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**REFUGEE YOUTHS:
ADAPTATION AND MENTAL HEALTH SERVICE
PROVISION**

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A thesis submitted in fulfilment of the requirements of the degree of
Doctor of Philosophy in Psychology at the University of Auckland, 2013.

Abstract

Adolescents comprise a significant portion of refugees, yet little is known about the particular challenges this group faces in resettlement, or their needs for mental health service provision. Fifty three adolescents from refugee backgrounds were recruited to participate in focus group discussions and structured interviews to investigate stressors experienced throughout the pre-migration, transit and post-migration stages, their coping strategies, and experiences with and attitudes to mental health services. In addition, focus groups were also completed with 20 mental health service providers. A thematic analysis revealed issues of dealing with loss, worry about family left behind, discrimination, money worries, difficulties with learning a new language, struggles to make friends, adjusting to the new culture and school, and family conflict. Adolescents regarded coping with such stressors as being something to be done privately – rather than through talk with others - but described a range of other coping mechanisms they use. Barriers to accessing mental health services included differences in cultural understandings of their issues, challenges associated with use of interpreters , fear of stigma, and fear of privacy not being maintained. Service providers identified refugee adolescents’ mental health difficulties arising from trauma and its lingering impact, clash of cultures, loss, missing relationships, lack of meaningful activities, lack of financial resource, different rates of adaptation to parents, parent’s lack of familiarity with the parent role, family health and functioning, parents’ expectations and family’s attitude towards mental health services. Service providers further identified language difficulties and different cultural understandings impacted on the wide range of intervention they provided. Adolescents and service providers identified a range of options for improving service delivery to refugee adolescents. Implications of this research are presented for resettlement programmes and mental health care.

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Table of Contents

ABSTRACT.....	II
ACKNOWLEDGEMENTS.....	III
TABLE OF CONTENTS.....	IV
LIST OF TABLES.....	VII
LIST OF FIGURES.....	VIII
LIST OF APPENDICES.....	IX
CHAPTER ONE INTRODUCTION AND LITERATURE REVIEW.....	1
Stressors Affecting Young People	4
Prevalence of Mental Health Problems in Refugee Populations	5
Pre-migration and Migration Stressors	8
Post-migration Stressors	9
Culture and Acculturation in People from Refugee Backgrounds.....	15
Acculturation and Acculturative Stress.....	16
Stress, Appraisal and Coping	18
Coping Strategies	20
Utilisation of Mental Health Services.....	25
Barriers and Facilitators to Accessing Mental Health Services.....	27
Mental Health Services for People from Refugee Backgrounds.....	30
Refugees in New Zealand	38
Refugee Quota Programme	38
Issues Pertinent to Refugee Adolescents in New Zealand	40
Rationale and Overview of the Study	41
The Current Research.....	41
Aims of the Study	41
CHAPTER TWO METHODOLOGY.....	44
Qualitative Approach	44
Thematic Analysis	45
Semi-structured Interview Schedule	46
Focus Groups and Individual Interviews.....	47
Reflexivity.....	48

CHAPTER THREE STUDY ONE REFUGEE YOUTHS: STRESSORS, COPING, AND EXPERIENCE OF MENTAL HEALTH SERVICES..... 52

Method	53
Focus Group Participants	53
Individual Interview Participants	55
Interview Schedules	55
Individual Interview Schedule	56
Procedure.....	57
Data Analysis	64
Analysis of Interviews: Focus Groups and Individual Interviews.....	64
Life Prior to New Zealand.....	64
Resettlement.....	68
Coping Mechanisms/Dealing with Difficulties.....	90
Experience of Mental Health Services	96
Barriers to Engagement:.....	96
Facilitators to Engagement:	99
Discussion	102
Diverse range of Issues, Challenges and Stressors	104
Coping Mechanisms.....	111
Experience of Mental Health Services	115
Summary	117

CHAPTER FOUR STUDY TWO SERVICE PROVIDER EXPERIENCE OF REFUGEE YOUTH MENTAL HEALTH..... 119

Method	120
Participants.....	120
Focus Group Interview Schedule	121
Procedure.....	123
Data Analysis	124
Analysis of Focus Groups - Results.....	124
Mental Health Problems with Youths from Refugee Backgrounds.....	124
Beliefs about Factors that Contribute to Youths From Refugee Backgrounds Mental Health Problems	126
Service Provision: Types of Therapy	145
Service Provision: Process Issues.....	152

