). Not only has this approach borne valuable findings in elucidating important psychological consequences of exposure to war and other associated traumata, it has enabled researchers to document and quantify the impact of human rights abuses globally, with large, diverse and disparate populations (Kirmayer, Rousseau & Drepeau, 2004; Schweitzer & Steel, 2008). Despite this, there are inherent limitations in this approach.

There is much debate surrounding the use of PTSD in non-Western populations, largely because of questions over the diagnosis' cross-cultural validity and clinical utility (Bracken et al., 1995; Hinton & Lewis-Fernandez, 2011; van Rooyen & Nqweni, 2012). Regarding cross-cultural validity, debate has ensued as to whether western-based conceptualisations of disorder can be applied to culturally diverse populations that may have differing expressions of psychological distress (Summerfield, 2012). Some have argued that there are specific aspects of PTSD that are uniquely expressed in certain cultures and not in others, such as flashbacks in western populations (Jones et al., 2003), which therefore calls into question how applicable the disorder is across cultures (Hinton & Lewis-Fernandez, 2011; van Rooyen & Nqweni, 2012). In terms of clinical utility, others have argued that even if the disorder is present in non-western cultures, it does not necessarily mean that it is of a primary concern for those affected, nor that it is the sole manifestation of psychological distress (Miller et al., 2009; Summerfield, 1999).

Despite the aforementioned critiques, there is established evidence that people from non-western countries experience psychiatric symptomatology consistent with the symptom profile of PTSD as defined by present-day diagnostic criteria (Hinton & Lewis-Fernandez, 2011; Miller et al., 2009; Sack, Seeley & Clarke, 1997). Though this is countered by those who argue that the use of standardized questionnaires, based on westernized notions of disorder, to study the prevalence of disorders in non-western populations amounts to *category fallacy* (Bracken, Giller & Summerfield, 1995; Kleinman, 1987; Summerfield, 2012). Category fallacy is defined by Kleinman (1987, pp. 452) as "…the reification of a nosological category developed for a particular cultural group that is then applied to members of another culture for whom it lacks coherence and its validity has not been established".

That the PTSD diagnosis lacks clinical utility in some cultures provides evidence for the argument that the condition is not as relevant in some sociocultural contexts as others (Miller et al., 2009; Summerfield, 1999). Even in those who do evidence clinical levels of the disorder, many are not functionally impaired as a result (Miller et al., 2009; Summerfield, 1999). Summerfield and Hume (1993), for example, found that three-quarters of Nicaraguan war-injured ex-soldiers meeting diagnostic criteria for PTSD were well adjusted and did not present with any difficulties in their daily functioning. Along these lines, some have argued that even when the syndrome is clearly present, it may not be of a primary concern for the people affected (Breslau, 2004; Englund, 1998; Miller et al., 2009). In their study of war-exposed adult Afghans, Miller and colleagues (2009), for example, found that PTSD was highly prevalent and indeed valid in the population studied, but only limited support was found for its clinical utility. Despite the high prevalence of PTSD in this population, the effects of war-related trauma and loss that were most salient for Afghans in this study were the impacts of indigenous expressions of profound sadness resulting from these experiences, a phenomenon termed *jigar khun*.

Stemming from phenomen like jigar khun in Afghans, a further critique of PTSD is its failure to account for culturally-specific indigenous manifestations of distress (Hinton & Lewis-Fernandez, 2011). In Latino cultures, for example, *ataque de nervios* (attack of nerves) is a cultural syndrome manifest as "...acute, dramatic episodes which occur as the result of a major stressful event, particularly in the family sphere" (Guarnaccia, Lewis-Fernández & Melissa Rivera, 2003, pp. 352). It has been hypothesized that ataque de nervous may increase Latino people's vulnerability to the development of PTSD, and thus demonstrate that "the conditional probability of PTSD is modified by the presence of a cultural syndrome" (Hinton & Lewis-Fernandez, 2011, pp. 781)", something which is arguably not accounted for in the westernised nosology of the condition. Many have thus expressed concerns that the use of westernised measures to assess for mental health problems will neglect to detect culturally-bound expressions of distress (Phan, Steel & Silove, 2004; Steel et al., 2009), fail to account for the culturally-specific conceptions of mental-ill health, and may contribute to diagnostic inaccuracy (Phan & Silove, 1997).

Many non-western cultures conceptualise mental ill-health from a holistic perspective, as opposed to the comparatively dualistic (wherein physical and mental illnesses are considered distinct) and individualized models that underpin western nosological systems (Agbayabi-Siewert, Takeuchi & Pangan, 1999; Sheikh & Furnham, 2000). Anthropological studies demonstrate that western and non-western cultures hold different explanatory models for mental illness (Kleinman, 1987). While, in general, non-western societies attribute social and supernatural causes to mental distress, western industrialised cultures view mental health from individualised, patient-centred explanations (Sheikh & Furnham, 2000). The Vietnamese, for example, uphold inclusive conceptual frameworks for understanding physical and mental health, in which the "mind, body and the cosmos are regarded as closely interconnected" (Phan & Silove, 1999, pp. 89). In line with non-western nosologies and

evidence attesting to the multifaceted nature of conditions such as PTSD in refugees, many have called for research into mental health of refugee populations to shift towards more holistic and ecologically-based paradigms of enquiry (De Haene et al., 2007; Porter, 2007; Silove, 1999).

3.6.2 New paradigms of enquiry into the mental health of refugee populations.

Partly in response to the critique that research into the impact of the refugee experience is too reductive in its emphasis on examining westernised psychopathological outcomes (De Haene et al., 2007; Papadopoulous, 2007; Porter, 2007; Silove, 1999), there has been a shift in the literature to study mental health and wellbeing under new paradigms of enquiry. While some have looked at how broader societal (e.g., Ellis, MacDonald, Lincoln & Cabral, 20008; Silove et al., 2010), familial (e.g., Almqvist & Broberg, 1999; Weine et al., 2013) and resettlement factors (e.g., Berthold, 2000; Liebkind, 1996; Montgomery, 2008) act to influence mental health, including PTSD, others have adopted the use of qualitative research techniques to overcome issues of cross-cultural validity and to explore more nuanced perspectives and of mental health from refugee participants themselves (e.g., Gifford et al., 2009; Shakespeare-Finch & Wickham, 2009; Whittaker, Hardy, Lewis, & Buchan, 2005). Some, such as Eisenbruch (1991) and Kirmaryer (2002), have called for the mental health impacts of the refugee experience to be considered using culturally sensitive frameworks. While finally, alternate theoretical models of the psychological impact of the refugee experience have been put forth by some as new ways in which to conceptualise the impact of such experiences.

Authors including Silove (1999), Papadopoulous (2007), De Haene, Grietens and Verschueren (2007) and Porter (2007) are proponents of models that examine the refugee experience from ecologically-based modes of enquiry. These authors postulate that the refugee experience impacts upon people in a range of life-domains, and, given this, the

impact of the refugee experience cannot be studied in an isolated manner (in contrast to studies which utilise solely life-events and individualistic modes of enquiry; De Haene et al., 2007; Porter, 2007; Silove, 1999). These aforementioned theorists and their proposed models are discussed in the following sections.

Silove's (1999) Core Adaptive Systems Model.

Silove (1999) developed The Core Adaptive Systems model to address the perceived flaws of the Western diagnostic paradigm that refugee mental health research has largely focussed on. The theory draws heavily from studies with Holocaust survivors (e.g., Bergmann & Jucovy, 1982; Krell, 1997) which demonstrated that the experience of gross human rights violations may "…exert more pervasive effects on adaptation than is encompassed by the symptoms included in the more recent formation of PTSD" (Silove, 1999, para. 16). Such research found that some survivors experienced profound changes in a range of cognitive, psychological, intra and interpersonal domains, and stemmed terms such as the *torture syndrome* (Allodi, 1991; Malt, Schnyder & Weisaeth, 1996) to categorise such responses.

In citing Holocaust studies and evidence on the relatively low rates of PTSD in refugee populations, despite their being exposed to numerous traumas, Silove (1999) posits that examining how adaptive processes are impacted may better explicate aetiological mechanisms behind psychological morbidity outcomes. The Core Adaptive Systems model posits that the trauma experiences refugees endure threatens their five adaptive systems, which serve the functions of personal safety (*The Safety System*), attachment and bond maintenance (*The Attachment System*), identity and role functioning (*The Identity/Role System*), justice (*The Justice System*) and existential meaning (*The Existential Meaning System*).

Regarding The Safety System, Silove (1999) cites evidence to support the notion that PTSD is linked with perceived threat to life, wherein PTSD symptoms increase as the perceived threat to life during the index trauma event(s) increases (Dyregrov et al., 2000; Fazel et al., 2012; Reed et al., 2012). He therefore suggests that such experiences may trigger psychobiological mechanisms, which are partly manifest as PTSD symptoms, that are associated with the preservation of safety. Silove further asserts that threats (though the nature of such threats is not elaborated upon) in the resettlement environment may further compound people's compromised feelings of safety, thereby exacerbating symptoms.

The Attachment System of the ADAPT model is predicated on the notion that disruptions to interpersonal bonds and relationships are a central experience of people from refugee backgrounds and survivors of torture (Silove, 1999). Silove (1999) also asserts that such experiences impart symbolic losses upon people who endure them, wherein there is a loss of connections to place, to culture and of a continuity between generations.

The Identity/Role System posits that the experiences of refugees, and, in particular, torture survivors can profoundly threaten people's self concept and sense of identity (Silove, 1999). Silove (1999) writes that one of the key aims of torture is to undermine survivors' sense of control and agency, whilst the physical injury and subsequent impairments experienced after torture may further compromise people's sense of self. For refugees, the anonymity of spending time in a detention centre or refugee camp, and the lack of recognition of previous roles and qualifications in the resettlement environment may undermine one's sense of agency and self concept.

Regarding the Justice System, Silove (1999) asserts that refugees and torture survivors may exhibit a sense of profound injustice due to being victim to experiences which are intended to degrade, dehumanize and humiliate. It is further not uncommon for known perpetrators of human rights violations to live unpunished in communities with survivors,

thus serving to remind victims of the profound and ongoing injustices they were victim to. For some refugees and torture survivors, Silove writes that they may experience chronic anger and rage as a psychological response to the injustices they were victim to, resulting in chronic feelings of anger and rage.

Finally, The Existential- Meaning System asserts that exposure to traumatic events associated with the refugee experience may "…shake the foundations of the survivor's fait in the beneficence of life and humankind" (Silove, 1999, para. 27). As a result, refugees' sense of faith and trust in people and in the world in general may be profoundly negatively affected, and may result in a sense of emotional isolation and alienation from humankind. Silove (1999) asserts that existential processes are often central to psychopathology among refugees and torture survivors.

Eisenbruch's (1991) model of Cultural Bereavement.

Eisenbruch (1991) developed the concept of *cultural bereavement*, based on his studies of Cambodian refugees' subjective experiences of distress and loss. Cultural bereavement encompasses communities' subjective and culturally defined experiences of loss as a result of their collective refugee experience. While Eisenbruch acknowledges that many refugees who are experiencing cultural bereavement would concurrently meet diagnostic criteria for PTSD, he cautions that mental health practitioners need to view PTSD symptomology under a broader, culturally sensitive framework. Kirmayer (2002) takes a similar standpoint to Eisenbruch (1991), in his writings of the impact of the experiences of trauma, loss and displacement on refugees' relations between the self and the community. He posits that refugees' experiences should be conceptualised in terms of the interacting social dynamics between refugee communities and host societies, given that most refugees have endured state-organised violence and persecution.

Papadopoulous' (2007) Adversity-Activated Development model.

In likeness to Silove (1999), Papadopolous (2007) is critical of the tendency for mental health professionals to consider the impacts of the refugee experience in purely psychopathological terms, wherein refugees are considered to be traumatized populations. Papdopoulous asserts that there are some refugees who not only survive their refugee experiences with a strong degree of psychological wellbeing, but who have also been strengthened by their adversities, a response termed *Adversity-Activated Development* (AAD). For people who experience AAD, two processes take place. Firstly, they experience positive, "growthful" (pp. 307) developments which are a direct result of the experiences gained from being exposed to adversity/trauma, and secondly, new characteristics that were not present in people before the adversity emerge. Papadoupoulous stresses that mental health clinicians in particular should consider processes of AAD when working with individuals from refugee backgrounds, instead of making undue presumptions about PTSD as being the most likely outcome of such an experience.

De Haene, Grietens and Verschueren's (2007) family perspective.

De Haene, Grietens and Verschueren (2007) posit that research into the psychosocial wellbeing of children and adolescents from refugee backgrounds should progress from a family-perspective. Citing evidence from studies attesting to the impact of post-migration and familial factors on refugee youth's mental health, they posit that examining psychosocial functioning from a family-perspective may overcome many of the shortcomings the extant literature has been critiqued for. They further assert that taking a family perspective would elucidate important risk and protective factors that are yet to be identified, and thus inform interventions with refugee populations. Based upon these premises, De Haene, Grietens and Verschueren have proposed a model which conceptualises the refugee family experience as

being an interplay between cycles of the following four disruptive processes: *traumatisation* (including pre-migration experiences of persecution, torture, war and disappearances); *acculturation* (attempts at integrating into a new cultural environment, a process that may lead to different adjustment processes amongst family members and changed familial relationships as a result); *uprooting* (associated with the profound uncertainties and disruptions to life during exile, the fragmentation of families because of separations, and the challenges facing families' identity in new cultural environments); and *marginality* (families' experiences of social and cultural isolation in resettlement countries and history of marginality in countries of origin). They stipulate that this model allows the refugee experience, both pre-and post-migration, to be considered for its interactive and multifaceted impacts upon the psychosocial functioning of those involved.

Porter's (2007) Biopsychosocial model.

Porter (2007) cites evidence from a meta-analytic study (Porter & Haslam, 2005) of research conducted with refugee and comparative groups over the past five decades, which found a range of social and community factors, including refugees' residency status and social functioning variables such as overcrowding, daily hassles and community crime rates, related to mental health outcomes. Given these findings, Porter concludes that in order to understand the broader implications of refugee adaptation and psychological wellbeing, consideration must be given to the interactions between biological, psychological and social domains, in line with a biopsychosocial conceptualisation. He further argues that the social domain has been understudied in research into refugees' psychological wellbeing and adaptation. This is despite considerable evidence attesting to its importance in the psychological functioning of refugees, including the notable direct and moderating relationships social factors were found to impart in Porter and Haslam's meta-analytic findings.

3.6.3 Summary.

The prevailing message from the theorists is that a broader conceptualisation of the interacting causal relationship between the impacts and consequences of the refugee experience is needed (De Haene et al., 2007; Porter, 2007; Silove, 1999). While not necessarily disputing the fact that PTSD symptoms are experienced by a significant subset of refugees (Porter, 2007; Silove, 1999), they argue that the literature should not focus on this as being a the central outcome of the refugee experience (Eisenbruch, 1991). It is further argued that studies that examine PTSD in refugee populations, a broader framework is needed from which to examine the cause and correlates of the condition in expanding upon the historical focus of life-events models of disorder (De Haene et al., 2007; Porter, 2007).

It is important to note that these new approaches need not replace approaches of the past, but complement them (Miller & Rasco, 2004; Tempany, 2008). The western models, as well as the proposed new directions of enquiry have, and will continue to provide valuable insights into the impact of the refugee experience on mental health and wellbeing outcomes. Given that the psychological impacts of the refugee experience are complex and multicausal (De Haene et al., 2007; Porter, 2007; Silove, 1999), research which takes this into consideration will shed new light on our understandings of how conditions such as PTSD are manifest in refugee populations (Porter, 2007).

3.7 Introduction to Qualitative Research of the Mental Health Impacts of the Refugee Experience

Despite the extant literature on refugee populations being dominated by quantitative approaches (Borwick, Schweitzer, Brough, Vromans & Shakespeare-Finch, 2013; Khawaja et al., 2008), there has been an increase in the number of qualitative studies on refugee issues in

recent years. Qualitative methodologies allow for an exploration of how people make meaning out of significant experiences in their lives (Braun & Clarke, 2013), and thus present an ideal means by which to explore their lived experiences as refugees (Borwick et al., 2013; Khawaja et al., 2008). Qualitative research with refugee populations has examined topics including: mental health service utilisation by refugee adolescents (De Anstiss & Ziaian, 2010); influences on the use of coping processes (Huassain & Bhushan, 2011a; Khawaja et al., 2008) and processes contributing to refugees' adaptation and wellbeing (Gifford et al., 2009; McMichael & Manderson, 2004; Shakespeare-Finch & Wickham, 2009). An overview of the most prominent findings in qualitative research with refugee populations will be provided in the following sections.

3.7.1 Coping processes.

Unlike quantitative methods, qualitative research designs are arguably better suited to ascertain how specific coping approaches are used in response to specific stressors (Borwick et al., 2013; Coyne & Racioppo, 2000; Leaman & Gee, 2012), given that studies generally seek to explore the idiographic ways in which participants describe and conceptualise their use of coping strategies (e.g., Goodman, 2004; Khawaja et al., 2008). As a result, these studies are driven from a "bottom-up" or inductive approach, wherein the data derived are strongly linked to participants' own accounts, and are not necessarily based on any prior theoretical standpoint (Braun & Clarke, 2006).

Qualitative findings indicate that refugee populations utilise a range of coping strategies in response to a variety of stressors, both during their refugee experiences and in the resettlement environment (Khawaja et al., 2008). The use of religious coping methods has been found in a number of studies, with a number of ethnic groups, to be used in response to a variety of stressors (Goodman, 2004; Khawaja et al., 2008; Schweitzer, Greenslade & Kagee, 2007). In a study with a group of 'Lost Boys' who fled Sudan's civil war without

their parents, Goodman (2004) found that participants referred to their cultural and religious beliefs in making meaning out of the suffering they had endured. Interpreting their traumatic experiences as being 'God's will' helped them to cope with the impact of such experiences. Likewise, participants in Khawaka, White, Schweitzer and Greenslade's (2008) study reported that they "…believed that their fate was in the hands of God" (pp. 506), and thus that their suffering would eventually end because God would intervene. The use of prayer was also cited as a particular coping behaviour used to manage environmental stressors, a finding echoed in another study with a group of resettled Sudanese refugees (Schweitzer, Greenslade & Kagee, 2007). Hussain and Bhushan (2011a) also obtained similar results in a study with Tibetan refugees. The maintenance of Buddhist beliefs and practices was cited by participants as being of central importance for healthy coping behaviours and psychological resilience. Finally, in a recent study with resettled Burmese refugees in Australia, a subset of participants reported praying or putting faith in God when faced with hardships (Borwick et al., 2013).

The use of social support has also been cited in various studies as an important resource when coping with difficulties (Borwick et al., 2013; Goodman, 2004; Khawaja et al., 2008; Isakson & Jurkovic, 2013; Schweitzer, Greenslade & Kagee, 2007). In Goodman's (2004) study with a group of Sudanese unaccompanied minors, participants spoke in collective terms when detailing their experiences of fleeing from Sudan. They conveyed the importance of collective coping and social support in facilitating their survival through a profoundly dangerous and likely traumatic experience. Further, participants reported that thinking about their family members during times of hardship gave them a self-described will to survive. This was a finding replicated in another qualitative study with a group of Sudanese 'Lost Boys' (Luster et al., 2009). Similarly, in a study with Burmese refugees resettled in Australia, participants spoke of the importance of relationships with family,

friends and community members in giving them strength to endure difficulties (Borwick et al., 2013). Social support was also spoken of in other studies in terms of its importance in coping with difficulties and adapting to life in the resettlement environment (Hussain & Bhushan, 2011a; Isakson & Jurkovic, 2013; Khawaja et al., 2008).

Cognitive coping strategies are also commonly featured in the qualitative coping literature (Goodman, 2004; Isakson & Jurkovic, 2013; Khawaja et al., 2008; Luster et al., 2009). Interestingly, among the studies with adult refugees, higher-order cognitive processes, such as reframing and normalising (Isakson & Jurkovic, 2013; Khawaja et al., 2008) were reported as being utilised relatively extensively in the populations studied. Whereas in studies with younger populations, emotion-focussed cognitive strategies, namely the use of avoidance and distraction behaviours predominated (Goodman, 2004; Luster et al., 2009), possibly demonstrating evidence for the developmental variances in cognitive coping behaviours (Skinner & Zimmer-Gembeck, 2007).

3.7.2 Adaptation in refugee populations.

Belongingness and the concept of home.

Given refugees' upheavals from their homelands and having to adapt to new ways of life in countries of resettlement (Borwick et al., 2013; Papadopoulous, 2007), establishing an understanding of their conceptions of belongingness and home are particularly warranted. Findings from studies that have examined such notions are informative and have important implications for how we conceptualise refugees' responses to such events (Borwick et al., 2013).

In a study with resettled Bosnian women in the US, Keyes and Kane (2004) found that one of the major processes central to women's experiences as refugees was the notion of belonging. The authors defined belonging as, "the experience of being valued and the experience of fitting in through shared characteristics" (pp. 815), thus implying that a sense

of belonging is inextricably entwined in social systems. Participants discussed how their sense of belonging to their known culture and community had been irrevocably disrupted because of their experiences during the Bosnian war. In particular, they attributed this to the impact the war had on their ethnic identity. Prior to the war, Bosnians lived in communities dominated by mixed ethnicities and religions (predominantly Serbs, Croats and Muslims; United States Department of State Office of the Historian, 2013), where intermarrying was encouraged. During the war however, which was characterised by ethnic conflict and acts of genocide (Keyes & Kane, 2004; United States Department of State Office of the Historian, 2013), the nature of interethnic relations fundamentally changed. Belongingness became predicated on being a member of the correct ethnicity or religion, and those who did not fit this mould were forced to flee their homelands.

Findings from Rosbrook and Schweitzer's (2010) study into a group of Karen and Chin refugees' meaning of home elaborate on those reported by Keyes and Kane's (2004). Three overarching themes explicating participants' meanings of home demonstrated that the notion of home had multiple meanings, and, following from this, the loss associated with leaving home multidimensional impacts. Firstly, participants spoke of home in terms that connoted it was more than just a place, it represented a psychological space of safety and retreat also. Secondly, home was intertwined with familial connections; it was discussed in terms of being a socioemotional space through which participants were connected to their family. Thirdly, and in relation to the first point, home was considered as being more than just a physical landscape, it was a "geographical-emotional landscape" (pp. 166) which participants described having an emotional connection to.

Familial processes of adaptation.

A further particular line of enquiry in the qualitative literature base has been to examine refugee families and children's processes of adaptation (e.g., Atwell, Gifford &

McDonald-Wilmsen, 2009; Gifford et al., 2009; Weine et al., 2013). Results from this line of research are strikingly similar, with studies finding that refugee families are faced with a range of challenges in their resettlement environment, including changed familial roles (Gifford et al., 2009; Hynie, 2012; Weine et al., 2004), difficulties associated with familial separations (Gifford et al., 2009; McMichael et al., 2011; Rousseau, Rufagari, Bagilishya & Measham,2004) and conflict between family members (Atwell, Gifford & McDonald-Wilmsen, 2009; Gifford et al., 2009; Hynie, Guruge & Shakya, 2012; McMichael et al., 2011).

Families, and youth within them, face a multitude of challenges in resettling and adapting to their lives in a new country (De Haene et al., 2007; Gifford et al., 2009; Hynie, Guruge & Shakya, 2012; Weine et al., 2004). For youth, there are particular challenges in resettlement that centre around the family (Hynie, Guruge & Shakya, 2012), partly due to the fact that they tend to adapt to cultural and linguistic aspects of host cultures faster than their parents (New South Wales Department of Community Services, 2006). Hynie, Guruge and Shakya (2012) for instance, qualitatively examined familial relationships in youth resettled in Canada from Afghanistan, Burma and Sudan. They found that adolescents took on new roles in the family, including getting paid work to contribute to the family's finances and in acting as interpreters for family members, due to their parents' difficulties in being able to manage such tasks. Such results were also echoed in McMichael, Gifford and Correa-Velez's (2011) longitudinal research with resettled young refugees in Australia. This study found that young people's families underwent considerable change in household composition across the period of the study (3 years post-arrival to Australia). While family members were central figures of support for young people, in likeness to Hynie, Guruge and Shakya's findings, young people also took on supportive roles within the family unit, including caring for other family

members, doing work around the house, and undertaking part-time work to assist the family financially.

Family separations are a key issue most refugees are faced with upon resettling into third countries (Atwell, Gifford & McDonald-Wilmsen, 2009; Gifford et al., 2009; Rousseau, Rufagari, Bagilishya & Measham, 2004). Backing up findings from the quantitative literature (e.g., Nickerson et al., 2010), qualitative research provides first-hand accounts of the emotional difficulties refugees face in being separated from loved ones (Rousseau, Rufagari, Bagilishya & Measham, 2004; Gifford et al., 2009). Further, findings illustrate other associated difficulties with familial separations, such as the obligation to send money back to family remaining in their homelands (Gifford et al., 2009) and the difficulties associated with navigating resettlement countries' resettlement policies in facilitating family reunifications (Rousseau, Rufagari, Bagilishya & Measham, 2004).

Studies that have particularly focussed on the adaptational experiences of resettled refugee youth have found that familial conflict can be a significant, and at times pervasive, issue (Gifford et al., 2009; Hynie, Guruge & Shakya, 2012; McMichael et al., 2011). For participants in Hynie, Guruge and Shakya's (2012) study, conflict centred around youth's perception that their parents did not allow them enough freedom. While part of may be interpreted as developmentally-appropriate adolescent behaviour (McMichael et al., 2011), the youth in this study specifically attributed such conflict to their adoption of more westernised cultural values which went against their parents' cultural values and norms. Such reports were echoed by McMichael, Gifford and Correa-Velez (2011) participants, in which youth reported a desire for independence and freedom to make their own choices on things like spending time with friends and having boyfriends and girlfriends. While young people reported maintaining a sense of connection to their cultural backgrounds, they felt that the tensions between themselves and their parents were due to differences in their parents'

expectations, which could be attributed to their cultural beliefs. Further notable findings from McMichael, Gifford and Correa-Velez's study were that young people's sense of trust in their family significantly diminished, while familial conflict increased over the 3 years of the study. A number of this study's participants spoke of recurrent instances of familial conflict, which in some cases escalated to physical violence between family members.

Despite the many difficulties reportedly faced by families, studies also demonstrate that families are at the centre of refugees' refugee and resettlement experiences, and act as central support mechanisms throughout all stages of their refugee and resettlement journeys (Gifford et al., 2009; McMichael et al., 2011; Rosbrook & Schweitzer, 2010; Weine et al., 2013). Young people in Hynie, Guruge and Shakya's (2012) and McMichael, Gifford and Correa-Velez's (2011) studies for instance, commonly discussed the important role parents played in providing close emotional and instrumental support and advice. While adult refugees in Borwick, Schweitzer, Brough, Vromans and Shakespeare-Finch's (2013) study reported how central their ties to their family were to them, and how the support they received from these relationships were a particular source of strength when they experienced adverse events in their refugee experiences. In a comprehensive longitudinal mixed-methods study with resettled refugee adolescents Weine et al. (2013) found that better psychological adjustment (measured in terms of youth's relationships and positive behaviours at home and school, their mastery of the English language, involvement in extracurricular activities and established future goals) was associated with family factors, including living with both parents and parental employment.

3.8 Summary and Limitations of Existing Literature

Up until relatively recently, the literature on the impact of the refugee experience on children and adolescents could be summarised by the following quote from Lustig et al.

(2004, pp. 32), “The impact of war among young refugees manifests empirically as psychopathology defined by Western models of illness”. PTSD has been one of the most studied conditions under this paradigm (Drury & William, 2012; Schweitzer & Steel, 2008), and is one of the most frequently reported psychological disorders to be experienced by people from refugee backgrounds (Drury & Williams, 2012; Fazel & Stein, 2002).

Historically, as Lustig et al. (2004) allude to, the examination of PTSD in refugee populations has been conducted under westernised conceptualisations of the disorder (Porter, 2007; Schweitzer & Steel, 2008). In line with the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013) criteria for PTSD, and life-event models of disorder (Porter, 2007; Porter & Haslam, 2005), research focussed on examining how trauma events experienced during refugee experiences affect the development of the condition (Khawaja et al., 2008; Porter, 2007; Porter & Haslam, 2005). This approach has borne informative findings (Porter, 2007): there is a well-developed knowledge base, with adult refugee populations in particular, about factors inherent to refugees’ experiences that act in the development of PTSD (Drury & Williams, 2012; Lustig et al., 2004; Lindencrona, Ekblad & Hauff, 2008). Further, studies have continuously demonstrated that a significant, though relatively small, proportion of refugee populations experience clinically significant levels of PTSD symptomatology, even after many years of resettlement (Fazel & Stein, 2005; Sack et al., 1993).

Despite these contributions, the examination of mental health disorders, PTSD in particular, experienced by refugees has been the topic of much critique and debate (e.g., Bracken, 1995; Summerfield, 2000). In broad terms, criticisms have been directed firstly towards the cross-cultural applicability and validity of examining westernised constructs of mental ill health with non-western populations (Borwick et al., 2013; Hinton & Lewis-Fernandez, 2011; Summerfield. 2000); secondly on the stated reductionism in examining

psychopathology, particularly PTSD, as the major outcome of the refugee experience when broader psychosocial impacts are clearly implicated (Porter, 2007; Silove, 1999; Weine et al., 2013); and finally, that the approach pathologizes what could arguably interpreted as normal human responses to abnormal conditions (Porter, 2007), and does not account for the potentially positive psychological impacts that may arise from such experiences (Copping, Shakespeare-Finch & Paton, 2010; Hussain & Bhushan (2011b); Shakespeare-Finch & Wickham, 2009).

Findings from the refugee literature exemplify the assertion put forth by others (e.g., Rosen, Spitzer & McHugh, 2008; Sharp, Fonagy & Allen, 2012) that the disorder is more complex than its current diagnostic framework, in which an individual's traumatic exposure is conceptualised as the catalyst for the condition's development (Rosen, Spitzer & McHugh, 2008). Research with refugee populations demonstrate that psychosocial factors inherent to aspects of the resettlement environment (including unemployment and social relations) directly relate to PTSD in refugees (Carlsson et al., 2006; Hermanson, 2006; Lie, 2002). While further evidence suggests that complex and dynamic interrelationships between individual, familial, pre-migration and resettlement factors act in the manifestation and maintenance of the disorder (De Haene et al., 2007; Porter & Haslam, 2005; Steel et al., 1999). Such findings challenge the current aetiological conceptualisation of the disorder (Rosen, Spitzer & McHugh, 2008; Sharp, Fonagy & Allen, 2012), and back-up arguments that updated theoretical frameworks should be developed in order to guide future research into the condition (Sharp, Fonagy & Allen, 2012).

Findings from qualitative studies with refugee populations provide detailed evidence on the multidimensional impact of people's refugee and resettlement experiences (Borwick, 2013; Khawaja, 2008). In broadening and contextualising findings from the quantitative literature base, results indicate that a range of processes, at individual (Borwick et al., 2013;

Khawaja et al., 2008; Weine et al., 2013), familial (Gifford et al., 2009; McMichael & Manderson, 2004; Weine et al., 2004) and societal levels (Keyes & Kane, 2004), are impacted by the refugee experience. Such findings illustrate the importance of considering such broader processes in young refugees' mental health outcomes (Khawaja et al., 2008; Porter, 2007), and demonstrate that the examination of processes of adjustment and adaptation can be conducted without relying solely on an examination of psychopathological outcomes (Weine et al., 2013).

3.9 Research Aims and Hypotheses

The first broad aim of this thesis was to jointly investigate how familial separations and the use of coping styles related to PTSD symptomatology in resettled refugee youth. This was investigated in the first quantitative empirical study (Chapter 5). The specific aims of this study were to:

(a) Examine whether youth who reside without all members of their immediate family had more PTSD symptoms than a comparative sample who lived with their immediate family unit intact.

(b) Investigate whether the use of coping styles varied between youth according to their familial makeup.

(c) Examine the relationship between the use of coping styles and PTSD symptomatology.

The following hypotheses were made relating to the study's aims:

(a) That youth who had resettled in Australia with their immediate family intact would exhibit comparatively less PTSD symptoms when compared to those separated from immediate family members.

(b) That there would be differential uses of coping strategies amongst participants who had resettled with their immediate families compared to those who had not. No assertions were made as to the nature of these differences due to an absence of prior literature from which to draw upon.

(c) That avoidant coping styles would be positively associated with PTSD symptoms, while support-seeking coping would be negatively associated; no hypotheses were made regarding active or distraction coping due to an absence of prior literature from which to draw upon.

The second overarching aim of the thesis was to explore, based on adolescents' accounts of their refugee and resettlement experiences, possible psychosocial and adaptive mechanisms that may play a role in PTSD symptomatology. This was investigated in the second empirical paper (Chapter 6). This specific aim of this study was to:

(a) Explore whether psychosocial and adaptive mechanisms differentiated adolescents who had minimal PTSD symptoms to those who had elevated levels of PTSD symptomatology.

The third and final broad aim of the thesis was to provide detailed understandings of the impact of the refugee experience on adolescents through examining first-hand accounts of their experiences. This was investigated in the third empirical study (Chapter 7). The specific aims of this study were to:

(a) Explore the applicability of the ADAPT model (Silove, 1999) to adolescents' accounts of their refugee and resettlement experiences, in order to establish preliminary evidence for its validity in a population of refugee youth.

(b) Examine the influences of the refugee experience on adolescents' adaptive processes as conceptualised by the ADAPT model

Chapter 4. Methodology

4.1 Introduction

The present chapter provides an expanded description of the overarching methodology for the thesis, and the three empirical research papers that follow this chapter. An overview of the rationale for the study's methodological approach will be provided, which will be elaborated upon in subsequent sections pertaining to the methodology of the three empirical papers. This section will also detail the study procedures, including recruitment and data collection. Following this, an overview of participant details for each empirical study will be provided, along with an elaboration of the three studies' measures, further to that provided in the three empirical papers. Likewise, an expanded data analysis section is reported, particularly pertaining to the qualitative methodologies used for studies 2 and 3. Finally, a discussion and overview of the ethical issues anticipated and encountered in the project's planning and undertaking is provided.

4.2 Rationale for the Methodological Approach

The current study utilized a mixed-method design, in its combination of quantitative and qualitative methodologies. This was done firstly because the research questions lent themselves to the use of both techniques (the rationale pertaining to the methodology for each paper will be described in more detail subsequently); and secondly due to the complementary nature of using qualitative and quantitative techniques given their ability to expand upon each respective method's limitations (i.e., qualitative methods can expand upon and contextualise quantitative findings; Johnson & Onwuengbuzie, 2004; Weine et al., 2013). Finally, such approaches are arguably well suited to research with ethnically diverse populations (Weisner & Fiese, 2011).

The issue of cross-cultural applicability of westernized constructs of mental health as they pertained to this study was a consideration. As discussed in Chapter 3, it is acknowledged that there are issues of validity in examining Westernized constructs such as PTSD in refugee populations (Borwick et al., 2013; Bracken, Giller, & Summerfield, 1995; Summerfield, 1999). However, this study was also informed by the literature pertaining to the evidence for the cross-cultural validity of PTSD (see Hinton & Lewis-Fernandez, 2011, for a review), and, as such, the examination of the construct with cross-cultural issues taken into account was deemed to be a valid and legitimate pursuit. Indeed, it was hoped that this research would expand on the field's knowledge of PTSD given the use of qualitative techniques to elaborate on the quantitative findings (Gifford, Bakopanos, Kaplan & Correa-Velez, 2007). As a result, the quantitative measures to examine coping styles and PTSD symptomatology were chosen by considering both cross-cultural and psychometric issues, the details of which are explicated in Section 4.5.

Qualitative research techniques seek to contextualize understandings of social phenomena by examining such processes through the perspective of research participants themselves (Braun & Clarke, 2013; Smith, Flowers & Larkin, 2009). In comparison to quantitative, "numbers based" techniques, qualitative research approaches allow for rich and detailed understandings of phenomena; furthermore, they allow for a retained focus on the meanings people ascribe to events, as opposed to those pre-imposed upon them by the framing and content of quantitative questionnaires (Braun & Clarke, 2013). For this study, as stated, qualitative methods were chosen in part to compliment and elaborate upon quantitative findings (Johnson & Onwuengbuzie, 2004), particularly in response to one of the study's aims, to explore possible differences in psychosocial and adaptive processes in participants with high and low levels of PTSD symptomatology. The suitability for use with ethnically-diverse populations; the ability to use both inductive and deductive approaches in

analyzing qualitative data; the flexible and exploratory approach; and the ability to give voice to a participant group that is often absent from the extant literature were further important reasons for the choice of qualitative methodology in this study (Ahearn, 2000; Braun & Clarke, 2013; Smith, Flowers & Larkin, 2009).

4.3 Procedure

The current study was approved by Monash University (Project number CF11/1664-2011000913; Appendix A) and University of Tasmania (Ethics Ref H0013080; Appendix B) Human Research Ethics Committees, and the Victorian (Project number 2011_001174; Appendix C) and Tasmanian (File number 2013-19; Appendix D) State Departments of Education and Early Childhood Development.

4.3.1 Consultation with key informants.

Prior to commencement of data collection, a meeting with a key informant (a youth worker from a Non-Government Organisation (NGO) who worked with refugee and asylum seeker children in Melbourne) was held to discuss the nature of the study, its design, procedures and overarching aims. She provided insights into the nature of some of the issues faced by young people from refugee backgrounds in resettling to Australia, and also gave some feedback and advice regarding the interview schedule (YES-R; McGregor, Melvin & Newman, 2014).

Another key informant was met with approximately half-way through data collection, after being introduced to him by another contact. He was originally from Burma and had come to Australia as a refugee, and at the time of the meeting he was working with Burmese youth from refugee backgrounds. Given the large cohort of Burmese participants in the study, a meeting was held to discuss his insights into issues facing Burmese young people in their resettlement in Australia.

The purpose of this consultation process was primarily to inform the researcher's methodology and interpretation of the data, to ensure that accurate reflections and interpretations about the issues young people from refugee backgrounds were made. While these processes served to triangulate the data in some respects, the information ascertained from these meetings was not analysed in any way.

4.3.2 Recruitment procedures.

Given the anticipated difficulty in recruiting participants for this study, multiple approaches were utilized. For the pilot study and data collection phase in Melbourne, firstly, principals of Melbourne secondary schools (n = 24) located within known areas of refugee resettlement were contacted about the study, and invited to meet with the lead researcher to discuss possible participation. One school consented for their involvement in the study following this approach. Secondly, established professional contacts (a psychologist and a social worker) who worked within the field were approached and informed of the research, and through these means contacts within one secondary school and one English language school were approached and informed of the research. Consent to conduct the research at these schools was obtained following meetings with the school principals and relevant staff. A final total of two secondary schools and one English language school in Melbourne granted permission for the research to be conducted with consenting students.

At consenting schools, prospective participants were informed of the research during pre-arranged class and lunch times. At this time, an overview of the research project was provided to students and they were invited to take home participant and parent/guardian information and consent forms (Appendix E and F respectively) for further consideration, if they expressed an initial interest in taking part. Translated consent forms were made available (in Arabic, Dari, Burmese, Karen and Pashto) for both participants and parents/guardians. In instances where there were no translated consent forms available or participants reported their

parents/guardians were illiterate, arrangements were made for the researcher to contact them to discuss the study and obtain verbal consent for their children's participation with the use of an interpreter. Young people wishing to take part in the study were asked to return the signed consent forms to a contact teacher or staff members who were assisting the researcher at each school. Young people who returned both signed consent forms met with the researcher either during lunch times or, with the permission of teachers, during class times, on two occasions. For those who only returned the signed participant consent form, they were met with by the researcher and arrangements were made for informed consent by parents/guardians to be obtained through the use of an interpreter.

As a result of the Melbourne-based recruiting, a total of 27 participants (including the four pilot study participants and one participant who was later dropped from all analyses) took part in the study. Given the way in which participants were informed of the project (in class or lunch times that were under significant time pressures), it was not possible to ascertain how many students were provided with information about the study, and therefore response rates were unable to be gleaned. Refer to Figure 1 for a schematic overview of the recruitment and associated data collection procedures.

Further data collection was carried out in Hobart, Tasmania, to broaden the catchment area for potential participants. As in Melbourne, multiple approaches to recruitment were undertaken. Firstly, meetings with community workers at Hobart and Glenorchy city councils were held to inform them of the study and to seek advice as to possible avenues of recruitment. This resulted in contact being made at two secondary schools, and one community organisation that worked with resettled refugees; recruitment through these avenues however did not eventuate. Through other established professional contacts in Hobart (a nurse and a doctor working with refugee patients), contacts were made with a University, a Technical and Further Educational centre (TAFE), a refugee health clinic at the

Royal Hobart Hospital and a community General Practice (GP) clinic that specialized in seeing people from refugee backgrounds. Meetings with staff members and letters were sent to Principals of three secondary schools with high populations of students from refugee backgrounds, one of these secondary schools gave consent for data collection to be carried out with their students.

Where participants were recruited through TAFE or schools, the same process for data collection undertaken in Melbourne took place (as detailed above). For those who were recruited through University, a staff member who worked specifically with students from refugee backgrounds in a cross-cultural support program sent an email to students informing them of the research project, and asked students to contact the researcher should they be interested in hearing more about the project and/or to participate. For participants recruited through the refugee health clinic at the Royal Hobart Hospital, treating doctors identified potential participants (doctors were met with prior to the study to inform them of the nature and purpose of the study and the selection criteria; all doctors at the clinic gave their consent to be involved) and prospective participants who expressed an interest in taking part were then met by the researcher at the clinic. Finally, a doctor at a Hobart-based GP practice sent out letters to prospective participants who met the selection criteria informing them that the research was being conducted and asking them to contact the researcher should they be interested in participating. She also discussed the project with patients during appointments. In cases where patients expressed an interest in hearing more about the project and in participating, the doctor obtained their consent to pass their contact details on to the researcher, who then made contact with participants. From the Hobart-based recruitment, a total of 24 participants took part in the study. In likeness to the recruitment procedures carried out in Melbourne, participant response rates from the Hobart-based data collection were unable to be estimated.

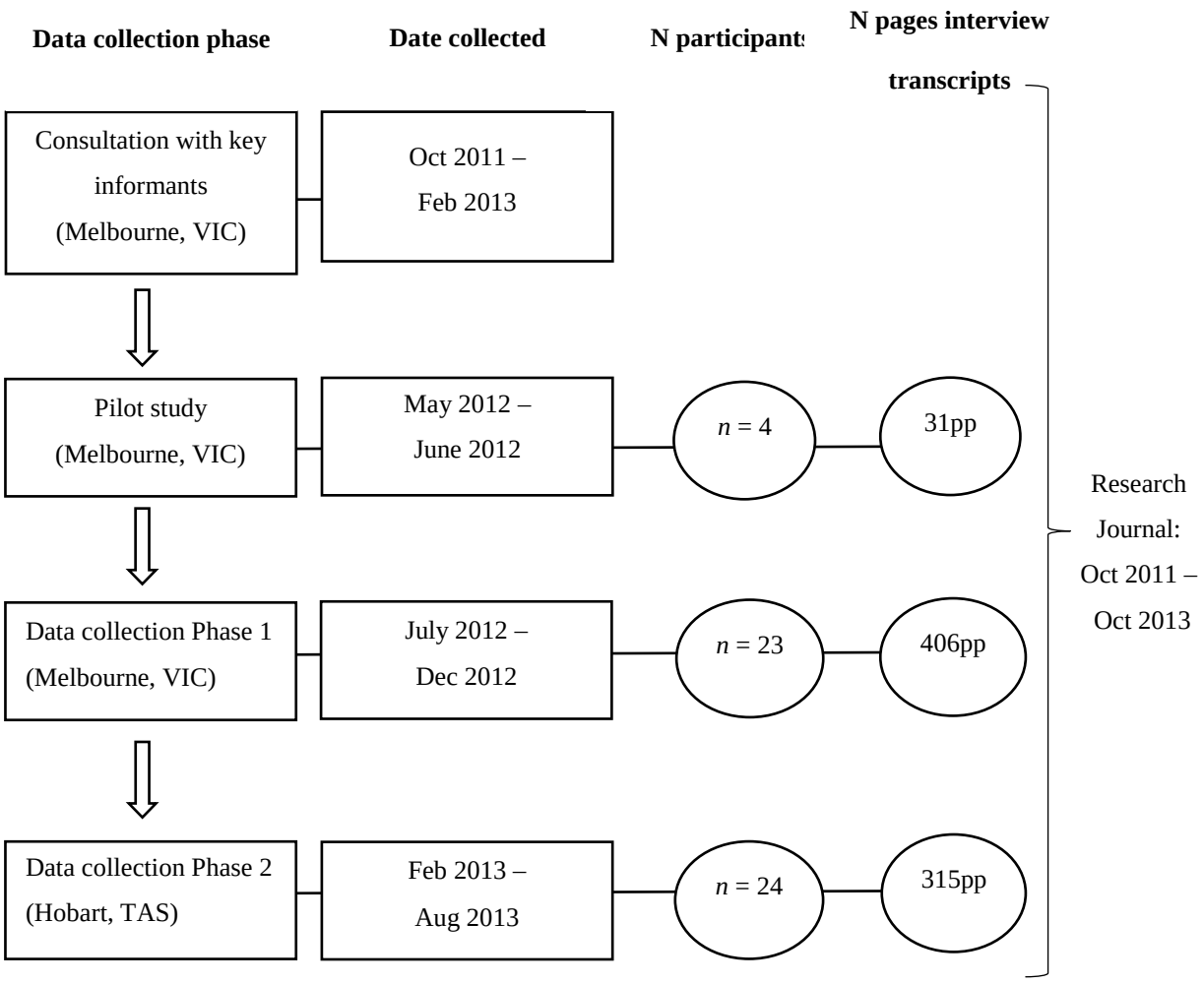

Figure 1. Schematic overview of recruitment procedures.

4.3.3 Data collection procedures.

Data collection involved two sessions with each participant: in the first session, participants completed the questionnaires, and in the second session took part in the semi-structured interview. In the first session, participants were given the option of completing the questionnaires themselves or having the researcher read the questions aloud to them (a method that has been used in past research with refugee youth, and has been found to increase comprehension rates; Geltman et al., 2005).

The second session was used to provide the participants with feedback on their questionnaire results and to undertake the semi-structured interview, which was conducted by the researcher and took between 30 and 90 minutes. Where participants gave their consent,

the interview was audio-recorded. Four participants (9%) did not consent to their interview being recorded and written notes were taken in lieu of audio-data. At the completion of the interview, movie vouchers were provided to participants as an appreciation gift for their participation in the study.

In cases where the quantitative questionnaire results were above clinical cut-off scores, feedback was provided to the participants specifically regarding these results (this process is further detailed in Section 4.7. In anticipating that some participants may either discuss issues that warranted professional involvement, or obtain clinically elevated scores in the quantitative measures, contact was made with a Melbourne-based refugee clinic prior to the commencement of the study to inform them of the nature of the research and that some referrals and/or information pertaining to their service may be provided to participants of the study (such notification was not deemed necessary in Hobart, as the major specialized health services for refugees were already involved in and aware of the project). Information on services participants could attend for psychological support and assistance was provided in verbal and written form on the participant and parent/guardian information and consent forms. For those who were under 18 years of age, contact was made with parents and/or guardians to also provide them with this feedback verbally (in most cases with an interpreter), and, where parents/guardians requested, with a follow-up written letter. Specific and comprehensive case notes documenting these actions were also kept (see Appendix G for an example excerpt). A discussion of the ethical issues pertaining to this process is provided subsequently, in Section 4.7.

4.4 Participants

This section details the selection criteria, participant details, and the sampling methods used to select participants for each study component, expanding on detail presented

in the associated sections of each empirical paper (Chapters 5, 6 and 7). Given the project's use of a mixed-methods approach, a trade-off between sample size in the quantitative study and pragmatic limits on the quantity of qualitative data was made. Considering this, as well as possible drop-outs, a goal of recruiting 50 participants was set, and deemed a feasible, albeit large, sample size for the qualitative component of the study.

4.4.1 Selection criteria.

Selection criteria for the study were left deliberately broad in order to enhance recruitment rates. They comprised: (a) that prospective participants self-identify as being from a refugee or asylum-seeker background; (b) are aged between 12 and 21 years of age; (c) have resided in Australia for six months or more; and (d) have sufficient English capabilities if they did not wish to use an interpreter. There were no exclusion criteria.

4.4.2 Sampling and recruitment: Complete sample, pilot study, studies 1, 2 and 3.

In total, 51 participants (including those in the pilot study) took part in this study. After conducting an interview with one participant, it was clear that their English skills were not of a level allowing for meaningful participation in the project. As a result, the participant's results were dropped from all analyses, leaving a total sample of $N = 50$. There were three participants who were classified as being drop outs for the qualitative component of the study due to non-attendance at the interview, however their quantitative data was still included in the study. Table 1 presents the complete sample's demographic statistics.

Table 1

Demographic Characteristics of Participants by City of Residence

Characteristics	Whole sample (*n* = 50)	Melbourne (*n* = 26)	Hobart (*n* = 24)
	n (%) / *M (SD*)	*n* (%) / *M (SD*)	*n* (%) / *M (SD*)
Demographics			
Male gender	19 (38%)	12 (46%)	7 (29%)
Participant age	16.64 (2.51%)	15.19 (3.56%)	18.21 (1.93%)
Years resettled in Australia	4.35 (3.48%)	3.56 (3.16%)	5.17 (1.93%)
Immediate family living together			
Intact	20 (40%)	7 (26.9%)	13 (54.2%)
Non Intact	22 (44%)	11 (42.3%)	11 (55.8%)
Recruitment source			
TAFE	7 (14%)	0	7 (29%)
English Language School	11 (22%)	11 (42%)	0
University	2 (4%)	0	2 (8%)
Secondary School	20 (40%)	15 (58%)	5 (21%)
Health Clinics	10 (20%)	0	10 (42%)
Country of birth			
Burma	15 (30%)	15 (57.69%)	0
Sudan	3 (6%)	1 (3.85%)	2 (8.33%)
Kosovo	1 (2%)	1 (3.85%)	0
Afghanistan	5 (10%)	4 (15.38%)	1 (4.16%)
Pakistan	1 (2%)	1 (3.85%)	0
Guinea	1 (2%)	1 (3.85%)	0
Tanzania	1 (2%)	1 (3.85%)	0
Uganda	1 (2%)	1 (3.85%)	0
Nepal	6 (12%)	0	6 (25%)
Syria	2 (4%)	0	2 (8.32%)
Ethiopia	3 (6%)	0	3 (12.50%)
Kenya	2 (4%)	0	2 (8.32%)
Rwanda	5 (10%)	0	5 (20.83%)
Iran	2 (4%)	1 (3.85%)	1 (4.16%)
Congo	1 (2%)	0	1 (4.16%)
Bhutan	1 (2%)	0	1 (4.16%)

Pilot study.

Four participants, three female and one male, were recruited for the pilot study component from a Melbourne secondary school. Their mean age was 13 years (*SD* = .82), and had spent a mean of 2.5 years (*SD* = 1.00) living in Australia, and all were born in Burma. Only administrative changes (in order to increase rapport and facilitate feedback

processes on the questionnaire data) were made to the procedures after the pilot study. Hence, pilot study participants' results were included in the final total sample.

Study 1.

For Study 1, the sample consisted of a total of 50 participants, 31 female and 19 male, who had been in Australia on average 4.35 years (range 6 months - 11 years) and aged between 12 – 21 (M = 16.63, SD = 2.51). As is detailed in the empirical study (Chapter 5), participants were categorized in terms of whether their families were intact (n = 20) or non-intact (n = 22) at the time of their participation in the study. It was not possible to ascertain the required information on the status of the family units for eight participants. Participants were classified into the non-intact group if: (a) an immediate family member/spouse was deceased; (b) if an immediate family member/spouse was residing in another country; (c) if an immediate family member was residing in a different residential abode to the participants due to parental separation or divorce (included due to the finding by Hjern, Angel and Jeppson (1998), which children whose parents divorced following resettlement had increased psychological symptoms compared to those whose parents did not separate). Full details pertaining to the participants' demographic characteristics for Study 1 are presented in Table 1, Chapter 5.

Study 2.

For Study 2, the Interpretative Phenomenological Analysis (IPA) study, a total of 10 participants (8 female, 2 male) who had completed both the questionnaires and the semi-structured interview were selected. Participants were chosen based on the length and detail of their interview data, as well as whether they obtained particularly high (a Child PTSD symptom scale [CPSS] total score above 15) or low (a CPSS total score of 10 or below) CPSS scores. The final sample of 10 participants was divided into a 'high' and a 'low' group, with 5 participants in each, in correspondence with their CPSS scores.

Participants had a mean age of 17.60 years (SD = 2.17), and had been in Australia on average 6.5 years (SD = 3.97). Table 1, Chapter 6, presents participant demographic data for this study.

Study 3.

For Study 3, of the 47 participants who took part in the interview, 43 consented to do so with the use of audio-recording. As a result, due to the inability to carry out thematic analysis without transcribed data, the final sample size for Study 2 was 43. Of the participants, there were 26 female and 17 male, who had been in Australia on average 4.43 years (range 6 months – 11 years) and aged between 12 – 21 (*M* = 16.58; *SD* = 2.62). Table 1, Chapter 7, presents participant demographic data for this study.

4.5 Measures

4.5.1 Demographics.

Demographic data pertaining to participants' ages and gender were collected during the first session in which the questionnaires were completed. Further information pertaining to participants' birth countries, their length of time spent in Australia and their familial makeup was collected at the time of the interview.

4.5.2 Participant self report measures.

Two self-report measures were used in the present study, the Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny & Treadwell, 2001; Appendix H), and the Children's Coping Strategies Checklist – Revision 1 (Program for Prevention Research, 1999; Appendix I).

Posttraumatic stress disorder (PTSD) symptomatology.

The CPSS (Foa et al., 2001), a 17-item self-report inventory based on DSM-IV criteria, was employed to screen for symptoms of PTSD. The measure was designed to assess the presence and severity of PTSD symptoms in children and adolescents, and aligns with the

DSM-IV classification of the disorder. The CPSS assesses for the presence of PTSD symptoms over the past month on a four-point Likert scale, yielding a total score ranging from 0 – 51. The measure has three subscales, which correspond to symptom clusters as reported in the DSM-IV: re-experiencing, avoidance and arousal. A clinical cut-off score of 15, as recommended by the International Society for Traumatic Stress Studies (2013) for use with this measure, is indicative of a high level of PTSD symptoms. The scale has adequate internal consistency (Jaycox et al., 2002), external validity (Foa et al., 2001; Kassam-Adams, Marsac & Cirilli, 2010), and had an internal consistency of Cronbach's α = .90 in the current study.

Aside from the measure's good psychometrics and its alignment with the DSM-IV, the CPSS was chosen because it has been used previously, with good reliability, with ethnically diverse populations, including children from Indonesia (Tol et al., 2008); former child soldiers (Kohrt et al., 2008) and a population of conflict affected Nepalese children (Jordans et al., 2010); and populations of recently immigrated Russian, Mexican and Armenian children (Jaycox et al., 2002).

Coping styles.

The Children's Coping Strategies Checklist – Revision 1 CCCSC; Program for Prevention Research, 1999), a 42-item self-report inventory, was used to measure coping styles. The measure comprises ten subscales of conceptually distinct coping strategies, which make up the four superordinate dimensions of *avoidance* (behavioural and cognitive efforts to avoid problems and stressful situations), *distraction* (efforts to work off unwanted feelings with physical activities and to avoid thinking about problems by using distracting stimuli, entertainment or other forms of activity), *active* (cognitive efforts to change thought processes around the problem and the use of problem-solving strategies), and *support-seeking* (where people are used as resources to help with problem solving processes as well as with

emotional support) coping styles. Scores for the coping dimensions are obtained by taking the combined mean score of all subscale items, with higher scores indicating greater use of the coping strategy/dimension. The CCSC demonstrates strong construct validity (Ayers et al., 1996; Compas et al., 2001). In the present study, internal consistencies for the avoidance, active and support-seeking coping dimensions were Cronbach's α = 82, .83 and .72, respectively. The distract coping dimesion had poor internal consistency, Cronbach's α = .56, and as a result was excluded from any further analyses.

To the researcher's knowledge, the CCSC has not been used with refugee populations in previous research. Despite this, the measure was chosen for use in this study due to its demonstrable construct validity and the fact that it is developed based on a theoretically viable coping model (Compas et al., 2001), and because it has been used in ethnically diverse populations and has, according to Gaylord-Harden, Gipson, Mance and Grant (pp. 11, 2008) "demonstrated the greatest invariance across ethnicity".