Recommendations for Service Development.....	165
Discussion	173
Mental Health Problems Presented and Attribution of Causes.....	173
Service Provision: Types of Therapy	179
Service Provision: Process issues	181
Recommendations by Service Providers.....	184
Summary	185
CHAPTER FIVE CONCLUSIONS AND RECOMMENDATIONS.....	187
Youth From Refugee Backgrounds Stressors and Challenges	188
Coping Mechanisms and Service Provision	191
Implications for Mental Health Services	193
Limitations of Research	198
Future Research	201
Conclusion	202
REFERENCES.....	204

List of Tables

Table 1. Demographics of service-user focus groups (Total n=20).....	54
Table 2. Demographics of non-service focus groups (Total n=17)	54
Table 3 Demographics of participants in the individual interviews (Total n=16).....	55
Table 4. Professional backgrounds and genders of focus group participants (Total n=20)...	120
Table 5. Service provider focus group composition (Total n=20).....	121

List of Figures

<i>Figure 1.</i> Diagram of a phased model approach to intervention. Sourced from (Ehnholt & Yule, 2006).	32
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List of Appendices

Appendix A. Refugee Youth Experience of Mental Health Services in New Zealand	218
Appendix B. Participant Information Sheet For Youth Focus Group Interviews.....	219
Appendix C. Contact Reply Slip.....	221
Appendix D. Participant Information Sheet For Individual Youth Interviews.....	222
Appendix E. Consent Form For Youth Participants	224
Appendix F. Participant Information Sheet For Professional Focus Group Discussions	226
Appendix G. Consent Form For Mental and Community Health Professionals	229

CHAPTER ONE

Introduction and Literature Review

The struggle for power, control and dominance has resulted in ongoing war and conflict in many regions of the world, particularly in parts of Africa, Eastern Europe, the Middle East, South America and Southeast Asia. As a consequence of the effects of conflict on peace, stability and security, many individuals within these areas have moved or been displaced.

A refugee, according to the 1951 Refugee Convention is someone who:

...owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country, or to return there, for fear of persecution. (United Nations High Commissioner for Refugees [UNHCR], 2012).

There are currently over 10 million refugees as defined by Article 1 of the United Nations 1951 Convention, with an estimated 34.4 million refugees of concern (United Nations High Commissioner for Refugees., 2012). The discrepancy between the two estimates relates to inclusion of internally-displaced individuals who have been forced from their homes for refugee-like reasons, but are still within the borders of their country. Furthermore, it is likely that these figures underestimate the refugee numbers as many refugees in other countries do not declare themselves for fear of being sent back to their country of origin.

The 1951 Refugee Convention differentiates refugees from migrants who have left their home on a voluntary basis (e.g., economic migrants seeking employment or financial opportunities within a different country). Legally, the term “refugee” applies to individuals who are afforded the title before arriving in their new country, while asylum seekers declare themselves as refugees after arrival. However, this distinction is not typically applied in common use and all people fleeing armed conflicts or war are generally known as refugees (Howard & Hodes, 2000).

With the growing number of people from refugee backgrounds worldwide, there has been an increase in research examining the mental health and psychosocial wellbeing of refugees, with particular interest in the negative impact of refugee experiences (Tempany,

2009).

Of the 10 million refugees estimated by the UNHCR, children and adolescents constituted nearly half (United Nation High Commissioner for Refugees., 2012). Given the numbers, the coping and mental health of adolescents from refugee backgrounds in particular warrant more research and attention (Lustig et al., 2004). There are a number of reasons for this. First, the childhood and adolescent developmental years are instrumental in shaping critical identity and values within the young person. Exposure to trauma or significant stressors during this period can adversely affect development, and subsequently mental health and functioning. Second, adolescents from refugee backgrounds must navigate developmental challenges at the same time as adjusting to ongoing life stressors (Brough, Gorman, Ramirez & Westoby, 2003). Gibbs and Huang (2003) state that, at an immediate level, the refugee youth has to maintain the family system in the context of a new cultural system, negotiate educational systems, comprehend the intricacies of migration and manoeuvre through an impersonal social service system. Third, and in common with other age groups, there is the need to master a new language, a new culture and a new set of behaviours and expectations. Furthermore, like all people from refugee backgrounds, the adolescent needs to integrate the experience of flight, the abandonment of homeland and loss of family and friends into his or her current state of existence.

Children and adolescents' vulnerability to developing physiological and psychological difficulties as a result of their refugee experience has been well documented (Henley & Robinson, 2011; Howard & Hodes, 2000; Lustig, Kia-Keating et al., 2004; Montgomery & Foldspang, 2008; Westermeyer, 1991). However, despite the high proportion of youths from refugee backgrounds throughout the world, and their vulnerability to developing mental health problems as a result of their refugee experience, there is evidence suggesting a lack of access to mental health services. For example, in examining mental health and help-seeking among ethnic minority adolescents, Barker and Adelman (1994) reported that there was low level professional service utilisation for behavioural, emotional and personal problems, in spite of the apparent widespread need. It has further been reported by de Anstiss, Ziaian, Procter, Warland, and Baghurst (2009) that many young people from refugee backgrounds with mental health problems are not accessing mental health services. Given the high risk of mental health difficulties among youths from refugee backgrounds, and the apparent underutilisation of mental health services, it is important to improve knowledge about the

factors that contribute to the barriers or facilitators to accessing mental health services.

My interest in this research area originated from both my experience as a youth from a refugee background who grew up in New Zealand and as a clinical psychologist who has trained and worked in Community Child and Adolescent Mental Health Services. I readily recognised the particular needs and vulnerabilities of adolescents from refugee backgrounds, leading me to ask several questions. How did adolescents from refugee backgrounds cope with challenges? What contributed to their limited use of mental health services? Were the reasons for apparently low access to mental health services related to the adolescents themselves in terms of their coping style, perception and experience with mental health services? Conversely, was it related to lack of culture fit, poor assessment and intervention with the clinicians and services that worked with these young people and their families? Was it a combination of both systems interacting with one another in a complex and dynamic relationship, set against the backdrop of the unique social, political, historical and cultural context of both adolescents and mental health services? Ultimately, if greater understanding can be achieved about the reasons for the discrepancy in needs and access, then changes can be made so that appropriate support and assistance can be provided to those that are vulnerable.

This thesis aims to investigate stressors experienced by adolescents from refugee backgrounds and their coping behaviours. It also explores their perceptions of and engagement with mental health services. It addresses these questions from the perspective of adolescents from refugee backgrounds themselves as well as from the perspective of the mental health professionals who work with them. Thus the thesis consists of two projects, both utilising a qualitative methodological approach, but presented here as two distinct chapters with their own aim, method, analysis and discussion. In Chapter 1, stressors affecting adolescents from refugee background are first reviewed, and then broken down into pre-migration and post-migration factors. Stressors affecting adults from refugee backgrounds are also reviewed, as adolescents are often directly and indirectly affected if their key caregiver struggles to cope. Topics include life prior to resettlement, resettlement challenges, coping mechanisms and experience of mental health services. With regard to coping mechanisms, a review of acculturation and acculturative stress is provided as a framework for understanding the adaptation of refugees. Chapter 2 discusses the methodology in more depth. The first study involved both focus groups and one-on-one

interviews with adolescents from refugee backgrounds, with findings presented in Chapter 3. The second study involved focus groups with service providers, with detailed analysis of the findings presented in Chapter 4. Chapter 5 summarises the findings and discusses implications, including limitations of the study and future research recommendations.

Mental health services can assist adolescent coping; however their effectiveness is influenced by appropriate engagement, understanding and identification of the young person's needs, as well as implementation of the appropriate intervention. There is evidence that service utilisation is low, and the reasons why this may be so are described. Possible responses or solutions to this are then discussed. Finally, I describe the particular situation for people from refugee backgrounds in New Zealand, before summarising the aims and objectives of this study.

Stressors Affecting Young People

Children and adolescents from refugee backgrounds are a highly vulnerable group with specific health needs associated with their background and experiences. Not only are they subjected to many forms of risk and stressors in their homeland, they are also exposed to traumatic stressors in the course of their forced migration process (Lustig et al., 2004).

Adolescents from refugee backgrounds are often exposed to a number of pre-migration and post-migration stressors. Pre-migration stressors include trauma such as witnessing violence (Westermeyer, 1991), loss of family members, and disappointment when unsuccessful in being accepted under a refugee quota (Silove, Steel, Bauman, Chey & McFarlane, 2007). Other pre-migration stressors include exposure to war, rape, physical injuries, little sense of safety, living in fear, imprisonment and torture (Vaage, Garlov, Hauff & Thomsen, 2007), family separation and disappearances, refugee camp life with a daily struggle for survival, and a sense of disempowerment (Poole, 2007; Schmidt & Poole, in press). Further stressors include the experiences of injustice, extreme poverty and deprivation. Post-migration stressors include adjusting to a new culture (language, people, religion and custom), loss of control over autonomous choices and beliefs, absence of extended family for support, fear of being sent back, shame, confusion, loss of confidence and dignity, loss of lifestyle and career aspirations and, for some, the onset of post-traumatic stress disorder (PTSD) symptoms (Poole, 2007). Moreover, people from refugee backgrounds may