4.5.3 Semi-structured interview.

Given that a major aim of the study was to examine the applicability of the ADAPT model (Silove, 1999) to the participants' reported refugee and adaptational experiences, the interview schedule, The Youth Experience Scale for Refugees (YES-R; McGregor, Melvin, Newman, 2014; refer Appendix J) was constructed based broadly on the major components of the ADAPT model. It was constructed specifically for use in this project, given the lack of past research on the topic.

The YES-R consists of open-ended questions, designed to explore participants' experiences of their refugee and resettlement journeys, in line with the five major adaptive systems explicated in the ADAPT model (Silove, 1999): Safety and security (*Safety System*); Maintenance of bonds and interpersonal relationships (*Attachment System*); Effective mechanisms for administering justice (*Justice System*); Capacity to perform roles and uphold

identity (*Identity/Role System*); and, ability to express aspirations that confer meaning (*The Existential-Meaning System*). See Appendix K with example questions as they pertained to each system of the model. Although the essence of the interview-schedule was followed for all interviews, questions were used flexibly, and were adapted or omitted where indicated, in order to promote individual participants' agency over the interview process.

Once developed, the interview schedule was provided for feedback to three professionals who worked with youth from refugee backgrounds (two psychologists, and a youth worker), and a member of the Sudanese community who ran a volunteer-based community services agency. Specifically, each informant gave feedback on the applicability of questionnaire items to youth from refugee backgrounds, provided suggestions on wording, highlighted the questions they thought most pertinent, and provided guidance on the interview process itself. Some minor changes to the wording of questions, and their administration to participants were made as a result of this process.

The interview schedule and quantitative measures were firstly administered to the pilot group of participants (n = 4), to test the administration procedures and questions of the YES-R. Following this, a review of the YES-R findings with the research supervisors and an experienced qualitative researcher, Dr. Katie Vasey from Monash University, who has conducted studies with people from refugee backgrounds, minor changes to the interview schedule and the administration procedures were made. This resulted in minor changes to the way in which the interview questions were delivered. For instance, instead of commencing the interview with a closed question, such as "Where did you come from before arriving in Australia?", this was changed to being an open-ended and participant-led approach, with the introductory question being instead, "Let's start by you telling me a bit about yourself".

4.6 Data Analysis

This section details the data analysis procedures used in each empirical study, and provides a brief rationale for their choice as they relate specifically to the aims of each study.

A common critique of qualitative literature is that it can lack scientific rigour, with studies published without methodological processes clearly detailed and described (Braun & Clark, 2013; Attride-Stirling, 2001). In response to this, a comprehensive description of the qualitative methodologies employed for studies 2 and 3 will be provided.

4.6.1 Data analysis for Study 1.

The aims of Study 1 were to: (a) examine whether youth who resided without all members of their immediate family would have more PTSD symptoms than a comparative sample who lived with their immediate family unit intact; (b) investigate whether the use of coping styles varied between youth according to their familial makeup; and, (c) examine the relationship between the use of coping styles and PTSD symptomology.

The hypotheses and data analysis procedure for each were as follows: (a) That youth who had resettled in Australia with their immediate family intact would exhibit comparatively less PTSD symptoms when compared to those separated from family. To examine the relationship between family separations and PTSD symptoms, Spearman's rho bivariate correlations were conducted to examine the association between the family separation variable and mean CPSS scores, and an independent samples *t* test was conducted on transformed data to examine the difference in CPSS scores between the groups; (b) That there would be differential uses of coping strategies amongst participants who had resettled with their immediate families compared to those who had not, but no assertions were made as to the nature of these differences due to an absence of prior literature from which to draw upon. Mann-Whitney U tests were employed to examine any differences in the use of coping styles between the intact and non-intact groups due to the non-normality of the data and its

resistance to transformations; and (c) The avoidant coping style would be positively associated with PTSD symptoms while support-seeking coping would be negatively associated; no hypotheses were made regarding active or distraction coping due to an absence of prior literature with child and adolescent refugee populations from which to draw upon. The relationships between coping styles and CPSS scores were examined using hierarchical multiple regressions.

4.6.2 Data analysis for Study 2.

The aim of Study 2 was to compare and explore self-described refugee and resettlement experiences of two select groups of adolescents, based on their PTSD symptom profile. More specifically, the aim was to establish whether there were factors in adolescents' accounts that differentiated them based on their PTSD levels. As discussed previously, participants were chosen based on the length and detail of their interview data, as well as whether they obtained particularly high or low CPSS scores. The final sample of 10 participants was divided into a 'high' and a 'low' group, with 5 participants in each, in correspondence with their CPSS scores. Participants were selected into the high group if they had CPSS scores above a cut-off score of 15, while participants were selected into the low group were selected if they had a CPSS score of 10 or below.

The sample size and nature of the between-groups analysis was deemed an appropriate design for an *Interpretative Phenomenological Analysis* (IPA) approach, given the method's use with small sample sizes (Smith, Flowers & Larkin, 2009), and the ability to compare results between groups (Braun & Clarke, 2013). Furthermore, IPA was deemed the most suitable qualitative method to use for the aims of the study, given its in-depth examination of how people perceive, and make sense of their lived experiences. Although the analytic procedures of IPA are not necessarily prescriptive, the guidelines and recommendations made by Smith, Flowers and Larkin (2009) and Braun and Clarke (2013)

were followed for this analysis. The process was also influenced by the broader reading of other research with refugee populations that have used such an approach (including Borwick et al., 2013; Hussain & Bhushan, 2011a; Khawaja, White, Schweitzer & Greenslade, 2008 and Whittaker, Hardy, Lewis & Buchan, 2005).

IPA's main tenet is to explore people's lived experiences, and the associated meanings and interpretations they give to these experiences. IPA also asserts that the researcher examines participants' experiences according to their own interpretative tendencies and capacities. This process is termed the *double hermeneutic*, and reflects the dual interpretative process that occurs in IPA - the participant interprets their own world, whilst the interpreter tries to make sense of the participant's interpretation (Braun & Clark, 2013). In acknowledging this component of IPA's data analysis process, the researcher adopted reflexive approaches to the data analysis, by maintaining a research journal (refer Appendix L for example extracts); ensuring that initial observations and ideas relating to the data (i.e., the 'researcher's noticings') were left aside initially so that the emphasis remained on participants' meanings; and by consciously thinking about how the researcher was personally influencing the interpretative process (Braun & Clark, 2013; Smith et al., 2009).

In further considering issues of reflexivity, it is important to note some personal details regarding the researcher as they pertained to this study, and the research in general. This research stemmed from a motivation to study 'refugee issues' at a postgraduate level, that had commenced after a long-held interest in the political, social and psychological aspects the refugee experience. The researcher became particularly interested in such issues after volunteering with an organization in New Zealand that worked to assist newly arrived refugee families resettle into the country. The researcher volunteered with a family from Bhutan, who had arrived in Christchurch with two young children who had spent their entire lives in a refugee camp. In watching the children adapt so quickly to their lives in New

Zealand, the researcher became interested in how other children and young people may navigate such processes of resettlement, and what factors differentiate those who resettle 'successfully' versus those who find the process more difficult. Yet despite having some experience in working with people from refugee backgrounds, the researcher acknowledged that by her growing up in New Zealand and Australia as a Caucasian of a middle-class background, she had little understanding of the lived experiences that people from refugee backgrounds would endure. Therefore it is important to acknowledge that the researcher's values, opinions, biases and background would have contributed to the way in which the IPA analysis in particular was conducted, but also the research process at large.

Smith, Flowers and Larkin (2009) assert that the process of IPA is a fluid and iterative one, and thus the steps of the analysis can be different according to the person conducting the analysis. The researcher's experience of conducting an IPA analysis was an iterative process, and as such, the steps to the analysis that will be outlined below were not always followed in a linear fashion for all participants.

The data analysis process for this study involved six phases. Given that IPA is heavily idiographic (Smith et al., 2009), the following series of phases were undertaken for each individual participant in turn. Firstly, familiarization with the dataset was achieved through the transcription of the data, reading and re-reading of the transcripts, and the writing of initial notes on the researcher's impressions pertaining to the data. The final stage of the first step, as recommended by Braun and Clarke (2006; 2013), was to put the content, and the initial thoughts pertaining to, the transcribes aside in order to come back to the data with a fresh focus for the second phase.

Secondly, initial coding and commenting took place on an individual participant's transcript. The coding was carried out at three levels: (1) a descriptive level, which focuses on the data at 'surface level' and on the lived worlds and experiences of participants; (2) a

linguistic level, which focused on the language in which participants used to communicate their stories and ideas; and (3) an abstract or conceptual level (refer Appendix M for a sample extract of coding at these levels), where coding and comments remain in line with the participant's experience, but the researcher takes more of an analytical stance wherein some interpretation is made on the transcript from the researcher's perspective (i.e., the researcher uses themselves and their experiences as basis from which to explore and interpret what the participants are describing). Other interpretative strategies that were recommended by Smith, Flowers and Larkin (2009) that were used in this phase included underlining extracts of text which seemed to be important, then an annotation explaining why they were important was written down next to the text (Braun & Clarke, 2013; Smith et al., 2009); see Appendix N for an excerpt.

The third phase involved searching for and developing emergent themes, based on the data that had been coded and commented upon. This process involved being wedded to the complexity of the data, but also to reduce the volume of the data into definable themes. Rather than working with the interview transcript itself, this stage involved an analytical shift to working with the codes and comments made on the data. The main process of this phase involved producing a "concise and pithy statement of what was important in the various comments attached to a piece of transcript (Smith, Flowers & Larkin, Step 3: Developing Emergent Themes, para no. 4, 2009)". Themes were developed to reflect both the content of the data whilst maintaining a conceptual element.

Fourth, a review of the themes was undertaken. This involved searching for connections across the emergent themes developed in the third phase of the analysis, and constructing higher-order subordinate themes, with emergent themes nested under them, based on their interrelationships. Subordinate themes and emergent themes were defined (see Appendix O for an example) and named. Thematic tables (refer Appendix P for an example),

with definitions of themes and extracts from the transcripts, were used to assist with this process, and visual means were used to assist in the identification of connections between themes.

The fifth stage in the analysis involved repeating steps 1 through 4 for every other participant.

The sixth and final stage involved reviewing themes across participants' transcripts, to look for differences and commonalities at an individual, within-group and also at an across group level. To facilitate this process, print outs of every participant's thematic tables were laid out to visually compare the data. Commonalities between participants' themes were identified, and subordinate theme titles were adjusted in cases where subordinate themes, with differing labels, could be conceptualized in similar ways for different subjects. For the purposes of this study, themes were examined particularly for their potency at a group level, and examined to see how they differentiated between groups. Themes that had particular salience within groups, particularly within the low CPSS group, and that differentiated from those in participants in the high group, were chosen for the analysis for the study. Upon the completion of this phase, the analysis and interpretation was discussed with the research supervisors, to enhance collaboration and ensure the coherence and plausibility of the interpretation (see Appendix R for the final master table of the subordinate and emergent themes).

4.6.3 Data analysis for Study 3.

The aim of Study 3 was to explore the applicability of the ADAPT model (Silove, 1999) to adolescents' accounts of their refugee and resettlement experiences, in order to establish preliminary evidence for its validity in a population of refugee youth, and to examine the influences of the refugee experience on adolescents' adaptive processes as conceptualized by the ADAPT model.

Thematic analysis (TA) is a method of data analysis which identifies, analyses and reports patterns (themes) of meaning across a dataset (Braun & Clarke, 2013). It was deemed the most applicable qualitative method for use in this study given the interest in identifying themes in participants' accounts in line with the ADAPT model (Silove, 1999) and in commonalities in adolescents' accounts of their refugee and resettlement experiences.

Given that a primary aim of this study was to examine the applicability of Silove's (1999) theoretical model to adolescents' accounts, a deductive TA, or "top down" analytic approach, wherein the analysis is driven by, and based upon an overarching theoretical paradigm, in this case the ADAPT model (Braun & Clarke, 2006; Silove, 1999), was utilized. Data analysis was also partly driven by an inductive, or "bottom up" approach (Braun & Clarke, 2013), where the content of participants' accounts that did not necessarily align with components of the ADAPT model, but were nonetheless important in conceptualizing their resettlement and adaptational experiences were also analysed. The data analysis was correspondingly driven partly by the five systems of the ADAPT model in developing themes, but participants' accounts also informed some of the coding and data analysis process (Braun & Clarke, 2006). The ontological position underpinning this research was critical realism (Braun & Clarke, 2013); participants' accounts of their experiences were taken as reality, but were considered in terms of pertinent historical, political and cultural contexts in which they operated (Opperman, Braun, Clarke & Rogers, 2013).

The process of TA was conducted in accordance with the guidelines set out by Braun and Clarke (2006; 2013), but also influenced by other qualitative studies that had employed similar methodology (including, Coulson, 2005; Griffiths, Ryan & Foster, 2011; Lambert & O'Halloran, 2008 and Singer & Hunter, 1999). The TA was conducted over a series of six phases of analysis. First, familiarization with the dataset was achieved through the transcription of the data. Given the amount of data (n = 43 interview transcripts), a research

assistant assisted in the transcription of four (9%) of the transcripts. The research assistant took part in this procedure after being granted ethics approval to do so, and was given instructions as to how to go about transcribing. For example, they were instructed to treat the audio file as confidential, to note pauses of a few seconds by typing […], to note verbatim participants' utterances (such as "umms"), and to note if wording was unclear or indecipherable by writing [unclear]. The researcher then checked these transcripts against the audio files for accuracy. Following this, transcribes were read and re-read and initial impressions on the data were noted (see Appendix Q for an example). This process was analogous to that which was detailed in Study 2, and thus will not be further reported on.

The second step involved conducting complete coding of the data corpus, wherein codes were developed on all content that was deemed relevant to the study (Braun & Clarke, 2013). Codes were generated based on the data's semantic content, where themes were identified based on the "surface level" of the data (Braun & Clarke, 2006), this encompassed codes such as *language acquisition in Australia*; as well as latent content, where underlying ideas and conceptualizations were coded (Braun & Clarke, 2006), as they related to the systems of the ADAPT model but also as they related to themes pertinent to participants' refugee and resettlement experiences that were not directly applicable to the ADAPT model, such as the code, *insight into their own psychological functioning*. Data extracts were often coded multiple times, due to a number of possible codes being relevant to the data. Coding processes were assisted through the use of Nvivo 10 software (QSR International, 2012).

Thirdly, the coded information was collated into themes. This involved collating codes that cohered together meaningfully into themes, resulting in themes that were clearly definable and distinguishable between one another. A table of the codes and their definitions was used to assist in this process (see Appendix R for an extract).

The fourth phase involved reviewing the themes for the purposes of defining and refining them. Themes without enough supporting evidence (in terms of the amount of data relating to the theme and the quality of the data), and that did not pertain directly to the research questions for the study were removed from the study. Following this, preliminary classifications of themes into hierarchies (overarching themes, themes and sub-themes) was undertaken, by identifying commonalities between themes and theme content, and in accordance with the five systems within the ADAPT model. The relationships between different hierarchies of themes was established by consensus of the researcher and project supervisors.

The fifth phase involved re-labelling and defining the themes, in accordance with both the coded data within the theme itself and, where relevant, in accordance with the components of the ADAPT model.

Before the final phase of generating the report for the study, cross-coding was carried out in order to check the reliability of the coding process. Although this is not a procedure that Braun and Clarke (2013) necessarily advocate, it was recommended by the research project's supervisors, as well as another highly experienced qualitative researcher, Dr. Narelle Warren from Monash University. The cross-coding was carried out by two independent raters who had no involvement in the research but were experienced in qualitative data analysis. Twenty five percent of the interviews were randomly selected (n = 12), and the researcher's coding scheme of subordinate themes and themes were checked for accuracy (given the large quantity of data and the time constraints associated with carrying out such a process, this was deemed to be the most feasible approach). The cross-coders were provided with detailed instructions on how to go about undertaking the coding process, as well as the definitions of the themes (refer Appendix S). While processes were in place should cross-coders disagree with the authors' coding scheme (wherein discussions with the cross-coders and the

researcher would be held about the data in question, and a resolution would be made as to the most appropriate code to use), these were not required as the cross-coders were in agreement with the entirety of the researcher's coding scheme.

The sixth and final phase of the analysis involved generating the report for the study (Chapter 7). Relevant extracts from participants' interviews were chosen for inclusion according to their relevance to the study's aims and their reflection of components of the ADAPT model (Silove, 1999). Data pertaining to the themes obtained through the data analysis process were reported specifically as they related to the five adaptive systems of the ADAPT model (Silove, 1999). This process of comparison allowed for patterns of consistency and inconsistency to be made across content of the adolescents' account.

4.7 Ethical Issues Anticipated and Encountered

A range of logistical and ethical challenges were anticipated and encountered throughout this project, including: informed consent, recruitment procedures, re-traumatisation, feedback pertaining to elevated questionnaire results and confidentiality, challenges posed by cultural differences between the researcher and participants, and linguistic issues. These issues, with reference to past literature and its recommendations on the topic, will be discussed in detail in this section.

Careful consideration of ethical and logistical issues were made when designing the study given the possibility that multiple and complex issues were anticipated to arise throughout the research process (Jacobsen & Landau, 2003; Mackenzie, McDowell & Pittaway, 2007; Lustig et al., 2004). In line with recommendations made by Gifford, Bakopanos, Kaplan & Correa-Velez (2007), conducting the pilot phase of the research was seen to be an important means of testing procedures, logistics and possible ethical difficulties,

that may have arisen throughout the rest of the project. As mentioned, logistical procedures were changed slightly as a result of this process.

4.7.1 Consent procedures.

Gaining informed consent from both participants and their parents/guardians was seen to be a potentially difficult, but very important issue, in the research process. Thus, steps were made to ensure that there were numerous translations of the information and consent forms available. This process was informed by meeting with staff members at the schools and other institutions that took part in the research prior to data collection commencing, whose advice was sought as to the most common languages that were spoken amongst their refugee students. As mentioned, where there were no consent forms available in parents'/guardians' language, or where participants' parents/guardians reported to be illiterate, telephone interpreters were used to gain verbal consent. The procedures around informing participants were conducted so as to enhance prospective participants' agency in the process, and to remediate potential power imbalances and possible feelings of obligation to take part (Block, Warr, Gibbs & Riggs, 2013). In school settings, participants were verbally informed of the nature of the project and then given information and consent forms. They were invited to think about whether they wanted to take part in the project and to return their forms to a teacher or drop-box if they wished to do so. The processes enacted in other recruitment settings largely enabled participants to contact the researcher should they wish to take part. Both of these methods were conducted with the aim being to remove any feelings of obligation to take part in the study, to empower participants and to promote their agency in the process of consent (Mackenzie et al., 2007).

4.7.2 Confidentiality of research data.

Upon meeting with participants in the first session, the researcher ensured that the nature of the research was explained again to ensure that consent was genuinely informed. Particular care was taken to ensure that the limits to confidentiality and the provision of feedback to parents/guardians (in cases where participants were under 18) if their questionnaire results were clinically elevated, were discussed. This was deemed a particularly necessary process, given it was anticipated both participants, and their parents/caregivers, would not necessarily be familiar with western notions of research and, due to past experiences, may be mistrustful of such processes (Mackenzie et al., 2007; Block et al., 2013).

4.7.3 Recruitment considerations.

It was anticipated that the recruitment process would be difficult, particularly given the number of participants that were sought. While the recruitment process did indeed eventuate into being a difficult one, ethical considerations had to be prioritized even when uptake for the study was very low and recruitment took longer than originally planned. For example, three Melbourne-based homework clubs that worked with large populations of refugees were contacted and gave their consent for the researcher to recruit from there. However after visiting the homework clubs on multiple occasions, recruitment was deemed logistically unfeasible and potentially ethically inappropriate. Due to issues with accessibility for many young people to the homework clubs, and because their time spent at the homework clubs was highly valued, it was not deemed appropriate to meet with them during the time that the clubs were run (the only way and time that was deemed to be feasible to access these young people) to conduct the research. It was important that recruitment and data collection procedures remained flexible in order to best suit the participants' needs, even when participant uptake was low.

4.7.4 Data collection: retraumatisation.

The possibility of re-traumatisation during the interview or when completing the questionnaires was also a strong consideration in designing and carrying out the study. As such, the semi-structured interview was designed so that there were few questions pertaining to past experiences that may have triggered unwanted memories. Furthermore, the researcher tried to ensure the interview process was participant-led and conversational in nature, thus promoting participants' empowerment in the process and their ability to 'take the lead' in a situation that could have been a power imbalance between the researcher and the participant (Block et al., 2013). While the researcher was well-placed to address any issues that arose in the interview process, due to her training as a provisional psychologist in the Doctor of Clinical Psychology course and her having access to research supervisors who were mental health professionals themselves, caution was taken into not entering a dual counsellor role rather than a researcher with participants. The majority of participants evidenced a willingness and, for many, stated their enjoyment in talking about themselves, often at a highly personal level, throughout the interview process. For example, at the end of her interview after the researcher thanked her for her involvement, Samantha stated, "I'm very glad to talk about this". Indeed, very few participants evidenced any outward form of distress in the interview, and those that did were able to self-regulate their emotions. The researcher ensured she checked in with participants at the end of the interview to see how they were feeling, and made particular effort to do so with the aforementioned participants who did evidence some distress in the interview.

The procedures around administering the questionnaires were designed so as to ensure that the researcher was on hand should the participants encounter any difficulties in completing the questionnaire (participants were also reminded at this stage that they could opt out of completing questionnaires at any stage); and that the feedback process on the

results of the questionnaires could be undertaken in the second session. Procedures were also arranged with the researcher's supervisors so that they could be contacted on their mobile telephones in case there was a situation the researcher needed immediate help with. The coping styles questionnaire was administered to participants last in the set of questionnaires, in order to finish the session on a more neutral topic. At the completion of the questionnaires, the researcher ensured that time was spent talking with the participants, checking how they found the process and how they felt before ending the session.

4.7.5 Data collection: feedback.

Providing feedback to participants regarding elevated questionnaire results, and their parents/guardians where participants were under 18, was undertaken with particular care. When questionnaire results were elevated, as mentioned, the researcher discussed this with participants in the second session. On these occasions, feedback was provided as to the meaning of the results, and participants' questions and any concerns were discussed. Participants were also provided with verbal and written information as to where they could go to for psychological assistance pertaining to matters that were brought up in the questionnaires. For many participants, this process was something they were open to, in many cases they were appreciative of the feedback and reported that they were not surprised with the nature of the results. Where participants were under 18, the researcher's need to inform their parents/guardians about the nature of the results was discussed. In these cases, particular care was undertaken by the researcher to explain why she had to go about doing this, the nature of what would be discussed with their parents/guardians, and in starting a conversation with participants about any concerns or questions they had about this process. Again, for many participants they were open and understanding when this process had to be undertaken. However, for a small minority, there was understandable reluctance. On such occasions, after discussing the matter with the research supervisors, extra meetings with participants were

held in order to talk in more detail about what their concerns were with regards to the researcher contacting their parents. It was acknowledged that on such occasions there was a pronounced power imbalance between the researcher and the participants, yet the duty of care to participants was paramount.

Discussing such matters with parents/guardians also posed some ethical challenges. Firstly, given most of these discussions with parents were conducted with interpreters, issues of confidentiality and the way in which feedback was conveyed to the parents/guardians needed to be considered. To try to combat possible issues of confidentiality, a large, Australia-wide, interpreting agency was used to enhance the possibility that interpreters would not be known to the parents/guardians (this was particularly applicable to the Tasmanian context, where refugee communities are very small, and there is only one state-wide interpreting agency). Further, a lengthy briefing of the interpreters prior to discussions with parents/guardians was held to inform them of the nature of the conversation that was to be held, to discuss any potential issues they could see arising due to cross-cultural or linguistic factors, and to inform them of the confidential nature of the conversation. The vast majority of parents/guardians understood the feedback that was provided to them and were receptive of it. Many expressed their gratitude for the researcher's involvement and were thankful for being provided with the information. While one parent appeared to find the feedback process difficult and evidenced some initial misunderstanding of the nature of the phone call, she appeared to understand the message after a lengthy conversation was held with the researcher. Information on services they could attend with their child for assistance was provided to parents/guardians over the phone, and by follow-up letter where parents/guardians wished to receive one.

Chapter 5. Familial Separations, Coping Styles, and PTSD Symptomatology in Resettled Refugee Youth

5.1 Preamble to Empirical Paper

The following Chapter presents the first empirical study of the thesis. The aim of this paper was to examine how familial separations and coping styles relate to PTSD symptomatology, and whether the use of coping styles varied amongst resettled refugee youth with and without familial separations. While previous research has explored associations between psychopathology, familial and coping factors in refugee populations, studies have largely focussed on investigating unaccompanied minor and adult refugee populations. Furthermore, there is little research which examines how such factors act in concert. This study makes a significant contribution to the literature by finding evidence for the integrity of the family unit as being a correlate for PTSD symptomatology in accompanied resettled refugee youth.

This article was submitted to the Journal of Nervous and Mental Disease on 18 July, 2014. The Journal of Nervous and Mental Disease publishes articles concerning theory, aetiology and social impact of illness. The journal has an impact factor of 1.84, with a five-year Impact Factor of 2.29. This paper has been formatted in accordance with the style specified by the editorial board of this journal.

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Monash University

5.2 Declaration for Thesis Chapter 5

Declaration by candidate

In the case of Chapter 5, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Literature review, formulation of study design, data collection, data analysis and writing of paper.	70%

The following co-authors contributed to the work. Co-authors who are students at Monash University must also indicate the extent of their contribution in percentage terms:

Name	Nature of contribution
Dr. Glenn Melvin	Consultation in formulation of study design, data collection input, discussion of ideas expressed in manuscript and critical review of manuscript.
Prof. Louise Newman	Consultation in formulation of study design, data collection input, discussion of ideas expressed in manuscript and critical review of manuscript.

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature	[redacted]	**Date** 21/07/2014
Main Supervisor's Signature	[redacted]	**Date** 21/07/2014

Familial Separations, Coping Styles, and PTSD Symptomatology in Resettled Refugee Youth

Lucy McGregor[a], Glenn A. Melvin[a] & Louise K. Newman[a].

[a] Centre for Developmental Psychiatry & Psychology

Department of Psychiatry

School of Clinical Sciences

Faculty of Medicine Nursing & Health Sciences

And

School of Psychological Sciences

Faculty of Medicine Nursing & Health Sciences

Centre for Developmental Psychiatry and Psychology

270 Ferntree Gully Rd, Building 1, Notting Hill VIC 3168, Australia

[redacted]

[redacted]

Corresponding author: Lucy McGregor

Centre for Developmental Psychiatry and Psychology

270 Ferntree Gully Rd

Building 1

Notting Hill VIC 3168, Australia

[redacted]

Abstract

Youth from refugee backgrounds have been found to experience high rates of posttraumatic stress disorder (PTSD), even after years of resettlement. The present study sought to investigate how familial separations and coping styles act as correlates for the condition in resettled refugee youth (N = 50). Participants completed self-report questionnaires assessing PTSD symptoms and their use of coping styles, and engaged in a semi-structured interview designed by the authors to investigate their resettlement and adaptational experiences in Australia. Youth who were separated from immediate family members demonstrated significantly more PTSD symptoms than their counterparts, and there was a relationship between avoidant coping and PTSD, although this diminished once possible confounds were controlled for. This study found evidence for the integrity of the family unit as a correlate of PTSD in refugee youth, but no evidence of a relationship between coping style and family separations.

*Keywords:*refugees, adolescence, PTSD symptomatology, family separations

Introduction

Prior to their resettlement, refugee youth endure cumulative, and often prolonged traumata, including exposure to violence and warfare, involuntary displacement, and separations from family members (Almqvist & Brandell-Forsberg, 1997; Papageorgiou et al., 2000; Rousseau et al., 1999). It is well established that exposure to such events has significant impacts upon psychological wellbeing and adaptation (Fazel & Stein, 2003; Murray et al., 2008), with findings from epidemiological studies consistently pointing to significant psychiatric morbidity, including, but not limited to, anxiety and depressive disorders, in resettled refugee youth (Bronstein & Montgomery, 2011; Fazel & Stein, 2003; Porter & Haslam, 2005). Hodes (2000), for example, estimates that up to 40% of refugee youth resettled in the United Kingdom would meet diagnostic criteria for a psychiatric disorder. Further, results of many comparative studies show higher prevalence of psychopathology in resettled refugee youth than in matched local populations (e.g., Fzel & Stein, 2003; Reed et al., 2012).

Posttraumatic stress disorder (PTSD) is one of the most frequently reported psychological conditions in refugees (Drury & Williams, 2012; Fazel & Stein, 2002). Although contention exists about the use of Western-based nosology and the associated cross-cultural applicability of PTSD (Bracken et al., 1995; Marsella, 1996), there is established evidence for its validity in refugee populations (Hinton & Lewis-Fernandez, 2011; Sack et al., 1997; van Rooyen & Nqweni, 2012). Despite varying rates reported throughout the literature, findings demonstrate that PTSD prevalence is relatively high in young refugee populations, even after years of resettlement in a host country (e.g., Sack et al., 1993). A comprehensive meta-analysis found 11% (7-17% range) of resettled refugee youth experienced PTSD, with the authors concluding that resettled refugees may be up to ten-times more likely than age-matched local populations to suffer from PTSD (Fazel et al.,

2005). Focused attention has been devoted in the literature to date on risk for the development and maintenance of PTSD in refugee populations. Exposure to violence and severity of exposure to war-related truama, for example, are particularly implicated in the development of PTSD (Drury & Williams, 2012; Ehntholt & Yule, 2006). Despite this, there remains much speculation as to why many refugees do not in fact meet diagnosable levels of PTSD symptomatology, and thus what protective factors act to confer resilience against the development of the condition (Silove, 1999). For these reasons, and others detailed herein, it is questionable as to whether we have in fact gained a comprehensive understanding of the mechanisms behind the development of PTSD in refugee populations.

Historically, studies on PTSD in refugee populations have been conducted under the paradigm of a life-events model of disorder (Porter, 2007), in which PTSD symptomatology is conceptualised as a reaction to trauma endured during the refugee experience (Porter & Haslam, 2005). This approach has been critiqued as being reductionistic in its failure to account for other psychosocial and intraindividual factors that may contribute to the aetiology of distress (Berman, 2001; Papadopoulos, 2007; Porter, 2007); exemplified by findings that factors in the resettlement environment, such as discrimination (Ellis et al., 2008) and language abilities (Halcon et al., 2004), are associated with PTSD symptomology. Such findings attest to the suggestion by many that more complex ecologically-based paradigms of enquiry into PTSD are needed in order to promote a better understanding of the condition in refugee populations (Porter, 2007; Silove, 1999).

Taking a family-perspective in examining psychological difficulties in young refugee populations may provide deeper understandings into risk and protective factors for the development of conditions such as PTSD (De Haene et al., 2007). The family unit for refugee youth is highly important, but given that factors that may compromise the family unit's functioning abound (including family separations, resettlement stress and financial

difficulties), family factors may act as both risk and protective factors (Gifford et al., 2009). Regarding psychological functioning generally, some family factors, including family cohesion and supportive family relations (Fazel et al., 2012), are protective against the development of pathology in refugee children. On the other hand, there are aspects of family functioning that impart risk for the development of psychopathology. In resettled refugee youth in Sweden, stress in the family unit led to increased mental health symptoms (Hjern et al., 1998), and there is established evidence for the intergenerational transmission of psychopathology, including PTSD (Ajdukovic & Adjukovic, 1993; Panter-Brick et al., 2013; Sack et al., 1995).

While it has been shown that familial factors impart both risk and protective factors in the manifestation of refugee children's psychological difficulties, having a parent or caregiver present throughout all phases of the refugee journey is strongly protective (Huemer et al., 2009). Freud and Burlington's (1943) seminal work provides some of the earliest evidence for this. They found that children who remained with their parents during World War II, despite being exposed to consistent bombardment, had comparably better psychological outcomes than those who were relocated for the period of the war without their parents. Unaccompanied refugee minors (URMs), who resettle without family members, are generally found to experience considerably elevated rates of psychopathology, and PTSD specifically, compared to their accompanied counterparts (see Huemer et al., 2009 for a review). Further, accompanied children who separate from parents post-resettlement are at risk of experiencing psychological difficulties (Hjern et al., 1998), with findings also demonstrating that boys who lived with both biological parents in their resettlement country had five times lower rates of psychopathology compared to those living in other family arrangments (Tousignant et al.,1999).

As well as the relations between familial factors and psychpathology, theoretical and empirical evidence demonstrates that children's stress responses, including their use of coping styles, are inextricably related to parental and familial factors (Compas et al., 2001; Punamäki, 1997; Compas, 1987). Coping is defined by Compas, Connor-Smith, Saltzman, Harding Thomsen and Wadsworth (2001, pp. 88), as "conscious volitional efforts to regulate emotion, cognition, behavior, physiology, and the environment in response to stressful events or circumstances". Children learn coping styles and behaviours directly from parents, through processes of socialisation (Abaied & Rudolph, 2011; Gaylord-Harden et al., 2013) and modelling (Kliewer, Fearnow & Miller, 1996), with early familial environmental factors influential also (Gaylord-Harden et al., 2013; Taylor & Stanton, 2007). In the limited literature that exists on coping processes and familial factors in refugee youth, two studies have found that transactional dynamics between parents' and children's coping styles (Almqvist & Broberg, 1999), and parental openness with children about past traumas they had experienced (Montgomery et al., 1992), influenced children's use of coping strategies.

In the broader literature, certain coping styles have been linked with the maintenance of PTSD, with individual differences in coping leading to differential morbidity outcomes following trauma exposure (Olff et al., 2005). In adult refugees, support-seeking coping styles have been found to be negatively associated with PTSD morbidity (Finklestein et al., 2012), whilst positive correlations have been found between the use of avoidance coping styles and PTSD symptomatology (Ai et al., 2007; Finklestein & Solomon, 2009; Hujits et al., 2012). In comparison, such research with refugee youth is in its infancy; little is known about the interrelatonships between coping styles and PTSD in these populations.

It is clear that the determinants and correlates for psychopathology in refugee populations are complex and multifaceted. While familial factors have important relationships with youth's psychological morbidity (De Haene et al., 2007), so too do aspects of the trauma

endured prior to resettlement (Bronstein & Montgomery, 2011), as well as intraindividual factors, such as coping styles (Ai et al., 2007; Finklestein et al., 2012; Hujits et al., 2012). Given this complexity, it is important that research moves beyond examining PTSD in refugee populations from a purely life-events model of disorder, and instead is driven by ecological paradigms of enquiry. The current study seeks to take such an approach, by jointly investigating how familial separations as well as the use of coping styles relate to PTSD symptomatology in resettled refugee youth.

The primary aims of the research are to: (a) examine whether youth who reside without all members of their immediate family would have more PTSD symptoms than a comparative sample who live with their immediate family unit intact; (b) investigate whether the use of coping styles varies between youth according to their familial makeup; and, (c) examine the relationship between the use of coping styles and PTSD symptomology.The following hypotheses were made: (a) That youth who had resettled in Australia with their immediate family intact would exhibit comparatively less PTSD symptoms when compared to those separated from family; (b) That there would be differential uses of coping strategies amongst participants who had resettled with their immediate families compared to those who had not, but no assertions were made as to the nature of these differences due to an absence of prior literature from which to draw upon; and (c) The avoidant coping style would be positively associated with PTSD symptoms while support-seeking coping would be negatively associated; no hypotheses were made regarding active or distraction coping due to an absence of prior literature with refugee youth from which to draw upon.

Methods

Participants

A total of 50 young people who self identified as being from a refugee background, and were living in Hobart or Melbourne, Australia, participated in the study. Inclusion criteria for all participants comprised: (a) 12 and 21 years of age; (b) residing in Australia for six months or more; and (c) sufficient English capabilities if they did not wish to use an interpreter. A total of 20 participants were living with intact immediate families, whilst 22 were residing without all members of their immediate family. It was not possible to ascertain the required information on the status of the family units for eight participants, due to ambiguous or missing data and therefore these participants were excluded from analyses involving this variable. Data was collected from between April, 2012 and August, 2013.

Measures

Posttraumatic stress disorder (PTSD) symptomatology

The Child PTSD Symptom Scale (CPSS; Foa et al., 2001), a 17-item self-report inventory based on DSM-IV criteria, was employed to screen for symptoms of PTSD. The measure was designed to assess the presence and severity of PTSD symptoms in children and adolescents and has been applied to ethnically diverse populations (Jaycox et al., 2002; Jordans et al., 2010; Tol, 2008). The CPSS asks about the presence of PTSD symptoms over the past month on a four-point Likert scale, yielding a total score ranging from 0 – 51. The measure has three subscales, which correspond to symptom clusters as reported in the DSM-IV: re-experiencing, avoidance and arousal. A clinical cut-off score of 15, as recommended by the International Society for Traumatic Stress Studies (2013) for use with this measure, is indicative of a high level of PTSD symptoms. The scale has adequate internal consistency

(Jaycox et al., 2002), external validity (Kassam-Adams, Marsac & Cirilli, 2010), and had an internal consistency of Cronbach's α = .90 in the current study.

Coping styles

The Children's Coping Strategies Checklist – Revision 1 (CCSC; Program for Prevention Research, 1999), a 42-item self-report inventory, was used to measure coping styles. The measure comprises ten subscales of conceptually distinct coping strategies, which make up the four superordinate dimensions of *avoidance* (behavioural and cognitive efforts to avoid problems and stressful situations), *distraction* (efforts to work off unwanted feelings with physical activities and to avoid thinking about problems by using distracting stimuli, entertainment or other forms of activity), *active* (cognitive efforts to change thought processes around the problem and the use of problem-solving strategies), and *support-seeking* (where people are used as resources to help with problem solving processes as well as with emotional support) coping styles. Scores for the coping dimensions are obtained by taking the combined mean score of all subscale items, with higher scores indicating greater use of the coping strategy/dimension. The CCSC demonstrates strong construct validity (Ayers et al., 1996; Compas et al., 2001. In the present study, internal consistencies for the avoidance, active and support-seeking coping dimensions were Cronbach's α = 82, .83 and .72, respectively. The distract coping dimesion had poor internal consistency, Cronbach's α = .56, and as a result was excluded from any further analyses.

Resettlement experiences and adaptational outcomes

The Youth Experience Scale for Refugees (YES-R; McGregor et al., 2014[1]) is a semi-structured interview constructed based on the *Adaptation and Development After Persecution and Trauma* model (ADAPT model; Silove, 1999) to examine participants' resettlement and adaptational experiences. A study-specific measure, this interview schedule was developed

[1] Measure available from corresponding author.

specifically for use with young refugees, with questions covering the following themes: individual and familial adaptation to life in Australia; prior expectations of what resettling in Australia would be like for the participant and their family; cross-cultural differences between life in Australia and participants' homelands; nature of peer relations in Australia; and, participants' future aspirations. Information gleaned from this interview regarding participants'reports of familial separations was used to categorise participants into the 'intact'and 'non-intact'groups. Further detailed results pertaining to interview properties and qualitative results from the questionnaire data are currently in pre-publication.

Procedure

The current study was approved by Monash University and University of Tasmania Human Research Ethics Committees, and the Victorian and Tasmanian State Departments of Education and Early Childhood Development. Participants were recruited through the combined use of convenience and snowball techniques from consenting educational (two public schools, an English language school, a Technical and Further Educational centre (TAFE) and University) and community-based institutions (a hospital-based refugee health clinic and a local GP practice) in Melbourne and Hobart, Australia. Written consent was obtained from all participants, and, where younger than 18 years of age, from their parents or guardians. Translated versions of consent forms were made available in numerous languages (including Arabic, Burmese and Karen). Phone interpreters were also made available in cases where no written translated consent form was available in the parents/guardians' language and in instances where the participant reported that their parent/guardian was illiterate. A movie voucher was provided as an appreciation gift for participation in the study.

An initial pilot study was conducted with a small group of participants (n = 4) to test the feasibility of the study protocol. Minor administrative adjustments were made as a result of these procedures. Data collection occurred over two sessions. Basic demographic data (e.g., age, country of birth, family characteristics, length of time residing in Australia) was collected and the CPSS and CCSC adminstered in the first session, while the YES-R was conducted by the first author in the second session. Only one participant chose to use an interpreter, despite the opportunity being offered to all. Interviews lasted between 30 and 90 minutes, and were recorded and transcribed verbatim. Four participants did not consent to interviews being recorded and therefore written notes were taken in lieu of audio-data. When participants' CPSS scores were within clinical ranges (a score of 11 and above, as prescribed by the measure's author), participants and their parents or guardians (where the participant was aged under 18) were provided with feedback on the study result as well as relevant referral information and advice.

Data Analysis

Initially, data was screened to identify missing cases and check for normality. Before further analyses, a dichotomised variable was created based on the criteria employed by Schweitzer, Melville, Steel and Lacherez (2006): participants who were residing with all members of their immediate family (*intact* group) and participants who were residing without their complete immediate family (*non-intact* group). Due to a floor effect of low scores in the intact group, CPSS scores were transformed using a square root transformation.

To examine the relationship between family separations and PTSD symptoms, Spearman's rho bivariate correlations were used between the family separation variable and CPSS scores, and an independent samples *t* test was conducted on transformed data to examine the difference in CPSS scores between the groups. Mann-Whitney U tests were

employed to examine any differences in the using of coping styles, between the intact and non-intact groups due to the non-normality of the data and its resistance to transformations. The relationships between coping styles and CPSS scores were examined using hierarchical multiple regressions. Assumptions were met for all analyses.

Results

Participant demographics

The sample consisted of a total of 50 participants, 31 female and 19 male, who had been in Australia on average 4.35 years (range 6 months - 11 years) and aged between 12 – 21 (M = 16.63, SD = 2.51). Of those in the non-intact group, 8 (36%) were separated from their father; 7 (32%) from sibling(s); 3 (14%) from father and sibling(s); 2 (9%) from their spouse; 1 (4.5%) participant was separated from all of their immediate family members and was living with her husband; and 1 (4.5%) was separated from all immediate family members and living with an uncle. Participants were from a range of ethnic origins which generally matched Australia-wide resettlement statistics for the period 2008 – 2013 (Department of Immigration and Citizenship, 2013b), with a slight over-representation of participants from Burma. Further demographic statistics are summarised in Table 1.

Participant clinical characteristics for the whole sample and intact and non-intact groups

For the whole sample, 40% of participants scored above the conservative cut-off score of 15 for PTSD symptoms, proposed by the International Society for Traumatic Stress Studies (2013) for use with the CPSS. Participants utilised the active and avoidant coping dimensions in largely equal amounts, followed by support-seeking coping (Table 2).

Participants in the non-intact group had significantly higher PTSD symptoms than those in the intact group, t (40) = 2.19, $p < .05$. The magnitude of the differences in the means

(mean difference = 1.01, 95% *CI*: .08 – 1.95) was moderate (*d* = .67). There were no differences between groups in their use of either active coping, *U* = 195.00, *z* = -.63, *p* = n.s.; avoidant coping, *U* = 191.00, *z* = -.73, *p* = n.s.; or support-seeking coping, *U* = 219.50, *z* = -.01, *p* = n.s. Participants in both the intact and non-intact group endorsed using the active coping dimension the most frequently, followed by avoidant coping and support-seeking coping.

Correlations between participant demographics and PTSD symptomatology

Table 3 displays correlations between demographic variables, coping dimensions and PTSD symptomatology. The relationships between demographic factors and CPSS scores were analysed using spearman's rho bivariate correlations in order to identify possible covariates. There was a significant moderate negative correlation between family separations and PTSD symptomatology (ρ = -.37, *p* <.05); all other demographic variables were non-significant.

Relationships between coping styles and PTSD symptomatology

In a model predicting PTSD symptomatology (Table 4), the family separations variable was entered at Step 1 as a covariate, given its significant correlation with CPSS scores. Active and avoidant coping entered at Step 2 (support-seeking coping was omitted from the analysis due to its potential multicolinearity (ρ = .50) with the active coping dimension); the resulting increase in the variance in PTSD scores was not statistically significant, *F* change (2, 38) = 2.56, *p* =.09. The overall model was significant, *F* (3, 38) = 3.06, *p* <.05, with the avoidant coping providing a statistically significant unique contribution to the variance in PTSD scores (*beta* = .39, *p* <.05).

Relationship between avoidant coping and PTSD symptomatology, controlling for CPSS avoidant subscale

Given the presence of avoidance-based cognitions and behaviours in the aetiology of PTSD (American Psychiatric Association, 2013), it was thought possible that participants with high levels of PTSD symptomatology may endorse using high levels of avoidance coping. Because some items in the CCSC may overlap with PTSD symptoms for such participants (e.g., Question 15, "Try to stay away from things that make me feel upset"), possible confounds between measures were statistically controlled for by examining the relationship between avoidant coping and PTSD symptoms whilst controlling for the avoidant subscale of the CPSS in a second hierarchical multiple regression.

For this analysis, the dependent PTSD variable was the CPSS total score, without the avoidance scale. The family separations variable was entered at Step 1. At Step 2, avoidant coping was added, explaining a non-significant additional 6% of variance to that accounted for by family separations, F change (1, 39) = 2.73, p = .11. The overall model approached significance, F (2, 39) = 2.87, p = .07 (Table 5).

Discussion

The current study sought to examine whether coping styles and familial separations in the resettlement environment related to PTSD symptomatology in resettled refugee youth. Levels of PTSD symptomatology were significantly higher for participants who were residing without their intact immediate family; however there were no differences between groups in their use of coping styles. There was a significant relationship between avoidant coping and PTSD symptomatology, although this was not significant once possible confounds between measures were controlled for.

Findings regarding the prevalence of PTSD symptomatology in this study are comparable to findings in other populations of resettled refugee youth (Papageorgiou et al., 2000; Sack et al., 1996). Sack et al. (1993), for example, found a 38% prevalence rate of PTSD in a sample of Cambodian adolescents resettled in America, while in another study, 28% of Bosnian refugee and war exposed children scored in the clinical range for PTSD symptoms (Berthold, 1999). That 40% of this sample met a conservative clinical cut-off score for PTSD symptomatology is concerning, particularly given that they had been resettled in Australia for, on average, over 4 years.

Supporting our hypothesis, young people who were residing in Australia with all members of their immediate family had significantly lower PTSD symptomatology than those who had familial separations. These findings present an important contribution to the literature, as, to the authors' knowledge, there have been no prior studies with accompanied refugee youth that have explicitly examined PTSD symptoms in relation to familial separations. These findings are in concert with literature on adult resettled refugees, in which separation from family members who remained in their countries of origin predicted increased in PTSD and emotional distress (Nickerson et al., 2010; Rousseau, Mekki-Berrada & Moreau, 2001). Findings from the literature on unaccompanied refugee minors indicate that separation from family members is a potent risk factor for PTSD symptom development (Hepinstall et al., 2004; Huemer et al., 2009). That participants in this study had comparably less severe separation experiences than unaccompanied minors in the aforementioned research (some, for example were in Australia with both parents but were separated from siblings), yet still demonstrated significantly worse PTSD symptomatology than their counterparts who resided with their entire immediate family, attests to the likely importance of the family unit when considering adolescent refugee mental health. Further studies are needed to explicate the mechanisms behind such results. This finding may be indicative of

compounding effects, whereby the likelihood of psychological difficulties increases as the number of risk factors, in this case, separation from immediate family members, accumulates (Fazel & Stein, 2002).

In partial support of the hypothesis, there was an initial significant relationship between avoidance coping and PTSD, however this diminished in magnitude and was non-significant once possible confounds between measures were controlled for by the omission of the PTSD avoidance subscale in a subsequent analysis. The avoidance criterion for PTSD in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) entails, "Persistent effortful avoidance of distressing trauma-related stimuli after the event"; whilst the avoidance coping scale of the CCSC questions the use of efforts to behaviourally and cognitively avoid problematic and stressful situations. While directionality cannot be established from these findings, it may be that participants with high levels of PTSD symptomatology who also endorsed using high levels of avoidance coping did so due to their experience of avoidance PTSD symptomatology rather than a tendency to use avoidance-based coping efforts more generally. This finding is important to note given that other studies have found similar significant relationships between avoidant coping and PTSD but have not controlled for possible confounds between avoidant coping styles and avoidance-based PTSD symptomatology (e.g., Finklestein et al., 2012; Matheson et al., 2008). These results may therefore be spurious (Coyne & Racioppo, 2000; Stanton, Danoff-Burg, Cameron & Ellis, 1994).

Another possibility is that this study's small sample size and resultant possibility of Type II error may have precluded obtaining significant relationships between avoidance coping and PTSD symptomatology after the statistical controls were introduced. Indeed, findings from prospective longitudinal studies show use of avoidant coping prior to index-

traumas to be a risk factor for PTSD development (DiGangi et al., 2013; Lengua, Long & Meltzoff, 2006), whilst avoidant coping has also been implicated in the maintenance of PTSD symptoms (Hujits et al., 2012; Pineles et al., 2011). More prospective and longitudinal studies are needed to explicate these relationships in refugee populations.

The use of coping styles did not vary between participants in the intact and non-intact groups. One explanation for this result may be that family intactness did not influence young people's utilisation of coping styles in this population. While social relationships and familial dynamics have an important role in the development of coping styles and strategies throughout childhood (Gaylord-Harden et al., 2013; Taylor & Stanton, 2007), these factors diminish in importance as the child ages, becomes more self-reliant and is increasingly able to use self-directed cognitively based coping strategies in adolescence, the age-range of participants in the present study (Skinner & Zimmer-Gembeck, 2007).

Given the study's modest sample size and ethnically heterogeneous population, the results should be treated as preliminary. The study is further limited by its cross-sectional design, thus not allowing for conclusions to be made as to the directional nature of relationships between variables. Further, while the CPSS has been used with ethnically diverse populations in previous studies, the CCSC has not been used or validated on refugee populations. Further research is needed to demonstrate the cross-cultural validity of this measure in refugee populations. A final limitation of this study was that participants' historical trauma exposure was not examined, nor controlled for in the analyses, thereby potentially acting as a confounding variable between familial separations and PTSD symptoms.

Despite these factors, this study contributes to the existing limited literature base on psychopathology in resettled young refugees in Australia, demonstrating that even after some years of resettlement many still experience significant psychological difficulties. Contributing

to the literature on coping in resettled refugee youth, these results provide evidence for their use of a variety of coping styles, and also exemplify the need to consider the possibility of confounds in cross-sectional research that examines psychopathology and coping concurrently. Extending upon the extant literature on unaccompanied refugee minors, findings provide evidence for the importance of the family unit as a correlate of PTSD, and support many authors' calls for broader ecological paradigms of enquiry into the mental health of young refugees.

References

Abaied, J., & Rudolph, K. (2011). Maternal influences on youth responses to peer stress. *Developmental Psychology, 6*, 1776-1785. doi: 10.1037/a0025439

Ai, A. L., Tice, T. N., Whitsett, D. D., Ishisaka, T., & Chim, M. (2007). Posttraumatic symptoms and growth of Kosovar war refugees: The influence of hope and cognitive coping. *The Journal of Positive Psychology, 2*(1), 55-65. doi: 10.1080/17439760601069341

Ajdukovic, M., & Ajdukovic, D. (1993). Psychological well-being of refugee children. *Child Abuse and Neglect, 17*(6), 843-854. doi: 10.1016/S0145-2134%2808%2980014-2

Almqvist, K., & Brandell-Forsberg, M. (1997). Refugee children in Sweden: post-traumatic stress disorder in Iranian preschool children exposed to organised violence. *Child Abuse and Neglect, 21*(4), 351-366. doi: 10.1016/S0145-2134(96)00176-7

Almqvist, K., & Hwang, P. (1999). Iranian refugees in Sweden: Coping processes in children and their families. *Childhood: A Global Journal of Child Research, 6*(2), 167-188. doi: 10.1177/0907568299006002002

American Psychiatric Association ; American Psychiatric Association. DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders : DSM-5* (Fifth edition ed.). Arlington, VA: American Psychiatric Association.

Ayers, T. S., Sandler, I. N., West, S. G., & Roosa, M. W. (1996). A dispositional and situational assessment of children's coping: Testing alternative models of coping. *Journal of Personality, 64*(4), 923-958. doi: 10.1111/j.1467-6494.1996.tb00949.x

Berman, H. (2001). Children and war: Current understandings and future directions. *Public Health Nursing, 18*(4), 243-252. doi: 10.1046/j.1525-1446.2001.00243.x

Berthold, S. (1999). The effects of exposure to community violence on Khmer refugee adolescents. *Journal of Traumatic Stress, 12*(3), 455-471. doi: 10.1023/A:1024715003442

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995). Psychological responses to war and atrocity: The limitations of current concepts. *Social Science and Medicine, 40*(8), 1073-1082. doi: 10.1016/0277-9536%2894%2900181-R

Bronstein, I., & Montgomery, P. (2011). Psychological Distress in Refugee Children: A Systematic Review. *Clinical Child and Family Psychology Review, 14*, 44-56. doi: 10.1007/s10567-010-0081-0

Compas, B. E. (1987). Coping with stress during childhood and adolescence. *Psychological Bulletin, 101*(3), 393-403. doi: 0033-2909/87/$00.75

Compas, B. E., Connor-Smith, J. K., Saltzman, H., Harding Thomsen, A., & Wadsworth, M. E. (2001). Coping with stress during childhood and adolescence: Problems, progress and potential theory and research. *Psychological Bulletin, 127*(1), 87-127. doi: 10.1037//033-2909.127.1.87

Coyne, J., & Racioppo, M. (2000). Never the twain shall meet? Closing the gap between coping research and clinical intervention research. *American Psychologist, 55*(6), 655-664. doi: 10.1037//0003-066X.55.6.655

De Haene, L., Grietens, H., & Verschueren, K. (2007). From symptom to context: A review of the literature on refugee children's mental health. *Hellenic Journal of Psychology, 4*(3), 233-256. doi: 10.1080/17542863.2012.713371

Department of Immigration and Citizenship. (2013b). Migration stream by ethnicity. *Settlement reporting.* Retrieved 21/02/2014, from Retrieved from the Department of Immigration and Border Protection website http://www.immi.gov.au/settlement/srf/

DiGangi, J. A., Gomez, D., Mendoza, L., Jason, L. A., Keys, C. B., & Koenen, K. C. (2013). Pretrauma risk factors for posttraumatic stress disorder: A systematic review of the literature. *Clinical Psychology Review, 33*(6), 728-744. doi: 10.1016/j.cpr.2013.05.002

Drury, J., & Williams, R. (2012). Children and young people who are refugees, internally displaced persons or survivors or peretrators of war, mass violence and terrorism. *Current Opinion in Psychiatry, 25*, 277-284. doi: 10.1097/YCO.0b013e328353eea6

Ehntholt, K. A., & Yule, W. (2006). Practitioner review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of Child Psychology and Psychiatry, 47*(12), 1197-1210. doi: 10.1111/j.1469-7610.2006.01638.x

Ellis, B., MacDonald, H. Z., Lincoln, A. K., & Cabral, H. J. (2008). Mental health of Somali adolescent refugees: The role of trauma, stress, and perceived discrimination. *Journal of Consulting and Clinical Psychology, 76*(2), 184-193. doi: 10.1037/0022-006X.76.2.184

Fazel, M., Reed, R., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *Lancet, 379*, 266-282. doi: 10.1016/S0140-6736(11)60051-2

Fazel, M., & Stein, A. (2002). The mental health of refugee children. *Archives of Disease in Childhood, 87*, 366-370. doi: 10.1136/adc.87.5.366

Fazel, M., & Stein, A. (2003). Mental health of refugee children: Comparative study. *BMJ: British Medical Journal, 327*(7407), 134. doi: 10.1136/bmj.327.7407.134

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet, 365*, 1309-1314. doi: 10.1016/S0140-6736(05)61027-6

Finklestein, M., Laufer, A., & Solomon, Z. (2012). Coping strategies of Ethiopian immigrants in Israel: Association with PTSD and dissociation. *Scandinavian Journal of Psychology, 53*(6), 490-498. doi: 10.1111/j.1467-9450.2012.00972.x

Finklestein, M., & Solomon, Z. (2009). Cumulative trauma, PTSD and dissociation among Ethiopian refugees in Israel. *Journal of Trauma & Dissociation, 10*(1), 38-56. doi: 10.1080/15299730802485151

Foa, E. B., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30*(3), 376-384. doi: 10.1207/S15374424JCCP3003_9

Freud, A., & Burlingham, D. (1943). *War and Children*. New York, N.Y.: Medical War Books.

Gaylord-Harden, N., Elmore, C., & Montes de Oca, J. (2013). Maternal parenting behaviors and child coping in African American families. *Journal of Family Psychology, 27*(4), 607-617. doi: 10.1037/a0033414

Gifford, S., Correa-Velez, I., & Sampson, R. (2009). Good Starts for recently arrived youth with refugee backgrounds : Promoting wellbeing in the first three years of settlement in Melbourne, Australia. La Trobe Refugee Research Centre.