experience extreme isolation, humiliation and immense losses, some of which are existential, including loss of loved ones, the homeland, culture, identity, hope, trust, meaning in life and faith in a just world (Burnett & Gebremikael, 2005). Furthermore, unrealistic expectations of opportunities or life in the new country can develop during the process of migration, and may ultimately contribute to feelings of disappointment and disillusionment when their lived experience is not in accordance with their expectations (Baumann, 2009).

There are many adaptive challenges within the post-displacement environment. These include adapting to a new society, learning a new language, and developing a new support system, including making sense of a foreign cultural context. It is stated that adolescents from refugee backgrounds who are not infants on arrival in the host country will experience similar challenges and adaptive adversities as adults in the post-displacement setting (Almqvist & Hwang, 1999).

Prevalence of Mental Health Problems in Refugee Populations

Evidence exists on the impact of the refugee experience; however identifying the prevalence of psychiatric disorders in youth from refugee backgrounds is problematic. There are difficulties making assessments for psychiatric disorders in non-Western people from refugee backgrounds because the validity of the psychiatric instruments developed with Western populations restricts this (Fazel, Wheeler & Danesh, 2005). There is also a lack of reliable prevalence estimates for psychiatric disorders in children from refugee backgrounds, owing to methodological variations such as sampling methods, assessment tools (e.g., questionnaires versus interviews) and the psychological constructs being measured (e.g., type of trauma experienced) (de Anstiss et al., 2009). Furthermore, the general prevalence of worldwide refugee psychiatric disorders has been difficult to determine because of the heterogeneity of the refugee population. Being mindful that many people from refugee backgrounds are internally displaced (within their own country), those who have not been accepted into relatively wealthy Western countries, are also unlikely to participate in research studies, which presumably affects the reported outcomes.

Children and adolescents experience different types of exposure and responses to war, violence and trauma. However, psychiatric morbidity in children from refugee backgrounds is generally estimated to be higher than that seen in the general population (de Anstiss et al.,

2009). Fazel et al.'s (2005) meta-analysis of psychiatric interviews with more than 260 children from refugee backgrounds (younger than 18 years old) from Bosnia, Central America, Iran, Kurdistan and Rwanda, who had resettled in Canada, Sweden and the United States of America (USA), found the prevalence of PTSD was 11 percent.

In a more recent systematic review of psychological distress in children from refugee backgrounds (defined as those aged 25 years and under) Bronstein and Montgomery (2011) examined 22 studies including a total of 3003 children across six countries of asylum (Canada, Denmark, the Netherlands, Sweden, United Kingdom and the USA). They found that levels of PTSD ranged from 19 to 54% and depression from 3 to 30%. Bronstein and Montgomery further identified that older age was significantly related to higher levels of PTSD, in addition to greater levels of internalising and externalising problems. In addition, it was further reported that female children from refugee backgrounds experienced greater internalising, depression and emotional difficulties. In contrast, males were identified as having higher scores for PTSD and conduct problems. A deficit in support and difficulties in the process of immigration and discrimination were further identified to increase PTSD scores in children from refugee backgrounds (Bronstein & Montgomery, 2011).

In another review on mental health of immigrants and people from refugee backgrounds, Pumariega, Rothe and Pumariega (2005) reported that cumulative adverse pre-migration experiences predicted increased internalising, externalising and PTSD difficulties. Post-migration stress was also found to be directly associated with higher scores of PTSD and depression. Although PTSD is the most frequently reported disorder in children from refugee backgrounds and adolescents, co-morbid depression (Pumariega et al., 2005) and anxiety (Keyes, 2000; Schweitzer, Melville, Steel & Lacherez, 2006) are also commonly reported. Other problems such as psychosis, intellectual disabilities and conduct disorder have also been identified in studies with adolescents from refugee backgrounds. For example, Williams and Westermeyer (1983) studied the adjustment of 28 Southeast Asian adolescent from refugee backgrounds who were seen at a psychiatric clinic in the USA. Six of these adolescents received a diagnosis of functional psychosis and six were diagnosed as mentally retarded; however, all 12 had exhibited these problems before migration. Pre-existing difficulties such as intellectual disability, pervasive developmental disorder and personality disorders may also be adversely affected or exacerbated by the refugee experience (de Anstiss & Ziaian, 2010). In their study, the migration process apparently intensified these disorders

and led to more severe presentation of psychoses, suicide attempts, disruptive behaviour and school crises. Other diagnoses of adolescents in this sample included depression, conduct disorder, somatic disorder, personality disorder and learning disorder. Williams and Berry (1991) further noted psychosocial problems such as intergenerational conflicts typical of migrating families. Other mental health or psychosocial difficulties have included sleeping difficulties and hyperactivity (Montgomery, 2011).

Socioeconomic status and levels of educational attainment have also been found to affect resettlement and subsequent health outcomes. Porter and Haslam (2005) have identified that people from refugee backgrounds who had higher socioeconomic status, including having achieved higher levels of education in their country of origin, had poorer resettlement outcomes compared with those who had lower socioeconomic status and lower levels of education. In a study of 135 Somali adolescent from refugee backgrounds, aged between 11 and 20 years, who had resettled in the United States of America, post resettlement stress, acculturative stress and perceived discrimination each significantly contributed to the development or maintenance of PTSD symptoms (Ellis, Lincoln, MacDonald & Cabral, 2010). Furthermore the researchers found that exposure to cumulative traumatic events strongly related to the presence of PTSD.

When considering the prevalence and incidence of mental health problems in people from refugee backgrounds populations, it is also important to recognise the limitations of such research. A number of writers have expressed their concerns regarding the accuracy of Western diagnostic tools in assessing mental disorders across cultures (Davidson, Murray & Schweitzer, 2008; Steel, Silove, Chey, Bauman & Phan, 2005; Tempny, 2009). Specifically, Western diagnostic tools may result in lack of consideration and recognition of indigenous expressions of distress, resulting in bias and deceptive prevalence rates. For example, studies examining prevalence of disorders such as PTSD are confounded by the instruments that have been used to measure particular constructs of trauma and psychological distress. Furthermore, different cultural understanding, interpretation and responses to psychological distress and cross-cultural adjustment are not always factored into these measures. For example, somatisation may reflect both a somatic and psychological interpretation of distress within particular cultures (Davidson et al., 2008). Alternatively, somatic representation may be considered a culturally acceptable means of expressing distress, especially within cultures where mental illness has stigma and shame attached to it (Marin, Organista & Chun, 2003).

Other limitations are the lack of culturally sensitive instruments, sampling bias and size, cohort variations in levels of traumatic exposure and reliance on medical models of refugee wellbeing (Tempany, 2009). Davidson et al. (2008) also state that common PTSD diagnostic formulation of intrapsychic distress risks labelling what might be normal human emotions to everyday and extreme stressors as a symptom or a medical problem.

Pre-migration and Migration Stressors

Pre-migration factors have been identified to impact people from refugee backgrounds mental health (Montgomery, 2011; Poole, 2007). While the focus of this thesis is adolescents, an overview of stressors for adults is first given because the same stressors are often present in adolescents too. In addition, stressors impacting on parents have been found to both directly and indirectly impact children and adolescents as their parents or caregivers struggle to adapt.

A quantitative study of 63 Sudanese people from refugee backgrounds (over the age of 18 years) was performed in Australia to assess the impact of pre-migration traumatic experiences, post-migration living difficulties and social support on symptoms of anxiety, depression, somatisation and PTSD (Schweitzer et al., 2006). The authors found that their sample population had experienced a wide range of pre-migration traumas, including separation from family members, experiencing or witnessing violence (as in the murder of loved ones), existing without basic needs such as food or shelter, loss of loved ones in the migration process and social isolation during exile. Separation from family was significantly associated with current mental health problems with greater emotional distress reported in individuals where family had become displaced. The authors also described that in a quarter of their sample, traumatic experiences such as rape or sexual abuse, being kidnapped or isolated from others and brainwashing were reported. Schweitzer et al. observed that these traumatic experiences increased the individual's vulnerability and may accentuate poor adjustment when paired with psychological stress. Pre-migration trauma was found to be a significant predictor of mental wellbeing, and different forms of trauma affected different forms of functioning. For example, trauma experienced directly by the individual was found to be associated with PTSD and somatic symptoms. On the other hand, trauma experienced by a family member appeared to be directly related to depression and anxiety.