Halcon, L., Robertson, C., Savik, K., Johnson, D., Spring, M., Butcher, J., Westermeyer, J., Jaranson, J. (2004). Trauma and coping in Somali and Oromo refugee youth. *Journal of Adolescent Health, 35*(1), 17 - 25. doi: 10.1016/j.jadohealth.2003.08.005

Hepinstall, E., Sethna, V., & Taylor, E. (2004). PTSD and depression in refugee children: Associations with pre-migration trauma and post-migration stress. *European Child and Adolescent Psychiatry, 13*, 373-380. doi:10.1007/s00787-004-0422-y

Hinton, D. E., & Lewis-Fernandez, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. *Depression and Anxiety, 28*(9), 783-801. doi: 10.1002/da.20753

Hjern, A., Angel, B., & Jeppson, O. (1998). Political violence, family stress and mental health of refugee children in exile. *Scandanavian Journal of Social Medicine, 26*(1), 18-25. doi: 10.1177/14034948980260010701

Hodes, M. (2000). Psychologically Distressed Refugee Children in the United Kingdom. *Child and Adolescent Mental Health, 5*(2), 57-68. doi: 10.1111/1475-3588.00286

Huemer, J., Karnik, N. S., Voelkl-Kernstock, S., Granditsch, E., Dervic, K., Friedrich, M. H., & Steiner, H. (2009). Mental health issues in unaccompanied refugee minors. *Child and Adolescent Psychiatry and Mental Health, 3*, 13. doi: 10.1186/1753-2000-3-13

Hujits, I., Kleijn, W. C., Van Emmerik, A. A., Noordhof, A., & Smith, A. J. (2012). Dealing with man-made trauma: the relationship between coping style, posttraumatic stress, and quality of life in resettled, traumatized refugees in the Netherlands. *Journal of Traumatic Stress, 25*, 71-78. doi: 10.1002/jts.21665

International Society for Traumatic Stress Studies. (2013). CHILD PTSD SYMPTOM SCALE. Retrieved 14/11/2013, from http://www.istss.org/ChildPTSDSymptomScale.htm

Jaycox, L., Stein, B., Kataoka, S., Wong, M., Fink, A., Escudero, P., & Zaragoza, C. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(9), 1104-1110. doi: 10.1097/01.CHI.0000020261.43550.30

Jordans, M., Komproe, I. H., Tol, W., Kohrt, B., Luitel, N., Macy, R., & De Jong, J. T. (2010). Evaluation of a classroom-based psychosocial intervention in conflict-affected

Nepal: a cluster randomized controlled trial. *Journal of Child Psychology and Psychiatry, 51*(7), 818-826. doi: 10.1111/j.1469-7610.2010.02209x

Kassam-Adams, N., Marsac, M., & Cirilli, C. (2010). Posttraumatic stress disorder symptom structure in injured children: Functional impairment and depression symptoms in a confirmatory factor analysis. *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(6), 616-625. doi: 10.1016/j.jaac.2010.02.011

Kliewer, W., Fearnow, M. D., & Miller, P. A. (1996). Coping socialization in middle childhood: Tests of maternal and paternal influences. *Child Development, 67*(5), 2339-2357. doi: 10.2307/1131627

Lengua, L. J., Long, A. C., & Meltzoff, A. N. (2006). Pre-attack stress-load, appraisals, and coping in children's responses to the 9/11 terrorist attacks. *Journal of Child Psychology and Psychiatry, 47*(12), 1219-1227. doi: 10.1111/j.1469-7610.2006.01664.x

Marsella, A. (1996). *Ethnocultural aspects of posttraumatic stress disorder : issues, research, and clinical applications*. Washington, DC: American Psychological Association

Matheson, K., Jorden, S., & Anisman, H. (2008). Relations between trauma experiences and psychological, physical, neuroendocrine functioning among Somali refugees: mediating role of coping with acculturation stressors. *Journal of Immigrant and Minority Health, 10*, 291-304. doi: 10.1007/s10903-007-9086-2

McGregor, L., Melvin, G., & Newman, L. (2014). *The Youth Experience Scale for Refugees*. Unpublished instrument.

Montgomery, E., Krogh, Y., Jacobsen, A., & Lukman, B. (1992). Children of torture victims: reactions and coping. *Child Abuse and Neglect, 16*, 797-805. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/1486509

Murray, K., Davidson, G., & Schweitzer, R. (2008). *Psychological wellbeing of refugees resettling in Australia: A literature review prepared for The Australian Psychological Society*. Melbourne: The Australian Psychological Society.

Nickerson, A., Bryant, R. A., Steel, Z., Silove, D., & Brooks, R. (2010). The impact of fear for family on mental health in a resettled Iraqi refugee community. *Journal of Psychiatric Research, 44*(4), 229-235. doi: 10.1016/j.jpsychires.2009.08.006

Olff, M., Langeland, W., & Gersons, B. P. (2005). The psychobiology of PTSD: Coping with trauma. *Psychoneuroendocrinology, 30*(10), 974-982. doi: 10.1016/j.psyneuen.2005.04.009

Panter-Brick, C., Grimon, M., & Eggerman, M. (2013). Caregiver-child mental health: a prospective study in conflict and refugee settings. *Journal of Child Psychology and Psychiatry, 54*(11), 313-327. doi: 10.1111/jcpp.12167

Papadopoulos, R. K. (2007). Refugees, trauma and Adversity-Activated Development. *European Journal of Psychotherapy and Counselling, 9*(3), 301-312. doi: 10.1080/13642530701496930

Papageorgiou, V., Frangou-Garunovic, A., Iordanidou, R., Yule, W., Smith, P., & Vostanis, P. (2000). War trauma and psychopathology in Bosnian refugee children. *European Child and Adolescent Psychiatry, 9*(2), 84-90. doi: 10.1007/s007870050002

Pineles, S. L., Mostoufi, S. M., Ready, C., Street, A. E., Griffin, M. G., & Resick, P. A. (2011). Trauma reactivity, avoidant coping, and PTSD symptoms: A moderating relationship? *Journal of Abnormal Psychology, 120*(1), 240-246. doi: 10.1037/a0022123

Porter, M. (2007). Global evidence for a biopsychosocial understanding of refugee adaptation. *Transcultural Psychiatry, 44*(3), 418-439. doi: 10.1177/1363461507081639

Porter, M., & Haslam, N. (2005). Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis. *JAMA: Journal of the American Medical Association, 294*(5), 602-612. doi: h10.1001/jama.294.5.602

Program for Prevention Research. (1999). *Manual for the Children's Coping Strategies Checklist and the How I Coped Under Pressure Scale*: (Available from Arizona State University, P.O. Box 876005, Tempe, AZ 85287-6005).

Punamäki, R., & Puhakka, T. (1997). Determinants and effectiveness of children's coping with political violence. *International Journal of Behavioral Development, 21*, 349-370. doi: 10.1080/016502597384910

Reed, R., Fazel, M., Jones, L., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *Lancet, 379*, 250-265. doi: 10.1016/S0140-6736(11)60050-0

Rousseau, C., Drapeau, A., & Platt, R. (1999). Family trauma and its association with emotional and behavioral problems and social adjustment in adolescent Cambodian refugees. *Child Abuse and Neglect, 23*(12), 1263-1273. doi: 10.1016/S0145-2134%2899%2900100-3

Rousseau, C., Mekki-Berrada, A., & Moreau, S. (2001). Trauma and extended separation from family among Latin American and African refugees in Montreal. *Psychiatry: Interpersonal and Biological Processes, 64*(1), 40-59. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/11383441

Sachs, E., Rosenfeld, B., Lhewa, D., Rasmussen, A., & Keller, A. (2008). Entering exile: trauma, mental health, and coping among Tibetan refugees arriving in Dharamsala, India. *Journal of Traumatic Stress, 21*(2), 199-208. doi: 10.1002/jts.20324

Sack, W., Clarke, G., & Seeley, J. (1996). Multiple forms of stress in Cambodian adolescent refugees. *Child Development, 67*(1), 107-116. Retrieved from: http://www.jstor.org/stable/1131689

Sack, W., Seeley, J., & Clarke, G. (1997). Does PTSD transcend cultural barriers? A study from the Khmer Adolescent Refugee Project. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(1), 49 - 54. doi: 10.1097/00004583-199701000-00017

Sack, W. H., Clarke, G. N., Him, C., Dickason, D., Goff, B., Lanham, K., & Kinzie, D. (1993). A 6-year follow-up study of Cambodian refugee adolescents traumatized as children. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(2), 431-437. doi: 10.1097/00004583-199303000-00027

Sack, W. H., Clarke, G. N., Kinney, R., Belestos, G., Him, C., & Seeley, J. (1995). The Khmer adolescent project: II. Functional capacities in two generations of Cambodian refugees. *Journal of Nervous and Mental Disease, 183*(3), 177-181. doi: 10.1097/00005053-199503000-00009

Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry, 40*(2), 179-188. doi: 10.1111/j.1440-1614.2006.01766.x

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: Toward an integrated conceptual framework. *Journal of Nervous and Mental Disease, 187*(4), 200-207. doi: 10.1097/00005053-199904000-00002

Silove, D., & Steel, Z. (2006). Understanding community psychosocial needs after disasters: Implications for mental health services. *Journal of Postgraduate Medicine, 52* (2), 121-125. Retrieved from: http://www.jpgmonline.com/text.asp?2006/52/2/121/25157

Skinner, E. A., & Zimmer-Gembeck, M. J. (2007). The Development of Coping. *Annual Review of Psychology, 58*, 119-144. doi: 10.1146/annurev.psych.58.110405.085705

Stanton, A., Danoff-Burg, S., Cameron, C., & Ellis, A. (1994). Coping through emotional approach: problems of conceptualization and confounding. *Journal of Personality and Social Psychology, 66*(2), 350-362. doi: 10.1037/0022-3514.66.2.350

Taylor, S., & Stanton, A. (2007). Coping resources, coping processes, and mental health. *Annual Review of Clinical Psychology, 3*, 377-401. doi: 10.1146/annurev.clinpsy.3.022806.091520

Tol, W., Komproe, I. H., Susanty, D., Jordans, M., Macy, R., & De Jong, J. T. (2008). School-based mental health intervention for children affected by political violence in Indonesia a cluster randomized trial. *JAMA, 300*(6), 655-662. doi:10.1186/1741-7015-12-56

Tousignant, M., Habimana, E., Biron, C., Malo, C., Sidoli-LeBlanc, E., & Bendris, N. (1999). The Quebec adolescent refugee project: Psychopatholoy and family variables in a sample from 35 nations. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(11), 1426 - 1432. doi: 10.1097/00004583-199911000-00018

van Rooyen, K., & Nqweni, Z. (2012). Culture and posttraumatic stress disorder (PTSD): a proposed conceptual framework. *Psychological Society of South Africa, 42*(1), 51-60. doi: 10.1177/008124631204200106

Table 1

Sample demographic characteristics (N = 50)

Characteristics	Whole sample (*N* = 50) *M* (*SD*) / *n* (%)	Intact (*n* = 20) *M* (*SD*) / *n* (%)	Non Intact (*n* = 22) *M* (*SD*) / *n* (%)
Demographics			
Participant age	16.63 (2.51)	17.00 (2.34)	17.05 (2.65)
Years resettled in Australia	4.35 (3.48)	5.58 (4.19)	4.03 (2.82)
Male gender	19 (38%)	10 (50%)	4 (18%)
City of residence			
Hobart	24 (48%)	13 (65%)	11 (50%)
Melbourne	26 (52%)	7 (35%)	11 (50%)
Recruitment source			
Educational Institution	37 (74%)	13 (65%)	20 (91%)
Health Clinics	13 (26%)	7 (35%)	2 (9%)
Country of birth			
Burma	15 (30%)	2 (10%)	5 (23%)
Sudan	3 (6%)	1 (5%)	2 (9%)
Kosovo	1 (2%)	1 (5%)	0
Afghanistan	5 (10%)	3 (15%)	2 (9%)
Pakistan	1 (2%)	0	1 (4%)
Guinea	1 (2%)	0	1 (4%)
Tanzania	1 (2%)	0	1 (4%)
Uganda	1 (2%)	0	1 (4%)
Nepal	6 (12%)	4 (20%)	2 (9%)
Syria	2 (4%)	1 (5%)	1 (4%)
Ethiopia	3 (6%)	1 (5%)	2 (9%)
Kenya	2 (4%)	0	2 (9%)
Rwanda	5 (10%)	5 (25%)	1 (4%)
Congo	1 (2%)	0	1 (4%)
Iran	2 (4%)	1 (5%)	1 (4%)
Bhutan	1 (2%)	1 (5%)	0

Table 2

Clinical characteristics

Clinical Characteristics	Whole sample (N = 50) M (SD) / n (%)	Intact (n = 20) M (SD) / n (%)	Non Intact (n = 22) M (SD) / n (%)	Statistical tests between intact and non-intact groups
PTSD Symptoms (CPSS)	13.06 (9.95)	11.05 (10.51)	16.91 (8.99)	t (40) = 2.19*
Total score at or above cut-off of 15 (CPSS)	20 (40%)	6 (30%)	13 (59%)	
Active Coping (CCSC)	2.76 (.54)	2.80 (.53)	2.87 (.45)	U = 195.00, z = -.63, p = .53
Avoidant Coping (CCSC)	2.72 (.64)	2.72 (.61)	2.84 (.58)	U = 191.00, z = -.73, p = .46
Support-Seeking Coping (CCSC)	2.13 (.60)	2.15 (.64)	2.14 (.60)	U = 219.50, z = -.01, p = .99

Note. Untransformed results have been presented for ease of interpretation.
CPSS = Child PTSD Symptom Scale; CCSC = Children's Coping Strategies Checklist.
p * <.05.

Table 3

Correlations between PTSD symptoms, coping dimensions and demographic characteristics

Spearman's rho	1.	2.	3.	4.	5.	6.	7.	8.
1. PTSD Symptoms (CPSS)	-	.02	.29*	.06	.13	-.04	.21	-.37*
2. Active Coping (CCSC)			.46**	.50**	.21	-.07	-.02	-.10
3. Avoidant Coping (CCSC)				.07	-.14	.01	-.02	-.11
4. Support-Seeking Coping (CCSC)					.22	-.06	.01	.00
5. Age						.03	.19	-.03
6. Years resettled in Australia							-.02	.19
7. Gender (1 = Male)								-.34*
8. Family separations (1 = Intact)								

Note. CPSS = Child PTSD Symptom Scale; CCSC = Children's Coping Strategies Checklist.
*Correlation is significant at the .05 level (2-tailed).
**Correlation is significant at the .01 level (2-tailed).

Table 4

Hierarchical multiple regression analysis with avoidant and active coping as predictors and family separations as covariate for PTSD symptoms

Predictor	*b*	SE *b*	*β*	*p*
Step 1: Family separations	-5.79	2.98	-.29	.06
Step 2: Avoidant coping (CCSC)	6.05	2.68	.39	.03*
Active coping (CCSC)	-3.29	3.14	-.18	.30

Note. CPSS = Child PTSD Symptom Scale; CCSC = Children's Coping Strategies Checklist.
R^2 = .09 for Step 1. ΔR^2 = .20 for Step 2.
* Significant at .05 level

Table 5

Hierarchical multiple regression analysis with avoidant coping as predictor and family separations a covariate for re-experiencing and arousal PTSD symptoms

Predictor	*b*	SE *b*	*β*	*p*
Step 1: Family separations	-3.08	1.81	-.26	.10
Step 2: Avoidant coping (CCSC)	2.34	1.42	.25	.12

Note. CPSS = Child PTSD Symptom Scale; CCSC = Children's Coping Strategies Checklist
R^2 = .07 for Step 1. ΔR^2 = .13 for Step 2.

Chapter 6. Differential Accounts of Refugee and Resettlement Experiences in Youth with High and Low Levels of PTSD Symptomatology: An Interpretative Phenomenological Investigation

6.1 Preamble to Empirical Paper

The following Chapter presents the second empirical study of the thesis. The aim of this paper was to gain a detailed and thorough understanding of the nature of the impacts of the refugee experience on a select group of adolescents from refugee backgrounds. The differences in accounts between adolescents who had high levels of PTSD symptomatology versus those with low symptom levels were specifically examined. The results of the study indicate that factors including adolescents' sense of belongingness and identity, familial and peer relationships and psychological functioning were particularly distinguishable between adolescents according to their levels of PTSD symptomatology. This study makes a significant contribution to the literature on PTSD and adaptational processes in general in refugee youth populations, given that there is a paucity of research into how psychosocial factors relate to psychopathology and wellbeing in refugee youth.

This article was submitted to the American Journal of Orthopsychiatry on 20th July, 2014. The American Journal of Orthopsychiatry is a multidisciplinary journal which publishes on topics which address topics concerning social justice, mental health and human rights. The journal has an impact factor of 1.60, with a five-year impact factor of 2.23. This paper has been formatted in accordance with the style specified by the editorial board of this journal.

Monash University

6.2 Declaration for Thesis Chapter 6

Declaration by candidate

In the case of Chapter 6, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Literature review, formulation of study design, data collection, data analysis and writing of paper.	70%

The following co-authors contributed to the work. Co-authors who are students at Monash University must also indicate the extent of their contribution in percentage terms:

Name	Nature of contribution
Dr. Glenn Melvin	Consultation in formulation of study design, data collection input, discussion of ideas expressed in manuscript and critical review of manuscript.
Prof. Louise Newman	Consultation in formulation of study design, data collection input, discussion of ideas expressed in manuscript and critical review of manuscript.

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature	[redacted]	**Date** 21/07/2014
Main Supervisor's Signature	[redacted]	**Date** 21/07/2014

Differential Accounts of Refugee and Resettlement Experiences in Youth with High and Low Levels of PTSD Symptomatology: An Interpretative Phenomenological Investigation

Lucy McGregor[a], Glenn A. Melvin[a] & Louise K. Newman[a].

[a] Centre for Developmental Psychiatry & Psychology

Department of Psychiatry

School of Clinical Sciences

Faculty of Medicine Nursing & Health Sciences

And

School of Psychological Sciences

Faculty of Medicine Nursing & Health Sciences

Centre for Developmental Psychiatry and Psychology

270 Ferntree Gully Rd, Building 1, Notting Hill VIC 3168, Australia

[redacted]

Corresponding author: Lucy McGregor

Centre for Developmental Psychiatry and Psychology

270 Ferntree Gully Rd

Building 1

Notting Hill VIC 3168, Australia

[redacted]

Abstract

Despite the multitude of studies into posttraumatic stress disorder (PTSD) in refugee populations, the utility of this diagnosis has come under increased debate and critique in recent years. This study was conducted in response to the call by many to broaden the conceptualisation and examination of PTSD in refugee populations, and used Interpretative Phenomenological Analysis (IPA) to gain a detailed and thorough understanding of the nature of the impacts of the refugee experience on a group of adolescents (N = 10) resettled in Australia. We specifically sought to explore whether adolescents' accounts of their refugee and resettlement experiences differed according to their level, 'high' or 'low', of PTSD symptomatology. The superordinate themes of *cultural belongingness and identification*, *psychological functioning*, *family unit functioning and relationships*, and *friendships and interpersonal processes*, were identified as having particular relevance for the study's participants and in distinguishing between participants with high and low levels of PTSD symptomatology. Findings were characterised by marked differences between adolescents' accounts according to their symptomatology levels, and may thereby inform important avenues for future research as well as clinical prevention and intervention programs with refugee youth.

Introduction

Posttraumatic stress disorder (PTSD) is one of the most frequently reported psychological conditions to be experienced by people from refugee backgrounds (Drury & Williams, 2012; Fazel & Stein, 2002). Despite evidence for its validity in refugee populations (Hinton & Lewis-Fernandez, 2011; Sack et al., 1997; van Rooyen & Nqweni, 2012), and consistent findings that a small but significant proportion of refugees experience the disorder (Fazel & Stein, 2002; Fazel et al., 2005), there remains ongoing controversy around the conceptualisation and the examination of the condition (De Haene et al., 2007; Porter, 2007).

Though the examination of PTSD has received particular emphasis in the refugee literature to date (Reed et al., 2012), many unanswered questions regarding the condition as it pertains to refugee populations prevail, including: why population prevalence rates of PTSD remain relatively low, despite the often considerable traumata refugees have endured (Drury & Williams, 2012; Fazel & Stein, 2005); whether the use of PTSD and other associated Westernised paradigms of mental health are appropriate and cross-culturally applicable to ethnically diverse populations (Borwick et al., 2013; Bracken, Giller, & Summerfield, 1995; Hinton & Lewis-Fernandez, 2011); the mechanisms behind the lack of psychosocial functional impairment in those who do meet clinical criteria for PTSD (Drury & Williams, 2012; Mels et al., 2010); and whether the focus on psychopathology in general, and PTSD specifically, as a major outcome of the refugee experience fails to explicate broader psychosocial and adaptive processes that may be impacted by the refugee experience (Porter, 2007; Silove, 1999).

In partly addressing some of the aforementioned critiques, Silove (1999) proposed an alternative theoretical approach (the *Adaptation and Persecution After Trauma model*; the ADAPT model) from which to view psychological impact of the refugee experience. He posited that investigating psychosocial adaptive processes that may be impacted by refugee

trauma may explicate intervening processes that link psychopathological outcomes, such as PTSD, to traumatic events. Indeed, research demonstrates that adaptive processes including coping strategies (Araya, Chotai, Komproe & De Jong, 2007; Sachs, Rosenfeld, Lhewa, Rasmussen & Keller, 2008; Seglem, Oppedal, Roysamb, 2014), emotional and social support (Fazel & Stein, 2012; Kovacev & Shute, 2004; Montgomery & Foldspang, 2007), positive familial relationships (Fazel & Stein, 2012; Rousseau et al., 1999), and maintaining a sense of faith and ideological conviction (Borwick et al., 2013; Sachs, Rosenfeld, Lhewa, Rasmussen & Keller, 2008), positively influence mental health in refugee populations. However, in comparison to adult studies, such findings with children and adolescent populations are relatively scarce (Fazel & Stein, 2012). Furthermore, there is a lack of evidence regarding the impact of adaptive processes on PTSD specifically, which may partially explain why we are yet to have a thorough understanding of the relatively low prevalence rates of the condition in refugee populations.

The present study draws influence from Silove's (1999) ADAPT model, the broader findings regarding adaptive and psychosocial processes implicated in refugee populations, and the aforementioned critique of the extant literature. In extending from much of the previous research on the topic, we sought to obtain adolescents' accounts of their refugee and resettlement experiences, in view of exploring possible psychosocial and adaptive mechanisms that may play a role in PTSD symptom profiles. We specifically sought to explore whether such factors differentiated those adolescents who had few symptoms, to those who had elevated levels of PTSD symptomatology. Importantly, we utilised a qualitative methodological approach, both in order to gain a detailed and thorough understanding of the nature of the impacts of the refugee experience on participants, but also to give voice to adolescents themselves, something which has been notably lacking in the literature to date (Borwick et al., 2013).

Methods

Participants

Participants who self-identified as being from a refugee background and were living in Hobart or Melbourne, Australia, participated in the study. Inclusion criteria for all participants comprised: (a) between 12 and 21 years of age; (b) residing in Australia for six months or more; (c) sufficient English capabilities if they did not wish to use an interpreter; and (d) consented for their interview to be audio-recorded and transcribed. Data was collected from between April, 2012 and August, 2013. Participants for the present study were selected from a larger participant pool, who had all completed the semi-structured interview and Child Posttraumatic Stress Scale (CPSS). Participants for the final sample were chosen based on the length and detail of their interview data, as well as whether they obtained particularly high or low CPSS scores. The final sample of 10 participants (8 females and 2 males), with 5 participants in each group. Participants were selected into the high group if they had CPSS scores above a cut-off score of 15, while participants were selected into the low group were selected if they had a CPSS score of 10 or below. Further demographic information pertaining to the participants' demographic information is shown in Table 1.

Measures

Semi-structured interview

Participants took part in a semi-structured interview, The Youth Experience Scale for Refugees (YES-R; Authors' names withheld, 2014), developed for use in this study. The interview schedule was developed to assess the *Adaptation and Development After Persecution and Trauma* model (the ADAPT model; Silove, 1999), as well as the authors' broader knowledge of issues experienced by youth from refugee backgrounds resettlement

and adaptational experiences. Prior to use with participants, the interview schedule was shown to three professionals who worked with youth from refugee backgrounds (two psychologists and one case worker), and a member of the Sudanese community who ran a volunteer-based community services agency. It was also piloted with a small sub-group of participants (n = 4). Minor changes to the administrative procedures of the interview schedule were made following this period of consultation and piloting.

The YES-R consists of open-ended questions, designed to explore participants' experiences of their refugee and resettlement journeys, in line with the five major adaptive systems of the ADAPT model (Silove, 1999): Safety and security (*Safety System*); Maintenance of bonds and interpersonal relationships (*Attachment System*); Effective mechanisms for administering justice (*Justice System*); Capacity to perform roles and uphold identity (*Identity/Role System*); and, ability to express aspirations that confer meaning (*The Existential-Meaning System*). Although the essence of the interview-schedule was followed for all interviews, questions were used flexibly, and were adapted or omitted where indicated, in order to promote individual participants' agency over the interview process.

Posttraumatic stress disorder (PTSD) symptomatology

The Child PTSD Symptom Scale (CPSS; Foa et al., 2001), a 17-item self-report inventory based on DSM-IV criteria, was employed to screen for symptoms of PTSD. The measure was designed to assess the presence and severity of PTSD symptoms in children and adolescents and has been applied to ethnically diverse populations (Jaycox et al., 2002; Jordans et al., 2010; Tol et al., 2008). The CPSS asks about the presence of PTSD symptoms over the past month on a four-point Likert scale, yielding a total score ranging from 0 – 51. The measure has three subscales, which correspond to symptom clusters as reported in the DSM-IV: re-experiencing, avoidance and arousal. A clinical cut-off score of 15, as recommended by the International Society for Traumatic Stress Studies (2013) for use with

this measure, is indicative of a high level of PTSD symptoms. The scale has adequate internal consistency (Jaycox et al., 2002) and external validity (Foa et al., 2001; Kassam-Adams et al., 2010).

Procedure

The current study was approved by Monash University and University of Tasmania Human Research Ethics Committees, and the Victorian and Tasmanian State Departments of Education and Early Childhood Development. Participants were recruited through the combined use of convenience and snowball techniques from consenting educational (two public secondary schools, an English language school, a Technical and Further Education Institution (TAFE) and a University, and community-based institutions (a hospital-based refugee health clinic and a local GP practice) in Melbourne and Hobart, Australia. Written consent was obtained from all participants, and, where younger than 18 years of age, from their parents or guardians. Translated versions of consent forms were made available in numerous languages (including Arabic, Burmese and Karen). Phone interpreters were also made available in cases where no written translated consent form was available in the parents/guardians' language and in instances where the participant reported that their parent/guardian was illiterate. A movie voucher was provided as an appreciation gift for participation in the study.

An initial pilot study was conducted with a small group of participants (n = 4) to test the feasibility of the study protocol. Only one participant chose to use an interpreter, despite the opportunity being offered to all. Interviews were conducted by LM, lasted between 30 and 90 minutes, and were audiorecorded, where participants gave written consent to do so.

Data analysis

Qualitative data analysis

Audiotaped interview transcripts were transcribed verbatim by LM and a research assistant (who transcribed four transcripts, which were checked for accuracy by LM upon completion). Given English was not participants' first language, the data were edited only to enhance readability (e.g., incorrect usage of pronouns). NVivo software (QSR International Pty Ltd., Version 10, 2012) was used for the coding of the data set.

Data were analysed using interpretative phenomenological analysis (IPA), as detailed by Smith, Flowers and Larkin (2009) and Braun and Clarke (2013). IPA was chosen for use in the present study given its focus on examining and detailing participants' idiographic accounts and interpretations of significant life experiences (Smith et al., 2009), and its ability to draw comparisons between the experiences of different groups (Braun & Clarke, 2013). As well as being rooted in phenomenology, IPA is underpinned by the researchers' own interpretative processes, and acknowledges that these are of a significant influence in the process of analysis (Braun & Clarke, 2013). As such, it is pertinent to note that the main author (LM) was a Caucasian, ethnic Australian, who had little contact with the participants prior to their partaking in the research project. Although she had prior experience in working with refugee populations, in recognising the fact that she could still bring preconceived views of the nature of refugees' experiences to her work with participants, a research journal was maintained throughout the project in order to enhance a reflective research process. The ontological position underpinning this research was critical realism (Braun & Clarke, 2013); participants' accounts of their experiences were taken as reality, but were considered in terms of pertinent historical, political and cultural contexts in which they operated (Opperman et al., 2013).

Data analysis was undertaken in accordance with procedures outlined by Smith, Flowers and Larkin (2009), and Braun and Clarke (2013). Data were analysed over a series of stages. First, familiarization with the dataset was achieved through the first author transcribing and reading through the interview data. Secondly, transcriptions were read through again, and initial impressions on the data were written informally in memo-form. Thirdly, initial coding was undertaken at three levels (in analysing the content of the transcript at a descriptive level, a semantic, and at an abstract or conceptual level) on each participant's transcript. Fourth, emergent themes were identified for each transcript, followed by the construction of subordinate themes based on connections and relationships between the transcript's emergent themes; both subordinate and emergent themes were named and defined. Steps one through five were undertaken for every participant. Finally, subordinate themes were reviewed across participants' transcripts, to look for differences and commonalities at an individual, within-group level, and also across participants at a between-group level. Subordinate theme titles were adjusted to reflect commonalities within and across groups. Themes that had particular salience within groups, and that differentiated across groups, were chosen for presentation in the present paper.

Results

Participant demographics

The sample consisted of a total of 10 participants (8 females and 2 males) who had been in Australia on average 6.5 years (*SD* = 3.99, range =.5 – 10 years) and were aged between 13 and 20 years (*M* = 17.5, *SD* = 1.96). There were 5 participants in the high CPSS group (4 female, 1 male; mean CPSS score = 26.8, *SD* = 9.07), and 5 in the low CPSS group (4 female, 1 male; mean CPSS score = 3.6, *SD* = 4.34). Further demographic statistics are summarised in Table 1.

IPA results

The analysis detailed a number of themes that were common across accounts of participants in the low group's accounts, and were of marked contrast or absent in those of the high group. Themes pertaining to: *cultural belongingness and identification*; *psychological functioning*; *family unit functioning and relationships*; and *friendships and interpersonal processes* were identified as having particular relevance for this study's participants, and in demonstrating particular contrasts between groups.

Cultural belongingness and identification

Low CPSS group

This theme was pertinent to all members of the low group's accounts. With the exception of Kato[2], all participants upheld strongly felt connections to their homelands, and a sense of identification with, and belongingness to, their cultures and customs. Yet they were not completely resolute: despite their strong ties with their homeland, participants also integrated aspects of Australian cultures and customs into their lives, and/or felt a sense of affiliation with aspects of Australian ways of life.

Hiwot, for instance, recalled her strong sense of connection to Rwanda upon returning to the country for a visit, "…you just feel really happy, like an overwhelming feeling of happiness and like you're supposed to be there. And really complete". Despite her ties with Rwanda and the resonance she felt with the way of life there, Hiwot believed that establishing ties to Australia was also important. She reported that she tried to learn about aspects of the Australia culture and, "…still keep my own culture but learn and integrate as opposed to completely shutting off one side". Eniola also endorsed a similar sentiment when giving

[2] All names and other identifying information has been changed to protect participants' anonymity

advice to others coming to Australia from similar backgrounds. She spoke of the importance for people not to lose ties to their cultural background when partaking in aspects of Australian culture, "… I just think integrate the two cultures… just have like a middle ground where you think well if I was where I am coming from, would I think that this is okay?".

Unlike the other participants of the low group, Kato demonstrated a strong sense of belongingness to Australia, as opposed to his birth country, Rwanda. He spoke keenly about how he enjoys aspects of the Australian culture, such as Australian Rules Football (AFL), and how he has always felt a sense of belongingness with Australia, as opposed to Rwanda. His felt "culture clash" he reported experiencing when he went back to Rwanda to visit relatives can be contrasted to his feelings about Tasmania (the state of Australia that he moved to and has stayed living in upon arriving to Australia as a 7 year old), "I've always recognised Tassie [Tasmania] as my home". For Kato, it appears that this sense of belongingness has come from his growing up considering himself as a typical Australian, as one of many who come to the country from a range of migrant backgrounds. For Kato, there was never any reason for him not to identify with being an Australian, as his quote regarding this topic emphasises, "It's what I know, it's what I am".

High CPSS group

In stark contrast to the low CPSS group, participants in the high CPSS group did not evidence strong ties to either their homeland or Australia. Unlike those of the low group, participants did not volunteer much information about their homelands, and appeared to maintain few ties and connections to their respective birth countries. They further evidenced a tendency to avoid thinking about ties to their home countries, perhaps indicating an association between their homeland and traumatic memories. Catherine, for instance, reported prior to the interview commencing that she did not wish to talk about things that had happened to her in the past, and, therefore understandably, volunteered little information

about her home country. In a similar vein, when asked if she had ever considered going back to Sudan, Mbali answered, “I never thought about that. I never think about it, I hardly do”. Also in contrast to the low group, participants did not evidence connections or identification with Australian culture either. Daara for instance, reported that, despite being in the country for 8 years, Australia still felt like a “foreign country” to him.

Psychological functioning

Low group

Insight into the nature of members of the low group’s psychological functioning, including reflective capacity, goal-directedness and ideological commitments, could be gleaned from their accounts. Participants were generally introspective, and demonstrated a high level of psychological insight particularly when discussing their thoughts pertaining to their and their family’s experiences as refugees. They further demonstrated a developed capacity to jointly think about and plan for their future, particularly regarding their educational and career goals. Further, participants held strong and well-formed moralistic beliefs and values, of which many of them reported trying to live their lives by.

Upon considering their past status as refugees and their families’ resettlement in Australia, participants generally demonstrated an ability to find meaning out of their situations and to be reflective as to how the events impacted upon them. In particular, they showed a propensity to compare themselves to others who they thought of as being less fortunate, and conclude that they in fact were “lucky” (to use Aela’s terms). Kabira, for example, spoke about her gratitude upon being allowed entry into Australia with her entire family, comparing her situation to fellow Syrians who had remained in the country:

> Thank God because I am here. I’m safe now, my and my family together, not like another people. Another people, the daughter is kept but her family no, her parents not. So everybody in Syria is maybe separate. But I stay with my family.

Hiwot, also compared her situation to that of her family's, and also demonstrated tendency to normalise her situation in the following account:

> …ask anyone from Africa, most African countries have been in some conflict or another. Not at the same rate, obviously, some things are worse than others. But so that was just the norm…to understand that your family…had lived through something, but back then we were so young, and coming to school it was easy for us…But now that we're older we look back and think how hard it would have been for the adults of our family, who knew, who had the history.

Having confidence in their choices regarding their future life-directions was an overarching trend for the low group's participants. Although many were yet to solidify their future plans, they demonstrated a clear sense of the direction in which they wished their lives to take, particularly with regards to their educational and career goals. Aela, for instance, spoke enthusiastically about how she wished to pursue a degree in psychology upon completing her schooling, and had already begun to think about the preparations she would need to make prior to her course commencing, "You know how year 12 finishes and you get a big holiday? During that time I'm going to work and I will prepare myself for uni. If I get an offer, I will prepare for that…get all the things I will need". While Eniola was clear in her convictions that she wished to stay living in Tasmania for the near future, despite some of her peers perceiving it to be an unfashionable decision, "I don't have to do what everyone [else] wants to do". Finally, Kabira demonstrated a likely propensity to face difficulties with an optimistic yet realistic attitude, and an aptitude to think of alternate options when faced with barriers. Her account detailing her plans for attending University in another country should she not be able to get in to an Australian institution illustrates this, "I said to my Mum, … if I can't go to University next year [in Australia], then maybe I study for two years or going to Arab country to complete my study".

Participants of the low group were also confident, and at times expansive, in discussing the ideals and morals by which they strive to live their lives. Kato described how the church "modelled" his moral beliefs and interpersonal behaviours, "…I guess like being grateful and like it's basically morals, like being nice to people…The church has sort of emphasised it so yeah I've just always followed that and done that". Likewise, Aela conducted her life according to religious ideals, and stated, "For me my religion is a big part of me and I support my religion in every way. I would never do something that goes against my religion".

High group

Participants in the high group demonstrated lower levels of reflectiveness compared to those in the low group. There was a further contrast in how they thought about and articulated their future plans, as well as an absence of discussion around their moralistic and life-values. Overall, it appeared that most of their thoughts were directed at managing situations in their lives that were occurring for them at the present time, and because of this they did not appear to have the capacity to think in higher-order, reflective terms.

Unlike the low group, participants in the high group generally evidenced a limited capacity to reflect upon their emotional states, instead preferring to use avoidance-based mechanisms when dealing with stressors. Daara, for instance, described how he avoided interacting with his family members upon arriving home, due to fractious relationships between himself and his father, "That's why I just go home on my laptop. I just talk with my mates, or watch movies". While Mbali described her tendency to avoid talking about emotionally uncomfortable topics, "I'm not really the type of person who says how I feel, so I just keep everything inside". In line with these findings, participants generally discussed little in the way of their inner emotional worlds, and did not demonstrate a high degree of psychological insight.

Regarding their future plans and goals, participants often spoke vagaries, with the exception of Catherine, who had clearly established future educational and career plans (although her future thinking process regarding other aspects of her life were comparably unclear). Although Dayo and Mbali reported that they had careers in mind upon leaving school, they were less detailed about the motivations for why they wished to pursue these career paths, and less expansive in their discussions about the topic than those in the low group. Mbali reported that she wished to be a history teacher, however did not evidence a clear plan for how to go about doing this, either in terms of the academic subjects she reported she had yet to choose for her year 12 subjects, nor in terms of a plan for undertaking university studies. Bageshri also evidenced a sense of uncertainty with which direction to take in her future studies and career pathway:

> (laughs) in Tuesday, the teacher came into the class and he was teaching us like our career (laughs). He just [asked] questions, like what do you want to do in the future, blah blah blah. But I don't know. I don't know in which course, in which field I am good. Still I don't know.

Bageshri's laughter in the above quote was interpreted at the time of the interview as being due to her finding the notion that someone coming to talk to her about her future career as ironic, given that she had little idea as to what she wanted to do in the future.

Finally, unlike those in the low group, high group participants did not evidence thinking about moralistic or ideological beliefs and values. Instead, some participants, like Daara, evidenced a lack of clarity regarding their thoughts on such matters. Daara reported that he used to be involved with gang activities, where he and fellow members got into fights with other youths. During this time, Daara said he, "always thought to myself, what am I doing, is that…right or wrong?". This account indicates that in some sense he felt that what he was doing was morally wrong (he also reported that he has distanced himself from these

peers, stating, "I actually try my best not to see them, like ever", providing further support for this supposition), however his account demonstrates that he was not entirely sure about where he stood on the matter. There was minimal content from the accounts of the other participants in the low group pertaining to this theme.

Family unit functioning and relationships

Low Group

Participants in the low group, with the exception of Kato[3], expressed strong intrafamilial relationships and connections. Family was conveyed as being of central importance to participants' lives. Participants also evidenced a shared sense of history with their families, they were largely aware of, and open in discussing, their family's refugee experiences. In line with this shared history, participants evidenced open lines of communication between themselves and their parents, and there were clear delineations and mutual understandings of people's roles within the family unit, as they pertained to things like house-work and chores. It is important to note that every participant in the low group lived in Australia within an intact family unit (i.e., with both parents and siblings), as this may have been a factor that would have contributed to the abovementioned processes.

Participants often spoke in collective terms when discussing their refugee and resettlement experiences, indicating that it was something they perceived they went through as a family together. For example, Aela, who arrived in Australia as an asylum seeker, said, "Well we did have a bit of a rough patch when we first came here because we came by boat and when we were on the seas it was quite hard for us". In a similar sense of family togetherness, Kabira indicated that while she finds it difficult to be in Australia without her Syrian friends, she now engages in joint social activities with her family instead, "…because

[3] Kato's interview was conducted in his family home, and his father was sitting in an adjacent room at the time of the interview. This may partly explain Kato's lack of discussion around family issues in the interview.

I don't have friend to [go] out with them, when we are going we always with my Mum or my sister… I have fun with my family".

Although it was not something the interview focussed on, participants spoke openly of their and their families' history as refugees. Kabira, for example, spoke of her intergenerational history of refugeedom, stemming from when her grandparents fled from Palestine to Syria, "My grandfather, he said to us, 'I don't leave another country, not like I did before'…because my grandparents, they left Palestine". Similarly, Eniola spoke about the way in which her family protected her from the impact of Rwanda's genocide, "…my parents tried really hard, 'cos I think after the genocide I was really traumatised and apparently when I saw people hug I burst into tears. So like they tried to shield us from that".

High group

In contrast to the low group, participants in the high group evidenced disruptions and difficulties within the family unit. There was also generally a lack of comparative openness in discussing their family's shared history, both in general terms and as it related to their refugee histories (with the exception of Dayo, who discussed the topic in great detail). For some participants, like Daara and Dayo, there were conflictual relationships between family members, while others, like Mbali and Bageshri, they were dealing with the impact of familial separations and attachment disruptions. It is important to note that four of the five participants in this group were residing in Australia with members of their immediate family either deceased or residing in other countries (Table 1). Unlike those in the low group whose families were intact, the impact of these separations appeared to be keenly felt by participants.

In stark contrast to the way in which members of the low group discussed their family relations, Catherine said, when discussing her family and the prospect of her moving away from them, "It's not that it's [family] is very important, I have a great attachment to my

family because I've never been away from them". This statement may be indicative of a need to minimise the importance of family connection, and the possible difficulty associated with this. Catherine's statement expresses contradictory thoughts about her family, which are suggestive of ongoing and unresolved anxiety about these relationships. While also in contrast to participants from the low group, Daara evidenced quite a pronounced sense of disrupted familial bonds. He stated of his older step-brother, "I hate him so much", his home-life in general, "when I go home I just don't feel right", and that his Dad "…doesn't like the way I am".

As mentioned, familial separations appeared to have a substantial direct, as well as flow-on effects on participants and their families. Bageshri, for instance, had moved to Australia with her husband, while the rest of her family unit had been granted refugee status in the United States of America. The emotional impact of this separation on Bageshri appeared to be very difficult for her to cope with, as she tearfully described in the interview, "…[it is] very hard. I miss my Mum and my family, but I miss my Mum so much". Dayo spoke openly and in detail about her family's refugee history, commencing when her father died in Uganda when she was an infant. She described living in a refugee camp characterised by transience and upheaval. Due to having a very large family and having only her mother as the primary caregiver, Dayo's mother had to leave the camp on many occasions to find work, leaving Dayo and her siblings living with various family members and family friends. Even upon resettlement in Australia, the effects of having only one primary caregiver still impacted upon Dayo and her family members, and the family had to be separated again (with two children moving to live with other people), due to her mother finding it "too hard to take care of all of us". The impact upon this separation of family members has resulted in changes to Dayo's family hierarchy. She spoke about having to now undertake many more chores around the house as a result of her sisters leaving, often leaving her feeling "frustrated" and

resulting in arguments with her mum. Finally, for Mbali, whose father had remained in Sudan, there appeared to be a sense that she had moved on from this relationship. She stated, "Dad is not here as well, he is in Africa… he has three other wives to look after, so yeah". Mbali's lack of emotion in this account perhaps indicates her feeling that her father is no longer a part of her life, particularly given that he has other obligations to "look after" his wives back in Africa; indeed, Mbali later said that she has not spoken to her father for some years.

Friendships and interpersonal processes

Low group

The theme of friendships and interpersonal processes could be applied to most participants of the low group's interviews. From those who discussed the topic, it was clear that friendships were important to them, and they took particular value in having peers from differing social circles and backgrounds.

Of his friendships, Kato said, "I love hanging out with my mates". He valued the fact that he had friends from a variety of social circles, and appeared to be confident and self-assured in his capacity to form and maintain relationships with a variety of people:

> I've got mates from church and school… Yeah the mates that I have from church are kind of different from my school mates. My school mates are like footy, and like Australian blokes and the ones from church aren't, but yeah I sort of like that.

Similarly, Eniola and Hiwot described having many Australian school friends, but valued the fact that they did not get involved in their peers' tendencies to only being friends with people from certain "groups". Hiwot, for example, said, "…you speak to people who are in like the whole group, not so popular, right through to the people who are very popular, you don't discriminate". While Eniola appeared to take pride in the fact that she formed friendships with those who were looked down upon by her peers, "…I just remember everyone bullying

her … through school and I was the only [one] who she could talk to. Sometimes I just used to ignore everyone and just go sit with her". Interestingly, Hiwot, Eniola and Kato all came from Rwanda.

Kabira, on the other hand, spoke about her difficulties with peer relationships in Australia. She reported that she found it difficult to fit in both with Australian people and with her classmates, who also share refugee backgrounds, but are from a variety of non-Arab countries, "…it's hard because I don't know about Australia… I don't know how I can talk with them [Australians]… or, for another refugee, like Nepal or Sudan…I don' know about them". Yet she still maintained strong ties with a close group of her Syrian friends, something that she indicated was helpful when she was having difficulties in adapting to life in Australia, as is illustrated in the following quote:

> Yes, so it's hard. But sometimes I can work with that, because I try to go with my friends in Syria and talking with them [on] skype. Sometimes I not worried about that because my friends still stay with me.

High group

With the exception of Dayo, who spoke in affectionate terms about her friendships, and Bageshri, who largely did not discuss the topic, the nature of interpersonal relationships and friendships of the other participants in the high group was qualitatively different to those in the low group. The accounts of Catherine and Mbali pointed to their possible social isolation, and while Daara reported that he valued his friendships highly, they were characterised as being transitory in nature.

Catherine evidenced particular difficulties with interpersonal relationships, particularly since arriving in Australia. Although she involved herself in various community groups and activities designed for young people her age, in a possible attempt to form meaningful interpersonal connections, she found her school peers were reticent to form

relationships with her, "…the first days it was very hard for me to find friends, and talk to people. For example, some students like looked down upon me, like they couldn't accept that I could do anything or that I could achieve anything". Mbali also experienced difficulties upon first arriving in Australia with her school peers, and spoke about how she had been bullied by others. Mbali's following account demonstrates her sense of vulnerability and alludes to her experience of significant stressors prior to coming to Australia, that she was then bullied by her peers subsequent to these experiences appeared to have compounded the impact:

> LM: What do you think the biggest issues, or the biggest challenges are for young people who come to Australia from a refugee background?
>
> Mbali: … I think mainly fitting in with the others, [the other] kids. Like, um no one really understands what you've been through…so like sometimes they say stuff or mean things, and they don't really know it gets to you.

Following the above quote, she went on to further say about her experience of being bullied, "'Cos you've already been through a lot, you don't want to go through a lot again".

Discussion

The present study's findings provide a rich account of some of the differentiating factors between select groups of youth from refugee backgrounds with high and low levels of PTSD symptomatology. While there was individual variation in participants' accounts, in general terms, the groups were distinguishable in the nature of issues they faced in the resettlement environment and in the way in which they dealt with and thought about them. Participants in the low group were characterised by their strong sense of cultural belongingness and identity, this was largely felt towards their respective homelands, with the exception of Kato, who reported a strong sense of belongingness to Australia. They were self-

reflective and insightful, and most found meaning out of their refugee experiences. They further demonstrated strong senses of moral beliefs and life values. The low group's core family units were intact, with family relationships characterised by affection and mutual understanding. Finally, participants in the low group generally demonstrated strong interpersonal bonds with peers from a variety of backgrounds.

In comparison to the low group, the content of the themes pertaining to the high group were generally of a starkly differing nature. Participants in the high group generally did not discuss issues of cultural belongingness, to either Australia nor their home countries, and of those who did discuss the topic, it was in terms of a felt disconnection. High group participants did not evidence the same level of psychological insight as those in the low group, and generally did not appear to engage in thinking reflexively about their past experiences as refugees, nor did they speak in detailed terms about their life or moralistic values. Instead, their thinking processes tended to be focussed on present-day concerns and stressors, and many appeared to use avoidant coping mechanisms when dealing with these stressors. The low group's family units were characterised by familial separations and, for one participant, acrimonious and conflictual relationships. Finally, while clearly being an important part of their lives for some, interpersonal relationships largely did not have the same resonance for participants in the high group compared to those in the low group, two participants in particular also had experienced pronounced interpersonal difficulties in the form of bullying and discrimination in their resettlement countries.

Participants of the low group in this study clearly perceived the importance of upholding a sense of connection with and belongingness to community. In likeness to other qualitative studies with resettled refugee youth (Gifford et al., 2009; Valentine, Sporton & Nielson, 2009) and adults (Keyes & Kane, 2004), for the majority of the participants in the low group, this identification and belongingness was felt towards their ethnic communities

and homelands. Participants of the high group, in contrast, largely evidenced a disconnect, not only from their homelands but also from aspects of Australian culture.

Early theorists wrote of belongingness as being a basic human need (Maslow, 1954; Thoits, 1982), while more recent writings on the concept of psychology of place have postulated that displacement may result in psychological difficulties due to the disruption of processes of place identity, familiarity and attachment (see Fullilove, 1996, for a review). Results from empirical research provide further evidence for the importance of this concept in refugee adolescents. In another study with resettled refugee adolescents in Australia, Kovacev and Shute (2004) found that those who had the most positive attitudes towards both Australian and their ethnic cultures had the highest self-worth and peer acceptance ratings, compared to those with negative attitudes in both domains. After going through the experience of being refugees, wherein ties and attachments to place are profoundly disrupted (Silove, 1999), maintaining a sense of connection and belongingness to place appears to be highly protective. Participants in the high group demonstrated that this is an aspect of their lives that is indeed disrupted, and, although directionality cannot be established from this study's findings, it may be that this is impacting upon their psychological difficulties.

Certain coping processes and the maintenance of ideological commitments have been found to be protective against psychopathology in refugee populations (Fazel et al., 2012; Lustig et al., 2004). That participants in the low group demonstrated using a variety of coping and, apparently, adaptive cognitive processes (such as their maintenance of strong moral and ideological beliefs) is perhaps illustrative of this notion. Optimistic thinking, problem-solving, normalisation, and ability to consider stressors from others' perspectives, all of which were evidenced by participants in the low group, have been found to relate to positive psychological outcomes (Ai, Tice, Whitsett, Ishisake & Chim, 2007; Compas et al., 2001). In comparison, there were some participants in the high group that demonstrated their use of

avoidant coping mechanisms, strategies that have been found in the adult refugee literature to relate to heightened PTSD symptomatology (Ai, Tice, Whitsett, Ishisake & Chim, 2007; Finklestein & Solomon, 2009; Hujits et al., 2012). Further preliminary evidence indicates that the maintenance of religious and ideological commitments is protective to resettled refugee youth (Goodman, 2004; Montgomery, 2008; Servan-Schreiber et al., 1998); that most participants in the low group discussed holding such beliefs provides further evidence that such processes may relate to positive mental health outcomes. Although the relationships between refugee trauma, psychological functioning, cognitive processes and ideological beliefs are undoubtedly complex (Fazel et al., 2012), this study provides important detailed accounts of the role that these processes play in many refugee adolescents' lives.

That the family unit played a significant role in both groups' accounts was to be expected, given that the refugee experience often imparts profound disruptions to families' makeup and functioning (De Haene et al., 2007; Gifford et al., 2009; McMichael et al., 2011), and because of the importance of the family to adolescents more generally (Parke & Buriel, 2008). Accounts from the low group's participants indicated their families' centrality to their lives, and the important protective roles their family, particularly their parents, played during refugee and resettlement experiences alike. These findings elaborate on evidence from the quantitative literature base, and concur with qualitative studies with refugee youth, that demonstrate that responsive and supportive caregiving as an important protective factor in young refugees' mental health (De Haene et al., 2007; Fazel & Stein, 2002; Gifford et al., 2009; Hodes, 2002; McMichael et al., 2011). Being separated from family members and a resultant change in familial structures and hierarchies is a common experience for refugee families (Gifford et al., 2009; Walter & Bala, 2004; Weine et al., 2004), and one that occurred for participants in the high group. In concert with other studies, findings from the present study demonstrated that such separations had significant effects on adolescents (such

as in the impact of changed familial roles and responsibilities and family structure) that continued well into the resettlement years (Gifford et al., 2009; McMichael & Manderson, 2004; Nickerson et al., 2010; Weine et al., 2004).

In likeness to the findings regarding the family unit, participants' accounts as they pertained to friendships and interpersonal processes give qualitative insights into established results from the quantitative literature. The protectiveness of supportive social relationships is a well-established finding in the refugee literature (Fazel et al., 2012; Lustig et al., 2004), and participants from the low group demonstrated that they had well-established, mutually supportive interpersonal relationships. Participants from the low group also spoke about how they maintained relationships with a variety of people, both with ethnic-peers and also, in most cases, with Australians. Such processes were demonstrated to relate to well-being outcomes in a study with adolescents in one of London's multiethnic communities (Bhui et al., 2005), wherein fewer mental health problems were demonstrated amongst adolescents who had friends from a range of cultural groups. Participants in the high group on the other hand, demonstrated transient interpersonal relationships and being victim to bullying and discrimination, an established correlate of negative mental health outcomes in resettled refugee populations (Fazel et al., 2012; Pederson & Thomas, 2013; Shedlin, Decena, Noboa & Betancourt, 2014).

Although the groups in the present study were small, the stark contrasts in accounts between those who had high levels of PTSD symptomatology versus those with low levels is notable. The findings from this study provide important avenues both for informing clinical interventions with refugee adolescent populations and in informing future research. The family unit's functioning was a major factor that distinguished the two groups in this study. Although there is a dearth of research examining how specific familial factors act in the aetiology of distress in refugee populations (De Haene et al., 2007; Fazel & Stein, 2012;

Weine et al., 2004), this study backs up established evidence attesting to the family unit's centrality in the lives of adolescents. Interventions which therefore focus on strengthening family relationships, particularly in those who have family separations, appear to be warranted. This study further demonstrates that interventions focussing on promoting adolescents' sense of cultural and social belongingness may also be warranted in refugee populations. Overall, high group participants were experiencing multiple stressors concurrently across different areas of their lives. The use of multimodal interventions, wherein difficulties at an individual, familial and socio-cultural level are addressed (Nickerson, Bryant, Silove & Steel, 2011) seem particularly worthwhile for these adolescents, and present an avenue for promising further research as to their efficacy in such populations (Tyrer & Fazel, 2014).

This study has several limitations that are of note. That the interview was conducted and interpreted by a Caucasian ethnic Australian may have had an effect on the nature of participants' responses, and also in the way in which the data were interpreted. Although the data analysis and sampling procedures were conducted with sensitivity to cross-cultural issues, it is impossible to tell if these factors did indeed play a role in the research process and findings. Further, in selecting the most detailed interviews for inclusion in this study may have skewed the sample towards older participants, who are likely to be more inclined to be open and reflective in discussing their experiences than younger children and adolescents.

Despite these limitations, findings from this study provide rich and detailed first-hand accounts of the issues faced by young people from refugee backgrounds in their resettlement, and also on the idiographic way in which their refugee and resettlement experiences are conceptualised. The marked differences in the issues faced, and the way in which experiences were discussed by adolescents in each group provide important clues as to the possible

correlates and protective factors implicated in PTSD, and provide important avenues for future enquiry into the condition in adolescents from refugee backgrounds.

References

Ai, A. L., Tice, T. N., Whitsett, D. D., Ishisaka, T., & Chim, M. (2007). Posttraumatic symptoms and growth of Kosovar war refugees: the influence of hope and cognitive coping. *The Journal of Positive Psychology, 2,* 55-65. doi: 10.1080/17439760601069341

Araya, M., Chotai, J., Komproe, I. H., & de Jong, J. T. (2007a). Effect of trauma on quality of life as mediated by mental distress and moderated by coping and social support among postconflict displaced Ethiopians. *Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care & Rehabilitation, 16,* 915-927. doi: 10.1007/s11136-007-9201-9

Borwick, S., Schweitzer, R., Brough, M., Vromans, L., & Shakespeare-Finch, J. (2013). Well-being of refugees from Burma: a salutogenic perspective. *International Migration, 51*(5), 91-105. doi: 10.1111/imig.12051

Bhui, K., Stansfeld, S., Head, J., Haines, M., Hillier, S., Taylor, S., Viner, R., & Booy, R. (2005). Cultural identity, acculturation, and mental health among adolescents in east London's multiethnic community. Journal of Epidemiology and Community Health, 59(4), 296-302. doi: 10.1136/jech.2003.014456

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995). Psychological responses to war and atrocity: the limitations of current concepts. *Social Science and Medicine, 40,* 1073-1082. doi: 10.1016/0277-9536%2894%2900181-R

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research a Practical Guide for Beginners*. London, UK: SAGE Publications Ltd.

Compas, B. E., Connor-Smith, J. K., Saltzman, H., Harding Thomsen, A., &

Wadsworth, M. E. (2001). Coping with stress during childhood and adolescence: problems, progress and potential theory and research. *Psychological Bulletin, 127(1),* 87-127. doi: 10.1037//033-2909.127.1.87

De Haene, L., Grietens, H., & Verschueren, K. (2007). From symptom to context: a review of the literature on refugee children's mental health. *Hellenic Journal of Psychology, 4,* 233-256. doi: 10.1080/17542863.2012.713371

Drury, J., & Williams, R. (2012). Children and young people who are refugees, internally displaced persons or survivors or peretrators of war, mass violence and terrorism. *Current Opinion in Psychiatry, 25,* 277-284. doi: 10.1097/YCO.0b013e328353eea6

Fazel, M., & Stein, A. (2002). The mental health of refugee children. *Archives of Disease in Childhood, 87,* 366-370. doi: 10.1136/adc.87.5.366

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet, 365,* 1309-1314. doi: 10.1016/S0140-6736(05)61027-6

Finklestein, M., & Solomon, Z. (2009). Cumulative trauma, PTSD and dissociation among Ethiopian refugees in Israel. *Journal of Trauma & Dissociation, 10*(1), 38-56. doi: 10.1080/15299730802485151

Foa, E. B., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30*(3), 376-384. doi: 10.1207/S15374424JCCP3003_9

Fullilove, M. T. (1996). Psychiatric implications of displacement: Contributions from the psychology of place. *The American Journal of Psychiatry, 153*(12), 1516-1523. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/8942445

Gifford, S., Correa-Velez, I., & Sampson, R. (2009). *Good Starts for recently*

arrived youth with refugee backgrounds: promoting wellbeing in the first three years of settlement in Melbourne, Australia. La Trobe Refugee Research Centre.

Goodman, J. H. (2004). Coping With Trauma and Hardship Among Unaccompanied Refugee Youths From Sudan. *Qualitative Health Research, 14*(9), 1177-1196. doi: 10.1177/1049732304265923

Hinton, D. E., & Lewis-Fernandez, R. (2011). The cross-cultural validity of posttraumatic stress disorder: implications for DSM-5. *Depression and Anxiety, 28,* 783-801. doi: 10.1002/da.20753

Hodes, M., Jagdev, D., Chandra, N., & Cunniff, A. (2008). Risk and resilience for psychological distress amongst unaccompanied asylum seeking adolescents. *Journal of Child Psychology and Psychiatry, 49,* 723-732. doi: 10.1111/j.1469-7610.2008.01912.x

Hujits, I., Kleijn, W. C., Van Emmerik, A. A., Noordhof, A., & Smith, A. J. (2012). Dealing with man-made trauma: the relationship between coping style, posttraumatic stress, and quality of life in resettled, traumatized refugees in the Netherlands. *Journal of Traumatic Stress, 25*, 71-78. doi: 10.1002/jts.21665

Jaycox, L., Stein, B., Kataoka, S., Wong, M., Fink, A., Escudero, P., & Zaragoza, C. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(9), 1104-1110. doi: 10.1097/01.CHI.0000020261.43550.30

Jordans, M., Komproe, I. H., Tol, W., Kohrt, B., Luitel, N., Macy, R., & De Jong, J. T. (2010). Evaluation of a classroom-based psychosocial intervention in conflict-affected Nepal: a cluster randomized controlled trial. *Journal of Child Psychology and Psychiatry, 51*(7), 818-826. doi: 10.1111/j.1469-7610.2010.02209x

Kassam-Adams, N., Marsac, M., & Cirilli, C. (2010). Posttraumatic stress disorder symptom structure in injured children: Functional impairment and depression symptoms in a confirmatory factor analysis. *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(6), 616-625. doi: 10.1016/j.jaac.2010.02.011

Keyes, E. F., & Kane, C. F. (2004). Belonging and adapting: mental health of Bosnian refugees living in the United States. *Issues in Mental Health Nursing, 25,* 809-831. doi: 10.1080/01612840490506392

Kovacev, L., & Shute, R. (2004). Acculturation and social support in relation to psychosocial adjustment of adolescent refugees resettled in Australia. *International Journal of Behavioral Development, 28*(3), 259-267. doi: 10.1080/01650250344000497

Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J., Keane, T., & Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child and Adolescent Psychiatry, 43,* 24-36. doi: 10.1097/00004583-200401000-00012

Maslow, L. A. (1954). *Motivation and Personality* (1st ed.). New York: Harper.

Authors' names withheld. (2014). *The Youth Experience Scale for Refugees*. Unpublished instrument.

McMichael, C., Gifford, S. M., & Correa-Velez, I. (2011). Negotiating family, navigating resettlement: family connectedness amongst resettled youth with refugee backgrounds living in Melbourne, Australia. *Journal of Youth Studies, 14,* 179-195. doi: 10.1080/13676261.2010.506529

McMichael, C., & Manderson, L. (2004). Somali Women and Well-Being: Social Networks and Social Capital among Immigrant Women in Australia. Human Organization, *63*(1), 88-99. doi: 10.1080/13676261.2010.506529

Mels, C., Derluyn, I., Broekaert, E., & Rosseel, Y. (2010). The psychological impact

of forced displacement and related risk factors on Eastern Congolese adolescents affected by war. *Journal of Child Psychology and Psychiatry, 51,* 1096-1104. doi: 10.1111/j.1469-7610.2010.02241.x

Montgomery, E. (2008). Long-term effects of organized violence on young Middle Eastern refugees' mental health. *Social Science and Medicine, 67,* 1596 - 1603. doi: 10.1016/j.socscimed.2008.07.020

Montgomery, E., & Foldspang, A. (2007). Discrimination, mental problems and social adaptation in young refugees. *European Journal of Public Health, 18*(2), 156-161. doi: 10.1093/eurpub/ckm073

Nickerson, A., Bryant, R. A., Brooks, R., Steel, Z., Silove, D., & Chen, J. (2011). The familial influence of loss and trauma on refugee mental health: a multilevel path analysis. *Journal of Traumatic Stress, 24*(1), 25-33. doi: 10.1002/jts.20608

Nickerson, A., Bryant, R. A., Steel, Z., Silove, D., & Brooks, R. (2010). The impact of fear for family on mental health in a resettled Iraqi refugee community. *Journal of Psychiatric Research, 44,* 229-235. doi: 10.1016/j.jpsychires.2009.08.006

Opperman, E., Braun, V., Clarke, V., & Rogers, C. (2013). "It feels so good it almost hurts"" Young adults' experiences of orgasm and sexual pleasure. *Journal of Sex Research, [Epub ahead of print]*, 1-13. doi: 10.1080/00224499.2012.756982

Parke, R., & Buriel, R. (2008). Socialization in the family: ethnic and ecological perspectives. In W. Damon & R. Lerner (Eds.), *Child and adolescent development. An advanced course*. Hoboken, New Jersey: John Wiley & Sons.

Pedersen, A., & Thomas, E. F. (2013). "There but for the grace of God go we": Prejudice toward asylum seekers. Peace and Conflict: Journal of Peace Psychology, 19(3), 253-265. doi: 10.1037/a0033738

Porter, M. (2007). Global evidence for a biopsychosocial understanding of

refugee adaptation. *Transcultural Psychiatry, 44,* 418-439. doi: 10.1177/1363461507081639

QSR International. (2012). NVIVO 10 [Computer Software]. Available from http://www.qsrinternational.com

Reed, R., Fazel, M., Jones, L., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *Lancet, 379,* 250-265. doi: 10.1016/S0140-6736(11)60050-0

Rousseau, C., Drapeau, A., & Platt, R. (1999). Family trauma and its association with emotional and behavioral problems and social adjustment in adolescent Cambodian refugees. *Child Abuse and Neglect, 23,* 1263-1273. doi: 10.1016/S0145-2134%2899%2900100-3

Sack, W., Seeley, J., & Clarke, G. (1997). Does PTSD transcend cultural barriers? A study from the Khmer Adolescent Refugee Project. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 49 - 54. doi: 10.1097/00004583-199701000-00017

Sachs, E., Rosenfeld, B., Lhewa, D., Rasmussen, A., & Keller, A. (2008). Entering exile: trauma, mental health, and coping among Tibetan refugees arriving in Dharamsala, India. *Journal of Traumatic Stress, 21*(2), 199-208. doi: 10.1002/jts.20324

Seglem, K. B., Oppedal, B., & Roysamb, E. (2014). Daily hassles and coping dispositions as predictors of psychological adjustment: A comparative study of young unaccompanied refugees and youth in the resettlement country. *International Journal of Behavioral Development, 38*(3), 293-303. doi: 10.1177/0165025414520807

Servan-Schreiber, D., Lin, B. L., & Birmaher, B. (1998). Prevalence of

posttraumatic stress disorder and major depressive disorder in Tibetan refugee children. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*, 874-879. doi: 10.1097/00004583-199808000-00018

Shedlin, M., Decena, C., Noboa, H., & Betancourt, O. (2014). Sending-country violence and receiving-country discrimination: effects on the health of colombian refugees in ecuador. *Journal of Immigrant and Minority Health, 16*, 119-124. doi: 10.1007/s10903-013-9777-9

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: toward an integrated conceptual framework. *Journal of Nervous and Mental Disease, 187(4),* 200-207. doi: 10.1097/00005053-199904000-00002

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis. Theory, Method and Research*. London: SAGE Publications.

Thoits, P. A. (1982). Conceptual, Methodological, and Theoretical Problems in Studying Social Support as a Buffer Against Life Stress. *Journal of Health and Social Behavior*, *23*(2), 145-159. doi: 10.2307/2136511

Tol, W., Komproe, I. H., Susanty, D., Jordans, M., Macy, R., & De Jong, J. T. (2008). School-based mental health intervention for children affected by political violence in Indonesia a cluster randomized trial. *JAMA, 300*(6), 655-662. doi:10.1186/1741-7015-12-56

Tyrer, R. A., & Fazel, M. (2014). School and community-based interventions for refugee and asylum seeking children: a systematic review. *PLoS ONE, 9*(2), e89359. doi: 10.1371/journal.pone.0089359

Valentine, G., Sporton, D., & Nielsen, K. B. (2009). Identities and belonging: a study of Somali refugee and asylum seekers living in the UK and Denmark. *Environment and Planning D: Society and Space, 27*(2), 234-250. doi: 10.1068/d3407

van Rooyen, K., & Nqweni, Z. (2012). Culture and posttraumatic stress disorder (PTSD): a proposed conceptual framework. Psychological Society of South Africa, 42(1), 51-60. van Rooyen, K., & Nqweni, Z. (2012). Culture and posttraumatic stress disorder (PTSD): a proposed conceptual framework. *Psychological Society of South Africa*, *42*(1), 51-60. doi: 10.1177/008124631204200106

Walter, J., & Bala, J. (2004). Where meanings, sorrow and hope have a resident permit: Treatment of families and children. In J. P. Wilson & B. Drozdek (Eds.), *Broken spirits the treatment of traumatized asylum seekers, refugees, war, and torture victims* (pp. 487-519). New York: Brunner-Routledge.

Weine, S., Feetham, S., Kulauzovic, Y., Besic, S., Lezic, A., Mujagic, A.,Muzurovic, D., Spahovic, D., Zhubi, M., Rolland, J. & Pavkovic, I. (2004). In K. Miller & L. Rasco (Eds.), The mental health of refugees: ecological approaches to healing and adaptation. Mahwah, NJ: Lawrence Erlbaum

Table 1

Participant demographic characteristics at time of the interview

	Low Group					High Group				
Demographics	Kabira	Aela	Eniola	Hiwot	Kato	Catherine	Bageshri	Daara	Mbali	Dayo
Age	18	16	19	17	17	19	20	18	18	13
Sex	f	f	f	f	m	f	f	m	f	f
Birth country	Syria	Afghanistan	Rwanda	Rwanda	Rwanda	Congo	Bhutan	Afghanistan	Sudan	Uganda
Years residing in Australia	0.5	10	10	10	10	1.5	1	8	7	7
City of residence	Hobart	Melbourne	Hobart	Hobart	Hobart	Hobart	Hobart	Melbourne	Hobart	Melbourne
CPSS Score	2	0	10	0	6	35	17	26	19	37
Familial living arrangements and separations	Parents, 2 siblings.	Parents, 3 siblings. 1 sibling at University, Sydney.	Parents, 3 siblings.	Parents, 3 siblings.	Parents, 3 siblings.	Parents, 2 siblings. 1 sibling at University, Brisbane; 1 in Africa.	Husband's family. Biological family in USA.	Parents, 3 siblings.	Mother, 2 siblings. Father and other siblings interstate / Africa.	Mother, 5 siblings. Father deceased. Other siblings with other families.

Note: Pseudonyms have been allocated, and some specific details have been altered to maintain anonymity; f = female, m = male; CPSS = Child PTSD Symptom Scale.

Chapter 7. A Qualitative Exploration of the Validity of the Adaptation and Development after Persecution and Trauma (ADAPT) Model with Resettled Refugee Adolescents in Australia

7.1 Preamble to Empirical Paper

The following Chapter presents the third and final empirical study of the thesis. The aim of this paper was to examine the applicability of a proposed model of refugee adaptation, the *Adaptation and Development After Trauma* (the ADAPT model; Silove, 1999), to adolescents' refugee and resettlement experiences. The literature on refugee populations has been dominated by studies that have conceptualised the impacts of the refugee experience in psychopathological terms, with research into broader psychosocial and adaptational processes scarce. This study found preliminary evidence for the validity of the ADAPT model to adolescents' self-described refugee and resettlement experiences. This study makes important contributions to the literature in demonstrating that adaptational processes may be affected by the refugee experience, and provides a more complex understanding of the role of psychosocial factors as they relate to adolescents' refugee and resettlement experiences.

This article was submitted to the Journal of Transcultural Psychiatry on the 4th of June, 2014 and is currently under review. The Journal of Transcultural Psychiatry draws on the disciplines of cultural psychology, medical anthropology and psychiatric epidemiology and publishes on topics concerning the social and cultural determinants of psychopathology. The journal has an impact factor of 0.99, and a five-year impact factor of .00. This paper has been formatted in accordance with the style specified by the editorial board of this journal.

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Monash University

7.2 Declaration for Thesis Chapter 7

Declaration by candidate

In the case of Chapter 7, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Literature review, formulation of study design, data collection, data analysis and writing of paper.	70%

The following co-authors contributed to the work. Co-authors who are students at Monash University must also indicate the extent of their contribution in percentage terms:

Name	Nature of contribution
Dr. Glenn Melvin	Consultation in formulation of study design, data collection input, discussion of ideas expressed in manuscript and critical review of manuscript.
Prof. Louise Newman	Consultation in formulation of study design, data collection input, discussion of ideas expressed in manuscript and critical review of manuscript.

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature	[redacted]	**Date** 21/07/2014
Main Supervisor's Signature	[redacted]	**Date** 21/07/2014

A Qualitative Exploration of the Validity of the Adaptation and Development after Persecution and Trauma (ADAPT) Model with Resettled Refugee Adolescents in Australia

Lucy McGregor[a], Glenn A. Melvin[a] & Louise K. Newman[a].

[a] Centre for Developmental Psychiatry & Psychology

Department of Psychiatry

School of Clinical Sciences

Faculty of Medicine Nursing & Health Sciences

And

School of Psychological Sciences

Faculty of Medicine Nursing & Health Sciences

Centre for Developmental Psychiatry and Psychology

270 Ferntree Gully Rd, Building 1, Notting Hill VIC 3168, Australia

[redacted]

Corresponding author: Glenn A. Melvin

Centre for Developmental Psychiatry and Psychology

270 Ferntree Gully Rd

Building 1

Notting Hill VIC 3168, Australia

[redacted]

Abstract

Refugee adolescents endure high rates of traumatic exposure, as well as subsequent resettlement and adaptational stressors. Research into the effect of trauma on refugee populations has focussed on examining psychopathological outcomes, in particular Posttraumatic Stress Disorder (PTSD). Yet this approach has questionable cross-cultural relevance, and fails to explicate the psychosocial and adaptive impacts of the refugee experience. The ADAPT model proposes an alternate conceptualisation of the refugee experience, in theorising that refugee trauma may challenge five core psychosocial adaptive systems, and it is the impact on these systems that may lead to psychological difficulties. This study examined the validity of the ADAPT model to adolescents' (n = 43) accounts of their refugee and resettlement experiences. Deductive thematic analysis was used to analyse responses to a semi-structured interview. The ADAPT model was found to be a valid paradigm from which to conceptualise the impact of adolescents' refugee and resettlement experiences, but with individual variation in the salience of particular adaptive systems to individuals' experiences. Findings are discussed in light of our current understandings of the psychological impact of the refugee experience on adolescents.

Keywords: refugees; adolescence; adaptation; theory

Introduction

Refugeedom is an inherently multifaceted phenomenon, imposing unique stressors on youth who are forced into such circumstances (Papadopoulos, 2007). Prior to their resettlement, refugee youth endure cumulative, often prolonged traumata, including exposure to warfare, involuntary displacement, and separations from family members (Almqvist & Brandell-Forsberg, 1997; Papageorgiou et al., 2000; Rousseau, Drapeau, & Platt, 1999). Significant stressors, including coping with loss, grief and trauma (Momartin, Silove, Manicavasagar, & Steel, 2004), discrimination (Lindencrona, Ekblad, & Hauff, 2008) (Shedlin, Decena, Noboa, & Betancourt, 2014), financial insecurity (Lindencrona Ekblad, & Hauff, 2008; Porter & Haslam, 2005), educational and occupational challenges (Beiser & Hou, 2001) often continue in the resettlement period.

While research demonstrates that there are significant psychological impacts resulting from such pre and post-migration experiences, the prevalence rates of psychopathological conditions, including posttraumatic stress disorder (PTSD), are lower than expected, given rates of traumatic exposure (Fazel, Wheeler, & Danesh, 2005; Silove, 1999; Steel, Silove, Phan, & Bauman, 2002). A comprehensive meta-analysis, for example, found that 9% of adult and 11% of child and adolescent resettled refugees were diagnosed with PTSD (Fazel Wheeler, & Danesh, 2005).While these rates are higher than age-matched general populations, they demonstrate that the vast majority of refugees do not develop clinical levels of psychopathology (Bronstein & Montgomery, 2012; Silove, 1999; Steel Silove, Phan, & Bauman, 2002). This raises questions as to the applicability of the PTSD diagnosis to diverse cultural groups and fundamental issues as to the cultural shaping of response to stress and trauma (Bracken, Giller, & Summerfield, 1995; Hinton & Lewis-Fernandez, 2011), as well as the possibility that there are other, as yet understudied factors, that might be at play in acting

to confer risk or protection in the manifestation of psychological distress (Porter, 2007; Silove, 1999).

In response to these issues, Silove (1999) has proposed a theoretical framework from which to study the psychological impact of the refugee experience. Citing early works with Holocaust survivors (e.g., Bergmann & Jucovy, 1982; Krell, 1997), Silove (1999, para. 16) writes that the experience of persecution and gross violations of human rights may "…exert more pervasive effects on adaptation than is encompassed by the symptoms included in the more recent formulation of PTSD". Examining processes of adaptation that may be impacted and impaired by traumata endured during refugee experiences may explicate intervening process that link psychological functioning to trauma events (Krell, 1997), and thus provide deeper understandings of the factors that act to confer protection and/or risk in the development of psychopathology.

The Adaptation and Development after Persecution and Trauma (ADAPT) model (Silove, 1999), posits that traumata endured by refugees and trauma survivors impacts upon five key psychosocial domains, or 'adaptive systems' (Silove, 1999). The five adaptive systems as they are described in the ADAPT model are described below, with linkages made to the broader literature base on adolescent populations where indicated, in order to operationalise constructs for use in the present study.

The Safety System

In discussing this component of the model, Silove (1999) cites literature on the impact of threat to life on the development of PTSD. There is established evidence that the likelihood of developing PTSD increases with the degree of perceived personal threat, and degree of exposure from the index trauma(s) (Dyregrov, Gupta, Gjestad, & Mukanoheli, 2000; Reed, Fazel, Jones, Panter-Brick, & Stein, 2012). Further, for many refugees, their

sense of safety is repeatedly challenged by what Silove (1999) terms ongoing "threats" (although the nature of these threats is not explicated) in the resettlement environment (Steel, Silove, Bird, McGorry, & Mohan, 1999). It is this further and continual challenge to their sense of safety and security that may act in the development and maintenance of psychopathology, particularly PTSD (Silove, 1999).

Resettled refugees are often the subject of racism and discrimination (Gifford, Correa-Velez, & Sampson, 2009; Pedersen & Thomas, 2013), with a recent Australian longitudinal study finding over a third of participants had been discriminated against due to their ethnicity or religion (Gifford et al., 2009). The broader literature base indicates that such events can have significantly detrimental impacts on mental health (see Priest et al., 2013 for a review). In examining this component of the model for the current study, we conceptualised the safety system as being based jointly upon the impact of exposure to trauma, and the experience of perceived threats, particularly racism and discrimination, in the resettlement environment.

The Attachment System

Separations and loss of family members and friends is a key component of the refugee experience (Rousseau, Rufagari, Bagilishya, & Measham, 2004; Silove, 1999), and have been demonstrated to be a significant contributing and correlating factor to various psychopathological outcomes (Authors' names withheld, Manuscript Submitted; Nickerson et al., 2011; Nickerson, Bryant, Steel, Silove, & Brooks, 2010). While the presence of social support has been found to be a notable protective factor in mental health of refugee youth (Fazel, Reed, Panter-Brick, & Stein, 2012; Mohlen, Parzer, Resch, & Brunner, 2005). Silove (1999) writes that the refugee experience may further impart symbolic losses (e.g., , a loss of a connection to place, of continuity between generations and of culture) upon refugees, and these may also act to cause disruptions to one's sense of belongingness and connection to

family, peers, and ethnic heritage in general (Eisenbruch, 1991; Silove, 1999). Thus, for the present study, the attachment system was conceptualised in terms of the nature of family and peer relationships, but also in terms of connection to participants' homelands and cultures.

The Justice System

Many refugees endure events that could be categorised as extreme human rights violations, including torture and forced betrayal (Carswell, Blackburn, & Barker, 2011; Silove, 1999). A sense of profound injustice may result from such experiences, and may stay with the victim for many years following the event(s). For some such refugees, Silove writes that they may experience chronic anger and rage as psychological responses to the injustices they were victim to, resulting in a clinical picture dominated by interpersonal aggression.

Adolescents and children are unfortunately not exempt from enduring torture and human rights violations prior to resettlement (Neugebauer et al., 2009; Slodnjak, Kos, & Yule, 2002), and evidence demonstrates that some refugee youth may too present with anger and aggressiveness, (Lustig et al., 2004; Mollica, Poole, Son, Murray, & Tor, 1997). For this paper therefore, the justice system was conceptualized in broad, yet developmentally-appropriate terms, and was coded when adolescents spoke of outward or felt expressions of anger and perceived injustices.

The Existential-Meaning System

Silove (1999) posits that exposure to traumatic events associated with the refugee experience may "shake the foundations of the survivor's faith in the beneficence of life and humankind (para. 27)". Resultantly, they may face a crisis in their sense of faith and trust in the world, and the meaning systems they hold more generally. Given the centrality of religion to many refugees' meaning systems, and (in inferring from the broader literature), the

potential for religious faith to be negatively impacted after experiencing human-inflicted trauma (Falsetti, Resick & Davis, 2003; Seirmarco et al., 2012), religion was conceptualised for this study as being an important part of the existential meaning system, as were participants' self-described moral values and beliefs.

The Identity/Role System

Well into their time in resettlement, refugees are faced with continually changing circumstances and associated uncertainties. Coupled with the disruptions to cultural, familial, educational and occupational connections, refugees face numerous threats to their identity and self-concept (Silove, 1999). Silove proposes that there may be linkages between such disruptions and subsequent feelings of passivity and hopelessness, and resultant psychopathology.

The challenges to refugee adolescents' identity systems may be markedly different to those faced by adults. While many adults resettle already having likely established, at least prior to their experiences as refugees, some sense of who they are as a person, children and adolescents are still in the process of making and forming such beliefs (Erikson, 1968; Meeus, 2011). It therefore is important to consider how the refugee experience may impact the development of identity, as opposed to the disruption of identity per se. Indeed, pertinent life-events as well as cultural and societal influences have been implicated in processes of identity-development (Grotevant, 1987). In likeness with other components of the study, the attachment system was therefore conceptualised in line with Silove's (1999) writings pertaining to the system, but in line with adolescent developmental norms.

Refugee children and adolescents are frequently categorised in the extant literature in dichotomous terms: they are "vulnerable" , yet "resilient" (Bronstein & Montgomery, 2011; Carlson, Cacciatore, & Klimek, 2012). Whilst there is undoubtedly truth to both standpoints,

it emphasizes the fact that we do not yet have nuanced understandings as to how psychopathological outcomes are manifest in populations of refugee youth (Betancourt & Khan, 2008; Porter, 2007; Silove, 1999). Studies with refugee populations are dominated by quantitative approaches, which focus on identifying diagnosable psychiatric symptomatology and conditions (Berman, 2001; Khawaja, White, Schweitzer, & Greenslade, 2008; Summerfield, 1999). This approach fails to consider the individualised nature and the broader psychosocial and adaptive consequences of the refugee experience (Papadopoulos, 2007; Silove, 1999). The aim of the present study therefore, was to begin to provide such detailed understandings into the impact of the refugee experience on young refugees. We sought to explore the applicability of the ADAPT model to adolescents' accounts of their refugee and resettlement experiences, in order to establish preliminary evidence for its validity in a population of refugee youth, and to examine the influences of the refugee experience on adolescents' adaptive processes as conceptualized by the ADAPT model.

Methods

Participants

A final sample of 43 young people who self identified as being from a refugee background, and were living in Hobart or Melbourne, Australia, participated in the semi-structured interview. Inclusion criteria for all participants comprised: (a) between 12 and 21 years of age; (b) residing in Australia for six months or more; (c) sufficient English capabilities if they did not wish to use an interpreter; and (d) consented for their interview to be audio-recorded and transcribed. Data was collected from between April, 2012 and August, 2013.]

Measures

Semi-structured interview

Participants took part in a semi-structured interview, The Youth Experience Scale for Refugees (YES-R; Authors' names withheld, 2014), was developed for use in this study. The interview schedule was developed based heavily on the ADAPT model (Silove, 1999), as well as the authors' broader knowledge of issues experienced by youth from refugee backgrounds resettlement and adaptational experiences. Prior to use with participants, the interview schedule was shown to three professionals who worked with youth from refugee backgrounds (two psychologists and one case worker), and a member of the Sudanese community who ran a volunteer-based community services agency. It was also piloted with a small sub-group of participants (n = 4). Minor changes to the interview schedule and administration were made following this process.

The YES-R consists of open-ended questions, designed to explore participants' experiences of their refugee and resettlement journeys, in line with the five major adaptive systems explicated in the ADAPT model (Silove, 1999): Safety and security (*Safety System*); Maintenance of bonds and interpersonal relationships (*Attachment System*); Effective mechanisms for administering justice (*Justice System*); Capacity to perform roles and uphold identity (*Identity/Role System*); and, ability to express aspirations that confer meaning (*The Existential-Meaning System*). Although the essence of the interview-schedule was followed for all interviews, questions were used flexibly, and were adapted or omitted where indicated, in order to promote individual participants' agency over the interview process.

Procedure

The current study was approved by Monash University and University of Tasmania Human Research Ethics Committees, and the Victorian and Tasmanian State Departments of

Education and Early Childhood Development. Participants were recruited through the combined use of convenience and snowball techniques from consenting educational (two public secondary schools, an English language school, a Technical and Further Education Institution (TAFE) and University and community-based institutions (a hospital-based refugee health clinic and a local GP practice) in Melbourne and Hobart, Australia. Written consent was obtained from all participants, and, where younger than 18 years of age, from their parents or guardians. Translated versions of consent forms were made available in numerous languages (including Arabic, Burmese and Karen). Phone interpreters were also made available in cases where no written translated consent form was available in the parents/guardians' language and in instances where the participant reported that their parent/guardian was illiterate. A movie voucher was provided as an appreciation gift for participation in the study.

An initial pilot study was conducted with a small group of participants (n = 4) to test the feasibility of the study protocol. Only one participant chose to use an interpreter, despite the opportunity being offered to all. Interviews were conducted by the first author, lasted between 30 and 90 minutes, and were audiorecorded, where participants gave written consent to do so. Four participants (9%) did not consent to interviews being recorded and written notes were taken in lieu of audio-data. Due to the inability to carry out thematic analysis on this data, results from these participants are not included in this report.

Data analysis

Audiotaped interview transcripts were transcribed verbatim by the first author and a research assistant (who transcribed four transcripts, which were checked for accuracy by the first author upon completion). Given English was not participants' first language, the data

were edited only to enhance readability (e.g., incorrect usage of pronouns). NVivo software (QSR International Pty Ltd., Version 10, 2012.) was used for the coding of the data set.

Data were analysed using largely deductive thematic analysis (TA; Braun & Clarke, 2006), but were also partly driven by an inductive approach. TA is a method of data analysis which identifies, analyses and reports patterns (themes) of meaning across a dataset. Deductive TA is driven by a 'top down' approach, wherein the analysis is driven by, and based upon an overarching theoretical paradigm, in this case the ADAPT model (Braun & Clarke, 2006; Silove, 1999). The ontological position underpinning this research was critical realism (Braun & Clarke, 2013); Participants' accounts of their experiences were taken as reality, but were considered in terms of pertinent historical, political and cultural contexts in which they operated (Opperman, Braun, Clarke, & Rogers, 2013). We, correspondingly, were driven partly by the five systems of the ADAPT model in developing themes, but participants' accounts also informed much of the coding and data analysis process (hence the inductive component; Braun & Clarke, 2006).

The process of TA was conducted over a series of stages. First, familiarization with the dataset was achieved through the first author transcribing and reading through the interview data. Initial codes were generated based on both semantic as well as latent content, as it related to the ADAPT model. Thirdly, the coded information was collated into themes, which were then classified into hierarchies (i.e., overarching themes, themes and sub-themes) by identifying commonalities between groups of code and in accordance with the ADAPT model. Following a final review of the codes, themes and their definitions, cross-coding was carried out by two independent raters who had no involvement in the research but were experienced in qualitative data analysis, to check the validity of the coding scheme. For this process, 25% of the interviews were randomly selected, and the authors' coding schemes were checked for accuracy. There were processes in place should cross-coders disagree with

the authors' coding scheme, however these were not required as the cross-coders were in agreement.

Results

Participant demographics

The sample consisted of a total of 43 participants, 26 female and 17 male, who had been in Australia on average 4.43 years (range 6 months – 11 years) and aged between 12 – 21 (M = 16.58; SD = 2.62). Further demographic characteristics pertaining to the study's participants are presented in Table 1.

Applicability of the ADAPT model to adolescents' accounts of their refugee and resettlement experiences

In broad terms, results of the thematic analysis revealed that the ADAPT system, with the possible exception of the justice system, was a valid conceptual framework from which to view participants' experiences as refugees and in resettling in Australia. The content of participants' qualitative accounts could be categorized into all components of the model, although there were some parts of the model that were more relevant than others to adolescents' accounts. Importantly and expectedly, there was individual variation in the salience of components of the model to individuals' refugee and resettlement experiences.

In examining the component parts of the model, the attachment, existential-meaning and identity/role systems were particularly relevant in participants' accounts of their refugee and resettlement experiences. These systems were further found to be particularly applicable to this study's participants because they encompassed issues and life-circumstances that were relevant for the majority of the participants' developmental stage. In comparison, while there was some content that was coded under the safety and justice systems, they were spoken

about in peripheral terms and by only a small subset of the sample. This was especially so for the justice system, relevant content for which was markedly limited.

The following section details the results of the thematic analysis pertinent to each of the five systems.

Safety

While over half of the participants discussed the topic of safety, it was not something they spoke about in great detail, demonstrating that it did not appear to be an issue of concern for the majority. When the topic was discussed, it was largely in terms of Australia being characterized as a "safe" place in comparison to the countries from which participants had originated, due to an absence of war and violence. For instance, Daara[4] [M; 18 years] stated, "…I'm safe here, like I don't have to wake up in the morning and think about oh how am I going to survive today, like Afghanistan it's like that but here it's not". Many Burmese participants contrasted their experiences of safety in Australia to those they experienced in transit in India and Malaysia, wherein they felt threatened because of their refugee status. Burmese participant Hla [F; 13], for example, spoke of feeling "scared of people" in India because of her status as a refugee, and compared this to Australia where she appeared to hold a sense of trust in Australians, who were described as "good", "nice and kind".

For some, like Aela [F; 16], a feeling of safety in Australia came with an associated sense of freedom, "Here is such a safe place and I can do what I want". For these participants, with safety came the ability to pursue opportunities and engage in activities in Australia that were not afforded to them in their homelands.

The issue of racism and discrimination was bought up by only a minority of participants. Daud [M; 13] for example, reported that his main concern in Australia was "being accepted". When asked if he had experiences of feeling unaccepted in Australia he

[4] All names have been changed to protect participants' and others' anonymity

responded, “No, but for some reason everyone seems to think that all Muslims are terrorists”. A small subset of participants also spoke of experiencing racism, and the subsequent sadness and hurt as a result. Mbali [F; 18] was one such participant who spoke about the hardship of experiencing bullying at school. She was particularly affected by the fact that teachers around her did nothing to help her when she was faced with these experiences, “…kids will always be kids and they don’t know what they’re saying, but the adults around them should take notice at least. Cos at [School’s name not reported to protect anonymity] they were useless”. This quote may also illustrate her feelings of injustice towards her teachers who did nothing to assist her, in line with the justice adaptive system of the ADAPT model. With the exception of the abovementioned instances, these results are contradictory to those found by Gifford, Correa-Velez and Sampson (2009), who found resettled youth had extensive experiences of racism directed toward them.

Attachment

Family attachment relationships

Family ties were spoken of in terms of their central importance in participants’ lives. For the majority of participants, their immediate family was characterized by mutually affectionate and supportive relationships. Many participants cited examples of ways in which their family members supported them throughout their refugee experience and in resettling and adapting to life in Australia. For example, Eniola [F; 19] spoke of how her parents protected her when she was a young child having recently moved to Australia from Rwanda:

> I mean my parents tried really hard ‘cos I think after the genocide I was really traumatized and apparently when I saw people hug I burst into tears. So like they tried to shield us from that like a lot like they wouldn’t let us see the bad side and they like really babied us.

While Kabira [F; 20] discussed how her father provides emotional support and encouragement to her and her siblings in adapting to their lives in Australia, "He told me, 'You don't need to learn English, English is coming to you! So … all your dreams, it's coming to you' Yeah so he's say always like this, for encourage us". These examples provide illustrations of the role that parents play in supporting their children emotionally throughout all phases of their refugee experiences, and corroborate wider research findings that children who go through such experiences unaccompanied fare worse than those who have a parent with them (Huemer et al., 2009).

For a minority of participants, the family represented a source of stress, which often appeared to have significant impacts upon their emotional wellbeing. Further, much of the stress within participants' families had apparent links to circumstances they were in as a result of their experiences as refugees. For example, Jack [M; 16], described feeling "scared when I sleep", because of his concerns about his family's future in Australia, "…my father didn't have a job and my mother they can't speak English. They don't know anything…I need to get a job and keep going at school". While Daara [M; 18] reported feelings of guilt over the strained relationship he held with his father, possibly partly due to, as the following quote illustrates, his father coming to Australia as an asylum seeker:

> …my Mum tells me it's your Dad, like he risked his life getting here, 'cos he was a boat refugee, and he risked his life to get here, just so you could have a better future, but like you're not taking advantage of that. You're not taking life seriously, you should listen to him.

Approximately half of the participants were separated from immediate family members (both through death as well as family members being resettled and/or moving elsewhere), whilst nearly all participants spoke of being separated from members of their broader family unit. Participants frequently spoke of the emotional difficulty both they and

their family members experienced because of such separations, like Edris [M; 18], who describes the angst his mother experiences due to his older sister remaining in Iran: "…from my mum's side, her body's here but her brain and heart's over there [in Iran]…things are hard for my mum…she cries all the time, talks about her [his sister]". These findings can be likened to that of studies with adult refugees, wherein separation from family members who remained in their countries of origin related to increased emotional distress (Nickerson et al., 2010; Rousseau, Mekki-Berrada, & Moreau, 2001), as well as findings from a previous study with the same participant pool as the present study, wherein PTSD symptoms were significantly elevated in youth who had resettled without members of their immediate family compared to those whose families were intact (Authors' names withheld, Manuscript under review). Finally, when asked about what they missed about their homelands, almost every participant reported that they missed their family members who remained.

Peer attachment relationships

Adolescence is a crucial period for the developing importance of peer relations (Allen, 2008). This is reflected in participants' interview results, in which peers were frequently mentioned and were spoken of in terms that indicated their centrality to their daily lives and emotional wellbeing. Kabira [F; 20] for example, spoke about how she often thought about returning to Syria because she was missing her friends, "sometimes, when I miss my country, I miss my friends, I say I want to go back to my country. Because this is the first time for me without my friends".

With the exception of a few participants who had been in Australia since they were young children, many participants distinguished between the sorts of relationships they had with Australian-born versus those they had with peers from similar ethnic and refugee backgrounds. While friendships with Australian-born peers were undoubtedly seen as important and emotionally fulfilling, they were characterized by many as necessary in order

to “fit in” with peers at school, and by others as something that was necessary to improve conversational English skills. They thus conveyed a sense that relationships with Australian-born peers were of a different quality to those they held with their ethnic peers, partly due to the shared cultural values they held with peers of the same ethnicity, as illustrated by Kagiso [F; 20] when she discussed the importance of having friends from African backgrounds:

> It’s important ‘cos I enjoy their company because having that shared thing with a person, like, you can make like inside jokes about weird things that your parents do that are so weird and peculiar and I can’t tell, like, my Australian born friends…

In accordance with Silove’s (1999) writing of a sense of belonging and social cohesion being an important component of the attachment system under the ADAPT model, there were a minority of participants whose sense of belonging appeared to be compromised in Australia, partly because of a lack of peer relations. Kabira [F; 20] for example, spoke extensively about how she missed her friends in Syria. Having resettled in Tasmania, where there were few other Syrians at the time, she found it difficult to fit in with her classmates at TAFE who were from various other ethnic backgrounds, but also difficult to find friendships with Australians:

> …sometimes it’s hard because I don’t know about Australia… I don’t know how I can talk with them [Australians], if you like this question or not, or you like this or not, yeah. And or, for another refugee, like [from] Nepal or Sudan, or another … I don’t know about them, I don’t know how or what I’m talking about [with] them. Yeah because it’s different culture, different everything.

The above quote indicates potential feelings of isolation expressed by Kabira. Due to her perceived differences between both Australian as well as her classmates (also of refugee backgrounds), she may have felt she lacked the capacity to form attachment relationships with these peers.

Extended social circle attachment relationships

Although not discussed in comparable detail to peer or family relationships, participants did endorse holding important interpersonal relationships with people in their social networks, particularly with 'family friends' from their ethnic background that they socialized with at family gatherings and at church. Interestingly, four Tasmanian participants spoke of the crucial role volunteers played in assisting their families settle in Australia, while no Melbourne participants reported such experiences. For these participants, they likened the volunteers to members of the family, and still maintained ongoing relationships with them years after their initial involvement, in a testament to their importance in their friendship network. Ife [F; 19], for example, stated of her volunteers, "And I would say to you, Andrew and Catherine was not just a volunteer for us, they was family for us and still, and still".

The Justice System

Findings relating to the justice system were few. Only two participants discussed issues that may be interpreted as them experiencing a sense of injustice, as is described in the ADAPT model. For one of these participants, Aela [F; 16], she spoke of her apparent incomprehension as to why terror attacks are carried out in her homeland of Afghanistan:

> These stupid people just come in their cars and they just shoot everything, just like that. It is very stupid what they think in their heads and then they call themselves religion. It says in the Quran that killing others is wrong, then they kill others and call themselves very religious and Muslims, you know seriously, what are you gaining out of it outside of innocent killings and lots of blood spillings, they gain nothing out of it.

For this participant, carrying out terror attacks in the name of Islam was to her fundamentally unjust, not only because the attacks were carried out against innocent people but also because they contradicted her notions of what it means to be a Muslim.

The other participant, Kabira [F; 20], who discussed issues pertaining to the justice system spoke about how she felt loyal to the Syrian government at the time because she was of Palestinian heritage, and the Syrian government had taken her family in as refugees. Like Aela, she too described what may be interpreted as a lack of comprehension over the reasoning behind the civil war, particularly because of its origins between Syrian people themselves. Her account indicates what may be a sense of incomprehension regarding the nature and cause of the war, "It's hard because err when you fighting with Syrian people, not with another one from another country, Syrian with Syrian people…why are you fighting?".

There was one participant, Daara [M; 18], who evidenced direct expressions of aggression, in line with Silove's (1999) writings on the justice system. Much of his anger, or self-described feelings of "frustration", appeared to be as a reaction to hostile familial relations, particularly stemming from times when his father had kicked him out of home, as illustrated by the following quote:

> … every time, every time I'd been kicked out, it was because my Dad was telling me stuff, and I wouldn't agree with it, and then, I'd end up getting violent and I'd punch the walls and stuff, and that's why I just get, frustrated.

The Existential-Meaning System

Unlike much of the description of the Existential Meaning System in Silove's (1999) original paper, wherein some refugees who have experienced torture are described as having a "crisis of trust, faith and meaning (para. 27)" in their lives, the majority of participants in this study appeared to hold coherent, and in many cases strong, belief and value systems.

Religious values

Religion was reported as being a significant part of many participants', and their families', lives. Perhaps due to their developmental stage, for many of the younger participants, their religious practices were spoken about in terms of them being something

that they ‘just did’, and were not reflected upon. Nonetheless, for many of these younger participants, religion appeared to be a central and unquestioned part of their lives, and was something they planned on continuing to maintain into adulthood.

Older participants were more reflective of the reasoning behind their religious practices and faith-based belief systems. For many, faith appeared to provide direction and an overarching sense of meaning, as Kagiso [F; 20] explained:

> I think at a time when I felt lost and such things it was that lack of faith because it’s been the thing that I’ve been grounded on for most of my life, and my life does not work without faith, like I don’t work without it.

Religious values were overtly dismissed by only a minority of participants. For one of these participants, Daara [M; 18], this may have been attributed to his experiences as a refugee from Afghanistan, “I dunno I don’t believe in religion I reckon it’s just the reason to kill each other”.

Meaning systems, moral values and beliefs

In likeness to the way in which participants spoke of religious values, it was the older participants who spoke of the belief and meaning systems they held. By and large, participants’ meaning and value systems appeared to have been influenced by their experiences as refugees and their resettlement in Australia. For these participants, it appeared that rather than facing a crisis in trust, faith and meaning, they had been shaped by their experiences as refugees and felt a stronger sense of meaning and direction in their lives as a result. In the main, they did not appear to begrudge their countries for their having to flee, as a quote by Kabira [F; 20] illustrates, “So Syria is like my homeland, like my mum. It’s not good to say no they are not good. But it’s war, it’s war, and nobody like war, so we escape from that”. Another participant, Ela [F; 20], however, was a notable exception to this. Although she was born in a refugee camp in Nepal, her family were forced to flee Bhutan.

Ela said, “but I really really hate Bhutan. I really don’t like it”, after a conversation was held about the human rights violations of the Bhutanese government towards its people. This quote perhaps illustrates her internalization of some of the abuses the country has imparted against her family and her people, and as a result, although she has never lived there before, she feels hatred towards the place.

There was also a strong sense that most participants felt, while acknowledging they experienced great hardship and danger as refugees, that they in fact have been lucky in their experiences, and that there are many opportunities available to them as a result. For example, Aela [F; 16], said:

> I will never take things for granted. I have so much here. I cherish everything here, I don’t sit here and think I don’t have this but this person has that. A lot of people don’t even have what I have, I have a roof over my head and other people don’t. So I consider myself extremely lucky.

While Kagiso [F; 20] discussed the positive side to her experiences as a refugee:

> …that’s the greatest thing about the whole you know going through that whole displacement, not having anywhere you belong and stuff like that is at the end when you do arrive you have or in [the] case of my family…we’re all given like kind of unlimited opportunity… and we have support and there’s possibilities and great people, good country…And that’s the best thing about it, like, that’s what it has given me and my sisters and my family.

Identity/Role System

As with the other systems of the model, not all participants’ interviews were detailed enough as to ascertain a sense of their self-concept. While this likely related to a range of factors (including language ability, personality characteristics and the focus and length of the interview), participants’ age is thought to have been a factor, with, again, older participants

being more inclined to discuss topics that indicated their sense of self, and to have the capacity for reflection and self-awareness to enable them to undertake such conversations (Byrne & Shavelson, 1996; Sebastian, Burnett, & Blakemore, 2008).

Most participants who were in their late adolescence did demonstrate a coherent and assured sense of self. They generally evidenced an understanding of their own emotional worlds, as well as a sense of how their peers and family members perceived them as people. In demonstrating not only their insight into their own self-concept but also their perceived importance of a coherent sense of self, many participants stressed that it was something they recommended other young people from refugee backgrounds foster in themselves. Kato [M; 16], for example, spoke of how important it was for young people from refugee backgrounds to embrace a sense of self in order to promote their adaptation to Australia, "…embrace who you are. As well as just being yourself, 'cos the teenage years are weird for anybody, no matter what culture. So if you can…be your own person during your teenage years, you'll do well". Indeed, this was a sentiment that was echoed by other participants, who, in giving advice to other young people from refugee backgrounds, said to "just be yourself (Hiwot [F; 17])", and "don't change your personality (Laura [F; 19])" when settling in Australia.

Discussion

Overall, the results of the current study provide preliminary evidence for the validity of the ADAPT model, with the possible exception of the justice system, as a means of conceptualizing the impact of the refugee and resettlement experience on adolescents from refugee backgrounds. The attachment, existential-meaning and identity/role systems had particular relevance to the participants' resettlement and refugee experiences, while, in comparison, the safety system, and, in particular, the justice system, did not. At an individual level, the findings demonstrated the validity of the domains to adolescents' experiences, but

individual variance in the salience of particular adaptive systems. This is to be expected, given that refugee and resettlement processes, as well as the ways in which people cope and adapt to such experiences, are highly individualised.

Silove (1999) conceptualized the safety system as impacting upon refugees due to both pre-migratory trauma experiences and resettlement 'threats'. Questions regarding pre-migratory traumatic experiences were omitted from the interview schedule (due to concerns over possible re-traumatisation), and were only discussed in instances where the participant brought the topic up themselves. This may account for a lack of data pertinent to the safety system as it relates to pre-migration trauma experiences. That there were relatively few findings in relation to participants' experience of racism and discrimination in the resettlement environment, is, however, unexpected, and contrary to findings obtained in a study with refugee adolescents resettled in Melbourne (Gifford et al., 2009). Given the interviewer is of a Caucasian, ethnic Australian background and had not had extensive dealings with the participants prior to their involvement in the study (unlike the participants in Gifford Correa-Velez and Sampson's [2009] study), they may have been reluctant to discuss such topics with the interviewer. Despite this, some participants did report experiencing racism and discrimination, and it was clear from their accounts that this had a lasting and negative impact upon them.

Much of the content of the participants' interviews was highly applicable to the ADAPT model's attachment system. It was clear that their experiences as refugees had shaped and influenced the nature of attachment relationships, particularly with regards to separations from family members. In concert with findings with adult refugees (Nickerson et al., 2010), unaccompanied minors (Huemer et al., 2009), and an earlier study by the current authors (Authors' names withheld, manuscript submitted), separations from family members were reported by participants as being a significant stressor for themselves and their family

members. Importantly, these findings provide qualitative accounts of the nature of such experiences and the self-reported impacts they have on participants, thus contextualizing and expanding upon those of the aforementioned quantitative studies.

In line with developmental norms (Allen, 2008), most participants' accounts demonstrated the centrality of peer relations in their lives. Notably, the nature of relationships with Australian peers versus those with peers of similar ethnic backgrounds were spoken of by many in qualitatively different ways; relations with peers from similar ethnic backgrounds were often characterized by mutual understanding and commonalities, whereas relationships with Australian peers were, for some participants, comparatively instrumental. These processes may be indicative of the concept of integration (Berry, 1997), wherein aspects of the host-society are adopted (in this case instrumental social relationships with Australian peers) that may benefit the adoptee, whilst ties to ethnic identities and cultures (in this case friendships with ethnic peers) are maintained (Berry, 1997; Jorden, Matheson, & Anisman, 2009; Schweitzer, Melville, Steel, & Lacherez, 2006).

There were minimal findings in relation to the justice system of the ADAPT model. Given that the interview directed few questions towards participants' refugee experiences, there may not have been opportunity for participants to discuss topics that were pertinent to this aspect of the model. Another possibility is that this aspect of the model was not implicated in participants' refugee experiences, with the exception of one participant, who experienced feelings of "frustration" and behavioural disruption due to intrafamilial conflict that appeared to have some relationship to the family's experience as refugees. Silove (1999) related this component of the model to the specific experiences of torture survivors, an experience that has been shown to engender profound effects on victims' sense of justice. It may be that the nature of traumata young people in this study experienced were of a different

quality to those that would be endured in torture survivors, thereby not engendering the same nature of response.

The majority of participants in this study appeared to hold strong and coherent moralistic and religious beliefs. Rather than being quashed by their refugee experience, many participants spoke in a manner that demonstrated their meaning systems were shaped and solidified by what they had been through. This relates to others' findings that some youth may experience heightened appreciation for life and spiritual growth following traumatic events (Meyerson, Grant, Carter, & Kilmer, 2011). Research has also demonstrated that religious and spiritual ideologies may be deepened by traumatic experiences (Shaw, Joseph, & Linley, 2005). In line with these findings, many young people expressed feelings of appreciation of their life circumstances (and yet still recognized the hardships they endured as refugees), and many expressed deeply held religious beliefs that were of central importance in their lives.

Many participants, particularly the older ones, gave accounts that demonstrated that they were insightful and self-reflective as to their own psychological functioning, and that they had age-appropriate senses of identity and self-concept. This was particularly telling when many stressed that other young people of refugee backgrounds should maintain a strong sense of self in order to enhance their adaptation to life in Australia. For these participants, it appears that they have reflected on their own processes of adaptation to life in Australia, and concluded that maintaining a grounded sense of self-identity helps in this process. While Silove (1999) postulates that refugees' sense of identity may be compromised by the refugee experience, the qualitative accounts provided by these adolescents would indicate that, at least for some of the present study's sample, this was not the case. This may be partly explicated by the fact that participants were recruited primarily from educational institutions, and were therefore engaged in important developmentally-appropriate educational pursuits.

Undertaking a similar study with a group of adolescents whose educational experiences have been disrupted, and who are not engaged in such educational programs, may produce results more in line with Silove's original conception of this system.

While this study demonstrates preliminary evidence for the validity of the model, the nature of the qualitative data demonstrates that the model takes on a distinctly different meaning for this study's participants to what Silove (1999) originally conceptualized. While Silove writes about how refugees' and torture survivors' sense of safety, attachments to others, self-concept and sense of meaning and religious faith may be disrupted and profoundly negatively impacted by the refugee experience, for the most part, participants in this study conveyed the sense that these facets of their life were largely functioning well and, in the case of the existential-meaning system, had even been enhanced. However, it is important to note that Silove constructed this model based on the premise that psychopathology in refugees may be explicated partly by the negative impact the refugee experience has on adaptive systems. Thus, his writings focus on how the refugee experience may disrupt, as oppose to enhance, adaptational processes. Given that we did not specifically seek to ascertain the negative impact of the refugee experience on participants' adaptational processes, and that this research was conducted with a community-based sample, these findings in some respects are unsurprising. Nonetheless, they demonstrate that the refugee experience may enhance young people's processes of adaptation, not unlike the literature on posttraumatic growth following traumatic refugee experiences (Powell, Rosner, Butollo, Tedeschi, & Calhoun, 2003). They also provide important preliminary data regarding the applicability of the model to a community sample of adolescents, subsequent research with clinic-based or other select groups would provide important comparative data to these findings.

This study has several limitations that are of note. Firstly, in not explicitly questioning participants about aspects of their pre-migratory refugee experiences, we may have not ascertained important information pertinent to aspects of the ADAPT model, particularly with regards to the safety and justice systems. The cross-sectional design of the study further restricts conclusions as to the relationships between aspects of the refugee experience and the adaptational processes of refugee youth, and as such, follow-up and longitudinal studies would be recommended in further studies examining such concepts in these populations.

Despite these limitations, this study provides important preliminary evidence for the validity of the ADAPT model to refugee adolescents' refugee and resettlement experiences. We demonstrated that adaptational systems as described in the ADAPT model, with the possible exception of the justice system, are impacted and affected by the refugee experience. That there were commonalities across adolescents' accounts, particularly with regards to the importance of family relations and having a strong sense of self-identity, provides grounds for the tailoring of programs and interventions to adolescents who may experience difficulties in such domains. While the findings pertaining to individual differences in the resonance of particular adaptive systems lend themselves to further research examining the impact of such individualised processes on adolescent outcomes.

References

Allen, J. (2008). The attachment system in adolescence. In J. Cassidy & P. Shaver (Eds.), *Handbook of Attachment, Second Edition: Theory, research, and clinical applications* (Second ed.). New York: Guilford Publications.

Almqvist, K., & Brandell-Forsberg, M. (1997). Refugee children in Sweden: post-traumatic stress disorder in Iranian preschool children exposed to organised violence. *Child Abuse and Neglect, 21*(4), 351-366. doi: 10.1016/S0145-2134(96)00176-7

Authors' names withheld. (Manuscript submitted). Familial separations, coping styles, and PTSD symptomatology in resettled refugee youth.

Beiser, M., & Hou, F. (2001). Language acquisition, unemployment and depressive disorder among Southeast Asian refugees: A 10-year study. *Social Science and Medicine, 53*(10), 1321-1334. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/11676403

Bergmann, M., & Jucovy, M. (Eds.). (1982). *Generations of the Holocaust.* New York: Basic Books.

Berman, H. (2001). Children and war: Current understandings and future directions. *Public Health Nursing, 18*(4), 243-252. doi: 10.1046/j.1525-1446.2001.00243.x

Berry, J. W. (1997). Immigration, Acculturation, and Adaptation. *Applied Psychology: An International Review, 46*(1), 5-34. doi: 10.1111/j.1464-0597.1997.tb01087.x

Betancourt, T. S., & Khan, K. T. (2008). The mental health of children affected by armed conflict: Protective processes and pathways to resilience. *International Review of Psychiatry, 20*(3), 317-328. doi:10.1080/09540260802090363

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995). Psychological responses to war and atrocity: The limitations of current concepts. *Social Science and Medicine, 40*(8), 1073-1082. doi: 10.1016/0277-9536%2894%2900181-R

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi: 10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research a Practical Guide for Beginners*. London, UK: SAGE Publications Ltd.

Bronstein, I., & Montgomery, P. (2011). Psychological Distress in Refugee Children: A Systematic Review. *Clinical Child and Family Psychology Review, 14*, 44-56. doi: 10.1007/s10567-010-0081-0

Bronstein, I., & Montgomery, P. D., Stephanie. (2012). PTSD in asylum-seeking male adolescents from Afghanistan. *Journal of Traumatic Stress, 25*, 551-557. doi: 10.1002/jts.21740

Byrne, B., & Shavelson, R. (1996). On the Structure of Social Self-Concept for Pre-, Early, and Late Adolescents: A Test of the Shavelson, Hubner, and Stanton (1976) Model. *Journal of Personality and Social Psychology, 70*(3), 599-613. doi: 10.1037/0022-3514.70.3.599

Carlson, B., Cacciatore, J., & Klimek, B. (2012). A risk and resilience perspective on unaccompanied refugee minors. *Social Work, 57*(3), 259-269. doi: 10.1093/sw/sws003

Carswell, K., Blackburn, P., & Barker, C. (2011). The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers. *International Journal of Social Psychiatry, 57*(2), 107-119. doi: 10.1177/0020764009105699

Dyregrov, A., Gupta, L., Gjestad, R., & Mukanoheli, E. (2000). Trauma exposure and psychological reactions to genocide among Rwandan children. *Journal of Traumatic Stress, 13*, 3-21. doi: 10.1023/A:1007759112499

Eisenbruch, M. (1991). From post-traumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees. *Social Science and Medicine, 33*(6), 673-680. doi: 10.1016/0277-9536(91)90021-4

Erikson, E. (1968). *Identity youth and crisis*. New York: W. W. Norton & Company, Inc.