Trauma exposure was the most important predictor of current mental health status in a study of 1413 Vietnamese people from refugee backgrounds who had been in Australia for an average of just over 11 years, with an average time post exposure to traumatic events of 14.8 years (Steel, Silove, Phan & Bauman, 2002). A positive relationship was found between the number of traumatic events and risk of persistent mental illness, with individuals who had been exposed to more than three traumatic events having an increased risk of persistent mental illness. In another study with 43 adult Sudanese from refugee backgrounds in Australia, separation from family was however found to correspond to significantly more emotional stress than exposure to other past trauma (Schweitzer et al., 2006).

In a more recent study of 311 Middle Eastern children from refugee backgrounds (aged 3-15 years old) that examined the risk indicators for anxiety or sleep disturbance on arrival in Denmark, Montgomery (2011) reported that prolonged exposure to organised violent environments (e.g., living in refugee camps, mother and or father exposed to torture, lack of opportunities for play because of war) was associated with anxiety on arrival. Montgomery further reported that more specific and accumulated exposure to violence against family members, such as death or torture of caregivers, was associated with sleeping disturbance. In a follow up study of 131 of the original children from refugee backgrounds, Montgomery (2011) reported that the number of types of traumatic events within the family prior to the birth of the child was the strongest predictor for sleep disturbance, whereas the parent's experience of torture was the strongest predictor for anxiety in the child. According to Montgomery, intergenerational transmission of trauma is related to the ways in which an event experienced by one person can have lingering effects on others. Coping and adaptation to trauma will be passed down through future generations; adolescents from refugee backgrounds do not necessarily have to experience the trauma themselves. In particular, how the trauma is conveyed to the young person through their parent's response to the trauma will affect the parent's ability to be actively present and responsive to the young person's immediate needs.

Post-migration Stressors

Although pre-migration factors may come to mind more readily when considering potential stressors that have impacted, or are still impacting on people from refugee

backgrounds, many studies have identified post-migration factors, such as difficulty acculturating to the new culture, as having a greater impact on the individual's mental health than pre-migration factors. One such study conducted in Australia highlights the impact of post-migration stressors on coping, participation and engagement in the host country (Khawaja, White, Schweitzer & Greenslade, 2008). In this qualitative semi-structured study with 23 Sudanese from refugee backgrounds, examining pre-migration, transit and post-migration experiences, the authors identified four major difficulties experienced in the post-migration period: a lack of environmental mastery, financial difficulties, social isolation and the impact of perceived racism. Environmental mastery related to adaptation demands such as learning a new language and familiarising themselves with a new set of cultural values and practices, including identifying ways to access the available resources. More than half of the respondents in the study considered learning English as an obstacle that severely limited their participation in Australian life. Their participants reported that without proficient English, their ability to form new social networks, cope with education, or attain adequate employment was hampered. The key issues in adapting to new cultural values and practices were related to expectations of familial roles, with some parents reporting that their children rejected traditional held beliefs about appropriate and expected behaviours within a family. Another key difficulty experienced by the adult Sudanese from refugee backgrounds in the study was the issue of social isolation and lack of social support. Other reasons for lack of social support included the breakdown of previously utilised and accessed social networks because of separation and/or death of family and friends during the transition, or marital separation for some following the arrival in Australia. Lack of social support led to feelings and reported experiences of social isolation and loneliness. Finally, another key difficulty reported was racism, as manifested in verbal abuse, perception of increased attention from police and discrimination in employment opportunities on the basis of their race and ethnicity (Khawaja et al., 2008).

Schweitzer et al. (2006) further reported that psychological wellbeing was also strongly predicted by post-migration experience which consisted of both social support and difficulties. Social support was specifically related to the presence of family members, including support from others within the Sudanese community, but not from the wider community. The authors stated that the struggle with loss of social support that is meaningful to the people from refugee backgrounds may be an ongoing form of trauma (given that social

support is an integral component of Sudanese cultural life). Post-migration difficulties were reported to be related to worries about family members not residing in Australia, struggles with employment and difficulty in adapting to the cultural life and environment in the host country. Additionally, there appeared to be a trend towards poorer mental health outcomes as length of residency increased. Schweitzer and colleagues suggested that an individual's experience in the host country may exacerbate existing mental health difficulties related to migration and the refugee journey.

Even when not directly traumatised themselves, hearing of traumatic events that have occurred to people of significance can impair the health and wellbeing of people from refugee backgrounds (Vaage et al., 2007). Post-migration stressors include acculturation difficulties, challenges with language acquisition, changes in family roles and dynamics, difficulties navigating the education system and adapting to a whole new environment (Lustig et al., 2004).