Fazel, M., Reed, R., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *Lancet, 379,* 266-282. doi: 10.1016/S0140-6736(11)60051-2

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet, 365*, 1309-1314. doi: 10.1016/S0140-6736(05)61027-6

Gifford, S., Correa-Velez, I., & Sampson, R. (2009). Good Starts for recently arrived youth with refugee backgrounds : Promoting wellbeing in the first three years of settlement in Melbourne, Australia. La Trobe Refugee Research Centre.

Grotevant, H. (1987). Toward a process model of identity formation. *Journal of Adolescent Research, 2*(3), 203-222. doi: 10.1177/074355488723003

Hinton, D. E., & Lewis-Fernandez, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. *Depression and Anxiety, 28*(9), 783-801. doi: 10.1002/da.20753

Huemer, J., Karnik, N. S., Voelkl-Kernstock, S., Granditsch, E., Dervic, K., Friedrich, M. H., & Steiner, H. (2009). Mental health issues in unaccompanied refugee minors. *Child and Adolescent Psychiatry and Mental Health, 3*. doi: 10.1186/1753-2000-3-13

Jorden, S., Matheson, K., & Anisman, H. (2009). Supportive and unsupportive social interactions in relation to cultural adaptation and psychological distress among Somali refugees exposed to collective or personal traumas. *Journal of Cross Cultural Psychology, 40*(5), 853-874. doi: 10.1177/0022022109339182

Khawaja, N., White, K., Schweitzer, R., & Greenslade, J. (2008). Difficulties and coping strategies of Sudanese refugees: A qualitative approach. *Transcultural Psychiatry, 45*(3), 489-512. doi: 10.1177/1363461508094678

Krell, R. (Ed.). (1997). *Psychiatry and the Holocaust* (Vol. 4). New Brunswick, NJ: Transaction Publishers.

Lindencrona, F., Ekblad, S., & Hauff, E. (2008). Mental health of recently resettled refugees from the Middle East in Sweden: the impact of pre-resettlement trauma, resettlement stress and capacity to handle stress. *Social Psychiatry and Psychiatric Epidemiology, 43*, 121-131. doi: 10.1007/s00127-007-0280-2

Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J., Keane, T., & Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(1), 24-36. doi: 10.1097/00004583-200401000-00012

McGregor, L., Melvin, G., & Newman, L. (2014). *The Youth Experience Scale for Refugees*. Unpublished instrument.

Meeus, W. (2011). The study of adolescent identity formation 2000 - 2010: A review of longitudinal research. *Journal of Research on Adolscence, 21*(1), 75-94. doi: 10.1111/j.1532-7795.2010.00716.x

Meyerson, D. A., Grant, K. E., Carter, J. S., & Kilmer, R. P. (2011). Posttraumatic growth among children and adolescents: A systematic review. *Clinical Psychology Review, 31*, 949-964. doi: 10.1016/j.cpr.2011.06.003

Mohlen, H., Parzer, P., Resch, F., & Brunner, R. (2005). Psychosocial support for war-traumatized child and adolescent refugees: Evaluation of a short-term treatment program. *Australian and New Zealand Journal of Psychiatry, 39*(1-2), 81-87. doi: 10.1111/j.1440-1614.2005.01513.x

Mollica, R. F., Poole, C., Son, L., Murray, C. C., & et al. (1997). Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 1098-1106. doi: 10.1097/00004583-199708000-00017

Momartin, S., Silove, D., Manicavasagar, V., & Steel, Z. (2004). Complicated Grief in Bosnian Refugees: Associations with Posttraumatic Stress Disorder and Depression. *Comprehensive Psychiatry, 45*(6), 475-482. doi: 10.1016/j.comppsych.2004.07.013

Neugebauer, R., Fisher, P., Turner, B., Yamabe, S., Sarsfield, J., & Stehling-Ariza, T. (2009). Post-traumatic stress reactions among Rwandan children and adolescents in the early aftermath of genocide. *International Journal of Epidemiology, 38*, 1033-1045. doi: 10.1093/ije/dyn375

Nickerson, A., Bryant, R. A., Brooks, R., Steel, Z., Silove, D., & Chen, J. (2011). The familial influence of loss and trauma on refugee mental health: a multilevel path analysis. *Journal of Traumatic Stress, 24*(1), 25-33. doi: 10.1002/jts.20608

Nickerson, A., Bryant, R. A., Steel, Z., Silove, D., & Brooks, R. (2010). The impact of fear for family on mental health in a resettled Iraqi refugee community. *Journal of Psychiatric Research, 44*, 229-235. doi: 10.1016/j.jpsychires.2009.08.006

Opperman, E., Braun, V., Clarke, V., & Rogers, C. (2013). "It feels so good it almost hurts"" Young adults' experiences of orgasm and sexual pleasure. *Journal of Sex Research, [Epub ahead of print]*, 1-13. doi: 10.1080/00224499.2012.756982

Papadopoulos, R. K. (2007). Refugees, trauma and Adversity-Activated Development. *European Journal of Psychotherapy and Counselling, 9*(3), 301-312. doi: 10.1080/13642530701496930

Papageorgiou, V., Frangou-Garunovic, A., Iordanidou, R., Yule, W., Smith, P., & Vostanis, P. (2000). War trauma and psychopathology in Bosnian refugee children. *European Child and Adolescent Psychiatry, 9*(2), 84-90. doi: 10.1007/s007870050002

Pedersen, A., & Thomas, E. F. (2013). "There but for the grace of God go we": Prejudice toward asylum seekers. *Peace and Conflict: Journal of Peace Psychology, 19*(3), 253-265. doi: 10.1037/a0033738

Porter, M. (2007). Global evidence for a biopsychosocial understanding of refugee adaptation. *Transcultural Psychiatry, 44*(3), 418-439. doi: 10.1177/1363461507081639

Porter, M., & Haslam, N. (2005). Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis. *JAMA: Journal of the American Medical Association, 294*, 602-612. doi: 10.1001/jama.294.5.602

Powell, S., Rosner, R., Butollo, W., Tedeschi, R. G., & Calhoun, L. G. (2003). Posttraumatic growth after war: A study with former refugees and displaced people in Sarajevo. *Journal of Clinical Psychology, 59*(1), 71-83. doi: 10.1002/jclp.10117

Priest, N., Paradies, Y., Trenerry, B., Truong, M., Karlsen, S., & Kelly, Y. (2013). A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people. *Social Science and Medicine, 95*, 115-127. doi: 10.1016/j.socscimed.2012.11.031

QSR International Pty Ltd. (Version 10, 2012.). NVivo qualitative data analysis software.

Reed, R., Fazel, M., Jones, L., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *Lancet, 379*, 250-265. doi: 10.1016/S0140-6736(11)60050-0

Rousseau, C., Drapeau, A., & Platt, R. (1999). Family trauma and its association with emotional and behavioral problems and social adjustment in adolescent Cambodian refugees. *Child Abuse and Neglect, 23*, 1263 - 1273. doi: 10.1016/S0145-2134%2899%2900100-3

Rousseau, C., Mekki-Berrada, A., & Moreau, S. (2001). Trauma and extended separation from family among Latin American and African refugees in Montreal. *Psychiatry: Interpersonal and Biological Processes, 64*(1), 40-59. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/11383441

Rousseau, C., Rufagari, M.-C., Bagilishya, D., & Measham, T. (2004). Remaking family life: Strategies for re-establishing continuity among Congolese refugees during the family reunification process. *Social Science and Medicine, 59*(5), 1095-1108. doi: 10.1016/j.socscimed.2003.12.011

Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry, 40*(2), 179-188. doi: 10.1111/j.1440-1614.2006.01766.x

Sebastian, C., Burnett, S., & Blakemore, S.J. (2008). Development of the self-concept during adolescence. *Trends in cognitive sciences, 12*(11), 441-446. doi: 10.1016/j.tics.2008.07.008

Shaw, A., Joseph, S., & Linley, P. (2005). Religion, spirituality, and posttraumatic growth: A systematic review. *Mental Health, Religion & Culture, 8*(1), 1-11. doi: 10.1080/1367467032000157981

Shedlin, M., Decena, C., Noboa, H., & Betancourt, O. (2014). Sending-country violence and receiving-country discrimination: effects on the health of colombian refugees in

ecuador. *Journal of Immigrant and Minority Health, 16*, 119-124. doi: 10.1007/s10903-013-9777-9

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: Toward an integrated conceptual framework. *Journal of Nervous and Mental Disease, 187*(4), 200-207. doi: 10.1097/00005053-199904000-00002

Slodnjak, V., Kos, A., & Yule, W. (2002). Depression and Parasuicide in Refugee and Slovenian Adolescents. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 23*(3), 127-132. doi: 10.1027//0227-5910.23.3.127

Steel, Z., Silove, D., Bird, K., McGorry, P., & Mohan, P. (1999). Pathways from war trauma to posttraumatic stress symptoms among Tamil asylum seekers, refugees, and immigrants. *Journal of Traumatic Stress, 12*, 421-435. doi: http://dx.doi.org/10.1023/A:1024710902534

Steel, Z., Silove, D., Phan, T., & Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: A population-based study. *The Lancet, 360*, 1056-1062. doi: 10.1016/S0140-6736%2802%2911142-1

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine, 48*, 1449-1462. doi: 10.1016/S0277-9536%2898%2900450-X

Table 1

Participant demographics

Pseudonym	Participant age in years	Birth country	Years in Australia	Sex	City of residence
Chit	14	Burma	2	F	Melbourne
Cho	13	Burma	4	F	Melbourne
Bourey	13	Burma	2	M	Melbourne
Aung	12	Burma	2	F	Melbourne
Htay	17	Burma	5	M	Melbourne
Fred	17	Kosovo	11	M	Melbourne
Aela	16	Afghanistan	10	F	Melbourne
Daud	13	Pakistan	8	M	Melbourne
Abene	17	Guinea	3	F	Melbourne
Aberash	15	Tanzania	5	F	Melbourne
Daara	18	Afghanistan	8	M	Melbourne
Habibah	18	Afghanistan	5	F	Melbourne
Dayo	13	Uganda	7	F	Melbourne
Henry	14	Burma	1	M	Melbourne
Jack	16	Burma	1	M	Melbourne
Naaz	14	Iran	1	F	Melbourne
Samantha	16	Burma	1	F	Melbourne
Hla	13	Burma	1	F	Melbourne
Htet	14	Burma	1	M	Melbourne
William	16	Burma	1	M	Melbourne
Sarah	17	Burma	1	F	Melbourne
Lwin	12	Burma	1	M	Melbourne
Aadinath	15	Nepal	1	M	Hobart
Kabira	20	Syria	0.5	F	Hobart
Eniola	19	Rwanda	10	F	Hobart
Hiwot	17	Rwanda	10	F	Hobart
Ife	19	Afghanistan	5	F	Hobart
Kagiso	20	Ethiopia	7	F	Hobart
Mbali	18	Sudan	7	F	Hobart
Nia	16	Kenya	8	F	Hobart
Onyeka	19	Ethiopia	8	F	Hobart
Laura	19	Kenya	6	F	Hobart
Catherine	19	Congo	1.5	F	Hobart
Kato	16	Rwanda	10	M	Hobart
Kayode	15	Rwanda	10	M	Hobart
Sipho	14	Rwanda	10	M	Hobart
Edris	18	Iran	4	M	Hobart
Ela	20	Nepal	1.5	F	Hobart
Abhik	20	Nepal	2	M	Hobart
Sabal	20	Nepal	4	M	Hobart
Chameli	21	Bhutan	1	F	Hobart
Bageshri	20	Nepal	1	F	Hobart
Bahni	20	Nepal	2	F	Hobart

Note: F: Female, M: Male.

Chapter 8. Discussion and Conclusions

8.1 Introduction

The following chapter synthesises and discusses the findings from the three empirical papers in the prededing chapters in the context of the wider literature. Following this, a discussion of the implication of findings for preventative interventions with refugee populations is provided. The Chapter concludes with a discussion of the clinical implications of the thesis findings, suggestions for future research, an overview of the thesis' limitations, and concluding remarks.

8.2 Review of the Aims of the Thesis

The existing literature on the mental health impacts of the refugee experience has focussed heavily on the examination of PTSD as a response to the traumas of the refugee experience (Khawaja et al., 2008; Lustig et al., 2004; Porter, 2007). While consistent findings attest to its relatively small, though clinically significant, prevalence in resettled refugee populations (Fazel & Stein, 2005), ongoing debate regarding the study of PTSD in refugee populations remains (De Haene et al., 2007; Summerfield, 2000). In particular, the literature has been criticised as being reductionistic in considering PTSD as a primary psychopathological outcome of the refugee experience (Porter, 2007), and the failure to consider how broader ecological and psychosocial factors may be implicated both in the disorder's manifestation and as a result of the refugee experience more generally (De Haene et al., 2007; Porter & Haslam, 2005; Silove, 1999) Evidence suggests that PTSD in refugee populations is not only due to trauma exposure, but that it is linked to pre-existing vulnerabilities (Almqvist & Broberg, 2003), resettlement factors (Porter & Haslam, 2005) and psychosocial variables (Fazel et al., 2012; Porter & Haslam 2005), and that these

relationships are interactive and multifaceted (Porter, 2007; Silove et al., 2010). Though these findings are mirrored in the broader literature base with non-refugee populations (Rosen, Spitzer & McHugh, 2008), it adds weight to the argument that PTSD as it is currently conceptualised does not provide an adequate explanatory framework for the aetiology of the condition in refugees (Porter, 2007; Silove, 19999). Such findings also support the argument that westernised constructs of psychopathology are not able to capture the entirety of the refugee experience (Porter, 2007; Silove, 1999), and that the focus on psychopathology, particularly PTSD, as a major outcome of the refugee experience fails to capture important broader psychosocial and adaptive impacts (De Haene et al., 2007; Papadopoulous, 2007; Silove, 1999).

In addressing these shortcomings of the literature, the overarching aim of this thesis was to examine PTSD symptoms from a broader, ecological, framework of enquiry. The goal was to elaborate upon studies that have examined PTSD solely under westernised notions of the disorder, and to utilise a mixed-methods approach in order to contextualise and expand upon quantitative findings. The second overarching goal of the thesis was to diverge from conceptualising the impacts of the refugee experience from a purely psychopathological perspective, and to qualitatively examine how the refugee experience impacts upon young people's adaptive processes, as conceptualised by the ADAPT model (Silove, 1999).

Three empirical studies were conducted in order to achieve the thesis' overarching goals. This included: an examination of how intraindividual coping styles and familial separations relate to youths' PTSD symptomatology in the first study (Chapter 5); an exploration of the differences between qualitative accounts of participants' refugee and adaptational experiences according to their PTSD symptom levels in the second study (Chapter 6); and an examination of the applicability of the ADAPT model (Silove, 1999) to adolescents' accounts of their refugee and resettlement experiences in the third study

(Chapter 7). The following sections discuss the results of the three studies and their implications in the context of the broader literature.

8.2.1 Aim 1: To jointly investigate how familial separations and the use of coping styles related to PTSD symptomatology in resettled refugee youth.

In concert with literature on adult refugees that has found familial separations to be related to increased emotional distress and PTSD symptomatology (Nickerson et al., 2010; Rousseau et al., 2001; Turner, Bowie, Dunn, Shapo & Yule, 2003), this study demonstrated that adolescents who were residing with non-intact immediate families had significantly elevated PTSD symptom levels relative to those who were residing with intact immediate families. This finding extends upon the pre-existing literature with young refugees, given that previous findings regarding such relationships have only been demonstrated in studies with unaccompanied refugee minors (URMs; e.g., Bean et al., 2007a; Hodes et al., 2008; Huemer et al., 2009).

Familial separations are unfortunately experienced by a great number of refugees (Gifford et al., 2009; Nickerson et al., 2010), and in many cases occur in a hasty, involuntary and traumatic manner (Nickerson et al., 2010; Rousseau et al., 2001; Turner, Bowie, Dunn, Shapo & Yule, 2003). Australia's Humanitarian Programme allows for people to propose for immediate family members to come to Australia through the *Special Humanitarian Programme* (Department of Immigration and Citizenship, 2013a). This process is a lengthy one (Department of Immigration and Citizenship, 2013a), and thus may act to compound the emotional distress of family members waiting for the outcome of such decisions (Rousseau et al., 2001). Indeed, this issue was discussed by some participants in the interview component of this study as being a significant stressor that their families were facing at the time.

Echoing other studies with refugee populations, over half of this thesis' participants for whom there was adequate data for were residing with non-intact immediate families

(Gifford et al., 2009; Nickerson et al., 2010; Rousseau et al., 2001). Research with adult refugees demonstrates that separation from family members is related to higher levels of emotional distress (Rousseau et al., 2001), PTSD symptomatology (Nickerson et al., 2010; Turner, Bowie, Dunn, Shapo & Yule, 2003), depression, and overall mental health disability (Nickerson et al., 2010). These findings exemplify the notion that being separated from family under such circumstances is associated with profound psychological impacts (Nickerson et al., 2010; Rousseau et al., 2001).

Research into the effects of familial separations on populations of young refugees has largely focussed on examining the experience of URMs. Studies generally demonstrate that URMs experience higher rates of psychological disorders, including PTSD, as compared with their accompanied counterparts, a finding that has been at least partly attributed to the impacts of URMs being separated from all members of their family is one reason behind these results (see Huemer et al., 2009 for a review). Yet it is important to contextualise these findings within the broader experiences URMs endure: URMs have been found to experience significantly elevated rates of trauma and loss (Derluyn, Mels & Broekaert, 2009), more extreme traumatic events (Derluyn et al., 2009), and more post-migration stressors (Bean et al., 2007a) than their accompanied counterparts. It is likely that URMs' increased rates of psychopathology are at least partly due to these experiences (Derluyn et al., 2009). Yet it is also highly likely that such factors interact with and are compounded by feelings of grief and loss, and lack of parental support and guidance resulting from their parental and familial separations (Bean et al., 2007a; Derluyn et al., 2009).

There are a limited number of studiesusing an attachment theory framework examining the experiences of young refugees, despite the fact that disruption of attachment relationships is common in this group (De Haene, Dalgaard, Montgomery, Grietens & Verschueren, 2013; De Haene, Grietens & Verschueren, 2010). Evidence from the few

studies that have examined the impact of the refugee experience on parent-child relationships suggests that this is an important avenue of enquiry (Almqvist & Broberg, 2003; De Haene et al., 2013; De Haene et al., 2010; Weine et al., 2013). It is widely accepted that situations of threat and distress trigger the attachment behavioural system's activation (Cassidy, 1988). The refugee and resettlement experience, characterised by the experience of cumulative traumas and stressors, may lead to this system being activated for prolonged periods of time (De Haene et al., 2010). Though evidence shows that parental traumatisation may impact upon parents' emotional availability, and thus exacerbate children's trauma responses (Almqvist & Broberg, 2003; De Haene et al., 2010), supportive parent-child and familial relationships can serve to moderate the effects of traumatisation by sensitively responding to children's affective and behavioural signals and thus deactivating children's attachment behavioural system (De Haene et al., 2013; Bowlby, 1982). For URMs, who do not have parents or attachment figures present during their flight and resettlement experiences, the effects of such stressors may be all the more profound (Bean et al., 2007a; De Haene et al., 2010; Lustig et al., 2004).

Given how common it is for refugee youth to resettle without the entirety of their immediate family (Gifford et al., 2009), and the consistent evidence demonstrating the elevated rates of psychopathology in URMs (Huemer et al., 2009), it is perhaps surprising that the mental health impacts of separations and attachment disruptions have not been examined as significant factors impacting psychosocial adaptation and pscyhopathology. Because this study was of a cross-sectional design, the directionality between increased PTSD symptomatology and familial separations cannot be ascertained. Despite this, it is likely that separations from family have adverse mental health outcomes (Nickerson et al., 2010; Nickerson et al., 2011), though the mechanisms behind such relationships are probably multicausal, and may differ according to refugees' particular circumstances (e.g., whether

they are young people separated from some of their immediate family; whether they are unaccompanied minors; or whether they are adults resettled without family members). For instance, Nickerson, Bryant, Steel, Silove and Brooks (2010) found that fears for family members left in Iraq was the most predominant contributory factor for increased PTSD symptomatology in adult refugees resettled in Australia. While for URMs, who have been found to endure increased rates of traumatic events (Derluyn et al., 2009), it may be that their increased trauma exposure is compounded by not having caregivers present to mitigate their adverse psychological impacts (De Haene et al., 2010). Such difficulties may not be as applicable to adolescents who resettle with some of their immediate families, like those who partook in the present study. For them, it may be the impact of things such as changed familial hierarchies (Gifford et al., 2009; Weine et al., 2004) and familial conflict (McMichael et al., 2011) occurring after separations that act to moderate or compound the relationships between the separations and psychopathology (Fazel & Stein, 2002).

The second major finding from this study was the absence of any significant relationships between coping styles and PTSD symptomatology. These results are contrary to findings with adult refugees, wherein the use of avoidant coping has been found to positively related to PTSD symptoms (Ai et al., 2007; Finklestein & Solmon, 2009; Hujits et al., 2012). Importantly, in the current study there was an initial significant relationship between avoidant coping and PTSD symptomatology, however once the possible confound between avoidance-based PTSD symptomatology and avoidance coping were controlled for, this relationship diminished to non-significance. This finding is notable given the literature on coping has been critiqued for the fact that coping and psychopathological symptoms are often confounded (Coyne & Racioppo, 2000; Stanton et al., 1994). This may be a particular issue in research that has examined the relationship between avoidant coping and PTSD symptomatology, given that avoidance-based symptoms are a key component of the disorder

(American Psychiatric Association, 2013; Finklestein et al., 2012; Hooberman et al., 2010). This research provides important evidence for the need to control for potential confounds in research examining coping and psychopathology. Given that there have been studies (e.g., , Finklestein et al., 2012; Matheson et al., 2008) that have reported associations between these two variables without controlling for possible confounds between them. This study's results suggest that these findings may in fact be spurious. Although the broader literature demonstrates that the use of avoidance coping is a risk for later development of PTSD in prospective studies (Gil & Caspi, 2006; Solomon, Mikulincer & Avitzur, 1988), the use of cross-sectional research designs which do not control for possible confounding relationships is arguably not an adequate framework of enquiry for such questions (Coyne & Racioppo, 2000; Stanton et al., 1994).

An alternative explanation for the insignificant relationships between coping styles and PTSD symptoms in the current study may be due to methodological factors; specifically, the use of a self-report coping checklist to assess coping styles. Although the coping measure for the present study was selected on the basis of previous research with non-western populations (Gaylord-Harden et al., 2008), and research attesting to its strong construct validity (Ayers et al., 1996; Compas et al., 2001). Use of such measures has been critiqued as being too generalised to usefully examine the specific effects of coping in response to specific stressors (Coyne & Racioppo, 2000; Somerfield & McCrae, 2000; Stanton et al., 1994). Though past research has linked the use of certain coping styles with PTSD symptomatology (e.g., Ai et al., 2007; Hujits et al., 2012; Olff et al., 2005), it can be argued that it is more pertinent to examine *how* the use of situational coping strategies related to PTSD symptoms.

While coping styles (dispositional coping), are habitual ways of managing stressors that are developed early in life and are influenced by personality variables (Carver & Sheier,

1994; Punamäki et al., 2008), situational coping strategies are used in response to the demands of certain stressors and can change from moment to moment, depending on the appraisal of the stressor (Punamäki et al., 2008). Given that the development of PTSD symptomatology is linked to, among other things, peritraumatic emotional response (Ozer et al., 2008), it may be that situational coping strategies are more implicated in PTSD symptom manifestation and maintenance than dispositional coping styles. Indeed, Punamäki et al. (2008, pp. 339) argue that "…adulthood traumatic events, including political imprisonment and torture, would be associated with situational coping strategies, but not with dispositional coping style(s)". This is an argument that may be applicable to children and youth's experiences also.

The third key finding of the first study was that youth's use of coping styles did not differ according to whether they were residing with intact or non-intact families. This finding may be interpreted in a number of ways. Firstly, the participants in this study were adolescents, with an average age of 16.63 years. It is thought that due to dispositional coping styles being linked to temperament and socialisation processes (Gaylord-Harden et al., 2013; Skinner & Zimmer-Gembeck, 2007; Taylor & Stanton, 2007), by adolescence, they are usually well-formed (Skinner & Zimmer-Gembeck, 2007). Thus, the impacts of familial separation processes at this age may not be as profound in terms of their effects on coping styles as they would be during childhood (Skinner & Zimmer-Gembeck, 2007). It must be noted, however, that this study did not ascertain at what age familial separations occurred, and there may have been some separations that did in fact occur during participants' childhood years. This would be a useful line of enquiry for future research to pursue. Secondly, some participants' familial separations were from siblings and not from parents. Although social relationships, likely including those with siblings, have important impacts upon coping (Skinner & Zimmer-Gembeck, 2007), the role of parents is particularly implicated in the development and

utilisation of coping processes (Power, 2004; Skinner & Zimmer-Gembeck, 2007). The effects of familial separations on coping processes may therefore not have been as pronounced for this study's non-intact group, given that not all participants were separated from parents. Lastly, the given the fact that the measure used to assess coping in this study was developed for use with a western population, it may have been less culturally relevant for the sample in the present study. As such, it may not have provided an accurate measure of participants' actual coping processes, as discussed further in the limitations section below.

8.2.2 Aim 2: To explore, based on adolescents' accounts of their refugee and resettlement experiences, possible psychosocial and adaptive mechanisms that may play a role in PTSD symptomatology.

The second study sought to explore whether adolescents' self-reported psychosocial and adaptive processes differed between those with high and low levels of PTSD symptomatology. Interpretative phenomenological analysis of participants' accounts revealed differences that discriminated between groups, with regards to cultural belongingness and identity, psychological functioning, family unit functioning and relationships and friendships and interpersonal processes. Findings from this study are in keeping with those from the wider literature, which has demonstrated relationships between mental health outcomes and: cultural connectedness (Ellis et al., 2008); the maintenance of ideological commitments (Ai et al., 2007; Compas et al., 2001; Lustig et al., 2004); family unit functioning (Fazel & Stein, 2002; De Haene et al., 2007; Weine et al., 2013); and social support (Fazel et al., 2012; Lustig et al., 2004) in refugee populations. The idiographic accounts from participants in this study provide detailed evidence for the importance of such factors in young people's lives, and thus extend upon and contextualise quantitative findings of the previous study, discussed above.

The concept of belongingness and cultural identity as it applies to refugee populations is multifaceted, being situated in individual, social, cultural and historical contexts (Valentine, Sporton & Nielsen, 2009). Despite the pronounced variety of topics examined under numerous theoretical paradigms in the literature on belongingness in refugee populations, findings from quantitative and qualitative studies alike attest to the protective effects of the maintenance of a sense ethnic identity and belongingness (Correa-Velez, Gifford & Barnett, 2010; Keyes & Kane, 2004; Kia-Keating & Ellis, 2007). Given the upheaval from their homelands, and the need to re-establish themselves in countries of resettlement that are often characterised by markedly different social values and cultural customs, refugees' notions of belongingness and ethnic identity can be profoundly challenged by their refugee and resettlement experiences (Correa-Velez et al., 2010; Keyes & Kane, 2004).

The results of the second study demonstrated that, in contrast to those with high levels of symptomatology, participants with low levels of PTSD symptoms generally evidenced a strong sense of ethnic identity and belongingness to their homelands, while concurrently demonstrating strong connections to Australia. As is the case for all of the research detailed in this thesis, findings pertaining to directionality cannot be established due to the cross-sectional nature of the research design. However, it is pertinent to compare these findings to the broader literature base, which has clearly demonstrated a protective relationship between belongingness and identity and wellbeing in refugee populations (Correa-Velez et al., 2010; Keyes & Kane, 2004; Kia-Keating & Ellis, 2007). In a study with Southeast Asian refugees resettled in Canada for example, a strong sense of ethnic identity was found to be beneficial in helping people deal with the negative impacts of having difficulties with the English language (Beiser & Hou, 2001). Similarly, results of a longitudinal study with resettled refugee youth in Australia found that young people's subjective health and wellbeing was

significantly influenced by their subjective social status in the broader Australian community, conceptualised by the authors as being an important indicator of belongingness (Correa-Velez et al., 2010). In a similar vein, a study that examined young people's perceived belongingness and connection to school found that lower levels of depression and higher levels of self-efficacy were associated with a greater sense of school belonging in the resettlement environment, regardless of the level of past exposure to adversities (Kia-Keating & Ellis, 2007).

Participants who had low levels of PTSD symptoms in the current study conveyed a sense of attachment to Australia, though they maintained a strong sense of belongingness to, and identification with, their homelands and ethnic identities. In effect, they evidenced a sense of attachment and belongingness to both Australia and their homelands, though the nature of these relationships was fundamentally different for each place. These results are similar to those found by Valentine, Sporton and Nielsen's (2009) when studying Somali refugees resettled in England and Denmark. Those who resided in England reported a perceived sense of belongingness to the country, even though they did not identify as being British. Valentine, Sporton and Nielsen (2009, pp. 247) asserted that this was because, "…at a local level they have a sense of security and emotional attachment that comes from having their own place, which gives them the space to define their own narratives of identity beyond narrow prescriptions of Britishness". These findings echo those demonstrated in this study, where most participants with low PTSD symptoms had clearly held attachments to Australia, partly due having a sense of safety and freedom in the country, but they still maintained a sense of identification with and perceived belongingness to their homelands. Thus, like participants in Valentine, Sporton and Nielson's study, their narratives around identity were multifaceted and took on different meanings for different places. Such findings allude to the apparently complex nature of such processes in refugee populations.

A second major finding of this study pertained to participants' psychological functioning. In contrast to those with high PTSD symptoms, participants with few PTSD symptoms evidenced use of a range of cognitive processes (including reflexivity, goal-directedness, and moralistic and ideological beliefs) in general, and specifically in response to stressors. Although it is important to again note that directionality cannot be established, these processes may have served a protective function for participants with low levels of symptoms.

The increased reflexivity evidence by those with low symptoms as compared to those with high levels of PTSD sympatoms the low group as compared with the high group could be interpreted in line with the theory of *mentalisation* (Fonagy, Gergely, Jurist & Target, 2007). Mentalisation, or reflective functioning, has been defined as "the capacity to understand and interpret – implicitly and explicitly – one's own and others' behaviour as an expression of mental states such as feelings, thoughts, fantasies, beliefs and desires" (Katznelson, 2014, pp. 108). Indeed, low group participants' accounts indicated they possessed many of these capacities: they were insightful and reflective of their emotional states, had established desires and plans for the future, and upheld well developed belief systems. Participants with high levels of PTSD, on the other hand, generally did not demonstrate such capacities.

Though the topic has received scant empirical attention to date in its relation to PTSD (Sharp, Fonagy & Allen, 2012), mentalisation is a core feature of Sharp, Fonagy and Allen's (2012) social cognitive theory of PTSD. They propose that an impaired mentalizing capacity, stemming from earlier trauma-related disruptions to attachment security, may play a role in the development of PTSD symptomatology. In referencing the established literature that has linked attachment security to people's stress response and PTSD symptoms (see Schore, 2002 and Mikulincer, Shaver & Horesh, 2006 for reviews), they argue that people with disrupted

attachments evidence impaired mentalizing processes (either hyperactivation or avoidance) during distressing events, and it is such processes that lead to psychopathology. Though there are few studies which have directly examined mentalisation capacities in trauma survivors with PTSD, results from a study with war veterans demonstrated that PTSD sufferers may have deficits in social cognitive processes, providing preliminary evidence for the role of mentalisation in the condition (Mazza et al., 2012).While there have been, to the author's knowledge, no published empirical papers on this topic in refugee populations, two studies reporting on successful treatment programs undertaken with refugees describe using treatment approaches that draw heavily on theories of mentalisation and reflective functioning (Bala, Mooren & Kramer, 2014; Schweitzer, Vromans, Ranke & Griffin, 2014), thereby indicating is potential role in psychopathological processes in refugees. The findings from the present thesis highlights the study of mentalisation as an important area for future research, given there are no studies on this construct in refugee populations.

Familial relationships and functioning of the family unit was the third major factor distinguishing between groups in the second study. While participants with few PTSD symptoms spoke of a sense of family cohesion, families of participants with high levels of PTSD symptoms were characterised by separations, disrupted relationships and a lack of open communication. These findings complement the findings of quantitative studies, which have demonstrated that cohesive family relationships to be associated with fewer mental health difficulties (Berthold, 1999; Kovacev & Shute, 2004; Rousseau et al., 2004).

Despite the profound disruptions the refugee experience can impart on interpersonal, including parent-child, relations (De Haene et al., 2007; Nickerson et al., 2010; Nickerson et al., 2011), the examination of attachment in refugee populations is only in its infancy (De Haene et al., 2013; De Haene et al., 2010). Indicating the role of attachment in the psychological effects of trauma, studies within the literature consistently show that particular

attachment styles have differing relations to PTSD symptomatology and traumatic responses following trauma exposure (Dieperink, Leskela, Thuras & Engdahl, 2001; Mikulincer, Florian & Weller, 1993; Sharp et al., 2012). Secure attachment styles have been shown to relate to lower levels of distress in adults following missile attack (Mikulincer et al., 1993) for example, as well as relating to fewer PTSD symptoms in former prisoners of war (Dieperink et al., 2001). Furthermore, while attachment styles are largely stable across the lifetime (Allen, McElhaney, Kuperminc & Jodl, 2004; Weinfield, Whaley & Egeland, 2004), they may be impacted, and in some instances changed, as a result of significantly stressful experiences (Hamilton, 2000; Waters, Hamilton & Weinfield, 2000). Though such processes have not been examined, to the writer's knowledge, in refugee populations, it is conceivable that refugees' attachment styles may be challenged, and in some cases changed, as a result of familial separations and altered parent-child relational dynamics (De Haene et al., 2013; De Haene et al., 2010). Following from this, it is also conceivable that refugees' mentalizing processes may also be negatively affected by such experiences (Sharp, Fonagy & Allen, 2012). In sum, it is conceivable that disrupted attachment relations may arise in refugee families following traumatic experiences, with such processes in turn negatively impacting upon mentalisation and psychopathology. Though this is only a preliminary hypothesis, based upon evidence from the broader literature, and the fact that participants with high and low PTSD symptoms in this study were strongly differentiated by such processes as familial relations, mentalisation and family separations, it presents an important avenue for future enquiry.

In addition to identifying an association between familial relationships and PTSD symptomatology, findings from this study also provide important experiential evidence on some of the potential processes behind the influence of familial factors on mental health. These findings are both novel and critical given that limitations of previous quantitative and

qualitative research conducted on the topic. In particular, although quantitative studies have identified significant relationships between familial processes and mental health, they have failed to examine the mechanisms involved in such relationships (De Haene et al., 2007; Fazel et al., 2012). Further, although qualitative studies provide important and detailed accounts of the nature of intrafamilial relationships (e.g., Atwell, Gifford & McDonald-Wilmsen, 2009; Hynie, Guruge & Shakya, 2012; Weine et al., 2004), such studies generally do not examine how these processes specifically relate to participants' psychological functioning.

In likeness to other qualitative studies (McMichael et al., 2011; Rousseau, Rufagari, Bagilishya & Measham, 2004; Rosbrook & Schweitzer, 2010; Rousseau et al., 2004; Shakespeare-Finch & Wickham, 2009), and in elaborating upon findings from the first study, the second study demonstrated that separations from family members had significant impacts, though individualised, upon many participants and their familial relationships. One participant, for example, spoke of her frustration at the changed family roles and responsibilities that arose after her sisters left her family, similar to reports by a number of participants in the study by McMichael, Gifford and Correa-Velez's (2011). Other participants spoke of the direct experience of feelings of grief and loss as a result of being separated from loved ones. Such findings underscore the need for future research to be tailored towards examining the multifaceted impacts of family separations.

The final differentiating factor between youth with high and low PTSD symptom levels was in regards to their interpersonal relationships. Developing and maintaining friendships with peers is a key normative task of adolescence (Allen, 2008), yet for those who arrive into resettlement countries from vastly different backgrounds to their peers, the challenges associated with forming and maintaining friendships can be immense (Kovacev & Shute, 2004). Given this, it is perhaps unsurprising that adolescents who evidenced low levels

of PTSD symptoms spoke of the importance of upholding friendships with peers from similar backgrounds. Participants appeared to take value in the fact that they had shared experiences with such friends, which interestingly is something Tedeschi and Calhoun (2004) posit as being a likely central component of *posttraumatic growth* among trauma survivors. In addition to failing to evidence the same level of ties with peers of similar situational and ethnic backgrounds as those in the low PTSD group, participants with high levels of PTSD symptomatology appeared to have difficulties with peer relationships in general. Participants who endured interpersonal difficulties spoke of the emotional toll such experiences had on them, concurring with other studies' findings of the negative mental health impacts bullying and discrimination can have on young refugees (Fazel et al., 2012; Montgomery, 2008).

Many studies that have examined peer and social relations in refugee adolescents have done so under the theoretical paradigm of acculturation (e.g., Birman, Trickett & Vinokurov, 2002; Ellis et al., 2008; Kovacev & Shute, 2004). Though there has been considerable debate on the use of the term, and research of the concept in general (Fazel et al., 2012; Rudmin, 2003), the present study does provide evidence for the utility of some of the concepts proposed by acculturation theory (Berry, 1997). One of four specific forms of acculturation proposed by Berry's (1997) theory is *integration*, defined as a process whereby people maintain a connection to their native culture, whilst also partaking and becoming an integral part of their host culture's social network. Although findings pertaining to the relationships between forms of acculturation and mental health have been mixed (Yoon et al., 2013), evidence from some studies suggests that integration, in comparison to other forms of acculturation, is related to better mental health outcomes (Berry, 1997; Birman, Simon, Chan & Tran, 2014; Yoon et al., 2013). In a study with resettled refugee youth in Australia, for example, Kovacev and Shute (2004) found that adolescents' integration into aspects of

Australian society (as assessed by their attitudes to acculturation and perceived peer acceptance) was significantly related to improved psychosocial outcomes.

Participants with low PTSD symptom levels could be conceptualised as being integrated into Australian culture and society: they upheld strong and meaningful interpersonal relationships with Australian and ethnic peers alike, and while they generally demonstrated strongly perceived ties to their homelands and their ethnic cultures, they spoke of adopting and identifying with Australian cultural practices also. When asked to provide advice to other young people who come to Australia from similar refugee backgrounds, some participants of this group explicitly discussed how they thought adopting aspects of Australian cultural values and practices whilst at the same time maintaining strong connections to people's ethnic cultures was particularly important in facilitating positive outcomes in the resettlement environment.

8.2.3 Aim 3: To explore the applicability of the ADAPT model (Silove, 1999) to adolescents' accounts of their refugee and resettlement experiences

The ADAPT model (Silove, 1999) is based on the premise that adaptive mechanisms may play intervening roles in the relationship between refugee trauma and psychopathological outcomes. Silove (1999) argues that by examining how people's safety, attachment, justice, existential-meaning and identity/role systems are affected, we may gain a deeper understanding of the psychosocial impacts of the refugee experience. This study demonstrated that this model, with the exception of the justice system, was a valid conceptual framework from which to view some of the self-reported impacts of adolescents' refugee and resettlement experiences. Importantly, findings demonstrated that the adaptive processes were not necessarily negatively affected, as Silove proposes they may be.

There were relatively few findings pertaining to the ADAPT model's first system, the safety system. Silove (1999) asserts that PTSD symptom development is closely linked to

experiencing events that are perceived as being life threatening, where people are more likely to develop symptoms when the trauma they are exposed to threatens their physical integrity. Whilst there is evidence from the literature on refugee populations to support this assertion (e.g., Bronstein et al., 2012; Neugebauer et al., 2009), findings also demonstrate that PTSD symptoms may arise following stressors that do not threaten one's physical integrity (Rosen, Spitzer & McHugh, 2008; Sharp, Fonagy & Allen, 2012). Studies with general populations for example, have found PTSD symptoms to arise in people following divorce and occupational stress (Gold, Marx, Soler-Baillo, Jose & Sloan, 2005), whilst discrimination (Ellis et al., 2008), language abilities (Halcon et al., 2004) and unemployment (Lie, 2002) in refugee studies have been shown to relate to PTSD symptomatology. Given that participants were not directly asked about prior traumatic experiences, there were few opportunities (unless participants brought the topic up themselves) for discussion around trauma exposure and the associated impacts upon their perceived sense of safety. Likely largely as a result of this, there were no findings in relation to how traumatic experiences may have compromised participants' ongoing sense of safety. It may have been more important to examine how stressors in the resettlement environment related to participants' sense of safety, given the evidence from the extant literature linking such stressors to PTSD symptomatology.

Silove acknowledges the role of the resettlement environment in influencing refugees' perceived sense of safety, in positing that stressors and perceived threats may mitigate or exacerbate posttraumatic reactions. For this study, ongoing threats to safety in the resettlement environment were largely conceptualised in terms of racism and discrimination, given the mental health impacts (Correa-Velez et al., 2010; Mestheneos & Ioannidi, 2002; Priest et al., 2013) and frequency of such experiences amongst resettled refugees (Gifford et al., 2009; Mestheneos & Ioannidi, 2002; Pederson & Thomas, 2013). Surprisingly, there were few participants who reported experiencing racism or discrimination, in contrast to another

study with resettled refugee youth in Australia (Gifford et al., 2009). Though those who did experience racism and discrimination endorsed the significant negative impacts such experiences had on their mental health. Such findings could be indicative of Silove's (1999) assertion that threats in the resettlement environment act to exacerbate pre-existing posttraumatic stress symptoms, though this is impossible to ascertain given the data from this study was derived by qualitative means and it was a cross-sectional research design.

In contrast to the original conceptualisation of the safety system, participants who did discuss their feelings of safety did so largely in terms of how they felt safe in Australia, in the context of comparing Australia to the situations they left in their homelands or in their countries of asylum. These results are comparable to other studies with resettled refugees. In a qualitative study with resettled Bosnian refugees, for example, participants discussed their relief and sense of safety upon being resettled in the United States (US; Keyes & Kane, 2004). In a study with a group of resettled refugees from the Soviet Union and a comparative US sample of residents from the same neighbourhood, Furr, Austin, Cribbs and Smoger (2005) examined levels of satisfaction and perceived levels of neighbourhood safety. While resettled refugees reported being less satisfied with their neighbourhoods than US residents, they had significantly higher perceived levels of safety. One possible explanation put forth by the authors for these results was that refugees may have compared their US living situation to their social environment of their homelands, in which they were exposed to structural impediments that limited their opportunities for meaningful engagement in society. Thus, in comparison to the participants from the US who conceptualised their safety in relation to their local environment, refugees may have perceived their safety to be linked to both local and societal contexts. Participants from the present study made similar comparisons between their felt safety in Australia compared to their homelands. Interestingly, they also explicitly linked

their perceived sense of safety to a described sense of freedom and opportunity that they had in Australia, also suggesting a conceptualisation of safety at both a local and societal context.

Of the ADAPT model's attachment system, Silove (1999) writes that one of the key disruptions refugees experience is in the realm of interpersonal bonds, wherein separations and losses of significant people in refugees' lives are commonplace. He further states that the loss of homes and possessions, as well as symbolic losses of notions of belonging and connection with homelands, also impact upon refugees and can result in experiences of traumatic grief (Eisenbruch, 1991). Given the large amount of data for the third study, only results regarding interpersonal bonds and attachment were analysed and reported upon for this study. Results illustrated the centrality of attachment relationships, particularly in the realms of familial and peer relationships, to participants' lives. In likeness to the broader literature base (Borwick et al., 2013; Gifford et al., 2009; Nickerson et al., 2010; Shakespeare-Finch & Wickham, 2009), and in concert with Silove's writings, it was clear that participants' refugee experiences had shaped and influenced the nature of attachment relationships, particularly with regards to familial separations. Familial relationships appeared to be particularly central to participants' lives, though in line with developmental norms (Allen, 2008). Participants spoke of the importance of peer relationships also.

Participants' qualitative accounts illustrated the significance of familial relationships, regardless of whether they were harmonious or strained. For those with harmonious relationships, family represented a central source of support, while for those with strained relationships, the family was a significant stressor. Participants who spoke about having positive familial relationships spoke largely in terms of how their parents in particular had provided strong support to them both during their refugee experiences and in the resettlement environment. Importantly, the way in which participants described their parents' support indicated it was in the form of emotional, rather than instrumental, support; that is, parents

were described as helping them deal with the psychological impacts of their refugee and resettlement experiences. Such forms of support may be particularly protective to young refugees' mental health outcomes. Kovacev and Shute (2004), for example, found that parental social support, operationalised as parents' capacity to listen and understand children's problems and care about their feelings, significantly positively related to adolescents' perceived self-worth.

There are relatively few studies that have examined how specific aspects of parental and familial relationships relate to refugee youths' mental health (Panter-Brick et al., 2013; Weine et al., 2013) and of the studies that have, few, with the notable exception of Kovacev and Shute (2004), have explicitly defined or operationalised the constructs under examination. Despite this, studies of parental support and family cohesiveness suggest that such factors are highly important in refugee youth mental health (Berthold, 2000; Fazel et al., 2012; Kovacev & Shute, 2004; Rousseau et al., 2004). Evidence from the present study, as well as Kovacev and Shute's findings, demonstrates that parental emotional support may be particularly protective. Indeed, this is backed up by the literature on general populations of children and adolescents (Gaylord-Harden et al., 2013; McCarty, Zimmerman, Digiuseppe & Christakis, 2005; Taylor, Lopez, Budescu & McGill, 2012). Findings from the attachment literature demonstrate that adolescents' attachment styles and aspects of psychological functioning are linked to specific parenting behaviours. For example, in Kobak and Sceery's (1988) widely cited study on working models of attachment in late adolescence, adolescents with dismissing attachment organisational styles were found to report low levels of social support from their family. This was in contrast to adolescents with secure attachment organisation, who were comparably less anxious, more ego-resilient and who reported significantly higher levels of familial social support.

The second major finding as it related to the ADAPT model's (Silove, 1999) attachment system was the role of peer relations. Bowlby's theory of attachment (1972; 1982) posits that the quality of attachment relationships with parents determines the nature of other relationships, including those with peers. In accordance with this, it appeared that participants who had difficulties with parental relationships also had difficulties with peer relationships. Such processes may be reflective of Silove's (1999) assertion that the refugee experience can result in profound disruptions to interpersonal relationships, and illustrate how adolescents may be at particular risk for the development of psychological difficulties because of the potential impact on developmentally normative processes including forming and maintaining peer attachment relationships (Ehntholt & Yule, 2006).

Participants who reported upholding strong interpersonal relationships clearly valued their peer relationships, and perceived these relationships to also be highly important. In particular, participants spoke of how peer relationships, especially those with peers of similar ethnic backgrounds, were central to their emotional wellbeing. These results concur with other studies with refugee youth, for which there is established evidence for the relationship between social support from peers and positive mental health outcomes (Berthold, 2000; Kia-Keating & Ellis, 2007; Kovacev & Shute, 2004). Taken together, findings from this study provide strong evidence attesting to the particular importance of the attachment component of the ADAPT model to participants in this study and also in conceptualising the impacts of the refugee experience more broadly (Gifford et al., 2009; Nickerson et al., 2010).

Of the ADAPT model's justice system, Silove (1999) writes that due to many refugees' experiences of extreme trauma and gross-human rights violations, a profound sense of injustice may arise. In some cases, such a response may trigger clinically significant anger and rage in refugees. Findings pertaining to this aspect of the model in the present study were few. Only two participants discussed what could be interpreted as feelings of injustice, while

one participant spoke of his felt "frustration" and occasional angry outbursts in response to familial conflict. Research into such concepts with refugee populations is likewise scarce, and as a result, it is difficult to contextualise these results. Though some studies with young refugees have reported elevated rates of acting out behaviour and self-reported feelings of anger (Gifford et al., 2009; Lustig et al., 2004; Mollica, Poole, Son, Murray & Tor, 1997; Paardekooper, De Jong & Hermans, 1999), there are no studies, to the authors' knowledge, that have examined such symptoms and behaviours in any further detail. Clearly this is an area that requires further research. One possible reason behind the absence of detailed results in this study may have been that the majority of participants had arrived in Australia through the Humanitarian Programme (Department of Immigration and Citizenship, 2013a), and had therefore not had experiences of being in immigration detention. Research shows that such detainment can result in significant and profound negative mental health impacts (Mares, Newman, Dudley & Gale, 2002; Newman et al., 2013; Steel et al., 2006), including sudden attacks of anger (Steel et al., 2006).

Findings pertaining to the existential-meaning system demonstrated that participants generally upheld strong ideological and moralistic beliefs. Furthermore, rather than being negatively impacted by their refugee experiences, many participants' worldviews appeared to have been shaped by their experiences as refugees. Importantly, these findings are in concert with the results from the second study, in which participants with few PTSD symptoms had strongly held moralistic and ideological views, with religiosity being an important factor within such beliefs. Silove (1999; para 27) wrote that, "characterising and operationalizing more clearly the impact on systems of values and faith brought about by exposure to human rights violations remains an important task for researchers in the field". This study, along with those from other qualitative refugee research (Borwick et al., 2013; Goodman, 2004;

Hussain & Bhushan, 2011a; Khawaja et al., 2008; Whittaker, Hardy, Lewis, & Buchan, 2005), provides some preliminary evidence for this.

In contrast to Silove's (1999) original conceptualisation of the existential-meaning system, wherein he posited that individuals may experience a crisis of faith and trust, many refugees in the present study appeared to have had their ideological views moulded and strengthened. Such findings may be interpreted in line with theories of posttraumatic growth (Cho & Park, 2013; Tedeschi & Calhoun, 1995), and demonstrate the potentially positive changes people can experience after going through traumatic events (Cho & Park, 2013; Myerson, Grant, Smith Carter & Kilmer, 2011; Shakespeare-Finch & Lurie-Beck, 2014).

Posttraumatic growth (PTG) is defined by Myerson, Grant, Smith Carter and Kilmer (2011, pp. 950) as "positive change experienced as a result of the struggle with trauma". Importantly, PTG has been shown to relate to PTSD symptoms (Shakespeare-Finch & Lurie-Beck, 2014), thus emphasising that negative as well as positive responses can co-occur in individuals following trauma exposure (Hussain & Bhushan, 2013; Laufer & Solomon, 2006; Shakespeare-Finch & Lurie-Beck, 2014). PTG can occur in a variety of ways, and include both behavioural (e.g., Shakespeare-Finch & Barrington, 2012) as well as cognitive changes (e.g., Kroo & Nagy, 2011).

Tedeschi and Calhoun (1996) have proposed a model for conceptualising PTG, containing the following 5 domains: *new possibilities*, *relating to others*, *personal strength*, *appreciation of life*, and *spiritual growth*. The results from this study appeared to be particularly resonant with the appreciation of life and spiritual growth domains of Tedeschi and Calhoun's model: many participants expressed feelings of appreciation of their life circumstances, whilst still recognising the hardships they endured as refugees; further, many also expressed deeply held religious beliefs that were of central importance in their lives, which, for some, appeared to have been shaped by their experiences as refugees.

Although directionality of relationships cannot be ascertained, the findings provide evidence to suggest that the appreciation of life and spiritual growth components of PTG (Meyerson et al., 2011; Tedeschi & Calhoun, 1996) may be particularly important in the experience of refugee adolescents. Interestingly, a recent study with Somalian adult refugees reported similar results (Kroo & Nagy, 2011), where religiosity, among other things, significantly positively related to PTG. In another study with Tibetan refugees, Hussain and Bhushan (2013), found that one of the major themes in participants' accounts as it pertained to PTG were positive changes in outlook both towards the world and to people, which may be likened to the notion of appreciation for life. These results present promising further avenues of enquiry with refugee youth, given that the concept as it pertains to this population has received scant attention in the literature to date (Ai et al., 2007; Powell, Rosner, Butollo, Tedeschi & Calhoun, 2003). While it is important to note that these findings do not necessarily refute those of Silove's (1999) writings on the potentially negative impact the refugee experience can have on refugees' world-view, they emphasise the need for practitioners and researchers alike to consider the fact that the negative and positive impacts of trauma can coexist (Shakespeare-Finch & Lurie-Beck, 2014).

Finally, the identity/role system of the ADAPT model (Silove, 1999) also appeared to be an adaptive system that was of relevance to participants, and the content of their qualitative interview data. Unlike Silove's original conceptualisation of this aspect of the model, wherein he writes that refugees' sense of identity and agency may be profoundly negatively affected, participants in this study largely demonstrated well developed and coherent senses of their own identities and self concept. A notable proportion of participants reported that they believed other young people coming to Australia from similar backgrounds should maintain a strong sense of identity in promoting positive adaptation to life in Australia, perhaps indicating that they felt they had done this successfully themselves. In

their longitudinal study with resettled refugee youth in Melbourne, Gifford, Correa-Velez and Sampson (2009) found similar results; young people generally evidenced holding a positive self-image and identity upon first arriving in Australia as well as in the first three years of resettlement.

The findings relating to participants' identity and self-concept for this study were conceptually broad, and thus may be somewhat limited given the multifaceted nature of the construct (Erikson, 1968; Gifford et al., 2009; Meeus, 2011). It may have been pertinent, for example, to have questioned how participants' experiences had impacted upon their ethnic identity formation, something which has been found to be particularly influenced by people's refugee and resettlement journeys (Beiser, 2006; Gifford et al., 2009; Liebkind, 1993), which was demonstrated in the second study as being a differentiating factor between select groups of participants with high and low PTSD symptom levels.

In sum, results from the third study of this thesis provide strong preliminary evidence for the relevance of the ADAPT model (Silove, 1999), with the possible exception of the justice system, as a way in which to examine the psychosocial adaptive processes that are affected by refugee experiences. In line with findings from the PTG literature which demonstrate that positive and negative outcomes can occur following trauma exposure (Shakespeare-Finch, & Lurie-Beck, 2014), the results from this study indicate that while many of the systems of the model were applicable to adolescents' experiences, they may have been impacted in positive ways, in contrast to Silove's (1999) writings. While this study did not ascertain how the impact on such processes affected participants' psychological functioning, as Silove (1999) hypothesises, the findings provide preliminary evidence for the implication of adaptive systems by the refugee experience.

8.3 Implications: Clinical Interventions

The present thesis contributes to a broadened understanding of the correlates of PTSD symptoms in adolescent refugee populations, and how such factors including familial and peer relationships and adaptive processes, are affected by the refugee experience. While the studies of this thesis did not address treatment specifically, the advances in understandings of PTSD symptomatology and broader adaptational processes in refugee adolescents provide useful clinical information for consideration in the tailoring of clinical interventions with refugee youth and families. While the following section is contextualised within the extant research, it is important to note that there are relatively few studies, particularly with youth populations, into intervention and prevention programs with refugee populations (Slobodin & de Jong, 2014). An important caveat of this section therefore is the fact that there are few guiding frameworks from which to draw upon in contextualising the thesis' findings as they pertain to clinical interventions (Slobodin & de Jong, 2014).

The finding that familial separations were related to increased PTSD symptomatology suggests that tailoring preventative intervention programs to mitigate the potential impacts of such experiences may be of benefit to refugee youth. Though it is unclear as to how familial separations specifically relate to heightened levels of PTSD symptoms, it is likely that the impacts on individuals are twofold. Firstly, there is likely to be a direct emotional toll of being separated from loved ones, as Nickerson, Bryant, Steel, Silove and Brooks (2010) demonstrate. Secondly, and in line with a stress accumulation model (Fazel et al., 2012), the changes to the family unit that arise following familial separations may impart significant and unique stressors upon family members (for example, the family may have reduced earning capacities if the separation is from a parent), which have their own unique emotional impacts (De Haene et al., 2007). Therefore, developing intervention programs which serve to address the emotional impact of familial separations, as well as developing preventative strategies to

identify potential stressors that may arise due to changes in familial makeup may be of benefit.

Considering this thesis' findings regarding the importance of the family unit in adolescents' PTSD symptomatology and adaptation more generally, interventions which are conducted with the whole family unit and that target familial relational difficulties are highly warranted (De Haene et al., 2007; Rousseau et al., 2004; Weine et al., 2004; Weine, 2011). There is preliminary evidence from studies that have examined the efficacy of such programs to suggest that they may positively impact on family hardiness, knowledge about mental health (Weine et al., 2003), and access to mental health services (Weine, 2008). Whilst evidence from the few studies that have examined the outcomes of family-based treatment approaches have demonstrated their efficacy in reducing anxiety and PTSD symptoms (Möhlen, Parzer, Resch & Brunner, 2005) and conduct and interpersonal problems in refugee populations (Durà-Vilà, Klasen, Makatini, Rahimi & Hodes, 2013).

Results from the qualitative studies of this thesis also point to the potential utility of preventative interventions for refugee youth. That participants with low PTSD symptom levels reported pronounced differences in their sense of identity and belongingness, as well as in the realm of peer relationships compared to those with high PTSD symptoms suggests that intervening to enhance such processes may be of benefit. Administering such programs through the use of group-work is indicated, given this would provide in-situ opportunities for group members to form peer relationships and bonds to the group. In particular, administering the program within a school-setting may also be of particular benefit for refugee children given such programs' effectiveness in overcoming service delivery and demographic barriers to refugee families accessing care (Fazel, Doll & Stein, 2009). A recent systematic review that evaluated the effectiveness of psychological interventions with refugee

and asylum seeking youth, for example, found that school-based programs were particularly effective in leading to positive treatment outcomes for participants (Tyrer & Fazel, 2014).

Evidence from this thesis, as well as other studies' findings, suggest using attachment-informed treatment modalities with refugee youth may also be particularly beneficial (Bala, Mooren & Kramer, 2014; De Haene et al., 2013; Schweitzer et al., 2014). Findings from the present thesis demonstrate that familial factors were correlated with PTSD symptoms, and were also described as being of central importance in participants' lives. Attachment-based interventions that enhance parent-child relationships and serve to mitigate any negative impacts the refugee experience may have had on such relationships are thus highly warranted (De Haene et al., 2013; De Haene et al., 2010), particularly given findings from other studies attesting to the profoundly negative impacts disrupted parent-child relationships may have on young refugees' mental health outcomes (Almqvist & Broberg, 2009; De Haene et al., 2010).

Finally, results from this thesis' second study indicated that mentalisation may have been a differentiating factor between those refugees with high and low PTSD symptom levels. This finding, along with evidence from treatment studies that have appeared to target mentalisation processes in working with clinical refugee populations (Bala et al., 2014; Schweitzer et al., 2014) suggest that it may be an important avenue for attachment-based interventions to specifically target.

8.4 Implications: Future research

The results presented in the current thesis indicate that psychosocial processes, within the family system in particular, are crucial considerations in understanding the impact of the refugee experience on adolescents. These results demonstrate that such factors are related to PTSD symptoms, and thus provide evidence for the assertion from many authors (e.g., De Haene et al., 2007; Porter, 2007; Silove, 1999) that mental health in refugee populations is

linked to the impact the refugee experience has on broader ecological processes. These findings further suggest that the adoption of an attachment framework, both at a theoretical and at an empirical level, may provide deeper understandings into some of the processes behind psychopathological outcomes in refugee youth.

Despite the clear conceptual links between the impact of the refugee experience on familial processes and the resultant impacts on refugee youth mental health, the study of the refugee family is in its infancy (De Haene et al., 2007; Weine et al., 2004; Weine et al., 2013). Studies which examine how specific familial processes are impacted by the refugee experience and how they may then affect children's outcomes, including in relation to PTSD symptomatology, are thus highly warranted (De Haene et al., 2007; Panter-Brick et al., 2013). Specifically, research into familial processes is well-placed to examine psychopathological and resilience processes in refugee youth, at both an individual and familial level (De Haene et al., 2007). Such research would enable the examination of how family factors, such as parental communication and support, result in refugee youth's psychopathological functioning (De Haene et al., 2007). This research would also allow for investigations into how resilience and psychopathological processes function at a family-level, through studying how transactional dynamics of the family unit (such as family roles and communication patterns) allow families to manage stressors and relate to psychological functioning (De Haene et al., 2007; Nickerson et al., 2011).

Closely aligned with the need for future research to examine refugee families in closer detail is the need for studies to specifically focus on how parent-child attachment processes are impacted by the refugee experience, and how such processes affect refugee youth's psychological functioning (De Haene et al., 2013). Such research may hold particular relevance for the examination of PTSD in refugee youth, given the implied centrality of

parental caregiving capacity in the disorder's manifestation in children and adolescents (Almqvist & Broberg, 2003; De Haene et al., 2010; De Haene et al., 2013).

A major finding of the present thesis concerns the preliminary validity of the ADAPT model (Silove, 1999) in conceptualising the impact of participants' refugee and resettlement experiences on adaptational outcomes. Future research which examines this model in further detail is thus highly warranted. In particular, studies which link the impact of adaptational processes to psychopathology, particularly PTSD, would serve to test Silove's (1999) hypothesis that such processes may explicate intervening mechanisms behind the development of psychopathology in refugees. Further studies which investigate how the refugee experience impacts upon other adaptational processes that were not explicated in the ADAPT model would also be of benefit.

A particular avenue of enquiry that this thesis did not examine specifically and only considered conceptually was the developmental impact of the refugee experience. This issue is particularly relevant for refugee children and adolescents given that the experiences they endure, including in the resettlement environment, may impart impacts on important developmental processes (Ehntholt & Yule, 2006), such as identity formation and friendship development, that may not be as relevant for adult refugees (Liebkind, 1993). Further studies which elucidate such relationships would help inform service provision and support arrangements for refugee youth, and would be particularly relevant for the tailoring of preventative programs to intervene with youth who may be at risk of adverse developmental trajectories.

In general terms, this thesis highlights the need for future studies with refugee populations to utilise prospective and longitudinal designs, given the impossibility of elucidating relationships' causality and direction through the cross-sectional studies. Furthermore, studies which utilise a mixed-methods approach, as was taken for the present

thesis, would serve to address some of the methodological limitations that often prevail in uni-modal research with refugee populations (Gifford, Bakopanos, Kaplan, Correa-Velez, 2007).

8.5 Limitations

While the results of the present thesis provide important findings on psychosocial and familial factors associated with PTSD in resettled refugee youth as well as elucidate the nature of some adaptive processes that are implicated in such experiences, they need to be considered in the context of several limitations. The limitations as they pertain specifically to each study have been noted in the three empirical papers but will be expanded upon in further detail herein; namely the assessment procedures around participants' prior trauma and PTSD symptomatology; the cross-cultural relevance of using westernised assessment measures of PTSD symptoms and coping styles; and the disadvantages of the mixed-methods approach utilised for the thesis.

Of specific relevance to this thesis' first empirical paper (Chapter 5) was the fact that prior trauma was not assessed and therefore not controlled for in the analyses. Though it was deemed inappropriate to do so, given the lack of a prior relationship between the researcher and the participants and the potential for retraumatisation, the significant difference between PTSD symptoms of participants who had familial separations versus those who did not may have been confounded by prior trauma exposure. Specifically, those with familial separations may have had higher levels of trauma exposure, as has been demonstrated in the literature with URMs (Derluyn et al., 2009; Wiese & Burhost, 2007), and therefore have higher PTSD symptom scores. A further limitation pertaining specifically to the first study was that only adolescents' self-reports were utilised to examine PTSD symptomatology. Though it was deemed unfeasible to utilise parent/guardian reports due to anticipated logistical difficulties

and, more importantly, potential issues of validity due language barriers, obtaining such information would have been beneficial in corroborating participants' self-reports.

Of further relevance to the first and also to the second empirical paper (Chapter 6), a primary limitation of this thesis was the use of quantitative assessment measures, the CPSS and the CCSC, to examine PTSD symptoms and coping styles respectively. The use of questionnaires that have not been validated in ethnically diverse populations is an oft-cited problem in the literature on refugee mental health (Gifford, Bakopanos, Kaplan, Correa-Velez, 2007; Hollifield et al., 2002). Despite the careful selection of measures that had been utilised in previous studies with ethnically diverse populations (Gaylord-Harden et al., 2008; Jaycox et al., 2010; Jordans et al., 2008; Tol et al., 2008), the issue of the cross-cultural validity remains. This is particularly relevant for the examination of coping styles, which are known to vary cross-culturally (Compas et al., 2001; Gaylord-Harden, et al., 2008). As a result, there may have been important coping styles that were not examined by the CCSC, and the coping styles and behaviours that were assessed by the measure not of relevance to the participants in the present thesis.

Finally, the mixed-method approach that was utilised by the present thesis may be considered both in terms of its strengths and weaknesses. While the mixed-methods approach can be particularly advantageous in studies with refugee populations (Gifford et al., 2007), it also has drawbacks. Enough data needed to be collected in order to establish power for the quantitative component of the study, yet the pragmatic limits of collecting and analysing data for the qualitative component of the research project needed to also be considered. As a result, while there was a large amount of data for the qualitative components of the research, the sample size for the quantitative research was small, and as such may have precluded meaningful results from being obtained. Furthermore, though the sample sizes of the qualitative studies were of a moderate size (Braun & Clarke, 2013), results may still be

limited by those of qualitative research in general wherein generalizability of findings is difficult due to small sample sizes and the idiographic nature of qualitative research (Braun & Clarke, 2013).

8.6 Conclusion

In conclusion, results from the present thesis attest to the multifaceted nature of the impacts of the refugee experience. Whilst a significant proportion of adolescents evidenced clinically elevated PTSD symptoms even many years after resettlement, many also demonstrated notably positive adaptational outcomes, with some explicitly detailing the beneficial aspects of their experiences as refugees. Results demonstrated that familial and psychosocial processes (including familial separations, psychological functioning, familial and peer relationships, and feelings of belongingness and identity) may be related to PTSD symptomatology, providing evidence for the need to consider how psychosocial impacts of the refugee experience relate to psychopathology, including PTSD, in refugees (De Haene et al., 2007; Porter, 2007; Silove, 1999). These results point to the need for future research to utilize familial and attachment-based frameworks from which to study and theorize about the psychological repercussions of the refugee experience, and point to the need for interventions to also be conducted under such frameworks (De Haene et al., 2007; De Haene et al., 2010; Sharp et al., 2012; Weine et al., 2013; Weine et al., 2004). Results further provided preliminary evidence for the validity of the ADAPT model (Silove, 1999), with the exception of the justice system, as a means of conceptualising the impact of the refugee experience on adolescents' adaptational processes. Importantly, such findings add to the literature that has examined aspects of the refugee experience from a theoretical perspective (Porter, 2007).

Taken in concert, this thesis' findings support claims by many that research with refugee populations must take a broader examination of psychological sequelae arising from

the refugee experience (Khawaja et al., 2008; Lustig et al., 2004; Porter, 2007). In considering how familial and psychosocial processes are impacted by such events, and in turn, how such impacts affect mental health, a more nuanced understanding of psychopathology in refugee youth may be obtained. Indeed, as Kagiso [F, 20 years] stated:

> I think families are at the heart of like every single issue or every single success story. Because most … service providers and policy makers and everyone else who's in the wider community underestimates the impact of family because our culture is really … focused on family ties and like everything really seriously revolves around the family. Like if you have a problem I bet you most of the time the family has something to do with it, and if you're doing well, your family has something to do with it too. Like that's just how it is.

References

Abaied, J., & Rudolph, K. (2011). Maternal influences on youth responses to peer stress. *Developmental Psychology, 6*, 1776-1785. doi: 10.1037/a0025439

Ackerman, P. T., Newton, J. E., McPherson, W., Jones, J. G., & Dykman, R. A. (1998). Prevalence of post traumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both). *Child Abuse and Neglect, 22*(8), 759-774. doi: 10.1016/S0145-2134%2898%2900062-3

Agbayani-Siewert, P., Takeuchi, D. T., & Pangan, R. W. (1999). Mental Illness in a Multicultural Context. In Carol S. Aneshensel, C. S. & Phelan, J. C. *Handbook of the Sociology of Menial Health* (pp. 19 - 36). Klumer Academic Press/ Plenum Publishers: New York

Ahearn, F. (2000). Theoretical issues in qualitative and quantitative research. In F. Ahearn (Ed.), *Psychosocial wellness of refugees: Issues in qualitative and quantitative research* (pp. 3-23). New York: Berghahn Books.

Ahmad, A., Sofi, M., Sundelin-Wahlsten, V., & Von Knorring, A. (2000). Posttraumatic stress disorder in children after the military operation "Anfal" in Iraqi Kurdistan. *European Child and Adolescent Psychiatry, 9*, 235-243. doi: 10.1007/s007870070026

Ai, A. L., Tice, T. N., Whitsett, D. D., Ishisaka, T., & Chim, M. (2007). Posttraumatic symptoms and growth of Kosovar war refugees: the influence of hope and cognitive coping. *The Journal of Positive Psychology, 2,* 55-65. doi: 10.1080/17439760601069341

Ajdukovic, M., & Ajdukovic, D. (1993). Psychological well-being of refugee children. *Child Abuse and Neglect, 17,* 843-854. doi: 10.1016/S0145-2134%2808%2980014-2

Al-Krenawi, A., Graham, J. R., & Kanat-Maymon, Y. (2009). Analysis of trauma exposure, symptomatology and functioning in Jewish Israeli and Palestinian adolescents. *British Journal of Psychiatry, 195,* 427-432. doi: 10.1192/bjp.bp.108.050393

Allen, J. P., McElhaney, K. B., Kuperminc, G. P., & Jodl, K. M. (2004). Stability and Change in Attachment Security across Adolescence. *Child Development, 75*(6), 1792-1805. doi: 10.2307/3696677

Allodi, F. (1991). Assessment and treatment of torture victims: a critical review. *Journal of Nervous and Mental Disease, 179,* 4-11. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/1985148

Almqvist, K., & Brandell-Forsberg, M. (1997). Refugee children in Sweden: post-traumatic stress disorder in Iranian preschool children exposed to organised violence. *Child Abuse and Neglect, 21,* 351-366. doi: 10.1016/S0145-2134(96)00176-7

Almqvist, K., & Broberg, A. (1999). Mental health and social adjustment in young refugee children $3^{1}/_{2}$ years after their arrival in Sweden. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 723-770. doi: 0890-8567/99/3806-0723

Almqvist, K., & Broberg, A. (2003). Young children traumatized by organized violence together with their mothers - The critical effects of damaged internal representations. *Attachment & Human Development, 5*(4), 367-380. doi: 10.1080/1461673031000163344 7

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing

Amnesty International. (2013). *This is breaking people. Human rights violations at Australia's asylum seeker processing centre on Manus Island, Papua New Guinea*. Broadway, NSW: Amnesty International. Retrieved from: http://www.amnesty.org.au/refugees/comments/33587/?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed:+AIACampaigns+Amnesty+International+Australia+Campaigns

Araya, M., Chotai, J., Komproe, I. H., & de Jong, J. T. (2007a). Effect of trauma on quality of life as mediated by mental distress and moderated by coping and social support among postconflict displaced Ethiopians. *Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care & Rehabilitation, 16*, 915-927. doi: 10.1007/s11136-007-9201-9

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research, 1*(3), 385-405. doi: 10.1177/146879410100100307

Atwell, R., Gifford, S. M., & McDonald-Wilmsen, B. (2009). Resettled refugee families and their children's futures: coherence, hope and support. *Journal of Comparative Family Studies*, 677-697. Retrieved from: http://www.jstor.org/discover/10.2307/41604320?uid=3737536&uid=2&uid=4&sid=21104355860977

Australian Human Rights Commission. (2013). *Tell me about bridging visas.* Retrieved 14 June, 2014, from: https://www.humanrights.gov.au/publications/tell-me-about-bridging-visas-asylum-seekers

Ayers, T. S., Sandler, I. N., West, S. G., & Roosa, M. W. (1996). A dispositional and situational assessment of children's coping: testing alternative models of coping. *Journal of Personality, 64*, 923-958. doi: 10.1111/j.1467-6494.1996.tb00949.x

Bala, J., Mooren, T., & Kramer, S. (2014). Cultural competence in the treatment of political refugees based on system approaches. *Clinical Neuropsychiatry, 11*(1), 32-39. Retrieved from: http://www.clinicalneuropsychiatry.org/pdf/balaweb.pdf

Bean, T., Derluyn, I., Eurelings-Bontekoe, E., Broekaert, E., & Spinhoven, P. (2007a). Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *Journal of Nervous and Mental Disease, 195,* 288-297. doi: 10.1097/01.nmd.0000243751.49499.93

Bean, T. M., Eurelings-Bontekoe, E., & Spinhoven, P. (2007b). Course and predictors of mental health of unaccompanied refugee minors in the Netherlands: One year follow-up. *Social Science and Medicine, 64*(6), 1204-1215. doi: 10.1016/j.socscimed.2006.11.010

Becker, D. F., Weine, S. M., Vojvoda, D., & McGlashan, T. H. (1999). Case series: PTSD symptoms in adolescent survivors of "ethnic cleansing." Results from a 1-year follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 775-781. doi: 10.1097/00004583-199906000-00027

Beiser, M. (2006). Longitudinal Research to Promote Effective Refugee Resettlement. *Transcultural Psychiatry, 43*(1), 56-71. doi: http://www.ncbi.nlm.nih.gov/pubmed/16671392

Beiser, M., & Hou, F. (2001). Language acquisition, unemployment and depressive disorder among Southeast Asian refugees: A 10-year study. *Social Science and Medicine, 53*(10), 1321-1334. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/11676403

Bergmann, M., & Jucovy, M. (Eds.). (1982). *Generations of the Holocaust.* New York: Basic Books.

Berman, H. (2001). Children and war: Current understandings and future directions. *Public Health Nursing, 18*(4), 243-252. doi: 10.1046/j.1525-1446.2001.00243.x

Berry, J. W. (1997). Immigration, Acculturation, and Adaptation. *Applied Psychology: An International Review, 46*(1), 5-34. doi: 10.1111/j.1464-0597.1997.tb01087.x

Berthold, S. (1999). The effects of exposure to community violence on Khmer refugee adolescents. *Journal of Traumatic Stress, 12,* 455-471. doi: 10.1023/A:1024715003442

Berthold, S. (2000). War traumas and community violence. *Journal of Multicultural Social Work, 8,* 15-46. doi: 10.1300/J285v08n01_02

Betancourt, T. S., & Khan, K. T. (2008). The mental health of children affected by armed conflict: Protective processes and pathways to resilience. *International Review of Psychiatry, 20*(3), 317-328. doi:10.1080/09540260802090363

Betancourt, T., Newnham, E., Layne, C., Kim, S., Steinberg, A., Ellis, H., & Birman, D. (2012). Trauma history and psychopathology in war-affected refugee children referred for trauma-related mental health services in the United States. *Journal of Traumatic Stress, 25,* 682-690. doi: 10.1002/jts.21749

Bhui, K., Stansfeld, S., Head, J., Haines, M., Hillier, S., Taylor, S., Viner, R., & Booy, R. (2005). Cultural identity, acculturation, and mental health among adolescents in east London's multiethnic community. Journal of Epidemiology and Community Health, 59(4), 296-302. doi: 10.1136/jech.2003.014456

Birman, D., Trickett, E. J., & Vinokurov, A. (2002). Acculturation and adaptation of Soviet Jewish refugee adolescents: Predictors of adjustment across life domains. *American Journal of Community Psychology, 30*(5), 585-607. doi: 10.1023/A:1016323213871

Block, K., Warr, D., Gibbs, L., & Riggs, E. (2012). Addressing ethical and methodological challenges in research with refugee-background young people: reflections from the field. *Journal of Refugee Studies, 26*(1), 69-87. doi: 10.1093/jrs/fes/002

Borwick, S., Schweitzer, R., Brough, M., Vromans, L., & Shakespeare-Finch, J. (2013). Well-being of refugeesfrom Burma: a salutogenic perspective. *International Migration, 51*(5), 91-105. doi: 10.1111/imig.12051

Bowlby, J. (1982). *Attachment and Loss* (2nd ed.). London: Hogarth

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995). Psychological responses to war and atrocity: the limitations of current concepts. *Social Science and Medicine, 40*, 1073-1082. doi: 10.1016/0277-9536%2894%2900181-R

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101. doi: 10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research a practical guide for beginners.* London, UK: SAGE Publications Ltd.

Braun-Lewensohn, O., Celestin-Westreich, S., Celestin, L.-P., Verleye, G., Verte, D., & Ponjaert-Kristoffersen, I. (2009). Coping styles as moderating the relationships between terrorist attacks and well-being outcomes. *Journal of Adolescence, 32*, 585-599. doi: 10.1016/j.adolescence.2008.06.003

Breslau, J. (2004). Cultures of trauma: anthropological views of posttraumatic stress disorder in international health. *Culture, Medicine and Psychiatry, 28(2),* 113-126. doi: 10.1023/B:MEDI.0000034421.07612.c8

Brewin, C. R., Andrews, B., & Valentine, J. (2000). Meta-analysis for risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology, 68*, 748-766. doi: 10.1037//0022-006X.68.5.748

Bronstein, I., & Montgomery, P. (2011). Psychological distress in refugee

children: a systematic review. *Clinical Child and Family Psychology Review, 14,* 44-56. doi: 10.1007/s10567-010-0081-0

Bronstein, I., Montgomery, P. D., & Dobrowolski, S. (2012). PTSD in asylum-seeking male adolescents from Afghanistan. *Journal of Traumatic Stress, 25,* 551-557. doi: 10.1002/jts.21740

Brough, M., Gorman, D., Ramirez, E., & Westoby, P. (2003). Young refugees talk about well-being: a qualitative analysis of refugee youth mental health from three states. *Australian Journal of Social Issues, 38,* 193-208. Retrieved from http://go.galegroup.com.ezproxy.lib.monash.edu.au/ps/i.do?action=interpret&ty=as&v=2.1&lm=&u=monash&it=search&s=RELEVANCE&p=EAIM&qt=TI~Young+refugees+talk+about~~SP~193~~IU~2~~SN~0157-6321~~VO~38&sw=w&authCount=1

Byrne, B., & Shavelson, R. (1996). On the Structure of Social Self-Concept for Pre-, Early, and Late Adolescents: A Test of the Shavelson, Hubner, and Stanton (1976) Model. *Journal of Personality and Social Psychology, 70*(3), 599-613. doi: 10.1037/0022-3514.70.3.599

Carlson, B., Cacciatore, J., & Klimek, B. (2012). A risk and resilience perspective on unaccompanied refugee minors. *Social Work, 57*(3), 259-269. doi: 10.1093/sw/sws003

Carlsson, J. M., Olsen, D. R., Mortensen, E. L., & Kastrup, M. (2006). Mental health and health-related quality of life: a 10-year follow-up of tortured refugees. *Journal of Nervous and Mental Disease, 194,* 725-731. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17041283

Carswell, K., Blackburn, P., & Barker, C. (2011). The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers.

International Journal of Social Psychiatry, 57(2), 107-119. doi: 10.1177/0020764009105699

Carver, C. S., & Scheier, M. F. (1994). Situational coping and coping dispositions in a stressful transaction. *Journal of Personality and Social Psychology, 66*(1), 184-195. doi: 10.1037/0022-3514.66.1.184

Cassidy, J. (1988). Child-mother attachment and the self in six-year-olds. *Child Development, 59*, 121-134. doi: 10.2307/1130394

Cho, D., & Park, C. L. (2013). Growth following trauma: Overview and current status. *Terapia Psicologica, 31*(1), 69-79. doi: 10.4067/S0718-48082013000100007

Commonwealth of Australia. (2013). *Australia's Offshore Humanitarian Program: 2012-2013*. Belconnen, ACT: Commonwealth of Australia Retrieved 25 February, 2014, from: http://www.immi.gov.au/media/publications/statistics/immigration-update/australia_offshore_humanitarian_prog_2012-13.pdf.

Compas, B. E. (1987). Coping with stress during childhood and adolescence. *Psychological Bulletin, 101*(3), 393-403. doi: 0033-2909/87/$00.75

Compas, B. E., Connor-Smith, J. K., Saltzman, H., Harding Thomsen, A., & Wadsworth, M. E. (2001). Coping with stress during childhood and adolescence: problems, progress and potential theory and research. *Psychological Bulletin, 127(1),* 87-127. doi: 10.1037//033-2909.127.1.87

Connor-Smith, J. K., Compas, B. E., Wadsworth, M. E., Thomsen, A. H., & Saltzman, H. (2000). Responses to stress in adolescence: measurement of coping and involuntary stress responses. *Journal of Consulting and Clinical Psychology, 68*, 976-992. doi: http://dx.doi.org/10.1037/0022-006X.68.6.976

Copping, A., Shakespeare-Finch, J., & Paton, D. (2010). Towards a culturally appropriate mental health system: Sudanese-Australians' experiences with trauma, Journal of

Pacific Rim Psychology. *Journal of Pacific Rim Psychology, 4*(1), 53-60. doi: 10.1375/prp.4.1.53

Correa-Velez, I., Gifford, S. M., & Barnett, A. G. (2010). Longing to belong: Social inclusion and wellbeing among youth with refugee backgrounds in the first three years in Melbourne, Australia. *Social Science and Medicine, 71*(8), 1399-1408. doi: 10.1016/j.socscimed.2010.07.018

Coyne, J., & Racioppo, M. (2000). Never the twain shall meet? Closing the gap between coping research and clinical intervention research. *American Psychologist, 55*, 655-664. doi: 10.1037//0003-066X.55.6.655

Cunningham, M., & Silove, D. (1993). Principles of treatment and service development for torture and trauma survivors. In J. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 751-762). New York: Plenum Press.

Daud, A., Klinteberg, B., & Rydelius, P. (2008a). Trauma, PTSD and personality: the relationship between prolonged traumatization and personality impairments. *Scandinavian Journal of Caring Sciences, 22*, 331-340. doi: 10.1111/j.1471-6712.2007.00532.x

Daud, A., Klinteberg, B., & Rydelius, P. (2008b). Resilience and vulnerability among refugee children of traumatized and non-traumatized parents. *Child and Adolescent Psychiatry and Mental Health, 2*(7). doi: 10.1186/1753-2000-2-7. doi: 10.1186/1753-2000-2-7

Davidson, G., Murray, K., & Schweitzer, R. (2008). Review of refugee mental health and wellbeing: Australian perspectives. *Australian Psychologist, 43*, 160 - 174. doi: 10.1080/00050060802163041

de Anstiss, H., & Ziaian, T. (2010). Mental health help-seeking and refugee

adolescents: qualitative findings from a mixed-methods investigation. *Australian Psychologist, 45,* 29-37. doi: 10.1080/00050060903262387

Dieperink, M., Leskela, J., Thuras, P., & Engdahl, B. (2001). Attachment Style Classification and Posttraumatic Stress Disorder in Former Prisoners of War. *American Journal of Orthopsychiatry, 71*(3), 374-378. doi: 10.1037/0002-9432.71.3.374

De Haene, L., Dalgaard, N. T., Montgomery, E., Grietens, H., & Verschueren, K. (2013). Attachment narratives in refugee children: Interrater reliability and qualitative analysis in pilot findings from a two-site study. *Journal of Traumatic Stress, 26*(3), 413-417. doi: 10.1002/jts.21820

De Haene, L., Grietens, H., & Verschueren, K. (2007). From symptom to context: a review of the literature on refugee children's mental health. *Hellenic Journal of Psychology, 4,* 233-256. doi: 10.1080/17542863.2012.713371

De Haene, L., Grietens, H., & Verschueren, K. (2010). Adult attachment in the context of refugee traumatisation: The impact of organized violence and forced separation on parental states of mind regarding attachment. *Attachment & Human Development, 12*(3), 249-264. doi: 10.1080/14616731003759732

Department of Health and Human Services (DHHS). (2010). *Refugee Health Services in Tasmania Overview and Review Recommendations: Department of Health and Human Services.* Retrieved 1 March, 2014, from: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/95835/Refugee_Health_Services_in_Tas_Overview_and_Review_Recommendations_2010.pdf

Department of Immigration and Border Protection (2013a). *Information Paper.* Retrieved February 25, 2014, from: http://www.immi.gov.au/media/publications/refugee/ref-hum-issues/pdf/humanitarian-program-information-paper-14-15.pdf

Department of Immigration and Border Protection. (2013b). *State and territory migration summary report: Department of Immigration and Border Protection.* Retrieved February 25, 2014, from: https://www.immi.gov.au/media/publications/statistics/immigration-update/state-territory-summary-dec-2013.pdf

Department of Immigration and Border Protection. (2014a). *Protection Visa (subclass 866).* Retrieved February 25, 2014, from: http://www.immi.gov.au/Visas/Pages/866.aspx

Department of Immigration and Border Protection. (2014b). *Immigration detention and community statistics summary*. *31 May, 2014.* Retrieved 19 July, 2014, from: http://www.immi.gov.au/managing-australias-borders/detention/_pdf/immigration-detention-statistics-may2014.pdf

Department of Immigration and Border Protection. (2014c). *Fact Sheet 83. Community detention.* Retrieved 1 March, 2014, from: https://www.immi.gov.au/media/fact-sheets/83acommunity-detention.htm

Department of Immigration and Citizenship (2013a). *Australia's Offshore Humanitarian Program: 2012-2013*. Retrieved February 25, 2014, from: https://www.immi.gov.au/media/publications/statistics/immigration-update/australia_offshore_humanitarian_prog_2012-13.pdf

Department of Immigration and Citizenship. (2013b). Migration stream by ethnicity. *Settlement reporting.* Retrieved 21 February 2014, from http://www.immi.gov.au/settlement/srf/

Derluyn, I., Mels, C., & Broekaert, E. (2009). Mental Health Problems in Separated Refugee Adolescents. *Journal of Adolescent Health, 44*(3), 291-297. doi: 10.1016/j.jadohealth.2008.07.016

DiGangi, J. A., Gomez, D., Mendoza, L., Jason, L. A., Keys, C. B., & Koenen, K. C. (2013). Pretrauma risk factors for posttraumatic stress disorder: A systematic review of the literature. *Clinical Psychology Review, 33*(6), 728-744. doi: 10.1016/j.cpr.2013.05.002

Drury, J., & Williams, R. (2012). Children and young people who are refugees, internally displaced persons or survivors or peretrators of war, mass violence and terrorism. *Current Opinion in Psychiatry, 25,* 277-284. doi: 10.1097/YCO.0b013e328353eea6

Durakovic-Belko, E., Kulenovic, A., & Ethapic, R. (2003). Determinants of posttraumatic adjustment in adolescents from Sarajevo who experienced war. *Journal of Clinical Psychology, 59,* 27-40. doi: 10.1002/jclp.10115

Durà-Vilà, G., Klasen, H., Makatini, Z., Rahimi, Z., & Hodes, M. (2013). Mental health problems of young refugees: Duration of settlement, risk factors and community-based interventions. *Clinical Child Psychology and Psychiatry, 18*(4), 604-623. doi: 10.1177/1359104512462549

Dyb, G., Jensen, T. K., Nygaard, E., Ekeberg, Ø., Diseth, T. H., Wentzel-Larsen, T., & Thoresen, S. (2014). Post-traumatic stress reactions in survivors of the 2011 massacre on Utøya Island, Norway. *The British Journal of Psychiatry, 204,* 361-367. doi: 10.1192/bjp.bp.113.133157

Dyregrov, A., Gupta, L., Gjestad, R., & Mukanoheli, E. (2000). Trauma exposure and psychological reactions to genocide among Rwandan children. *Journal of Traumatic Stress, 13,* 3-21. doi: 10.1023/A:1007759112499

Dyregrov, A., & Yule, W. (2006). A review of PTSD in children. *Child and Adolescent Mental Health, 11*(4), 176-184. doi: 10.1111/j.1475-3588.2005.00384.x

Ehntholt, K. A., & Yule, W. (2006). Practitioner review: assessment and treatment

of refugee children and adolescents who have experienced war-related trauma. *Journal of Child Psychology and Psychiatry, 47,* 1197-1210. doi: 10.1111/j.1469-7610.2006.01638.x

Eisenbruch, M. (1991). From post-traumatic stress disorder to cultural bereavement: diagnosis of Southeast Asian refugees. *Social Science and Medicine, 33,* 673-680. doi: 10.1016/0277-9536(91)90021-4

Elbedour, S., ten Bensel, R., & Bastien, D. T. (1993). Ecological integrated model of children in war: Individual and social psychology. *Child Abuse and Neglect, 17*(6), 805-819. doi: 10.1016/S0145-2134%2808%2980011-7

Ellis, B. H., MacDonald, H., Lincoln, A., & Cabral, H. (2008). Mental health of Somali adolescent refugees: the role of trauma, stress, and perceived discrimination. *Journal of Consulting and Clinical Psychology, 76,* 184-193. doi: 10.1037/0022-006X.76.2.184

Englund, H. (1998). Death, trauma and ritual: Mozambican refugees in Malawi. *Social Science and Medicine, 46,* 1165-1174. doi: 10.1016/S0277-9536(97)10044-2

Erikson, E. (1968). *Identity youth and crisis*. New York: W. W. Norton & Company, Inc.

Famularo, R., Fenton, T., Kinscherff, R., & Augustyn, M. (1996). Psychiatric comorbidity in childhood posttraumatic stress disorder. *Child Abuse and Neglect, 20,* 953-961. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8902292

Fazel, M., Doll, H., & Stein, A. (2009). A school-based mental health intervention for refugee children: An exploratory study. *Clinical Child Psychology and Psychiatry, 14*(2), 297-309. doi: 10.1177/1359104508100128

Fazel, M., Reed, R., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *Lancet, 379,* 266-282. doi: 10.1016/S0140-6736(11)60051-2

Fazel, M., & Stein, A. (2002). The mental health of refugee children. *Archives of Disease in Childhood, 87,* 366-370. doi: 10.1136/adc.87.5.366

Fazel, M., & Stein, A. (2003). Mental health of refugee children: Comparative study. *BMJ: British Medical Journal, 327*(7407), 134. doi: 10.1136/bmj.327.7407.134

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet, 365,* 1309-1314. doi: 10.1016/S0140-6736(05)61027-6

Finklestein, M., Laufer, A., & Solomon, Z. (2012). Coping strategies of Ethiopian immigrants in Israel: association with PTSD and dissociation. *Scandinavian Journal of Psychology, 53,* 490-498. doi: 10.1111/j.1467-9450.2012.00972.x

Finklestein, M., & Solomon, Z. (2009). Cumulative trauma, PTSD and dissociation among Ethiopian refugees in Israel. *Journal of Trauma & Dissociation, 10*(1), 38-56. doi: 10.1080/15299730802485151

Flouri, E., & Buchanan, A. (2003). The role of father involvement and mother involvement in adolescents' psychological well-being. *British Journal of Social Work, 33,* 399-406. doi: 10.1093/bjsw/33.3.399

Foa, E. B., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30*(3), 376-384. doi: 10.1207/S15374424JCCP3003_9

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (Eds.). (2007). *Affect Regulation, Mentalisation, and the Development of the Self*. London: Karnac Books.

Franz, B. (2003). Bosnian refugee women in (re)settlement: gender relations and social mobility. *Feminist Review* (73), 86-103. doi: 10.2307/1395994

Freud, A., & Burlingham, D. (1943). *War and Children*. New York, N.Y.: Medical War Books.

Fullilove, M. T. (1996). Psychiatric implications of displacement: Contributions from the psychology of place. *The American Journal of Psychiatry, 153*(12), 1516-1523. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/8942445

Furr, A., Austin, M., Cribbs, S. E., & Smoger, S. H. (2005). The effects of neighborhood satisfaction on perception of safety among refugees from the former Soviet Union. *Sociological Spectrum, 25,* 519-537. doi: 10.1080/02732170500175957

Gaylord-Harden, N., Gipson, P., Mance, G., & Grant, K. E. (2008). Coping patterns of African American adolescents: a confirmatory factor analysis and cluster analysis of the Children's Coping Strategies Checklist. *Psychological Assessment, 20*, 10-22. doi: 10.1037/1040-3590.20.1.10

Geltman, P., Grant Knight, W., Mehta, S., Lloyd-Travaglini, C., Lustig, S., Landgraf, J. M., & Wise, P. (2005). The "lost boys of Sudan": functional and behavioral health of unaccompanied refugee minors resettled in the United States. *Archives of Pediatrics and Adolescent Medicine, 6,* 585-591. doi: 10.1001/archpedi.159.6.585

Ghazinour, M., Richter, J., & Eismann, M. (2003). Personality related to coping and social support among Iranian refugees in Sweden. *Journal of Nervous and Mental Disease, 191,* 595-603. doi: 10.1097/01.nmd.0000087186.03513.38

Gifford, S. M., Bakopanos, C., Kaplan, I., & Correa-Velez, I. (2007). Meaning or Measurement? Researching the Social Contexts of Health and Settlement among Newly-arrived Refugee Youth in Melbourne, Australia. *Journal of Refugee Studies, 20*(3), 414-440. doi: 10.1093/jrs/fem004

Gifford, S., Correa-Velez, I., & Sampson, R. (2009). *Good Starts for recently arrived youth with refugee backgrounds: promoting wellbeing in the first three years of settlement in Melbourne, Australia*. La Trobe Refugee Research Centre.

Gil, S., & Caspi, Y. (2006). Personality traits, coping style, and perceived threat as predictors of posttraumatic stress disorder after exposure to a terrorist attack: a prospective study. *Psychosomatic Medicine, 68*, 904-909. doi: 10.1097/01.psy.0000242124.21796.f8

Gold, S. D., Marx, B. P., Soler-Baillo, J. M., & Sloan, D. M. (2005). Is life stress more traumatic than traumatic stress? *Journal of Anxiety Disorders, 19*(6), 687-698. doi: 10.1016/j.janxdis.2004.06.002

Goodman, J. H. (2004). Coping With Trauma and Hardship Among Unaccompanied Refugee Youths From Sudan. *Qualitative Health Research, 14*(9), 1177-1196. doi: 10.1177/1049732304265923

Griffiths, C. A., Ryan, P., & Foster, J. H. (2011). Thematic analysis of Antonovsky's sense of coherence theory. *Scandinavian Journal of Psychology, 52*(2), 168-173. doi: 10.1111/j.1467-9450.2010.00838.x

Grotevant, H. (1987). Toward a process model of identity formation. *Journal of Adolescent Research, 2*(3), 203-222. doi: 10.1177/074355488723003

Guarnaccia, P. J., Lewis-Fernández, R., & Melissa Rivera, M. (2003). Toward a Puerto Rican popular nosology: nervios and ataque de nervios. *Culture, Medicine and Psychiatry, 27*, 339-366. doi: 10.1023/A:1025303315932

Halcon, L., Robertson, C., Savik, K., Johnson, D., Spring, M., Butcher, J., Westermeyer, J., Jaranson, J. (2004). Trauma and coping in Somali and Oromo refugee youth. Journal of Adolescent Health, 35(1), 17 - 25. doi: 10.1016/j.jadohealth.2003.08.005

Hamilton, C. E. (2000). Continuity and Discontinuity of Attachment from Infancy through Adolescence. *Child Development, 71*(3), 690-694. doi: 10.1111/1467-8624.00177

Hepinstall, E., Sethna, V., & Taylor, E. (2004). PTSD and depression in refugee

children: associations with pre-migration trauma and post-migration stress. *European Child and Adolescent Psychiatry, 13,* 373-380. doi:10.1007/s00787-004-0422-y

Hermansson, A. C., Timpka, T., & Thyberg, M. (2002). The mental health of war-wounded refugees: An 8-year follow-up *Journal of Nervous and Mental Disease, 190*(6), 374-380. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/12080207

Hinton, D. E., & Lewis-Fernandez, R. (2011). The cross-cultural validity of posttraumatic stress disorder: implications for DSM-5. *Depression and Anxiety, 28,* 783-801. doi: 10.1002/da.20753

Hjern, A., Angel, B., & Jeppson, O. (1998). Political violence, family stress and mental health of refugee children in exile. *Scandanavian Journal of Public Health, 26*, 18-25. doi: 10.1177/14034948980260010701

Hodes, M. (2000). Psychologically distressed refugee children in the United Kingdom. *Child and Adolescent Mental Health, 5(2),* 57-68. doi: 10.1111/1475-3588.00286

Hodes, M., Jagdev, D., Chandra, N., & Cunniff, A. (2008). Risk and resilience for psychological distress amongst unaccompanied asylum seeking adolescents. *Journal of Child Psychology and Psychiatry, 49,* 723-732. doi: 10.1111/j.1469-7610.2008.01912.x

Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., Stevenson, J., & Westermeyer, J. (2002). Measuring trauma and health status in refugees: a critical review. *Journal of the American Medical Association, 288,* 611-621. doi: 10.1001/jama.288.5.611

Hooberman, J., Rosenfeld, B., Rasmussen, A., & Keller, A. (2010). Resilience in trauma-exposed refugees: the moderating effect of coping style on

resilience variables. *American Journal of Orthopsychiatry, 80,* 557-563. doi: 10.1111/j.1939-0025.2010.01060

Huemer, J., Karnik, N. S., Voelkl-Kernstock, S., Granditsch, E., Dervic, K., Friedrich, M. H., & Steiner, H. (2009). Mental health issues in unaccompanied refugee minors. *Child and Adolescent Psychiatry and Mental Health, 3*. doi: 10.1186/1753-2000-3-13

Hughes, M., Brymer, M., Chiu, W. T., Fairbank, J., Jones, R., Pynoos, R., . . . Kessler, R. C. (2011). Posttraumatic stress among students after the shootings at Virginia Tech. *Psychological Trauma: Theory, Research, Practice, and Policy, 3,* 403-411. doi: 10.1037/a0024565

Hujits, I., Kleijn, W. C., Van Emmerik, A. A., Noordhof, A., & Smith, A. J. (2012). Dealing with man-made trauma: the relationship between coping style, posttraumatic stress, and quality of life in resettled, traumatized refugees in the Netherlands. *Journal of Traumatic Stress, 25,* 71-78. doi: 10.1002/jts.21665

Hussain, D., & Bhushan, B. (2011a). Cultural factors promoting coping among Tibetan refugees: A qualitative investigation. *Mental Health, Religion & Culture, 14*(6), 575-587. doi: 10.1080/13674676.2010.497131

Hussain, D., & Bhushan, B. (2011b). Posttraumatic stress and growth among Tibetan refugees: the mediating role of cognitive-emotional regulation strategies. *Journal of Clinical Psychology, 67*(7), 720-735. doi: 10.1002/jclp.20801

Hussain, D., & Bhushan, B. (2013). Posttraumatic growth experiences among Tibetan refugees: A qualitative investigation. *Qualitative Research in Psychology, 10*(2), 204-216. doi: 10.1080/14780887.2011.616623

Hynie, M., Guruge, S., & Shakya, Y. (2012). Family relationships of Afghan, Karen and Sudanese refugee youth. *Canadian Ethnic Studies, 44*(3), 11-28.

International Society for Traumatic Stress Studies. (2013). *CHILD PTSD SYMPTOM SCALE.* Retrieved 14/11/2013, from: http://www.istss.org/ChildPTSDSymptomScale.htm

Isakson, B. L., & Jurkovic, G. J. (2013). Healing after torture: the role of moving on. *Qualitative Health Research, 23,* 749-761. doi: 10.1177/1049732313482048

Jacobsen, K., & Landau, L. B. (2003). The Dual Imperative in Refugee Research: Some Methodological and Ethical Considerations in Social Science Research on Forced Migration. *Disasters, 27*(3), 185-206. doi: 10.1111/1467-7717.00228

Jaycox, L., Stein, B., Kataoka, S., Wong, M., Fink, A., Escudero, P., & Zaragoza, C. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(9), 1104-1110. doi: 10.1097/01.CHI.0000020261.43550.30

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher, 33*(7), 14-26. doi: 10.3102/0013189x033007014

Jones, L., & Kafetsios, K. (2005). Exposure to political violence and psychological well-being in Bosnian adolescents: a mixed method approach. *Clinical Child Psychology and Psychiatry, 10,*157-176. doi: 10.1177/1359104505051209

Jones, E., Vermaas, R. H., McCartney, H., Beech, C., Palmer, I., Hyams, K., & Wessely, S. (2003). Flashbacks and post-traumatic stress disorder: the genesis of a 20th-century diagnosis. *The British Journal of Psychiatry, 182,* 158-163. doi: 10.1192/bjp.02.231

Jordans, M., Komproe, I. H., Tol, W., Kohrt, B., Luitel, N., Macy, R., & De Jong, J. T. (2010). Evaluation of a classroom-based psychosocial intervention in conflict-affected Nepal: a cluster randomized controlled trial. *Journal of Child Psychology and Psychiatry, 51*(7), 818-826. doi: 10.1111/j.1469-7610.2010.02209x

Jorden, S., Matheson, K., & Anisman, H. (2009). Supportive and unsupportive social interactions in relation to cultural adaptation and psychological distress among Somali refugees exposed to collective or personal traumas. *Journal of Cross Cultural Psychology, 40*(5), 853-874. doi: 10.1177/0022022109339182

Joshi, P. T., & O'Donnell, D. A. (2003). Consequences of child exposure to war and terrorism. *Clinical Child and Family Psychology Review, 6*(4), 275-292. doi: 10.1023/B:CCFP.0000006294.88201.68

Kassam-Adams, N., Marsac, M., & Cirilli, C. (2010). Posttraumatic stress disorder symptom structure in injured children: Functional impairment and depression symptoms in a confirmatory factor analysis. *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(6), 616-625. doi: 10.1016/j.jaac.2010.02.011

Katznelson, H. (2014). Reflective functioning: A review. *Clinical Psychology Review, 34*(2), 107-117. doi: 10.1016/j.cpr.2013.12.003

Keyes, E. F., & Kane, C. F. (2004). Belonging and adapting: mental health of Bosnian refugees living in the United States. *Issues in Mental Health Nursing, 25,* 809-831. doi: 10.1080/01612840490506392

Khamis, V. (2005). Post-traumatic stress disorder among school age Palestinian children. *Child Abuse and Neglect, 29,* 81-95. doi: 10.1016/j.chiabu.2004.06.013

Khawaja, N., White, K., Schweitzer, R., & Greenslade, J. (2008). Difficulties and coping strategies of Sudanese refugees: a qualitative approach. *Transcultural Psychiatry, 45,* 489-512. doi: 10.1177/1363461508094678

Kia-Keating, M., & Ellis, B. H. (2007). Belonging and connection to school in resettlement: Young refugees, school belonging, and psychosocial adjustment. *Clinical Child Psychology and Psychiatry, 12*(1), 29 - 43. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/17375808

Kinzie, D., Boehnlein, J. K., Leung, P. K., Moore, L. J., Riley, C., & Smith, D. (1990). The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees. The American Journal of Psychiatry, 147, 913-917. http://www.ncbi.nlm.nih.gov/pubmed/2356877

Kinzie, J., Sack, W., Angell, R., Clarke, G., & Ben, R. (1989). A three-year follow-up of Cambodian young people traumatized as children. *Journal of the American Academy of Child and Adolescent Psychiatry, 28,* 501-504. doi: 10.1097/00004583-198907000-00006

Kinzie, J., Sack, W. H., Angell, R. H., Manson, S. M., & Rath, B. (1986). The psychiatric effects of massive trauma on Cambodian children: I. The children. *Journal of the American Academy of Child Psychiatry, 25*, 370-376. doi: 10.1016/S0002-7138%2809%2960259-4

Kirmayer, L. J. (2002). The refugee's predicament. *L'Evolution Psychiatrique, 67,* 724-742. doi: 10.1016/S0014-3855%2802%2900166-4

Kirmayer, L., Rousseau, C., & Crepeau, F. (2004). Research ethics and the plight of refugees in detention. *Monash Bioethics review, 23*(4), 85-92. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15688516

Kleinman, A. (1987). Anthropology and psychiatry. The role of culture in cross-cultural research on illness. *British Journal of Psychiatry, 151,* 447-454. doi: 10.1192/bjp.151.4.447

Kliewer, W., Fearnow, M. D., & Miller, P. A. (1996). Coping socialization in middle childhood: Tests of maternal and paternal influences. *Child Development, 67*(5), 2339-2357. doi: 10.2307/1131627

Kobak, R., & Sceery, A. (1988). Attachment in late adolescence: Working models, affect regulation, and representations of self and others. *Child Development, 59*(1), 135-146. 10.2307/1130395

Kohrt, B., Jordans, M. J., Tol, W., Speckman, R., Maharjan, S. M., Worthman, C., & Komproe, I. (2008). Comparison of mental health between former child soldiers and children never conscripted by armed groups in nepal. *JAMA, 300*(6), 691-702. doi: 10.1001/jama.300.6.691

Kovacev, L., & Shute, R. (2004). Acculturation and social support in relation to psychosocial adjustment of adolescent refugees resettled in Australia. *International Journal of Behavioral Development, 28*(3), 259-267. doi: 10.1080/01650250344000497

Krell, R. (Ed.). (1997). *Psychiatry and the Holocaust* (Vol. 4). New Brunswick, NJ: Transaction Publishers.

Kroo, A., & Nagy, H. (2011). Posttraumatic Growth Among Traumatized Somali Refugees in Hungary. *Journal of Loss and Trauma, 16*(5), 440-458. doi: 10.1080/15325024.2011.575705

Kumssa, A., Herbert Williams, J., Jones, J., & Des Marais, E. (2014). Conflict and migration: the case of Somali refugees in northeastern Kenya. *Global Social Welfare.* doi: 10.1007/s40609-014-006-9

Lambert, S., & O'Halloran, E. (2008). Deductive thematic analysis of a female paedophilia website. *Psychiatry, Psychology and Law, 15*(2), 284-300. doi: 10.1080/13218710802014469

Laor, N., Wolmer, L., Mayes, L., Golomb, A., Silverberg, D., Weizman, R., & Cohen, D. (1996). Israeli preschoolers under Scud missile attack. A developmental perspective on risk modifying factors. *Archives of General Psychiatry, 53,* 416-423. doi: 10.1001/archpsyc.1996.01830050052008

Laufer, A., & Solomon, Z. (2006). Posttraumatic symptoms and posttraumatic growth among Israeli youth exposed to terror incidents. *Journal of Social and Clinical Psychology, 25*(4), 429-447. doi: 10.1521/jscp.2006.25.4.429

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping.* New York: Springer.

Leaman, S. C., & Gee, C. B. (2012). Religious coping and risk factors for psychological distress among African torture survivors. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*, 457-465. doi: 10.1037/a0026622

Lengua, L. J., Long, A. C., & Meltzoff, A. N. (2006). Pre-attack stress-load, appraisals, and coping in children's responses to the 9/11 terrorist attacks. *Journal of Child Psychology and Psychiatry, 47*(12), 1219-1227. doi: 10.1111/j.1469-7610.2006.01664.x

Lee, K. A., Vallant, G. E., Torrey, W. C., & Elder, G. H. (1995). A 50-year prospective study of the psychological sequelae of World War II combat. *American Journal of Psychiatry, 152*, 516-522. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/7900929

Lie, B. (2002). A 3-year follow-up study of psychosocial functioning and general symptoms in settled refugees. *Acta Psychiatrica Scandinavica, 106,* 415-425. doi: 10.1034/j.1600-0447.2002.01436.x

Liebkind, K. (1993). Self-reported ethnic identity, depression and anxiety among young Vietnamese refugees and their parents. *Journal of Refugee Studies, 6*(1), 25-39. doi: 10.1093/jrs/6.1.25

Liebkind, K. (1996). Acculturation and stress: Vietnamese refugees in Finland. *Journal of Cross Cultural Psychology, 27*, 161-180. doi: 10.1177/0022022196272002

Lindencrona, F., Ekblad, S., & Hauff, E. (2008). Mental health of recently resettled

refugees from the Middle East in Sweden: the impact of pre-resettlement trauma, resettlement stress and capacity to handle stress. *Social Psychiatry and Psychiatric Epidemiology, 43,* 121-131. doi: 10.1007/s00127-007-0280-2

Loughry, M., & Flouri, E. (2001). The behavioral and emotional problems of former unaccompanied refugee children 3-4 years after their return to Vietnam. *Child Abuse and Neglect, 25,* 249-263. doi: 10.1016/S0145-2134%2800%2900240-4

Luster, T., Qin, D., Bates, L., Johnson, D., & Rana, M. (2009). The lost boys of Sudan: coping with ambiguous loss and separation from parents. *American Journal of Orthopsychiatry, 79,* 203-211. doi: 10.1037/a0015559

Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J., Keane, T., & Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child and Adolescent Psychiatry, 43,* 24-36. doi: 10.1097/00004583-200401000-00012

Mackenzie, C., McDowell, C., & Pittaway, E. (2007). Beyond 'Do No Harm': The Challenge of Constructing Ethical Relationships in Refugee Research. *Journal of Refugee Studies, 20*(2), 299-319. doi: 10.1093/jrs/fem008

Malt, U., Schnyder, U., & Weisaeth, L. (1996). ICD-10 Mental and behavioral consequences of traumatic stress. In F. L. Mak & C. C. Nadelson (Eds.), *International Review of Psychiatry* (Vol. 2, pp. 151-176). Washington, DC: American Psychiatric Press.

Mares, S., Newman, L., Dudley, M., & Gale, F. (2002). Seeking refuge, losing hope: Parents and children in immigration detention. *Australasian Psychiatry, 10*(2), 91-96. doi: 10.1046/j.1440-1665.2002.00414.x

Marsella, A. (1996). *Ethnocultural aspects of posttraumatic stress disorder : issues, research, and clinical applications*. Washington, DC: American Psychological Association

Maslow, L. A. (1954). *Motivation and Personality* (1st ed.). New York: Harper.

Matheson, K., Jorden, S., & Anisman, H. (2008). Relations between trauma experiences and psychological, physical, neuroendocrine functioning among Somali refugees: mediating role of coping with acculturation stressors. *Journal of Immigrant and Minority Health, 10,* 291-304. doi: 10.1007/s10903-007-9086-2

Mazza, M., Giusti, L., Albanese, A., Mariano, M., Pino, M. C., & Roncone, R. (2012). Social cognition disorders in military police officers affected by posttraumatic stress disorder after the attack of An-Nasiriyah in Iraq 2006. *Psychiatry Research, 198*(2), 248-252. doi: 10.1016/j.psychres.2011.11.027

McCarty, C. A., Zimmerman, F. J., Digiuseppe, D. L., & Christakis, D. A. (2005). Parental Emotional Support and Subsequent Internalizing and Externalizing Problems Among Children. *Journal of Developmental and Behavioral Pediatrics, 26*(4), 267-275. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/16100499

McGregor, L., Melvin, G., & Newman, L. (2014). *The Youth Experience Scale for Refugees*. Unpublished instrument.

McMichael, C., Gifford, S. M., & Correa-Velez, I. (2011). Negotiating family, navigating resettlement: family connectedness amongst resettled youth with refugee backgrounds living in Melbourne, Australia. *Journal of Youth Studies, 14,* 179-195. doi: 10.1080/13676261.2010.506529

McMichael, C., & Manderson, L. (2004). Somali women and well-being: social networks and social capital among immigrant women in Australia. *Human Organization*, 63 (1), 88-99, doi: 10.1080/13676261.2010.506529

McNally, R. (2003). Progress and controversy in the study of posttraumatic stress disorder. *Annual Review of Psychology, 45,* 229-252. doi: 10.1146/annuarev.psych.54.101601.145112

McSpadden, L. A., & Moussa, H. (1993). I have a name: the gender dynamics in

asylum and in resettlement of Ethiopian and Eritrean refugees in North America. *Journal of Refugee Studies, 6,* 203-225. doi: 10.1093/jrs/6.3.203

Meeus, W. (2011). The study of adolescent identity formation 2000 - 2010: A review of longitudinal research. *Journal of Research on Adolscence, 21*(1), 75-94. doi: 10.1111/j.1532-7795.2010.00716.x

Mels, C., Derluyn, I., Broekaert, E., & Rosseel, Y. (2010). The psychological impact of forced displacement and related risk factors on Eastern Congolese adolescents affected by war. *Journal of Child Psychology and Psychiatry, 51,* 1096-1104. doi: 10.1111/j.1469-7610.2010.02241.x

Mestheneos, E., & Ioannidi, E. (2002). Obstacles to Refugee Integration in the European Union Member States. *Journal of Refugee Studies, 15*(3), 304-320. doi: 10.1093/jrs/15.3.304

Meyerson, D. A., Grant, K. E., Carter, J. S., & Kilmer, R. P. (2011). Posttraumatic growth among children and adolescents: A systematic review. *Clinical Psychology Review, 31*, 949-964. doi: 10.1016/j.cpr.2011.06.003

Mghir, R., & Raskin, A. (1999). The psychological effects of the war in Afghanistan on young Afghan refugees from different ethnic backgrounds. *International Journal of Social Psychiatry, 45,* 29-36. doi: 10.1177/002076409904500104

Mikulincer, M., Florian, V., & Weller, A. (1993). Attachment styles, coping strategies, and posttraumatic psychological distress: The impact of the Gulf War in Israel. *Journal of Personality and Social Psychology, 64*(5), 817-826. doi: 10.1037/0022-3514.64.5.817

Mikulincer, M., Shaver, P., & Horesh, N. (2006). Attachment bases of emotion regulation and posttraumatic adjustment In D. K. Snyder, J. A. Simpson & J. N. Hughes (Eds.), *Emotion regulation in families: Pathways to dysfunction and health* (pp. 77-99). Washington, DC: American Psychological Association.