Loss. In the post-migration environment, many families struggle with loss and grief. There is the loss of proximity to family members, but also loss of relationships and life as they knew it. During resettlement, the experience of personal and cultural loss has been related to refugees' mental health outcomes (Murray, Davidson & Schweitzer, 2010). In a grounded theory interview study with 10 participants from the group known as the Lost Boys of Sudan, Luster, Qin, Bates, Johnson and Rana (2009) examined their experience of separation and ambiguous loss including efforts to re-establish relationships with family members living in other countries. The authors reported that peers and elders acted as surrogate families until former relationships could be re-established. The authors also noted that, in addition to having experienced chronic hardship and multiple traumas, many of the boys also struggled with ambiguous loss in terms of not knowing whether members of their families were still living. Two types of ambiguous loss were reported. The first occurred when the family member was physically absent but psychologically present because it was uncertain if they are dead or alive. The second type occurred when the family member was physically present but psychologically absent, owing to their own challenges (such as depression or other mental health problems) that limited their ability to be fully present. The first type of ambiguous loss was found to be particularly present among the Lost Boys of Sudan (Boss, 2006). The reported effects of this loss on the boys included distress, sadness, loneliness, nightmares and worrying about their loved ones. Many of the adolescents also

reported that the loss resulted in feelings of frustration through a perceived lack of emotional support from their parents.

Family relationships. Migration not only involves movement between places, but it also involves movement within social relationships and community settings. Changes in structure and roles within families following migration can have significant impact on the family unit. The loss of social roles that had meaning and significance for a person, including some form of meaningful occupation, have also been found to be linked to poorer resettlement outcomes in terms of decreased participation in daily activities (Miller, 1999), low employment rate, greater economic hardship (Hyman, Vu & Beiser, 2000), and social isolation (Miller, Worthington, Muzurovic, Tipping & Goldman, 2002).

Parent-child conflicts are also exacerbated when families struggle with adapting to significant differences between their culture of origin and the new culture (Rousseau & Drapeau, 1998; Rousseau, Drapeau & Platt, 2004). Factors impacting on this include gender/role expectations, such as differences in practices around child rearing. Many struggle with changes within the family structure, particularly in solo mother families where the father has been separated or died in the conflict in their homeland (Codrington, Iqbal & Segal, 2011). In an article written about her experience as a general practitioner working with people from refugee backgrounds and asylum seekers, Montgomery (2007) reported that when children arrive in the new country with both parents they are more able to adapt, and negotiate stressors within the new environment. Rosseau, Drapeau and Platt (1999) interviewed 67 Cambodian adolescent from refugee backgrounds in their first year of high school and then two years later to examine the association between family exposure to war-related pre-migration trauma and the adolescent's emotional, behavioural and social adjustment difficulties. They reported that the family characteristics (such as the closeness in relationship between the adolescent and their parents) and processes play a mediating role in adolescents' adjustment after resettlement. Low levels of stress and high levels of cohesion have been identified in families from refugee backgrounds where the parent is 'mentally healthy', which has a positive effect on the parent's ability to support their children in adapting to the conditions of the new culture (Birman et al., 2005).

Not only do familial roles change post-migration, but hierarchy within the family also changes. A parent's role and position may be redefined as they struggle with the migration

process themselves. Critical and important people and relationships are lost, as are meaningful jobs and roles within their society (Rousseau et al., 2004). Because children often acquire the new language faster than adults, adults can struggle to maintain their leadership position within the family (Bjorn & Bjorn, 2004). Perceived responsibilities can also change after migration. Björn and Björn (2004) reported that children will try to hide their difficulties from their families if parents are observed to be depressed, which can add greater burden of responsibility on the young person.

In a qualitative discourse analysis based on semi-structured interviews with five Iraqi mother and daughter pairs, Joudi (2002) explored how Iraqi female migrants discuss and make sense of Arab culture, and the preservation of Arab culture in New Zealand. Joudi (2002) reported that the mothers worked hard to preserve their beliefs and culture in the host society. Their daughters, who were raised in New Zealand, sought freedom from parental and cultural control, including a desire to establish membership within their host society. Parents may therefore work harder to exercise control over their children's behaviour in order to preserve cultural beliefs and identity, which may further contribute to conflict and breakdown in communication and family relationships.