Miller, K. E., Omidian, P., Kulkarni, M., Yaqubi, A., Daudzai, H., & Rasmussen, A. (2009). The validity and clinical utility of post-traumatic stress disorder in Afghanistan. *Transcultural Psychiatry, 46,* 219-237. doi: 10.1177/1363461509105813

Miller, K. E., Omidian, P., Rasmussen, A., Yaqubi, A., & Daudzai, H. (2008). Daily stressors, war experiences, and mental health in Afghanistan. *Transcultural Psychiatry, 45,* 611-638. doi: 10.1177/1363461508100785

Miller, K. E., & Rasco, L. M. (Eds.). (2004). *The mental health of refugees: ecological approaches to healing and adaptation*. New Jersey: Lawrence Erlbaum Associates, Inc.

Möhlen, H., Parzer, P., Resch, F., & Brunner, R. (2005). Psychosocial support for war-traumatized child and adolescent refugees: Evaluation of a short-term treatment program. *Australian and New Zealand Journal of Psychiatry, 39*(1-2), 81-87. doi: 10.1111/j.1440-1614.2005.01513.x

Mollica, R. F., Poole, C., Son, L., Murray, C. C., & Tor. (1997). Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 1098-1106. doi: 10.1097/00004583-199708000-00017

Momartin, S., Silove, D., Manicavasagar, V., & Steel, Z. (2004). Complicated Grief in Bosnian Refugees: Associations with Posttraumatic Stress Disorder and Depression. *Comprehensive Psychiatry, 45*(6), 475-482. doi: 10.1016/j.comppsych.2004.07.013

Montgomery, E. (2008). Long-term effects of organized violence on young Middle Eastern refugees' mental health. *Social Science and Medicine, 67,* 1596 - 1603. doi: 10.1016/j.socscimed.2008.07.020

Montgomery, E. (2010). Trauma and resilience in young refugees: a 9-year

follow-up study. *Development and Psychopathology, 22*, 477-489. doi: 10.1017/S09545794100000180

Montgomery, E., & Foldspang, A. (2007). Discrimination, mental problems and social adaptation in young refugees. *European Journal of Public Health, 18*(2), 156-161. doi: 10.1093/eurpub/ckm073

Montgomery, E., Krogh, Y., Jacobsen, A., & Lukman, B. (1992). Children of torture victims: reactions and coping. *Child Abuse and Neglect, 16*, 797-805. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/1486509

Morgos, D., Worden, J., & Gupta, L. (2008). Psychosocial effects of war experiences among displaced children in Southern Darfur. *Omega: Journal of Death and Dying, 56*, 229-253. doi: 10.2190/OM.56.3.b

Murray, K., Davidson, G., & Schweitzer, R. (2008). Psychological wellbeing of refugees resettling in Australia: A literature review prepared for The Australian Psychological Society. Melbourne: The Australian Psychological Society. Retrieved from: http://www.psychology.org.au/assets/files/refugee-lit-review.pdf

Neugebauer, R., Fisher, P., Turner, B., Yamabe, S., Sarsfield, J., & Stehling-Ariza, T. (2009). Post-traumatic stress reactions among Rwandan children and adolescents in the early aftermath of genocide. *International Journal of Epidemiology, 38*, 1033-1045. doi: 10.1093/ije/dyn375

New South Wales Department of Community Services (2006). *Working with refugee & migrant young people.* Retrieved 19 July, 2014, from: http://www.yapa.org.au/openingdoors/migrants_refugees/needs_issues.php

Newman, L., Proctor, N., & Dudley, M. (2013). Seeking asylum in Australia: Immigration detention, human rights and mental health care. *Australasian Psychiatry, 21*(4), 315-320. doi: 10.1177/1039856213491991

Nghe, L. T., Mahalik, J. R., & Lowe, S. M. (2003). Influences on Vietnamese men: examining the traditional gender roles, the refugee experience, acculturation, and racism in the United States. *Journal of Multicultural Counseling and Development, 31*, 245-261. doi: 10.1002/j.2161-1912.2003.tb00353.x

Nickerson, A., Bryant, R. A., Brooks, R., Steel, Z., Silove, D., & Chen, J. (2011). The familial influence of loss and trauma on refugee mental health: a multilevel path analysis. *Journal of Traumatic Stress, 24*(1), 25-33. doi: 10.1002/jts.20608

Nickerson, A., Bryant, R. A., Steel, Z., Silove, D., & Brooks, R. (2010). The impact of fear for family on mental health in a resettled Iraqi refugee community. *Journal of Psychiatric Research, 44*, 229-235. doi: 10.1016/j.jpsychires.2009.08.006

Nickerson, A., Priebe, S., Bryant, R. A., & Morina, N. (2014). Mechanisms of psychological distress following war in the former Yugoslavia: the role of interpersonal sensitivity. PLoS ONE, 9(3), e90503. doi: 10.1371/journal.pone.0090503

Olff, M., Langeland, W., & Gersons, B. P. (2005). The psychobiology of PTSD: Coping with trauma. *Psychoneuroendocrinology, 30*(10), 974-982. doi: 10.1016/j.psyneuen.2005.04.009

Opperman, E., Braun, V., Clarke, V., & Rogers, C. (2013). "It feels so good it almost hurts"" Young adults' experiences of orgasm and sexual pleasure. *Journal of Sex Research, [Epub ahead of print]*, 1-13. doi: 10.1080/00224499.2012.756982

Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis. *Psychological Bulletin, 129,* 52-73. doi: 10.1037/0033-2909.129.1.52

Paardekooper, B., De Jong, J. T., & Hermans, J. (1999). The psychological impact of war and the refugee situation on south Sudanese children in refugee camps in northern

Uganda: An exploratory study. *Journal of Child Psychology and Psychiatry, 40*(4), 529-536. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/10357160

Panter-Brick, C., Grimon, M., & Eggerman, M. (2013). Caregiver-child mental health: a prospective study in conflict and refugee settings. *Journal of Child Psychology and Psychiatry, 54*(11), 313-327. doi: 10.1111/jcpp.12167

Papadopoulos, R. K. (2007). Refugees, trauma and Adversity-Activated Development. *European Journal of Psychotherapy and Counselling, 9*(3), 301-312. doi: 10.1080/13642530701496930

Papageorgiou, V., Frangou-Garunovic, A., Iordanidou, R., Yule, W., Smith, P., & Vostanis, P. (2000). War trauma and psychopathology in Bosnian refugee children. *European Child and Adolescent Psychiatry, 9(2),* 84-90. doi: 10.1007/s007870050002

Parke, R., & Buriel, R. (2008). Socialization in the family: ethnic and ecological perspectives. In W. Damon & R. Lerner (Eds.), *Child and adolescent development. An advanced course*. Hoboken, New Jersey: John Wiley & Sons.

Pedersen, A., Attwell, J., & Heveli, D. (2005a). Prediction of negative attitudes toward Australian asylum seekers: False beliefs, nationalism, and self-esteem. *Australian Journal of Psychology, 57*(3), 148-160. doi: 10.1080/00049530500125157

Pedersen, A., Clarke, S., Dudgeon, P., & Griffiths, B. (2005b). Attitudes toward Indigenous Australians and asylum seekers: The role of false beliefs and other social-psychological variables. *Australian Psychologist, 40*(3), 170-178. doi: 10.1080/00050060500243483

Pedersen, A., & Thomas, E. F. (2013). "There but for the grace of God go we": Prejudice toward asylum seekers. Peace and Conflict: Journal of Peace Psychology, 19(3), 253-265. doi: 10.1037/a0033738

Phan, T., & Silove, D. (1997). The influence of culture on psychiatric assessment:

The Vietnamese refugee. *Psychiatric Services, 48,* 86-90. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9117507

Phan, T., & Silove, D. (1999). An overview of indigenous descriptions of mental phenomena and the range of traditional healing practices amongst the Vietnamese. *Transcultural Psychiatry, 36,* 79-94. doi: 10.1177/136346159903600105

Phan, T., Steel, Z., & Silove, D. (2004). An ethnographically derived measure of anxiety, depression and somatization: the Phan Vietnamese Psychiatric Scale. *Transcultural Psychiatry, 41,* 200-232. doi: 10.1177/1363461504043565

Phillips, J., & Spinks, H. (2013). *Immigration detention in Australia.* Retrieved 25 February, 2014, from: http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22library%2Fprspub%2F1311498%22

Pineles, S. L., Mostoufi, S. M., Ready, C., Street, A. E., Griffin, M. G., & Resick, P. A. (2011). Trauma reactivity, avoidant coping, and PTSD symptoms: A moderating relationship? *Journal of Abnormal Psychology, 120*(1), 240-246. doi: 10.1037/a0022123

Porter, M. (2007). Global evidence for a biopsychosocial understanding of refugee adaptation. *Transcultural Psychiatry, 44,* 418-439. doi: 10.1177/1363461507081639

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. *Journal of the American Medical Association, 294,* 602-612. doi: 10.1001/jama.294.5.602

Powell, S., Rosner, R., Butollo, W., Tedeschi, R. G., & Calhoun, L. G. (2003). Posttraumatic growth after war: A study with former refugees and displaced people in Sarajevo. *Journal of Clinical Psychology, 59*(1), 71-83. doi: 10.1002/jclp.10117

Power, T. G. (2004). Stress and Coping in Childhood: The Parents' Role. *Parenting, 4*(4), 271-317. doi: 10.1207/s15327922par0404_1

Priest, N., Paradies, Y., Trenerry, B., Truong, M., Karlsen, S., & Kelly, Y. (2013). A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people. *Social Science and Medicine, 95*, 115-127. doi: 10.1016/j.socscimed.2012.11.031

Program for Prevention Research. (1999). *Manual for the Children's Coping Strategies Checklist and the How I Coped Under Pressure Scale*: (Available from Arizona State University, P.O. Box 876005, Tempe, AZ 85287-6005).

Punamäki, R. L. (2001). From childhood trauma to adult well-being through psychosocial assistance of Chilean families. *Journal of Community Psychology, 29*, 281-303. doi: 10.1002/jcop.1018

Punamäki, R., & Puhakka, T. (1997). Determinants and effectiveness of children's coping with political violence. *International Journal of Behavioral Development, 21*, 349-370. doi: 10.1080/016502597384910

Punamäki, R., Salo, J., Komproe, I., Qouta, S., El-Masri, M., & De Jong, J. T. (2008). Dispositional and situational coping and mental health among Palestinian political ex-prisoners. *Anxiety, Stress & Coping, 21*(4), 337-358. doi: 10.1080/10615800701797333

QSR International. (2012). NVIVO 10 [Computer Software]. Available from: http://www.qsrinternational.com

Reed, R., Fazel, M., Jones, L., Panter-Brick, C., & Stein, A. (2012). Mental health of

displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *Lancet, 379,* 250-265. doi: 10.1016/S0140-6736(11)60050-0

Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. *The British Journal of Psychiatry, 194*(4), 306-312. doi: 10.1192/bjp.bp.108.053223

Rosbrook, B., & Schweitzer, R. D. (2010). The meaning of home for Karen and Chin refugees from Burma: an interpretative phenomenological approach. *European Journal of Psychotherapy and Counselling, 12*, 159-172. doi: http://dx.doi.org/10.1080/13642537.2010.488876

Rosen, G. M., Spitzer, R. L., & McHugh, P. R. (2008). Problems with the post-traumatic stress disorder diagnosis and its future in DSM-V. *British Journal of Psychiatry, 192,* 3-4. doi: 10.1192/bjp.bp.107.043083

Rothe, E., Lewis, J., Castillo-Matos, H., Martinez, O., Busquets, R., & Martinez, I. (2002). Posttraumatic stress disorder among Cuban children and adolescents after release from a refugee camp. *Psychiatric Services, 53,* 970-976. doi: 10.1176/appi.ps.53.8.970

Rousseau, C., Drapeau, A., & Corin, E. (1997). The influence of culture and context on the pre- and post-migration experience of school-aged refugees from Central America and Southeast Asia in Canada. *Social Science and Medicine, 44,* 1115-1127. doi: 10.1016/S0277-9536%2896%2900243-2

Rousseau, C., Drapeau, A., & Platt, R. (1999). Family trauma and its association with emotional and behavioral problems and social adjustment in adolescent Cambodian refugees. *Child Abuse and Neglect, 23*, 1263-1273. doi: 10.1016/S0145-2134%2899%2900100-3

Rousseau, C., Mekki-Berrada, A., & Moreau, S. (2001). Trauma and extended separation from family among Latin American and African refugees in Montreal. *Psychiatry: Interpersonal and Biological Processes, 64*(1), 40-59. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/11383441

Rousseau, C., Rufagari, M. C., Bagilishya, D., & Measham, T. (2004). Remaking family life: Strategies for re-establishing continuity among Congolese refugees during the family reunification process. *Social Science and Medicine, 59*(5), 1095-1108. doi: 10.1016/j.socscimed.2003.12.011

Rudmin, F. W. (2003). Critical History of the Acculturation Psychology of Assimilation, Separation, Integration, and Marginalization. *Review of General Psychology, 7*(1), 3-37. doi: 10.1037/1089-2680.7.1.3

Sachs, E., Rosenfeld, B., Lhewa, D., Rasmussen, A., & Keller, A. (2008). Entering exile: trauma, mental health, and coping among Tibetan refugees arriving in Dharamsala, India. *Journal of Traumatic Stress, 21*(2), 199-208. doi: 10.1002/jts.20324

Sack, W. H., Clarke, G. N., Him, C., Dickason, D., Goff, B., Lanham, K., & Kinzie, D. (1993). A 6-year follow-up study of Cambodian refugee adolescents traumatized as children. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*, 431-437. doi: 10.1097/00004583-199303000-00027

Sack, W. H., Clarke, G. N., Kinney, R., Belestos, G., Him, C., & Seeley, J. (1995). The Khmer adolescent project: II. Functional capacities in two generations of Cambodian refugees. *Journal of Nervous and Mental Disease, 183*, 177-181. doi: 10.1097/00005053-199503000-00009

Sack, W., Clarke, G., & Seeley, J. (1996). Multiple forms of stress in Cambodian adolescent refugees. *Child Development, 67*, 107-116. Retrieved from: http://www.jstor.org/stable/1131689

Sack, W. H., Him, C., & Dickason, D. (1999). Twelve-year follow-up study of Khmer youths who suffered massive war trauma as children. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 1173-1179. doi: 10.1097/00004583-199909000-00023

Sack, W., Seeley, J., & Clarke, G. (1997). Does PTSD transcend cultural barriers? A study from the Khmer Adolescent Refugee Project. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 49 - 54. doi: 10.1097/00004583-199701000-00017

Sam, D. L., & Berry, J. W. (1995). Acculturative stress among young immigrants in Norway. *Scandinavian Journal of Psychology, 36,* 10-24. doi: 10.1111/j.1467-9450.1995.tb00964.x

Schore, A. N. (2002). Dysregulation of the Right Brain: A Fundamental Mechanism of Traumatic Attachment and the Psychopathogenesis of Posttraumatic Stress Disorder. *Australian and New Zealand Journal of Psychiatry, 36*(1), 9-30. doi: 10.1046/j.1440-1614.2002.00996.x

Schnurr, P. P., Friedman, M. J., & Rosenberg, S. D. (1993). Preliminary MMPI scores as predictors of combat-related PTSD symptoms. *American Journal of Psychiatry, 150,* 479-483. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/8434666

Schweitzer, R., Greenslade, J., & Kagee, A. (2007). Coping and resilience in refugees from the Sudan: a narrative account. *Australian and New Zealand Journal of Psychiatry, 41,* 282-288. doi: 10.1080/00048670601172780

Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry, 40*(2), 179-188. doi: 10.1111/j.1440-1614.2006.01766.x

Schweitzer, R., & Steel, Z. (2008). Researching refugees: methodological and ethical considerations. In P. Liamputtong (Ed.), *Doing cross-cultural research: ethical and methodological considerations* (pp. 87-102). The Netherlands: Springer

Schweitzer, R. D., Vromans, L., Ranke, G., & Griffin, J. (2014). Narratives of healing: A case study of a young Liberian refugee settled in Australia. *The Arts in Psychotherapy, 41*(1), 98-106. doi: 10.1016/j.aip.2013.10.006

Sebastian, C., Burnett, S., & Blakemore, S.J. (2008). Development of the self-concept during adolescence. *Trends in cognitive sciences, 12*(11), 441-446. doi: 10.1016/j.tics.2008.07.008

Seglem, K. B., Oppedal, B., & Roysamb, E. (2014). Daily hassles and coping dispositions as predictors of psychological adjustment: A comparative study of young unaccompanied refugees and youth in the resettlement country. *International Journal of Behavioral Development, 38*(3), 293-303. doi: 10.1177/0165025414520807

Servan-Schreiber, D., Lin, B. L., & Birmaher, B. (1998). Prevalence of posttraumatic stress disorder and major depressive disorder in Tibetan refugee children. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 874-879. doi: 10.1097/00004583-199808000-00018

Shakespeare-Finch, J., & Barrington, A. J. (2012). Behavioural changes add validity to the construct of posttraumatic growth. *Journal of Traumatic Stress, 25*(4), 433-439. doi: 10.1002/jts.21730

Shakespeare-Finch, J., & Lurie-Beck, J. (2014). A meta-analytic clarification of the relationship between posttraumatic growth and symptoms of posttraumatic distress disorder. *Journal of Anxiety Disorders, 28*(2), 223-229. doi: 10.1016/j.janxdis.2013.10.005

Shakespeare-Finch, J., & Wickham, K. (2009). Adaptation of Sudanese refugees in

an Australian context: investigating helps and hindrances. *International Migration, 48*(1), 23-46. doi: 10.1111/j.1468-2435.2009.00561.x

Sharp, C., Fonagy, P., & Allen, J. G. (2012). Posttraumatic stress disorder: a social-cognitive perspective. *Clinical Psychology: Science and Practice, 19,* 229-240. doi: 10.1111/cpsp.12002

Shaw, A., Joseph, S., & Linley, P. (2005). Religion, spirituality, and posttraumatic growth: A systematic review. *Mental Health, Religion & Culture, 8*(1), 1-11. doi: 10.1080/1367467032000157981

Shedlin, M., Decena, C., Noboa, H., & Betancourt, O. (2014). Sending-country violence and receiving-country discrimination: effects on the health of colombian refugees in ecuador. *Journal of Immigrant and Minority Health, 16,* 119-124. doi: 10.1007/s10903-013-9777-9

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology, 35,* 326-334. doi: 10.1007/s001270050246

Singer, D., & Hunter, M. (1999). The experience of premature menopause: A thematic discourse analysis. *Journal of Reproductive and Infant Psychology*, *17*(1), 63-81. doi: 10.1080/02646839908404585

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: toward an integrated conceptual framework. *Journal of Nervous and Mental Disease, 187(4),* 200-207. doi: 10.1097/00005053-199904000-00002

Silove, D., Brooks, R., Steel Bateman, C., Steel, Z., Amaral, F., Rodger, J., & Soosay, I. (2010). Social and trauma-related pathways leading to psychological distress and

functional limitations four years after the humanitarian emergency in Timor-Leste. *Journal of Traumatic Stress, 23,* 151-160. doi: 10.1002/jts.20499

Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression and PTSD in asylum-seekers: associations with pre-migration trauma and post-migration stressors. *British Journal of Psychiatry, 170,* 351-357. doi: 10.1192/bjp.170.4.351

Silove, D., & Steel, Z. (2006). Understanding community psychosocial needs after disasters: Implications for mental health services. *Journal of Postgraduate Medicine, 52* (2), 121-125. Retrieved from: http://www.jpgmonline.com/text.asp?2006/52/2/121/25157

Skinner, E. A., & Zimmer-Gembeck, M. J. (2007). The development of coping. *Annual Review of Psychology, 58,* 119-144. doi: 10.1146/annurev.psych.58.110405.085705

Slobodin, O., & de Jong, J. T. (2014). Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy? *International Journal of Social Psychiatry*. doi: 10.1177/0020764014535752

Slodnjak, V., Kos, A., & Yule, W. (2002). Depression and Parasuicide in Refugee and Slovenian Adolescents. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 23*(3), 127-132. doi: 10.1027//0227-5910.23.3.127

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis. Theory, Method and Research*. London: SAGE Publications.

Solomon, Z., Mikulincer, M., & Avitzur, E. (1988). Coping, locus of control, social support, and combat related posttraumatic stress disorder: a prospective study. *Journal of Personality and Social Psychology, 70*, 127-140. doi: 10.1037/0022-3514.55.2.279

Somerfield, M. R., & McCrae, R. R. (2000). Stress and coping research: Methodological challenges, theoretical advances, and clinical applications. *American Psychologist, 55*(6), 620-625. doi: 10.1037/0003-066X.55.6.620

Stanton, A., Danoff-Burg, S., Cameron, C., & Ellis, A. (1994). Coping through emotional approach: problems of conceptualization and confounding. *Journal of Personality and Social Psychology, 66*(2), 350-362. doi: 10.1037/0022-3514.66.2.350

State Government of Victoria. (2011). *Refugee status report. A report on how refugee children and young people in Victoria are faring*. Melbourne: State of Victoria (Department of Education and Early Childhood Development). Retrieved from: http://www.education.vic.gov.au/Documents/about/research/refugeestatusreport.pdf

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *JAMA: Journal of the American Medical Association, 302*(5), 537-549. doi: 10.1001/jama.2009.1132

Steel, Z., Silove, D., Bird, K., McGorry, P., & Mohan, P. (1999). Pathways from war trauma to posttraumatic stress symptoms among Tamil asylum seekers, refugees, and immigrants. *Journal of Traumatic Stress, 12,* 421-435. doi: 10.1023/A:1024710902534

Steel, Z., Silove, D., Phan, T., & Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: A population-based study. *The Lancet, 360*, 1056-1062. doi: 10.1016/S0140-6736%2802%2911142-1

Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *British Journal of Psychiatry, 188*(1), 58-64. doi: 10.1192/bjp.bp.104.007864

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine, 48,* 1449-1462. doi: 10.1016/S0277-9536%2898%2900450-X

Summerfield, D. (2000). Childhood, war, refugeedom and "trauma": three core questions for mental health professionals. *Transcultural Psychiatry, 37,* 417-433. doi: 10.1177/136346150003700308

Summerfield, D. (2012). Afterword: against "global mental health". *Transcultural Psychiatry, 49,* 519-530. doi: 10.1177/1363461512454701

Summerfield, D., & Hume, F. (1993). War and posttraumatic stress disorder: the question of social context. *Journal of Nervous and Mental Disease, 181,* 522. Retrieved from: http://journals.lww.com/jonmd/Citation/1993/08000/War_and_Posttraumatic_Stress_Disorder__The.12.aspx

Taylor, R. D., Lopez, E. I., Budescu, M., & McGill, R. K. (2012). Parenting practices and adolescent internalizing and externalizing problems: Moderating effects of socially demanding kin relations. *Journal of Child and Family Studies, 21*(3), 474-485. doi: 10.1007/s10826-011-9501-0

Taylor, S., & Stanton, A. (2007). Coping resources, coping processes, and mental health. *Annual Review of Clinical Psychology, 3,* 377-401. doi: 10.1146/annurev.clinpsy.3.022806.091520

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: growth in the aftermath of suffering*. London: Sage.

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*(3), 455-471. doi: 10.1002/jts.2490090305

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychological Inquiry, 15*(1), 1-18. Retrieved from: http://ptgi.uncc.edu/ptgi/files/2013/01/PTG-Conceptual-Foundtns.pdf

Tempany, M. (2008). *Concepts of mental health and wellbeing held by Sudanese Australian young people: a qualitative project*. Unpublished doctoral dissertation. Monash University, Melbourne, Australia

Thabet, A. A. M., Abed, Y., & Vostanis, P. (2004). Comorbidity of PTSD and depression among refugee children during war conflict. *Journal of Child Psychology and Psychiatry, 45*, 533-542. doi: 10.1111/j.1469-7610.2004.00243.x

The Liberal Party. (2013). *Media Release: Operation Sovereign Borders*. Retrieved 25 February, 2014, from http://www.liberal.org.au/latest-news/2013/07/26/operation-sovereign-borders

Thoits, P. A. (1982). Conceptual, Methodological, and Theoretical Problems in Studying Social Support as a Buffer Against Life Stress. *Journal of Health and Social Behavior, 23*(2), 145-159. doi: 10.2307/2136511

Tol, W., Komproe, I. H., Susanty, D., Jordans, M., Macy, R., & De Jong, J. T. (2008). School-based mental health intervention for children affected by political violence in Indonesia a cluster randomized trial. *JAMA, 300*(6), 655-662. doi:10.1186/1741-7015-12-56

Tousignant, M., Habimana, E., Biron, C., Malo, C., Sidoli-LeBlanc, E., & Bendris, N.

(1999). The Quebec adolescent refugee project: psychopatholoy and family variables in a sample from 35 nations. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 1426 - 1432. doi: 10.1097/00004583-199911000-00018

Turner, S. W., Bowie, C., Dunn, G., Shapo, L., & Yule, W. (2003). Mental health of Kosovan Albanian refugees in the UK. *The British Journal of Psychiatry, 182*(5), 444-448. doi: 10.1192/bjp.182.5.444

Tyrer, R. A., & Fazel, M. (2014). School and community-based interventions for refugee and asylum seeking children: a systematic review. *PLoS ONE, 9*(2), e89359. doi: 10.1371/journal.pone.0089359

United Nations High Commissioner for Refugees. (1951). *Text of the Convention and Protocol Relating to the Status of Refugees.* Retrieved 24 February, 2014, from http://www.unhcr.org/3b66c2aa10.html

United Nations High Commissioner for Refugees (2013). UNHCR monitoring visit to the Republic of Nauru 7 to 9 October 2013 Lyons, ACT: United Nations High Commissioner for Refugees, Regional Office. Retrieved February 25, 2014, from: http://unhcr.org.au/unhcr/images/2013-11-26%20Report%20of%20UNHCR%20Visit%20to%20Nauru%20of%207-9%20October%202013.pdf

United Nations High Commissioner for Refugees. (2014a). *Children.* Retrieved February 25, 2014, from: http://www.unhcr.org/pages/49c3646c1e8.html

United Nations High Commissioner for Refugees. (2014b). *Populations of Concern.* Retrieved February 25, 2014, from: http://www.unhcr.org/528a0a0fe.html

United Nations High Commissioner for Refugees. (2014c). *Durable Solutions.* Retrieved February 25, 2014, from: http://www.unhcr.org/pages/49c3646cf8.html

United Nations High Commissioner for Refugees. (2014d). *Voluntary repatriation*. Retrieved February 25, 2014, from: http://www.unhcr.org/pages/49c3646cfe.html

United Nations High Commissioner for Refugees. (2014e). *Local Integration.* Retrieved February 25, 2014, from: http://www.unhcr.org/pages/49c3646c101.html

United Nations High Commissioner for Refugees. (2014f). *Resettlement.* Retrieved February 25, 2014, from: http://www.unhcr.org/pages/4a16b1676.html

United Nations High Commissioner for Refugees. (2014g). *Asylum-Seekers*. Retrieved February 25, 2014, from: http://www.unhcr.org/pages/49c3646c137.html

United States Department of State Office of the Historian. (2013). The War in Bosnia, 1992-1995. Retrieved 21 June, 2014, from https://history.state.gov/milestones/1993-2000/bosnia

Valentine, G., Sporton, D., & Nielsen, K. B. (2009). Identities and belonging: a study of Somali refugee and asylum seekers living in the UK and Denmark. *Environment and Planning D: Society and Space, 27*(2), 234-250. doi: 10.1068/d3407

van Rooyen, K., & Nqweni, Z. (2012). Culture and posttraumatic stress disorder (PTSD): a proposed conceptual framework. Psychological Society of South Africa, 42(1), 51-60. van Rooyen, K., & Nqweni, Z. (2012). Culture and posttraumatic stress disorder (PTSD): a proposed conceptual framework. *Psychological Society of South Africa, 42*(1), 51-60. doi: 10.1177/008124631204200106

Waters, E., Hamilton, C. E., & Weinfield, N. S. (2000). The Stability of Attachment Security from Infancy to Adolescence and Early Adulthood: General Introduction. *Child Development, 71*(3), 678-683. doi: 10.1111/1467-8624.00175

Wang, C. W., Chan, C. L., & Ho, R. T. (2013). Prevalence and trajectory of

psychopathology among child and adolescent survivors of disasters: a systematic review of epidemiological studies across 1987-2011. *Social Psychiatry and Psychiatric Epidemiology, 48,* 1697-1720. doi: 10.1007/s00127-013-0731-x

Weine, S. (2008). Family roles in refugee youth resettlement from a prevention perspective. *Child and Adolescent Psychiatric Clinics of North America, 17*(3), 515-532. doi: 10.1016/j.chc.2008.02.006

Weine, S. M. (2011). Developing Preventive Mental Health Interventions for Refugee Families in Resettlement. *Family Process, 50*(3), 410-430. doi: 10.1111/j.1545-5300.2011.01366.x

Weine, S., Feetham, S., Kulauzovic, Y., Besic, S., Lezic, A., Mujagic, A.,Muzurovic, D., Spahovic, D., Zhubi, M., Rolland, J. & Pavkovic, I. (2004). In K. Miller & L. Rasco (Eds.), The mental health of refugees: ecological approaches to healing and adaptation. Mahwah, NJ: Lawrence Erlbaum

Weine, S., Raina, D., Zhubi, M., Delesi, M., Huseni, D., Feetham, S., Kulauzovic, Y., Mermelstein, R., Campbell, R., Rolland, J., & Pavkovic, I. (2003). The TAFES family-group intervention for Kosovar refugees. A feasability study. *The Journal of Nervous & Mental Disease, 191*(2), 100-107. doi: 022-3018/03/1912-100

Weine, S. M., Ware, N., Tugenberg, T., Hakizimana, L., Dahnweih, G., Currie, M., Wagner, M., & Levin, E. (2013). Thriving, managing, and struggling: a mixed methods study of adolescent African refugees' psychosocial adjustment. *Adolescent Psychiatry, 3,* 72-81. doi: 10.2174/2210676611303010013

Weinfield, N. S., Whaley, G. J. L., & Egeland, B. (2004). Continuity, discontinuity, and coherence in attachment from infancy to late adolescence: Sequelae of organization and disorganization. *Attachment & Human Development, 6*(1), 73-97. doi: 10.1080/14616730310001659566

Weisner, T., & Fiese, B. (2011). Introduction to Special Section of the Journal of Family Psychology, Advances in Mixed Methods in Family Psychology: Integrative and Applied Solutions for Family Science. *Journal of Family Psychology, 25*(6), 795-798. doi: 10.1037/a0026203

Whittaker, S., Hardy, G., Lewis, K., & Buchan, L. (2005). An Exploration of Psychological Well-being with Young Somali Refugee and Asylum-seeker Women. *Clinical Child Psychology and Psychiatry, 10,* 177-196. doi: 10.1177/1359104505051210

Wiese, E. B. P., & Burhorst, I. (2007). The mental health of asylum-seeking and refugee children and adolescents attending a clinic in the Netherlands. *Transcultural Psychiatry, 44*, 596-613. doi: 10.1177/1363461507083900

Yoon, E., Chang, C.-T., Kim, S., Clawson, A., Cleary, S. E., Hansen, M., . . . Gomes, A. M. (2013). A Meta-Analysis of Acculturation/Enculturation and Mental Health. *Journal of Counseling Psychology, 60*(1), 15-30. doi: 10.1037/a0030652

Zetter, R. (2007). More labels, fewer refugees: Remaking the refugee label in an era of globalization. *Journal of Refugee Studies, 20*(2), 172-192. doi: 10.1093/jrs/fem011

Appendices

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Appendix A: Monash University Human Ethics Approval

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

Date:	**7 October 2011**
Project Number:	**CF11/1664 - 2011000913**
Project Title:	**Adaptation and coping in adolescents from refugee backgrounds resettled in Australia**
Chief Investigator:	**Dr Glenn Melvin**
Approved:	**From: 7 October 2011 To: 7 October 2016**

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, and a copy forwarded to MUHREC before any data collection can occur at the specified organisation. **Failure to provide permission letters to MUHREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research**.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Ben Canny
Chair, MUHREC

cc: Ms Lucy McGregor, Prof Louise Kathryn Newman

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
Telephone [redacted] Facsimile +61 3 9905 3831
Email [redacted] www.monash.edu/research/ethics/human/index/html
ABN 12 377 614 012 CRICOS Provider #00008C

Appendix B: University of Tasmania Human Research Ethics Committee Approval

Social Science Ethics Officer
Private Bag 01 Hobart
Tasmania 7001 Australia
Tel: (03) 6226 2763
Fax: (03) 6226 7148
Katherine.Shaw@utas.edu.au

HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

UTAS

5 March 2013

Dr Glenn Melvin
Monash University Centre for Developmental Psychiatry & Psychology

Sent via email

Dear Dr Melvin

Re: PRIOR APPROVAL ETHICS APPLICATION APPROVAL
Ethics Ref: **H0013080 - Adaptation and Coping in Adolescents from Refugee Backgrounds**
Previously approved by: Monash University HREC

We are pleased to advise that acting on a mandate from the Tasmania Social Sciences HREC, the Chair of the committee considered and approved the above project on 4 March 2013.

This approval constitutes ethical clearance by the Tasmania Social Sciences Human Research Ethics Committee. The decision and authority to commence the associated research may be dependent on factors beyond the remit of the ethics review process. For example, your research may need ethics clearance from other organisations or review by your research governance coordinator or Head of Department. It is your responsibility to find out if the approval of other bodies or authorities is required. It is recommended that the proposed research should not commence until you have satisfied these requirements.

Please note that this approval is for four years and is conditional upon receipt of an annual Progress Report. Ethics approval for this project will lapse if a Progress Report is not submitted.

The following conditions apply to this approval. Failure to abide by these conditions may result in suspension or discontinuation of approval.

1. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval, to ensure the project is conducted as approved by the Ethics Committee, and to notify the Committee if any investigators are added to, or cease involvement with, the project.

Appendix C: Victoria Department of Education and Early Childhood Development Ethics Approval

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
DX 210083
GPO Box 4367
Melbourne, Victoria 3001

2011_001174

Miss Lucy McGregor
School of Psychology and Psychiatry
Monash University
Building 17
Wellington Road
CLAYTON 3800

Dear Miss McGregor

Thank you for your application of 31 May 2011 in which you request permission to conduct research in Victorian government schools and/or early childhood settings titled *Adaptation and coping in adolescents from refugee backgrounds resettled in Australia.*

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. The research is conducted in accordance with the final documentation you provided to the Department of Education and Early Childhood Development.

2. Separate approval for the research needs to be sought from school principals and/or centre directors and this is to be supported by the DEECD approved documentation and the letter of approval from a relevant and formally constituted Human Research Ethics Committee.

3. The project is commenced within 12 months of this approval letter and any extensions or variations to your study, including those requested by an ethics committee must be submitted to the Department of Education and Early Childhood Development for its consideration before you proceed.

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

5. You acknowledge the support of the Department of Education and Early Childhood Development in any publications arising from the research.

6. The Research Agreement conditions, which include the reporting requirements at the conclusion of your study, are upheld. A reminder will be sent for reports not submitted by the study's indicative completion date.

7. If DEECD has commissioned you to undertake this research, the responsible Branch/Division will need to approve any material you provide for publication on the Department's Research Register.

I wish you well with your research study. Should you have further enquiries on this matter, please contact Kathleen Nolan, Research Officer, Education Policy and Research, by telephone on [redacted]

Yours sincerely

[redacted]

Dr Elizabeth Hartnell-Young
Group Manager
Education Policy and Research

12/09/2011

enc

Appendix D: Tasmania Department of Education Ethics Approval

Department of Education
EDUCATIONAL PERFORMANCE SERVICES

2/73 Murray Street, Hobart
GPO Box 169, Hobart, TAS 7001 Australia

Tasmania

File: 2013-19

27 June 2013

Lucy McGregor
School of Psychology & Psychiatry
Monash University
c/- 2/288 Davey Street
SOUTH HOBART TAS 7004

Dear Ms McGregor

Application to conduct research

I have been advised by the Educational Performance Report Committee that the above research study adheres to the guidelines established and that there is no objection to the study proceeding.

Please note that you have been given permission to proceed at a general level, and not at individual school level. You will still need to seek permission from the principal of the schools involved in the study and advise how you intend to contact parents. We request that you do not offer incentives in the form of movie tickets, to students for their participation in the study.

A copy of your final report should be forwarded to Educational Performance Services, Department of Education, GPO Box 169, Hobart, 7001 at your earliest convenience and within six months of the completion of the research phase.

Yours sincerely

[redacted]

Tony Luttrell
Director
(Educational Performance Services)

Appendix E: Participant Explanation and Consent Form (Melbourne Version)

Participant Explanatory Statement and Consent Form

Full Project Title: Adaptation and coping in youth from refugee backgrounds resettled in Australia.

Researcher: Lucy McGregor. Doctor of Psychology (Clinical) Candidate, School of Psychology and Psychiatry, Monash University [redacted]

Supervisors: Dr. Glenn Melvin, Senior Lecturer and Psychologist, Monash Centre for Developmental Psychiatry and Psychology [redacted] and Professor Louise Newman, Director, Monash Centre for Developmental Psychiatry and Psychology [redacted]

Introduction

The aim of this research is to learn how teenagers from refugee backgrounds adjust to their new lives in Australia. You have been invited to take part in this research. We would like to hear from you about what things are important to you in your new lives in Australia, and how you have coped with the challenges of moving to Australia. We will also be looking at whether you are experiencing any emotional and/or behavioural difficulties. If you are having any of these difficulties, we will talk to you about these and about getting in touch with a professional who can help.

You have been invited to participate in this research along with a group of other students from refugee backgrounds. Students who were invited to participate have had to have been in Australia for at least 6 months.

This Information and Consent Form tells you about what is involved in the research project and what sort of things you will do as part of the project. Please read this information carefully and feel free to ask any questions about anything you want to know more about or don't understand.

Your participation in this research is voluntary. If you don't wish to take part in this research, you don't have to. If you decide to take part in this research but then change your mind at a later stage, you are free to stop participating in the project. But once you have completed the questionnaires, information from these cannot be withdrawn from the project. Your decision to take part or not, or to take part and then withdraw, will not affect your relationship with the researchers or your school.

If you decide that you are happy to take part in this research, you are asked to please sign the consent section of this form. By signing this you are telling us that you:

- understand what you have read;
- agree to take part in this research;
- agree to be involved in the procedures described in this document;
- agree to the use of your personal information as described in this document.

Your parent or caregiver will also be given a similar form and will be asked for their own signed consent for you to participate in this research.

You will be given copies of your information and consent forms to keep.

What does participation in this research project involve?

Firstly you will be asked to complete 3 questionnaires. These questionnaires will provide information about whether you are experiencing any emotional or behavioural difficulties, and will also find out what coping skills you use in dealing with various problems you may come across. The questionnaires should take approximately 20 minutes to complete.

You will then be asked to take part in a conversation with the researcher. The researcher will ask you about your experiences in adapting to your new life in Australia. These conversations will be audio-taped, and then written down. A copy of the written version of the interview can be given to you if you would like to read it. If you agree to take part in this discussion, the researcher would like to talk to you for up to 40 minutes. If you need an interpreter, one will be made available to you and they will sign a confidentiality agreement before they interpret for you.

We would also like to obtain copies of your school reports, to see how you have been going at school. You do not have to agree for us to have copies of your school reports though if you don't want us to. You may still take part in the other parts of the research without us having copies of your reports.

Your teachers will also be asked to complete a brief questionnaire about you. This questionnaire will be a teacher version of one of the questionnaires you will complete. It asks about your teachers' views of any emotional and behavioural difficulties you might be experiencing, as well as their views of your positive characteristics and skills. You do not have to agree for your teachers to take part in this part of the research if you do not want them to. You may still take part in the other parts of the research without your teacher taking part in the study.

What are the possible benefits of participating in this research?

The information gained from this research project will help us better understand the challenges facing teenagers from refugee backgrounds when they resettle into new countries, like Australia. In having greater understanding about the difficulties you face in adapting to Australian life, we can work to better meet your needs, and the future needs of other teenagers from refugee backgrounds who will come to Australia.

What are the possible risks?

Some teenagers may be upset in speaking about adjusting to life in Australia. In the unlikely event of you becoming upset as a result of the participation in the project, the researcher will discuss this with you and talk about the different options of support available to you.

Below is a list of helpful agencies who may be contacted in the event that you wish to speak to someone if you feel upset in speaking about your adjustment to life in Australia:

Organisation	Service provided	Contact number	Operating hours
Monash Medical Centre	24 hour psychological and medical emergencies	9594 6666	24 hour service
Lifeline	Telephone crisis support	13 11 14	24 hour service
Kids' Helpline	Telephone counselling service specifically for young people	1800 55 1800	24 hour service
Suicide Helpline	Telephone support service for people thinking about suicide or worried about the safety of someone else	1300 651 251	24 hour service
Parent Helpline	Telephone counselling service to parents of children from birth to 18 years	13 22 89	8am – midnight, 7 days a week
Foundation House	Provides a range of services to people from refugee backgrounds who have survived torture or war related trauma.	Brunswick Office: 9388 0022 Dandenong Office: 8788 3333	Business hours

What publications might stem from this research?

The results of this research will form a thesis, as part of the course requirements for the completion of the Doctor of Clinical Psychology program. There may also be publications in research journals and presentations made to conferences which discuss the results of this research. There will be no identifying information in any publications or presentations that will be based upon this research. **.**

How will we be informed about the final results of this research project?

You will be given feedback on progress over the course of the study.

What will happen to information about me?

Any information obtained from this research will be kept fully confidential. Information will only be disclosed with your permission, except as required by law. Clinicians are required to notify the Department of Human Services if they believe a teenager in their care, or another family member, is at risk of harm or discloses earlier experiences of physical or sexual abuse.

Information gathered will be stored securely for at least 5 years, or until you turn 21, upon completion of the study and then destroyed confidentially. The information collected will be stored in locked cupboards at the School of Psychology and Psychiatry at Monash University. It will only be used by the researcher. Your name and contact details will be kept separately from the information you provide. Also, there will be nothing in any report, presentation or publication on the study that could identify you or your family. You have a right to access and to request correction of information held about you in accordance with the Freedom of Information Act 1982 (Vic).

If you have any questions about the research project, please feel free to contact Lucy McGregor, School of Psychology and Psychiatry, Monash University, Clayton, VIC, 3800 (tel: [redacted]; email: [redacted]

Participant Consent Form

Title: Adaptation and coping in youth from refugee backgrounds resettled in Australia.

NOTE: *This consent form will remain with the Monash University researcher for their records*

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read, or have had read to me, the Explanatory Statement in a language I understand, which I keep for my records. I understand that agreeing to take part means that:

I agree to be interviewed by the researcher	☐ Yes	☐ No
I agree to allow the interview to be audio-taped	☐ Yes	☐ No
I agree to complete questionnaires asking me about my emotions and behaviours and about how I cope with challenges	☐ Yes	☐ No

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the interview and questionnaires for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.

I understand that data from the interview will be kept in a secure storage and accessible to the research team. I also understand that the data will be destroyed after a 5 year period unless I consent to it being used in future research.

Participant's name: _____

Signature: _____

Date: _____

Declaration by the researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed): _____

Signature: _____

Date: _____

** Note: All parties signing the consent form must date their own signature.*
If you have any complaints or concerns about this research project, please complete this slip of paper in the reply-paid envelope, and post it back to Monash University. Susie Thompson, a staff member from the Centre of Developmental Psychiatry and Psychology at Monash University who is not directly involved in the research project, will call you back at a suitable time with an interpreter to discuss your concerns further.

Please complete the following details and post this slip of paper back in the attached envelope.

Name: .....
Language/Dialect you require an interpreter in: .....
Phone number(s) to contact you on: .....
Preferred contact time (e.g., "Mondays from 3pm til 5pm"): .....

Appendix F: Parent/Guardian Explanation and Consent Form (Melbourne Version)

Parent and Guardian Explanatory Statement and Consent Form

Full Project Title: Adaptation and coping in youth from refugee backgrounds resettled in Australia.

Researcher: Lucy McGregor. Doctor of Psychology (Clinical) Candidate, School of Psychology and Psychiatry, Monash University (email: lucy.mcgregor@monash.edu).

Supervisors: Dr. Glenn Melvin, Senior Lecturer and Psychologist, Monash Centre for Developmental Psychiatry and Psychology (tel: 9902 4562) and Professor Louise Newman, Director, Monash Centre for Developmental Psychiatry and Psychology (tel: 9594 1354).

Introduction

The aim of this research is to gain a better understanding into how adolescents from refugee backgrounds cope with and adapt to their new lives in Australia. Your teenager has been invited to take part in this research. We would like to hear your teenager's opinions about what things are important to them in adapting to their new lives in Australia, and how they cope with the challenges of resettling into a new country. We will also be looking at the types of emotions and behaviours your teenagers are most commonly experiencing at this time. If any teenager is found to be having behavioural or emotional difficulties, they will be offered psychological assistance.

Your teenager has been invited to participate in this research along with a group of fellow students who are from refugee backgrounds. Students who were invited to participate have had to have been in Australia for at least 6 months. This information was sent to you from the school, our research team does not have your contact details.

This Information and Consent Form tells you about what is involved in the research project and what sort of things your teenager will do as part of the project. Please read this information carefully and feel free to ask any questions about anything you want to know more about or don't understand.

Your teenager's participation in this research is voluntary. If you don't wish for your teenager to take part in this research, they don't have to. If you and your teenager decide to take part in this research but then change your minds at a later stage, you are free to withdraw from the project. However, once the anonymous questionnaire data has been submitted it cannot be withdrawn from the project. You and your teenager's decision to take part or not, or to take part and then withdraw, will not affect your relationship with the researchers or the Southern Health Child and Adolescent Mental Health Services.

If you decide that you are happy for your teenager to take part in this research, you are asked to please sign the consent section of this form. By signing this you are telling us that you:

- understand what you have read, or have had read to you;
- consent for your teenager to take part in this research;
- consent for your teenager to be involved in the procedures described;
- consent to the use of your teenager's personal information as described.

Your teenager will also be given a similar form and will be asked for their own signed consent to participate in this research as well.

You and your teenager will be given copies of your information and consent forms to keep.

What does participation in this research project involve?

Firstly your teenagers will be asked to complete 3 questionnaires. These questionnaires will provide information about whether your teenagers are experiencing any emotional or behavioural difficulties, and will also find out what coping skills your teenagers use in dealing with various problems they may come across. The questionnaires should take approximately 20 minutes to complete.

Your teenager will then take part in a conversation with the researcher, during which they will talk about their experiences in resettling and adapting to their new life in Australia. These conversations will be audio-taped, and then transcribed. Your teenager will be shown the transcripts of the interview for their approval before they are included in the write up of the research. If you and your teenager agree to take part in this discussion the researcher would like to talk to them for up to an hour. If your teenager needs an interpreter, one will be made available to them and they will sign a confidentiality agreement before partaking in interpreting services.

Your teenager and their teacher will also be asked for permission to obtain copies of their school reports.

School teachers will also be asked to complete a brief questionnaire about your teenagers. This questionnaire will be a teacher version of one of the questionnaires your teenagers will complete, and asks questions about their views of the teenagers' emotional and behavioural difficulties, as well as their positive characteristics and attributes.

To show our appreciation for your child's participation , we will offer them a movie voucher after they have finished with the questionnaires and the interview.

What are the possible benefits of my teenager participating in this research?

The information gained from this research project will help us better understand the challenges facing youth from refugee backgrounds when they resettle into Western countries, like Australia. In having greater knowledge about the difficulties these young people face in adapting to Australian life, we can work to better accommodate their needs.

What are the possible risks?

There are no apparent risks in partaking in this project, however young people who are experiencing emotional and behavioural difficulties may be experiencing thoughts around death and self-harm. Below is a list of relevant agencies and their contact numbers, should there be any concerns:

Organisation	Service provided	Contact number	Operating hours
Monash Medical Centre	24 hour psychological and medical emergencies	9594 6666	24 hour service
Lifeline	Telephone crisis support	13 11 14	24 hour service
Kids' Helpline	Telephone counselling service specifically for young people	1800 55 1800	24 hour service
Suicide Helpline	Telephone support service for people thinking about suicide or worried about the safety of someone else	1300 651 251	24 hour service
Parent Helpline	Telephone counselling service to parents of children from birth to 18 years	13 22 89	8am – midnight, 7 days a week

In the unlikely event of a participant becoming upset or distressed as a result of the participation in the project, the clinician will discuss this with you and your son/daughter and offer further counselling and/or other appropriate support.

What publications might stem from this research?
The results of this research will form a Doctoral thesis, as part of the course requirements for the completion of the Doctor of Clinical Psychology program. It is also envisioned that publications in research journals as well as conference presentations will arise from the results of this research.

How will we be informed about the final results of this research project?
You will be given feedback on progress over the course of the study.

What will happen to information about my teenager?
Any information obtained from this research will be kept fully confidential. Information will only be disclosed with your permission, except as required by law. Clinicians are required to notify the Department of Human Services if they believe a teenager, or another family member, is at risk of harm or discloses earlier experiences of physical or sexual abuse.

Information gathered will be stored securely for at least 5 years, or until your child turns 21, upon completion of the study and then destroyed confidentially. The information collected will be stored in locked cupboards at the School of Psychology and Psychiatry at Monash University. It will only be used by the researcher. Your teenager's name and contact details will be kept separately from the information they provide. Also, there will be nothing in any report, presentation or publication on the study that could identify you or your family. Your teenager has a right to access and to request correction of information held about them in accordance with the Freedom of Information Act 1982 (Vic).

If you have any questions about the research project, please feel free to contact Lucy McGregor, School of Psychology and Psychiatry, Monash University, Clayton, VIC, 3800 ([redacted] email: [redacted]. If you have any concerns or complaints about the research project that have not been dealt with by the researcher, you can contact Susie Thomson, an administrative staff member at the Centre for Developmental Psychiatry and Psychology at Monash Medical Centre (tel: [redacted] who is not involved in the current research project. She will take note of your complaint and will ring you back at a convenient time with the aid of an interpreter, if required, to speak in more detail about the concern or complaint.

Parent/Guardian Consent Form

Title: Adaptation and coping in youth from refugee backgrounds resettled in Australia.

Chapter 2 ***NOTE:*** *This consent form will remain with the Monash University researcher for their records*

I agree for my child part in the Monash University research project specified above. I have had the project explained to me, and I have read, or have had read to me, the Explanatory Statement in a language I understand, which I keep for my records. I understand that agreeing for my child to take part means that:

I agree for my child to be interviewed by the researcher	☐ Yes	☐ No
I agree to allow the interview to be audio-taped	☐ Yes	☐ No
I agree for my child to complete questionnaires asking them about their emotions and behaviours and about how they cope with challenges	☐ Yes	☐ No

I understand that my child's participation is voluntary, that I can choose for them not to participate in part or all of the project, and that they can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the interview and questionnaires for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

I understand that any information my child provides is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.

I understand that data from the interview will be kept in a secure storage and accessible to the research team. I also understand that the data will be destroyed after a 5 year period or until my child reaches 21 years of age unless I consent to it being used in future research.

Name of person giving consent: _____

Relation to participant: _____

Signature: _____

Date: _____

Appendix G: Excerpt of De-identified Case Notes

Research on Adaptation and Coping in youth from refugee backgrounds resettled in Australia.
Ethics Project No. CF11/1664 - 2011000913

12/12/12	P/C to XXX's mother, XXX. Her mobile phone was not working properly, the writer could not hear her speak. Informed XXX that the writer will call her back. L McGregor. Provisional Psychologist. Student Researcher.
14/12/12	P/C to XXX, XXX' mother. No answer. L McGregor. Provisional Psychologist. Student Researcher.
17/12/12	Feedback session with XXX (participant # XXX). Informed him of the high CPSS results and the need for me to therefore contact his parents, under the writer's duty of care. XXX amenable to this and did not have any questions for the writer. XXX gave the writer his home phone number. Writer also gave XXX a list of agencies (see above) who he could go to for assistance. L McGregor. Provisional Psychologist. Student Researcher.
17/12/12	Feedback session with XXX (participant # XXX). Informed her that her CPSS results were clinically elevated, and suggested she speak with a professional to help her with any difficulties she might be experiencing, gave her the list of agencies (as above). As XXX now 18, writer informed her that she didn't have to call her parents, XXX reported that she was happy with this and did not wish for the writer to call them (writer said that she could still call them to discuss results anyway if she wished). L McGregor. Provisional Psychologist. Student Researcher.
18/12/2012	P/C to XXX's mother (participant ID XXX) with an interpreter. Discussed the elevated results she obtained in the CPSS questionnaire and suggested the names of some organisations she could go to for assistance (Migrant Information Centre, XXX Clinic). XXX's mother was amenable to this information and spoke about how XXX is nervous about the new school she is about to enter into next year, as it wasn't her first choice of where she wanted to go, she attributed the results of the questionnaire to this worry. XXX's mother was thankful for the call. L McGregor. Provisional Psychologist. Student Researcher.
18/12/2012	P/C to XXX's mother Phone call to XXX's mother to discuss results of the heightened CPSS questionnaires. She reported that she did not need an interpreter. She was amenable to the results and did not have many questions for me when I spoke with her. I passed on the contact numbers of the XXX Clinic and the Migrant information centre, should she and XXX decide to use them. L McGregor. Provisional Psychologist. Student Researcher.
18/2/2012	P/C to XXX, XXX's mother with a Swahili interpreter. Informed her of XXX's elevated CPSS results. XXX reported that she was not surprised about the results, and spoke about some concerns she had for her other daughter as well. I passed on contact details for the XXX clinic and XXX Headspace, which

	XXX took down. She was very grateful for the call and asked me to mail her a copy of a list of agencies that XXX and her sisters could go to for assistance (XXX said that she could have this information sent in English). Plan: send out information sheet on referral agencies to XXX's home address. L McGregor. Provisional Psychologist. Student Researcher.
18/2/2012	Posted out referral info sheet (see entry on 10/12/12) to XXX's mother. L McGregor. Provisional Psychologist. Student Researcher.

Appendix H: Child PTSD Symptom Scale

The Child PTSD Symptom Scale (CPSS) – Part I

Below is a list of problems that kids sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE LAST 2 WEEKS.

Please write down your most distressing event:

_____

Length of time since the event:

_____

0	1	2	3
Not at all or only at one time	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/almost always

1.	0	1	2	3	Having upsetting thoughts or images about the event that came into your head when you didn't want them to
2.	0	1	2	3	Having bad dreams or nightmares
3.	0	1	2	3	Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again)
4.	0	1	2	3	Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc)
5.	0	1	2	3	Having feelings in your body when you think about or hear about the event (for example, breaking out into a sweat, heart beating fast)
6.	0	1	2	3	Trying not to think about, talk about, or have feelings about the event
7.	0	1	2	3	Trying to avoid activities, people, or places that remind you of the traumatic event
8.	0	1	2	3	Not being able to remember an important part of the upsetting event
9.	0	1	2	3	Having much less interest or doing things you used to do
10.	0	1	2	3	Not feeling close to people around you
11.	0	1	2	3	Not being able to have strong feelings (for example, being unable to cry or unable to feel happy)

12.	0	1	2	3	Feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or having kids)

0	1	2	3
Not at all or only at one time	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/almost always

13.	0	1	2	3	Having trouble falling or staying asleep
14.	0	1	2	3	Feeling irritable or having fits of anger
15.	0	1	2	3	Having trouble concentrating (for example, losing track of a story on the television, forgetting what you read, not paying attention in class)
16.	0	1	2	3	Being overly careful (for example, checking to see who is around you and what is around you)
17.	0	1	2	3	Being jumpy or easily startled (for example, when someone walks up behind you)

The Child PTSD Symptom Scale (CPSS) – Part 2

Indicate below if the problems you rated in Part 1 have gotten in the way with any of the following areas of your life DURING THE PAST 2 WEEKS.

	Yes	No	
18.	Y	N	Doing your prayers
19.	Y	N	Chores and duties at home
20.	Y	N	Relationships with friends
21.	Y	N	Fun and hobby activities
22.	Y	N	Schoolwork
23.	Y	N	Relationships with your family
24.	Y	N	General happiness with your life

Appendix I: Children's Coping Strategies Checklist – Revision 1

Name: _____

I.D. Number: _____

CHILDREN'S COPING STRATEGIES CHECKLIST (CCSC)

Sometimes young people have problems or feel upset about things. When this happens, they may do different things to solve the problem or to make themselves feel better.

Below is a list of things young people may do when faced with a problem. For each item, circle the response that best describes how often you usually do the behavior when you have a problem. There are no right or wrong answers, just indicate how often you usually do each thing in order to solve the problem or to make yourself feel better.

RESPONSES:

(1) Never (2) Sometimes (3) Often (4) Most of the time

WHEN I HAVE A PROBLEM, I . . .

1. Think about what I could do before I do something. CDM
   Never Sometimes Often Most of the time

2. Try to notice or think about only the good things in life. PCR
   Never Sometimes Often Most of the time

3. Talk about how I am feeling with my mother or father. EFS
   Never Sometimes Often Most of the time

4. Go bike riding. PRE
   Never Sometimes Often Most of the time

5. Try to stay away from the problem. AVA
   Never Sometimes Often Most of the time

6. Do something to make things better. DPS
   Never Sometimes Often Most of the time

7. Think about why it has happened. SU
   Never Sometimes Often Most of the time

8. Listen to music. DA
   Never Sometimes Often Most of the time

9. Try to put it out of my mind. CA
   Never Sometimes Often Most of the time

10. Figure out what I can do by talking with one of my friends. PFS

Never Sometimes Often Most of the time

11. Think about what would happen before I decide what to do. CDM

Never Sometimes Often Most of the time

12. Tell myself it will be over in a short time. PCR

Never Sometimes Often Most of the time

13. Talk about how I am feeling with some adult who is not in my family. EFS

Never Sometimes Often Most of the time

WHEN I HAVE A PROBLEM, I . . .

14. Play sports. PRE

Never Sometimes Often Most of the time

15. Try to stay away from things that make me feel upset. AVA

Never Sometimes Often Most of the time

16. Try to make things better by changing what I do. DPS

Never Sometimes Often Most of the time

17. Ask God to help me understand it. SU

Never Sometimes Often Most of the time

18. Go for a walk. DA

Never Sometimes Often Most of the time

19. Imagine how I'd like things to be. CA

Never Sometimes Often Most of the time

20. Talk to my brother or sister about how to make things better. PFS

Never Sometimes Often Most of the time

21. Think about which things are best to do to handle the problem. CDM

Never Sometimes Often Most of the time

22. Remind myself that things could be worse. PCR

Never Sometimes Often Most of the time

23. Talk with my brother or sister about my feelings. EFS

Never Sometimes Often Most of the time

24. Go skateboard riding or roller skating. PRE

Never Sometimes Often Most of the time

25. Avoid the people that make me feel bad. AVA

Never Sometimes Often Most of the time

26. Do something to solve the problem. DPS

Never Sometimes Often Most of the time

27. Try to understand it better by thinking more about it. SU
Never Sometimes Often Most of the time

28. Read a book or magazine. DA
Never Sometimes Often Most of the time

29. Wait and hope that things will get better. CA
Never Sometimes Often Most of the time

30. Try to solve the problem by talking with my mother or father. PFS
Never Sometimes Often Most of the time

31. Think about what I need to know so I can solve the problem. CDM
Never Sometimes Often Most of the time

32. Tell myself it's not worth getting upset about. PCR
Never Sometimes Often Most of the time

WHEN I HAVE A PROBLEM, I . . .

33. Talk with one of my friends about my feelings. EFS
Never Sometimes Often Most of the time

34. Do some exercise. PRE
Never Sometimes Often Most of the time

35. Avoid it by going to my room. AVA
Never Sometimes Often Most of the time

36. Do something like video games or a hobby. DA
Never Sometimes Often Most of the time

37. Do something in order to get something good out of the situation. DPS
Never Sometimes Often Most of the time

38. Think about what I can learn from the problem. SU
Never Sometimes Often Most of the time

39. Watch TV. DA
Never Sometimes Often Most of the time

40. Wish that things were better. CA
Never Sometimes Often Most of the time

41. Try to figure out what I can do by talking to an adult who is not in my family. PFS
Never Sometimes Often Most of the time

42. Try to figure out why things like this happen. SU
Never Sometimes Often Most of the time

Appendix J: Youth Experience Scale for Refugees (YES-R)

Youth Experiences Scale for Refugees (YES-R)

When did you find out you were going to be coming to Australia?

How did you feel about this?

How did your family feel? How has your family found coming to Australia?

What did you know about Australia before you came?

What was it like for you when you first came to Australia?

- do you still notice these things that you found different at first now that you've been here for…. [period of time]?

How were things different for you in Australia compared to your life [in ….] before?

What are the things you miss about [… country]?

What are the things that you don't miss about […country]?

Do you feel you have made a new life in Australia? What things have helped you with this?

Do you feel that Australia is your home now?
What do you hope for […country of origin] for the future?

Do you feel safe in Australia?

Do you feel safer in Australia compared to at home? [Discuss]

Who do you live with in Australia? (if live with parents) → Do your parents work in Australia? What were their professions in [home country]?

Do you have any other family [like cousins, uncles, aunts etc] in Australia who came from [home country] that you can visit?

How does your community feel about their experiences as refugees?

Do you ever think about your situation in becoming a refugee?

Are there other members of your community that you visit/spend time with?

How did you find making friends when you got to Australia? What things do you do with your friends when you're not at school?

Do you feel that the number of friends you have has changed since settling in Australia compared to at home?

Have your relationships with your friends helped you adjust to life in Australia? If yes, how? If no, why not?

What's it like to be someone your age in Australia? Do your parents have different ideas about this?

Do you think that holding religious beliefs has helped you deal with things both in your journey here and in Australia? If yes, how? If not, why not?

Do you maintain any cultural traditions in Australia? If yes, what? Why do you maintain these traditions?

How do you like school? What things do you like most about school? (favourite subjects etc). How are you finding learning English?

Do you play in any sports teams or in school activities (bands, music etc)?

What do you do in your spare time in Australia? What do your family think of this?

What are your goals for the future?

What do your family hope for you in the future?

What advice would you give to other young people who come to Australia from multicultural backgrounds?

What do you think are the most important issues facing young people from multicultural backgrounds who move to Australia?

Appendix K: Examples of Questions of the YES-R as they pertain to the ADAPT model

Attachment System:

- Do you feel that the number of friends you have has changed since settling in Australia compared to at home?
- Have your relationships with your friends helped you adjust to life in Australia? If yes, how? If no, why not?

Identity/Role System:

- What do you do in your spare time in Australia? What do your family think of this?
- What are your goals for the future?
- What do your family hope for you in the future?

Safety System:

- Do you feel safe in Australia?
- Do you feel safer in Australia compared to at home? [Discuss]

Justice System:

- How does your community feel about their experiences as refugees?
- Do you ever think about your situation in becoming a refugee?

Existential-Meaning System

- Do you think that holding religious beliefs has helped you deal with things both in your journey here and in Australia? If yes, how? If not, why not?
- Do you maintain any cultural traditions in Australia? If yes, what? Why do you maintain these traditions?

Appendix L: Example Extracts of Research Journal

28/5/2013
Reading Silove's 1999 article on the Core Adaptive systems in thinking about how I can apply this theory to my coding. Good quote which elucidates some of the factors in the model, "One such system, the "safety" system, and its relationship to posttraumatic stress disorder (PTSD), has tended to attract much of the focus of recent research, with relatively less attention being given to the impact of trauma on other adaptive systems such as the capacity to form and nurture interpersonal bonds, to retain a sense of identity and role functioning, to maintain faith in a system of justice, and to sustain a sense of existential meaning, coherence, and hope". --> many of these factors are relevant to participant 2012208, where he has disrupted bonds with his family (interpersonal bonds) particularly.

**Important. Silove also writes about how it's important to identify the adaptive systems that are "mobilized". Keep this in mind when coding. As an initial thought, it could be that for many young people their motivations and goals for the future (could be conceptualised as 'hope' perhaps in silove's adapt model) become activated, as demonstrated by the huge number of young people who report really ambitious goals, particularly around study. Those young people who didn't report a strong sense of focus on goals, like 2012208 and 2013402, appear to be suffering more difficulties. - this could be conceptualised as "identity and role functioning" in Silove's model.

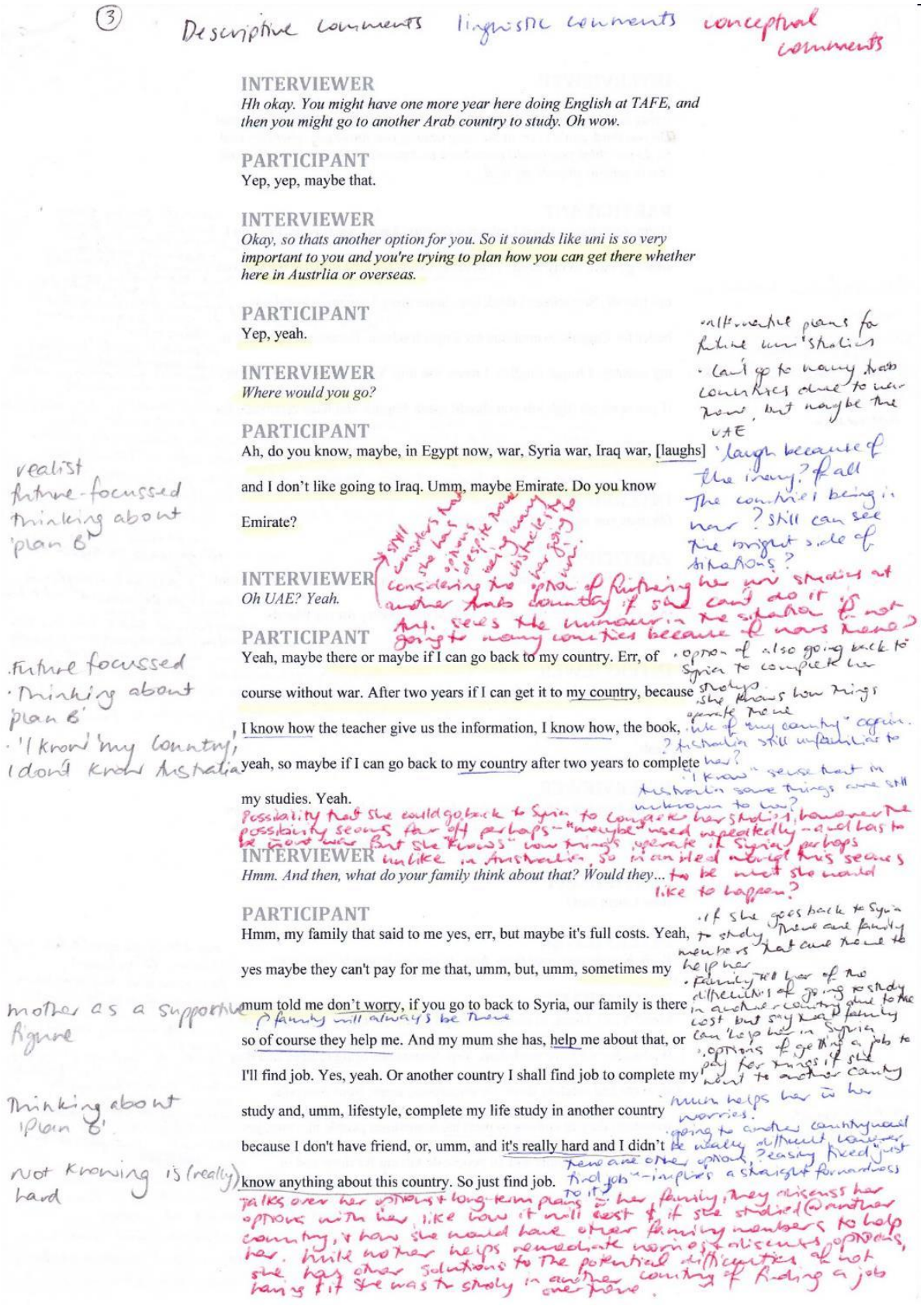
The existential meaning system - part of Silove's model. could be conceptualised as participantns' faith??

for the attachment node, i added two further child nodes for healthy and unhealthy/disrupted attachment, making it easier to distinguish between the two types when coding, and given that both types of attachment appear to be occurring in participnat 2012208's story.

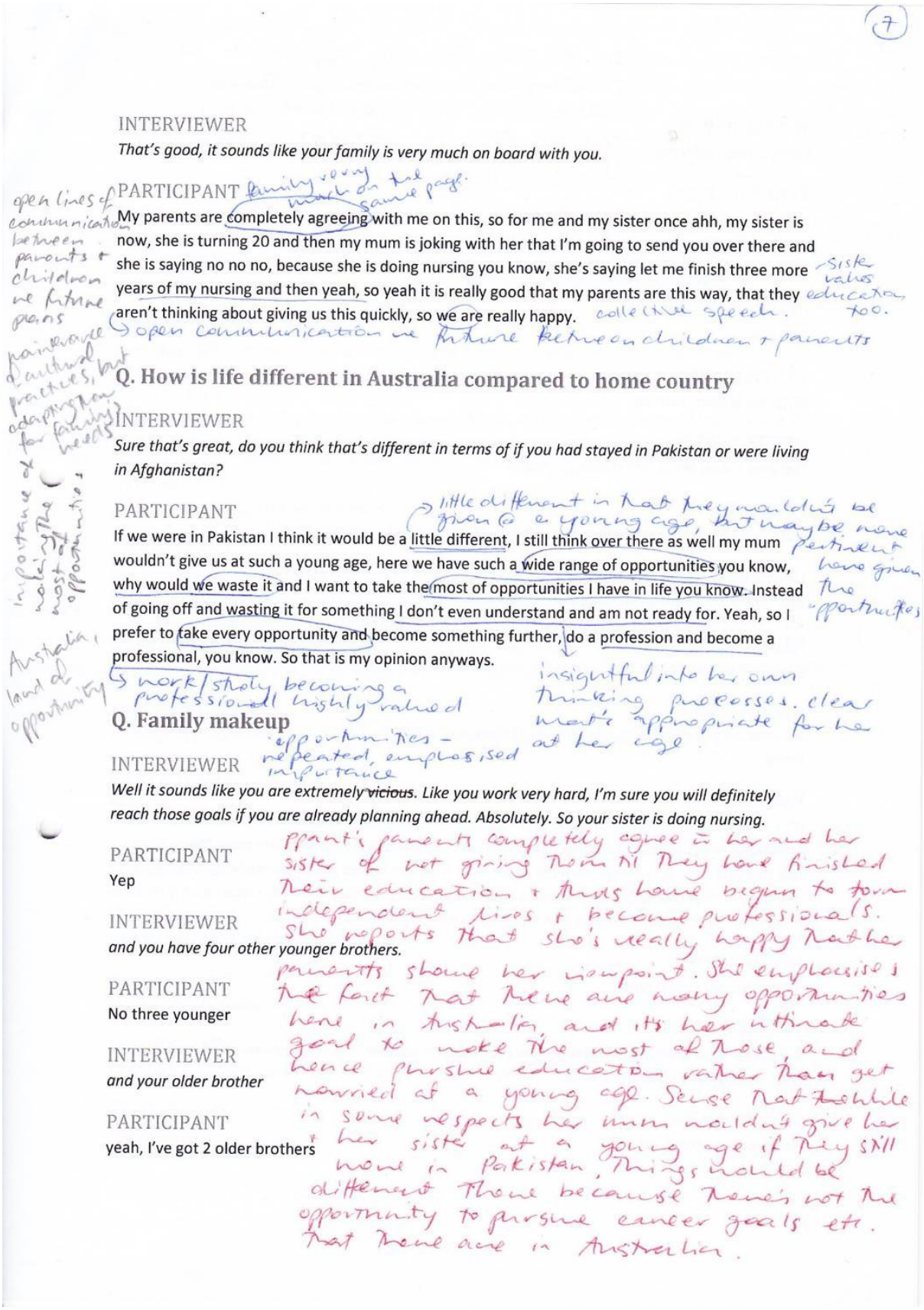
added a coping node, and put avoidance and escapism into that coping node, as i think these two things could be conceptualised as coping strategies. Need to have a look at my coding system for escapism and avoidance - these seem like they could be coding the same thing!!??

In the Justice Node, I'm coding aggressive actions and feelings (e.g., when the participant reports that they're frustrated) of the participant, based on Silove's discussion in his 1999 paper on aggressiveness and anger in people with PTSD and as he subsumed this discussion under the justice heading. however I don't know if it delineates well from Other meanings of justice I'm coding, where participants are talking about situations in which they felt (or it is inferred that they felt) a sense of injustice or where they discuss things that infer a sense of justice. Think therefore i might make a separate node for anger/aggressiveness and subsume it under psychological symptoms.

Appendix M: Example Extract of IPA Coding at Descriptive, Linguistic and Abstract Levels



Appendix N: Example Extract of a Second IPA Coding Strategy



7

INTERVIEWER

That's good, it sounds like your family is very much on board with you.

PARTICIPANT

My parents are completely agreeing with me on this, so for me and my sister once ahh, my sister is now, she is turning 20 and then my mum is joking with her that I'm going to send you over there and she is saying no no no, because she is doing nursing you know, she's saying let me finish three more years of my nursing and then yeah, so yeah it is really good that my parents are this way, that they aren't thinking about giving us this quickly, so we are really happy.

Q. How is life different in Australia compared to home country

INTERVIEWER

Sure that's great, do you think that's different in terms of if you had stayed in Pakistan or were living in Afghanistan?

PARTICIPANT

If we were in Pakistan I think it would be a little different, I still think over there as well my mum wouldn't give us at such a young age, here we have such a wide range of opportunities you know, why would we waste it and I want to take the most of opportunities I have in life you know. Instead of going off and wasting it for something I don't even understand and am not ready for. Yeah, so I prefer to take every opportunity and become something further, do a profession and become a professional, you know. So that is my opinion anyways.

Q. Family makeup

INTERVIEWER

Well it sounds like you are extremely ~~vicious~~. Like you work very hard, I'm sure you will definitely reach those goals if you are already planning ahead. Absolutely. So your sister is doing nursing.

PARTICIPANT

Yep

INTERVIEWER

and you have four other younger brothers.

PARTICIPANT

No three younger

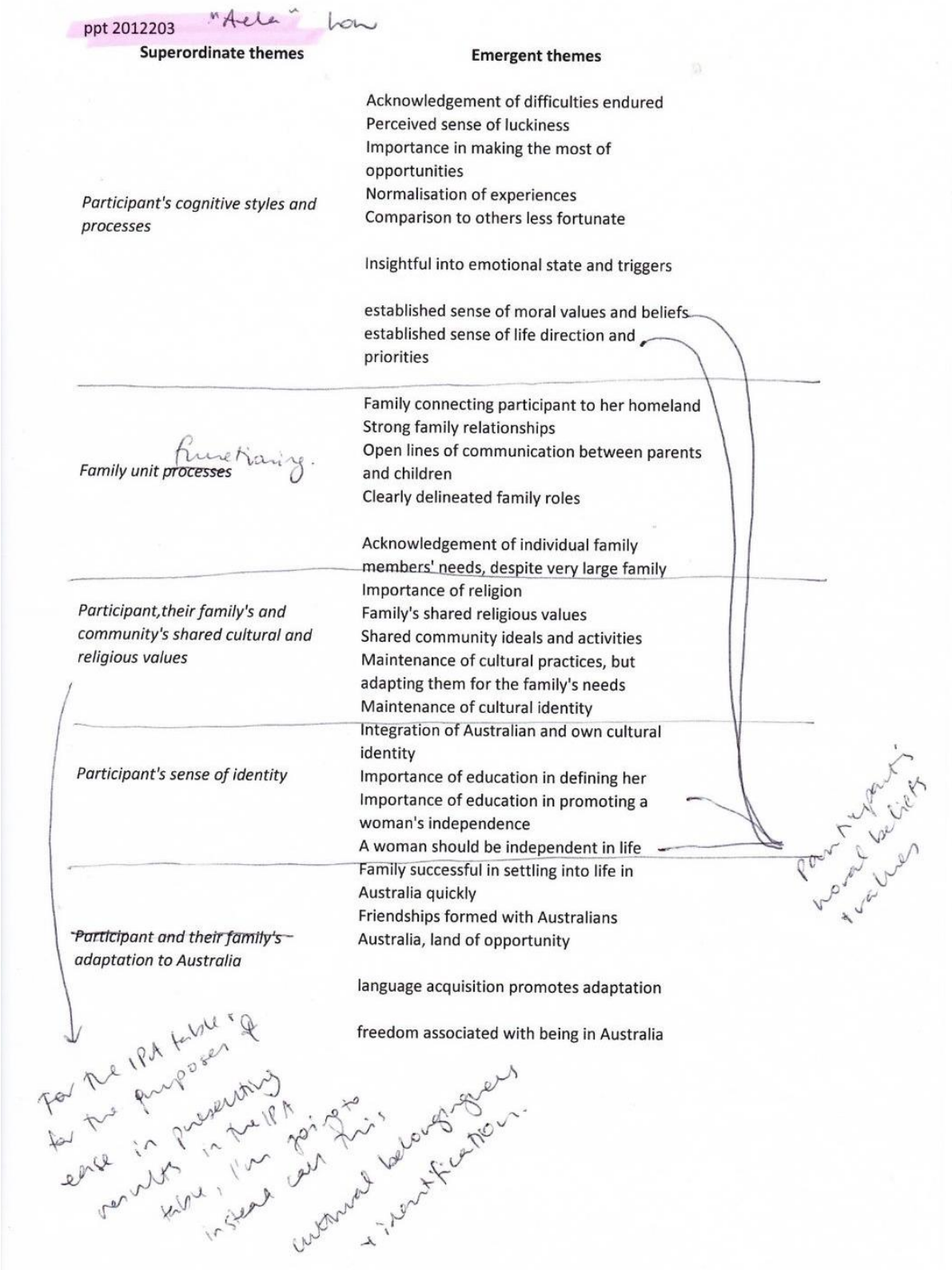
INTERVIEWER

and your older brother

PARTICIPANT

yeah, I've got 2 older brothers

Appendix O: Example extract of an IPA Analytic Procedure: Subordinate and Emergent Themes



Appendix P: Example Excerpt of a Participant's Thematic Table

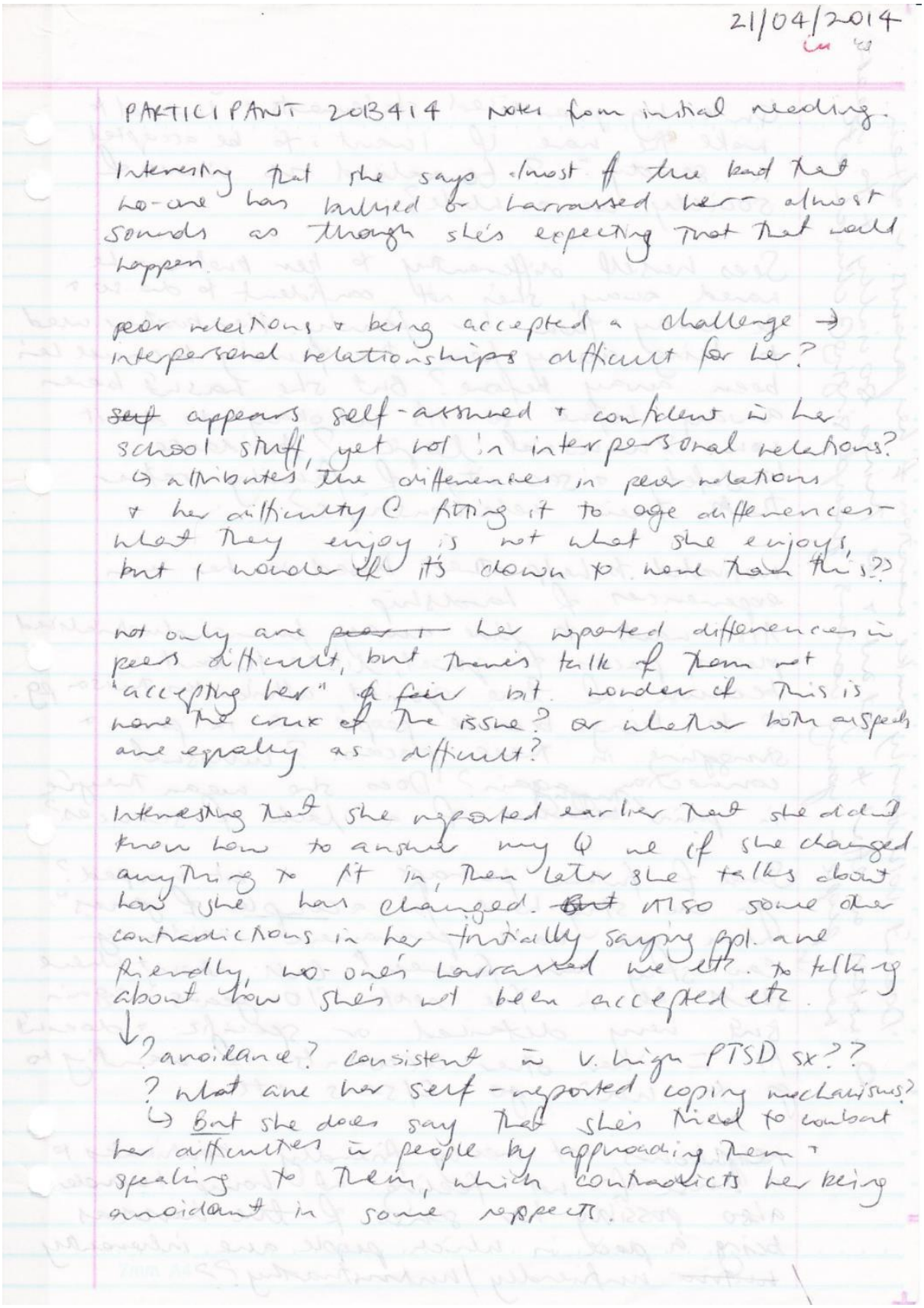
Themes	Page	Key words / quotes
Journey to get to Australia		
Lack of basic needs	13	They told us, "yes. But where is the bed?... where is the blanket, where is the pillow?".
Certainty/knowledge = safety	15	They said to us, "yeah, don't worry about that, you are coming now to Australia". And we are feel happy.
Absence of safety (perceived physical safety)	10	…maybe they take us to cell. You know cell? It's a police station. Maybe they take us…"
Attempts to regain control/power	10	So we were fighting with them, police.
Helplessness	10	Nobody can help us
Social isolation in Australia		
Social relations in Australia aren't social (may need to term this something else)	5	When asked how she finds interacting with Australian people through her class activities, "… yeah so I need to know everything about Australian people, because I live in Australia, not Syria [laughs]"
Outsider in peer relations in Australia	1	But sometimes it's hard because I don't know about Australia … I don't know how I can talk with them, if you like question or not, or you like this or not.
Too many differences to be friends	1-2	And, or, for another refugee, like Nepal, or Sudan, or another, like yes, ah, like you, I don't know about them, I don't know how or what I'm talking about [with] them. Yeah because it's different culture, different everything.
Lack of opportunities for social relations	22	I: *Are there other ways you can meet other young people?* P: Ummm. I don't have another ways. Just just in the school and in the school it's just refugee.
Social relations with peers from home		
Friends from home in heart	2	…sometimes I'm not worried about that because my friends still stay with me
Reciprocal supportive relationships with	2	Ah it's hard for me because they need me, because my friend her father is died.

friends from home		…and I'm not with her, to encourage her, to encourage my …friend … So I'm not there with them say "it's okay, don't worry about that".
Friends from home have more of a role than just friendship	9	…maybe if I do something wrong my friends tell me not good. Like drink alcohol, or cigarette, smoking, like this.
Familial attachment relationships		
Family unified in their experience	Throughout	Use of collective terms when discussing experiences she went through with family. E.g., pg. 12, "they told us, you can come to Thailand again everybody was friendly with us". Pg. 10 "…and our money is lose because we sit in airport. So we were fighting with them, police."
Family togetherness = safety	15	… thank God because I am here. I'm safe here now me and my friee-err, my family together. Not like another people. Another people the daughter err is kept but her family no, her parents not. So everybody in Syria is maybe separate.
Father, provider of wisdom (also supportive figure)	21	…he is telling for us to like Australia more and more. He always say for us "it's good for you because you are young you can come in with your life in Australia"
Mother, supportive figure	3 7	…sometimes my Mum tell me don't worry… I said to my mum, "no buses, no everything, no people" [her reaction to feeling disappointed in their initial home that was very quiet upon resettling was to turn to her mum]
Family as social system in Australia	22	…because I don't have friend to going out with them when we are going we always with my my mum or my sister… I have fun with my family
We don't have a country		
In Australia, you are a baby	6	[mother said to participant] "…it's a new life for you. Just think you are young people, you are like baby, yes, and you need to learn how can you speak. Yes everything is new"
Australia, the land of opportunity	6	When I came to Australia I said, "wow! I can complete my study, wow, I can get a be doctor!"
Syria, protector and provider	19	[on the Syrian government and war against them] …if I say he's [the president]

		not good everybody tell me from government tell me, "why? What we do for you? Did we say you are from Palestine don't eat this? Or don't wear these clothes? Or we said to you, you are Muslim, don't do that like this? We respect another religion from Palestine yes and we respect that, to complete your study at school for free".
Syria, "my country"	20	So Syria is like my homeland like my Mum
Identification with the term 'refugee'	13	They told us, now you are refugee in UNICEF, you don't need to go back to Syria. We felt happy.
Generational history of refugeedom	9 9-10	We told her we are in Syria war and we are from Palestine. Syria is not my homeland, yeah, my homeland is Palestine My grandparents were in Palestine and they were moved to Syria as refugees. Because in Palestine it's war. So when we told them that I know that we do not have country. Syria is not our country, it's like our country because we were born in Syria and grew up in Syria…
Australia and my country not different	17	I: *what sort of things are different about Syria to Australia?* P: do you know it's not different. Because in Syria umm how can I say this, nothing different because in Syria I can wear these clothes, in Australia too. Yeah I can do this, I can do this in Australia too so nothing different.
I know my country, I don't know Australia (may need to change this to differences between Australia and Syria)	8	…sometimes I miss that, sometimes I say, no, I want go back to Syria 'cos I want to going at 3 o'clock out with my friends
Cognitive processes		
Realist	3	I: *so it sounds like Uni is very important to you and you're trying to plan how you can get there, whether here in Australia or overseas…where would you go?* P: Ah do you know maybe in Egypt now, war, Syria war, Iraq war (laughs) and I don't like going to Iraq. Umm maybe Emirate…
Future focused	3	Maybe if I can go back to my country err of course without war. After two years if I can get into my country

Thinking about a plan B	2	I said for my Mum, if, for if I can [‘t] go to University next year, then maybe I study for two years or going to Arab country to complete my study. Just uni here, but complete at other country.
Goal driven	1	… I would complete my studies, and err like to be a … lawyer or a doctor, or study psychology. Yes I would complete that…I don’t like not complete my studies because study is very important
Always look on the bright side of life	13	[Upon finding out that participant and her family had to live in an airport with another family for an unknown period of time before being resettled] everybody doing, “this is my home, my home, this is my home!” yeah everybody have 5 in one family so you find life is fun.
Happiness is having a purpose / business and activity equate to happiness	22	Yeah they are happy because most of the time not just in the home so they are happy
Empathy	14	No, no, he didn’t really mind. He, my father, he he felt happy But another family feel sad, because we err nobody say we will take this family

Appendix Q: Example Extract of Initial Notings Following Transcription



21/04/2014

PARTICIPANT 2013414 Notes from initial reading.

Interesting that she says almost if true had had no-one has bullied or harassed her - almost sounds as though she's expecting that that would happen.

peer relations & being accepted a challenge → interpersonal relationships difficult for her?

~~self~~ appears self-assured & confident in her school stuff, yet not in interpersonal relations?
↳ attributes the differences in peer relations & her difficulty C RTing it to age differences - what they enjoy is not what she enjoys, but I wonder if it's down to more than this?>

not only are ~~peers~~ her reported differences in peers difficult, but there's talk of them not "accepting her" & fair bit. wonder if this is more the crux of the issue? or whether both aspects are equally as difficult?

Interesting that she reported earlier that she didn't know how to answer my Q re if she changed anything re RT in, then later she talks about how she has changed. ~~But~~ Also some other contradictions in her initially saying ppl. are friendly, no-one's harrassed me etc. re talking about how she's not been accepted etc.
↓
? avoidance? consistent in v. high PTSD sx??
? what are her self-reported coping mechanisms?
↳ But she does say that she's tried to combat her difficulties in people by approaching them & speaking to them, which contradicts her being avoidant in some respects.

Quite big generalised statements - "I need to make the move if I want to be accepted in society" ? Generalised -ve views of society as a whole?

Sees herself differently to her brother - he moved away, she's not confident to do so & be away from her family. Her brother used to being away from the family because he's been away before? But she hasn't been away before so it's not okay to do it now. ? unusual logic ? Avoidance.
↳ safety & security of family rather than their relationships?

motivated to help others based on her own experiences of hardship.
Also wants to live away from industrialised places, places of quiet, likes Hobart because of the quiet, attributes this on pg. 10 to being because people are in pain & struggling in these places. ? unusual connection again? Does she mean they're in pain/struggling because of a lack of services?

Sense of future perhaps is a bit warped? "you can stay here for a couple of years" when you have permanent residency. Can stay here forever! Call about where she'll be in the next "10 years" again isn't very detailed or specific & doesn't fit in her other accounts of wanting to go to uni, go O/seas etc.

neighbours not overly friendly - contributes to a sense of not feeling at home I wonder also possibly her sense of the world as being a place in which people are inherently ~~untru~~ unfriendly/untrustworthy??

'Doesn't voluntarily make mention of her parents v. often.
O makes an effort to get out & do things socially & to meet new people - young women's group, singing @ church etc.

Appendix R: Thematic Analysis Codes and Definitions

Theme/Code Name	Definitions and Instructions for coding	Excerpt from text
Adaptation to Australia		
	This theme relates to participants' and their families experience of adapting to life in Australia.	
Acculturation to Australia	Code for where ppant indicates their, and/or their family's acculturation to Australian cultural practices, the adoption of Australian ways of life. E.g., participant describes playing AFL, states that his father has begun to follow the AFL as well.	I also think that um not letting like communities like let's say the Sudanese community, cos we don't have a big enough community to do this example, but let's say like I think it's easier if you don't put them in a school where there's a lot of other Sudanese people because um they'll tend to stick to the other Sudanese kids cos it's a lot easier. When we went to XXX [school] there were no other African kids there so it was a lot easier to like... get into the culture. Not forget completely

		forget your own culture but to understand the culture and to make friends it's a lot easier. But if you go to a school where there's a lot of other African people you're gunna tend to go to like cos it's easier.
Australia, land of opportunities	Code when participant reports feeling that Australia has bought them/will bring them opportunities. Code also where participant reports their families believing that Australia affords them opportunities. Also code when participant discusses thinking that Australia has more opportunities available to them compared to their homeland.	Yes, because of over there we do not get these kinds of freedoms and opportunities, you can't do things like you can over here. To freely go to the shopping mall and freely buy whatever we want, to freely wear whatever we want. Over there it's not like that, here we have freedom you know. We have rights. We can choose if we want to study, we can choose not to study. Here we have choice; over there we have little choice.
Barriers to adaptation	Code for things that the participant discusses that could be conceived as being barriers to their, or their family's successful adaptation to life in Australia.	they make assumptions they make unnecessary assumptions and they underestimate students. Most teachers do. Cos um providing support is good, but when you provide support in a

	e.g., financial difficulties, difficulty finding work. Also code explicitly when participant discusses aspects that they and or their families have found difficult to adapt to.	way that kind of makes the person you're providing to feel undermined is really it ends up being condescending and it turns out really not helpful at all. Because I think some people try to overcompensate for things, and they generalize so much that if you are from a refuge background it automatically means that you were like challenged and you have more difficulties, and you have to be helped and you have to have kind of special considerations and those sorts of things.
Cross-cultural differences between Australia and homeland	Cutlural, physical, environmental factors that the participant discusses differs between Australia and homeland. Also code for factors that indicate psychological sense of difference, e.g., "australia feels like a foreign country to me"	We came here and it was really weird for me, like the buildings and the Melbourne airport and stuff. The first few months I remember having a hard time because in Pakistan we had like only two rooms. These rooms were big and we used to live with our aunty. It was like a room and then a room with just a balcony. In Afghanistan you sit on the floor and eat there. There is no

		dinner table. When guests come to your house it's on the ground where you bring them tea and stuff. Not on the table.
English language acquisition	Code where participant discusses their experience of acquiring English language, their views on the process of learning English, also their views on the importance of learning the language and around how they are taught English in Australia. Finally, also code for where participant talks about if they had had any prior English skills before coming to Australia.	Yeah, before I came... the first time I came to Australia it's hard to understand English. I don't know anything about English. Now I study at school and I ... understand English a little bit. I: if you have any advice for other young people that come to Australia from refugee backgrounds, what sorts of things do you think you would tell them? P: learn English before coming to Australia.
Ethnic language	Code when participant discusses their use of ethnic language(s), e.g., whether they still speak their ethnic language at home, how well they are able to maintain their ethnic language now in Australia, etc.	I: and do you still speak Burmese at home? P: yeah i do. I speak Burmese. Like my brother, i just speak Burmese to them sometimes we might English.

Factors that have promoted adaptation	Factors that the participant directly discusses, or factors that are inferred from what the participant says that could lead to the promotion of adapation to life in Australia in either the participant or their family.	ummm, well when I first came here my English was really bad, I didn't even understand anything. Then I started understanding little bits and I became the first one out of my siblings to understand fluent English. My mind was a little fresher; I learnt it very quickly and then after me were my elder brothers and then my sister. My mum can understand little bits and speak a little, but she is not that fluent. In terms of language it was hard to understand people but after that it was very easy, in a couple months we settled in quite well.
Family members' adaptation to Australia	Code in instances where participant describes their family's experiences in adapting to life in Australia, or also in instances where participants talk about how their family felt at the prospect of coming to Australia.	I: How does she find being in Australia? P: She finds it hard. Cos she doesn't, I mean she can understand English, but she doesn't really speak it.
Maintenance of cultural values and	Participant discusses things that they do in Australia that would indicate them and their family	We do a lot. We do like, we still do the dancing, we still cook African food, wear African clothes, dress up. And yeah.

practices	maintaining cultural practices of homeland in Australia. E.g., they may continue to cook ethnic foods, and partake in cultural traditions. Also code where participants report NOT continuing to do some of the aforementioned things.	
New beginnings, starting again in Australia	Code where participant talks about having to begin afresh, start anew with their life in Australia. Also code where participant doesn't explicitly use such terminology to discuss this, but where it is implied, e.g., participant may talk about parents having to go back to studying at TAFE even though they have professional qualifications in their homeland.	She said to me: "what do you want to go back for war? We are here just for war. Don't worry, you can't complete everything. Just forget your friends in Syria leave them in your heart. Err, just con-continue life, it's a new life for you. Just think you are young people, you are like baby, yes, and you need to learn how can you speak. Yes, everything is new.
Prior knowledge and expectations of Australia	Participant discusses their prior knowledge (or absence of) life in Australia, also code for where participant describes the expectations they had of life in Australia prior to resettling.	I: Did you know much about Australia before you came? P: No, not much.

Things that are missed about homeland	Code where participant talks about things (including people) that are missed about their homeland, ethnic culture etc.	I: Are there things that you miss about Thailand? P: yeah my friends. And my house. Even cousins.
Developmentally, age-based, age appropriate activities		
School	Miscellaneous factors not captured in the sub-codes that relate to participants' experiences of school.	I: what do you think has helped you make your new life in Australia? P: umm school. Cos um when I was always forced to go to school and then after that um thingy then I kind of got used to it and then it's like better. When I have tough times at home I come to school and everything just fades away and then when I go back home I'm like I'm not even mad anymore.
Spare time	Activities the participant undertakes in their spare time.	um, just stay home. Sometimes play ipad. like visit my grandma house. Watch movie and stuff.
Developmentally-based psychological and behavioural functioning		

	Where participant discusses things that may be conceptualised as being a factor unique to their developmental stage and age. E.g., engaging in particular behaviours or ways of thinking that could be considered developmentally, age appropriate. i.e., given that most participants are in adolescence, code for where they discuss things like the importance of the peer group over their parents, developing sense of idendependence etc. Note, this is done in line with Western conceptualisations of development, keep this in mind when writing up.	I: what Uni do you think you will go to to study Nursing? P: ACU or RMIT. ACU right near Brunswick st. went to the whole school to visit the unis. people talked about it. All my friends wants to be nurse. All friends from school want to do nurse. Even cousins I know (want to do nursing).
Atypical of of developmental stage, current age	As above, however where things are notably atypical of developmental stage and age. Where the participant does something that is not developmentally appropriate, not usual for their developmental age, goes against what many other	I still remember when I studied in grade 6, that time my one cousin took me and said "you cannot go to school, you have to do work for your family. Because you are the big girl. Children in this family, why you go to this school". And at that time I feel crying crying crying.

	'typical' young people would be doing at their age. e.g., dropping out of school early, getting married at a young age. Please note, this is coded as would be typical for Australian young people.	
Friends vs family	Code for instances where participant describes a conflict of sorts between what they do with their friends and what their family thinks of that.	so sometimes I miss that, sometimes I say, no, I want go to back to Syria, 'cos I want to going at 3 o'clock with my friends. [laughs] 'Cos I always said that when we are at uni, 'cos in my country my parents feel scared if I go outside with my friends at 3 oclock. Yeah, its not good. Cos if I've been just at uni, we get older, I know more about if that's good or not. Where I can going, what can I do without my family, outside, just with my friends. My friends too, I get older. So maybe if I do something wrong my friends tell me not good. Like a drink alcohol, or cigarette, smoking, like this.
Independence	Does something that indicates their independence (or developing sense of) in being able to accomplish,	Like, for me, its not much of a big deal if I get kicked out [of home] 'cos I know a lot of other people. Like I can usually just

	carry out, something largely on their own and unassisted by their parents.	ask one of them if I can stay over at theirs.
Family system		
Activities undertaken with parents and family members	Participant discusses undertaking activities with their parents (can be leisurely activities, but also including things like cultural activities and going to church etc). Also code for when participant talks about not doing things with their parents.	oh yeah, food's really traditional and umm ahh like like food and sometimes I do fasting. Yeah cos my Mum does and I do it with her just as a like do it together kind of thing.
Familial roles	Code for where ppant discusses varyingroles each family member plays in their family unit, including occupational roles, i.e., what the parents do for their occupation, but also where participant discusses roles in therm of the functioning of the family as a unit. E.g., participant may describe their mother as being the one children turn to for psychological support, whilst the father is discussed in terms of making the	And then we went my Mum went back to Africa she went to do like a funeral cos she didn't do a funeral for him when he died so then she went to do a proper one she went back to his cemetery and she bought cement to like bury him and she went back to Africa she did like a lot of funerals and then after that she came back. She went on January the 10th cos my sister, my big sister she came in from Brisbane to look after us and then until um until February the 25th going to March and

	decisions about choosing to leave their homeland.	then she came, that's when she went, and it was um it was my sister when she was like 16 or 17 at the time she was looking after us and with my brother, my oldest brother but he had to go work cos um he had to pay the bills and that. And then he went work from like and then he never came back. And then my sister from Warragul she came she came cos it was the holidays to look after us.
Family discord	Conflictual familial relationships, disharmony within the family unit, disagreements between participants and parents, disharmony in the home environment.	...before I got home I made a big drama. Cos I was really emotional then. Called my Dad, and was like, this is what my brother did to me. And he was yelling at me as though it was my fault. And I'm like, I'm the one who was stranded, and who went to Adelaide and back, but he's stilling at me. And he was like "I'd pick your older brother over you any day and time."
Family environment	Things concerning the nature of the family environment that the participant discusses.	Yeah, so as well as studying, I also do the housework. Me, My sister and my sister in law now also all do the housework. So

	Distinguished from family makeup (i.e., how many brothers and sisters the participant has), more concerned with family functioning, psychosocial family factors.	we cook, sometimes if my mum is sick either me or my sister cook...we cook like in every week, the Saturday or Sunday we clean the house. Our whole house is pretty big so we will vacuum. I do one side and my sister does the other side. So we can clean everything because now there is four ladies in the house, it doesn't take that long. If we are at school or studying or something, my mum does the cleaning. Sometime we give her a helping hand by washing the dishes, you know, or preparing the meals and everything like that.
Family harmony positive family relationships	Expressions of factors within the family that are going well, positive family relationships, aspects of the family that the participant likes.	And my Mum looks after my brother, and sometimes we get out of the home, sometimes city or Kingston like that. My Mum doesn't get outside that much because she has to look after my little brother, so sometimes I take her to the city or Rosny Park the shopping centre or somewhere like that, so she can know about it.
Family makeup	Makeup of the immediate family, i.e., how many	I have 2 sisters and 2 brothers. Younger brothers, they're little.

	brothers and sisters the paricipant has, whether they're the eldest etc.	Have a sister here, older in year 12, she finishes this year.
Family values	Where ppant discusses things that indicate the value system of their family, including their moral stance on issues, particularly parents. Include things such as what the family makes of how the participant spends their free time, what the family wish for the participant in the future, parents' ideologies etc.	They say to me that you can do whatever you want and we will support you in every way that you need. So they are okay with it and the good thing about it is my parents themselves and my sister and older brothers all think that we should all be independent in our own ways, so they fully agree with me when I say a lady should be independent, like a girl should not have to depend on others you know. So you know how in our culture they give us at a young age, my mum said that when you are ready I will give you, so when I want. When mum went over to Pakistan a lot of people came to her for me and my sister, she had to say like no no no they are studying, too young now.
Loss of family members, separations	Where ppant is separated from family members (include broader family, not only the immediate	yeah they miss my sister. My Mum, she always cry about my sister

from family members	family), or where family members have died.	Um, we came from Pakistan, we used to live there but because of the wars, my mum she moved here when I was about Four or Five when we came here. Our father passed away.
Interpersonal relationships		
	Code for other miscellaneous discussions regarding interpersonal relationships that aren't classified in the below codes.	
Peer relations	Code for other miscellaneous discussions regarding peer relationships that aren't classified in the below codes.	I: how have you found making friends when you got to Australia and meeting new people and things like that? P: Ah because I go to XXX [school's name] here and then like most of them most of the people are kind of like the same background as me so it's okay for me to make friends and things. But I'm not sure about the mainstream school because it's different.

		Umm, sometimes, when I miss my country, I miss my friends, I say no I won't go back to my country. Because this is the first time for me without my friends. Sometimes I think that.
Discrimination	Participant describes instance(s) whereby they, or their family and/or friends are discriminated against. Code for multiple forms of discrimination, including , e.g., , verbal abuse, racism, etc	mmm in India there were many people ah racism, and there are many dangerous things. And ah, they always, yeah Indian people don't like refugee and like yeah. yeah so like sometimes they say stuff or mean things, and they don't really know it gets to you. I mean as a joke, so you can take it as a joke as well, but…
Supportive relationships	As per below categories, code where participant discusses supportive interpersonal relationships. Can be both psychological support, as well as practical support, e.g., provision of accommodation, money, clothes	
Nature of speech itself		

	Relating to the nature of the use of language by the participant	
Speaking in the collective	Code quite generally where the participant speaks in the collective. E.g., when participant discusses their move to Australia, uses words such as "we", rather than "I". So the participant is discussing their experiences from the perspective of a group, rather than their individual experience of it.	During the first time everyone finds it hard to settle down I think, but eventually my dad had supported us quite well. We got our visas very quickly, in terms of that we were quite lucky.
Use of humour	Participant uses humour in their interviews, discusses things that are funny. Code also for where participant laughs.	I don't have very much time (laughs). Yeah, so I need to know everything about Australian people, because, I live in Australia. Not in Syria. [laughs].
Psychological functioning	Statements that are indicative of aspects of the ppants' psychological functioning/emotional state at a particular time. Largely where participant discusses a feeling state. e.g., "I felt happy when arriving in Australia". Also use	

	this to code where ppant discusses other people's emotional states.	
Coping strategies	Strategies/behaviours used by the ppant to cope with problems or unwanted feeling states.	I don't think about other stuff when I'm on weed. I know that society frowns on people who do drugs, but, I don't think that there's anything wrong with weed, like, it helps you, makes you forget things that you don't like.
Insights into their own and others' psychological functioning	Ppant discusses their own psychological/emotional functioning, or someone elses. Code where they demonstrate insight into either the feeling states of themselves or someone else.	
Negative emotional states	As above, where participant discusses feeling 'negative' (for want of a better term) emotional states. Also code for where ppant discusses things that may be interpreted as them experiencing the below emotional states, even if they don't explicitly use the below terms to describe what they're experiencing.	

Positive emotional states	As above, where participant discusses 'positive' (for want of a better term) emotional states	
Resettlement pathway		
	Discussions surrounding the resettlement experiences of participants, beginning from time spent in their home country, to their flight, to their initial resettlement in Australia.	I: and how did you think your family found coming to Australia from Thailand? P: at first like, want to go to America.but we can't go to America, so after like maybe 5 or 6 year, i mean, month, and then the people call us from the, I don't know what you call that? And so we go there and they ask us to come to Australia.
Pre-flight	Participant describes their life before undertaking the flight process from their homeland.	I dunno but my mother said that all the Nepalese people they have guns a gun, and the first day the government said keep your gun, and then the army, the Bhutanese ary came to the village and raped the girl and killed the men, killed the children. So that some people they are there, like my Mum got frightened, so they ran out. But I don't know, only my Mum said that story.

		They already in 2007 they told people are talking about resettle in third country resettlement, and many people didn't want to go to other countries because they want to go to homeland, and many people they're fighting with the Nepalese government and fighting with the Indian government and with the army and police, and they went to the border with India and Bhutan, but the Indian government said we don't allow to go because we already left the country through the gate, and Bhutan has got 9 gates around the border, and all the gates are now Indian, they captured them in the second world war, so we can't go. And when we came back coming to Nepal they just came through from there, and then when we wants to go they just close the gate only, so we can't.
Flight	Code for participants' experiences of fleeing their	And we stayed in Kakuma 1, and then whenever there's like

	homeland. Also code for discussions around participants time in transit, i.e., in second countries, such as time in refugee camps, prior to coming to Australia.	pretty much war we move from Kakuma 1 to Kakuma 2. And then um and then it had to get to a point where my Mum had to leave some of us to um some relatives or a really good friend while she had to travel to a different place so she can find work and all that sort of stuff. And then um we had to move with my Mum's sister's brother, wait, my Mum's sister's kid cos um she lived with her for like the rest of his life and then we came we kept on moving around and we found a place in Kakuma in one of the villages and then after that we stayed there, and then my Mum got a job as a teacher, she cooks food for the students and then I went to one of the primary schools with my brothers and sisters and that and then after that we walk from there to home from there to home and then my Mum made like um jewellery so she could sell and she made like um alcohol that she could sell, so she can get money, and then she kept on going for interviews and

		interviews to get us to Australia
In Australia	Code for miscellaneous things that the participant discusses about life in Australia	
Initial resettlement	Initial resettlement period in Australia. Code where participant talks about life in Australia upon immediately arriving here. Note: this is not tied in with a particular time frame as to what constitutes the initial resettlement period, gauge from what participant says as to what they conceptualise their initial resettlement period as being.	I think settling in in Australia was a little bit difficult….I don't know because first we didn't have a house, so we went to a place where they gave us a place to stay. And I think the thing with the visa is hard too, because we're still on a bridging visa. ... hard to find a house. And we live in Dandenong and we can't find house and we live in Dandenong for 3 months.
Silove's ADAPT		
	Nodes that comprise the aspects of Silove's ADAPT model	

Attachment	Nature of participants' interpersonal relationships, with peers but also with family memebers, both in Australia and abroad.	
Existential meaning	Participants' views on life,their sense of faith, and trust, and the meanings they hold. Code for where participant disucsses their sense of meaning in life, their sense of meaning towards human kind.	These stupid people just come in their cars and they just shoot everything, just like that. It is very stupid what they think in their heads and then they call themselves religion, it says in the Quran that killing others is wrong. Then they kill others and call themselves very religious and Muslims, you know, seriously what are you gaining out of it, outside of innocent killings and lots of blood spillings they gain nothing out of it. I:Politics is very hard. P: Yes its very hard. Because, really, if I say he's not good, everybody tell me, from government tell me: "why? What we do for you. Did we say: you are from Palestine, don't eat this? Or don't wear these clothes? Or we said to you, you are

		Muslim, don't do that like this. We respect another religion from Palestine. Yes and we respect that, to complete your study at school for free." Every, yeah, free. And uni free. So we can't say he's a bad man. Yeah, and err… If I said "no, he's a good man," umm, they err, opposite the government, told us: "ok, don't say that, because you are not from Syria. Yeah, but you can go back to your country." "But I can't!" But they will say like this. Yeah. And err, and they really hated Palestinian. Because in Syria, I can be lawyer, I can be doctor, like, like in Australia. I can work in the government, yeah, like Syria
Identity-role	Participants' sense of identity and self-concept. How they perceive their agency and control over their lives.	
Justice	As per Silove's writing, code things that indicate a sense of anger or rage, given that, "The importance of	So you see the suicide bombers and stuff and we all have to do calls over there to see if everyone is still okay, it's really scary,

	chronic anger and the extent to which ongoing rage is maintained by feelings of unmitigated injustice are issues that have been repeatedly raised in the field of human-engendered trauma". Also code subsequent events that may compound a sense of injustice, like perhaps being told off at school when they didn't feel they were at fault. In addition to this, code where participant talks of their sense of justice in moral terms. e.g., do they hold beliefs about their fleeing from their homeland which may relate to a sense of injustice?	everyone over here is really scared for them you know. We tell them from over here not to go to the markets very often; I mean go but only if it is completely urgent. These stupid people just come in their cars and they just shoot everything, just like that. It is very stupid what they think in their heads and then they call themselves religion, it says in the Quran that killing others is wrong. Then they kill others and call themselves very religious and Muslims, you know, seriously what are you gaining out of it, outside of innocent killings and lots of blood spillings they gain nothing out of it.
Safety	Code for things that relate to participants' sense of safety. Silove's article refers to long-term PTSD when he talks about safety, and how multiple threats in the resettlement environment can act to prolong PTSD. Hence, also code things that could be	um in Australia it's like easy if you want to go somewhere and if you want to walk at night you can sometimes feel safe. And then we had to um build that and then like my Mum didn't let us like and then there's like a lot of robbers that

	conceptualised as ongoing threats/retraumatisation in the resettlement environment. Regarding adolescents' experiences particularly of safety, also code for things that may be interpreted as threatening or unsafe to them, e.g., their experiences of being bullied, rather than a literal interpretation of safety in terms of physical integrity. Finally, also code for when participant may indicate that they have a foreshortened sense of future, given this resonates with Silove's model where he talks about people with chronic PTSD who experience the environment as chronically threatening, thus promoting a sense of uncertainty in the future.	come into our house at night and then there was animals that come inside our door, like um scorpion and that. Yeah and then like whenever you walk something pointy has to then like go inside your shoes or something cos your shoes weren't that strong and then after that like feeding the family. There's a lot of sickness and then the school they beat you up if you don't get the right answer.

Appendix S: Cross Coding Instructions

Instructions for cross-coding

Attached to these instructions is a spreadsheet containing the final (as at 3rd March, 2014) coding framework I've used to code my qualitative interviews. As you're both familiar with qualitative coding, I won't give too many detailed instructions, as most of it will be self-evident in referring to the coding framework in the excel spreadsheet.

- I thought the best way to do it would be to read the whole transcript through first, then on the second read, go through and do your coding.
- Doing it on the computer by using the comments section and/or the track changes function (whatever works for you) will probably be easiest given it will be tricky to exchange data if we all used NVIVO.
- Don't worry about providing a rationale for your coding, unless you feel that there is a pertinent theme or code that I have missed.
- Given the amount of data and codes that there are, the focus will be on the key themes (columns 1 and 2 in the excel spreadsheet), rather than the subthemes when I look at all of our final codes.
- When coding, it's good to select text around the particular excerpt you want to code, in order to contextualize quotes.
- As well as applying descriptive codes (in line with a TA approach), I have also coded for my interpretation for what participants have said (in line with a more IPA–based approach). For example, a participant may talk about the fact that they are able to do many things in Australia, things that they were not able to do in their homeland. While they do not explicitly mention it, I have coded this as the participant experiencing a *sense of freedom* in Australia.
- In many cases, multiple codes and themes will apply to an excerpt of text, it's fine to code for numerous themes and codes for the same piece of text when this happens.
- If there are sections of text that you don't think fit a code I've got, and don't think it's worthy of making up a whole new distinct code for it, don't worry about coding it – not everything needs to be coded.

You'll notice that I've given you uncoded transcripts. Once you've coded yours, I'll go back over my coding scheme to see if there are any discrepancies. At the end of this process, I'll speak to you both to talk about your thoughts on the transcripts and coding, and to discuss any discrepancies in the coding.

Thank you **very** much! Feel free to call/email if you've got any questions.