Acceptance/discrimination. In addition to struggles with grief and loss and changing family relationships, many adolescents from refugee backgrounds have reported experiences of discrimination within the host country and at the refugee camp. The reception that the young person receives in the host country can therefore lead to a number of challenges. Perceived attitudes and acceptance or discrimination by members of the host culture can significantly affect the wellbeing of adolescents from refugee backgrounds and their families. Negative attitudes can further serve to maintain feelings of oppression, while encouraging behaviours related to marginalisation (O'Doherty & Lecouteur, 2007). In New Zealand, Butcher, Spoonley and Trlin (2006) conducted focus groups with adult migrants and people from refugee backgrounds and found that people from refugee backgrounds, especially those from visible ethnic minority groups or a distinct cultural backgrounds, experienced significant challenges in gaining employment. They further found that people from refugee backgrounds reported a greater perception of discrimination in regards to accessing goods and services related to education and housing. Language was identified as the most significant barrier in accessing goods and services. Furthermore, it was reported that when discrimination was perceived, it was subtle rather than overt. Butcher et al. also found that

participants from a Muslim or Middle-Eastern background reported increased experiences or perceptions of discrimination in the aftermath of the events of September 11, 2001 in the USA. It is argued that people from refugee backgrounds' mental health can be profoundly affected by discrimination, particularly in relation to social marginalisation (Butcher et al., 2006). The implication is that experience of discrimination negatively affects mental health risk for adolescents from refugee backgrounds.

Language and schooling. Shared language acts as a mechanism for integrating into a new community through communication, while increasing the understanding between the two cultures (Poppitt & Frey, 2007). Second language difficulties have been significantly associated with feelings of being different from mainstream culture, and second language proficiency have been related to reduced stress and greater self-esteem (Milner & Khawaja, 2010). Developing English skills enables participation and inclusivity in New Zealand society. It assists with obtaining employment and interaction within the community, including access to housing, health and other welfare services. A lack of language or literacy skills increases the challenge of accessing education, training and future career opportunities. In Australia, language difficulties are identified as the most common cause of educational post-settlement difficulties (Tlhabano & Schweitzer, 2007).

Nguyen and Brown (2010) believe that systematic inequalities within a new environment may make it difficult for ethnic minority adolescents to gain acceptance as members of the host culture. Language, however, provides an adolescent with a tool to manage these inequalities and negotiate their identity and position within the new society. For example, adolescents from immigrant backgrounds who are able to speak more than one language and who dress in a style accepted with the host society are often perceived to have identities that are adaptable to many social situations (Nguyen & Brown, 2010).

In a qualitative research study that examined the adaption of 17 Somali adolescents to secondary school in Christchurch, New Zealand, Humpage (1998) found that the participants struggled to academically and culturally fit in at school as a result of gaps in their previous schooling and a lack of familiarity with New Zealand's academic style. Furthermore, the study found that parental language difficulties and financial difficulties limited parents' ability to help their children.

Poverty impacts access to schooling, as well as the development of basic literacy and

arithmetic skills. Pre-migration conditions, including the refugee camp environment, may have limited exposure of refugee adolescents to the routines and structures of a classroom environment. Despite such limitations, education and professional achievement are still highly valued by individuals from refugee backgrounds and their families (Humpage, 1998). Adapting to the schooling environment does not occur without its challenges. According to the Victorian Foundation for Survivors of Torture (2005), difficulties with language and communication can cause aggressive or withdrawn behaviours in the schooling environment. Pervasive difficulties and ongoing challenges with language acquisition limit interaction, social inclusion and community involvement (McMichael & Manderson, 2004). Ongoing psychological and physiological effects of trauma can affect people from refugee backgrounds' interactions with peers and academic performance in school (Driver & Beltran, 1998). Effects of trauma can include memory and concentration difficulties, anxiety and depression, which have been shown to negatively affect a child's academic achievement. Adults from refugee backgrounds also experience similar challenges in terms of the limited literacy classes available, impacting on their ability to develop their language, which in turn has consequences for employment, family relationships, access to goods and services, and general participation within the community.

Another key issue faced by children and adolescents from refugee backgrounds post displacement is related to negotiating the education system. The number of children or adolescents from refugee backgrounds who have arrived to New Zealand with little to no formal education is unknown. However, many are placed into classrooms according to their chronological age, irrespective of skills, knowledge or prior schooling experience. This leads to significant challenges for students, particularly those entering the schooling system at the higher level.

Culture and Acculturation in People from Refugee Backgrounds

Culture is defined as a collection of behaviours, beliefs, objects and other characteristics common to individuals of a particular group, which is passed down from one generation to the next to support human adaptation and adjustment. Individuals define themselves through culture as they contribute and conform to society's shared values. Culture therefore includes multiple societal aspects, including (but not limited to) values, customs, language, rules,

regulations and institutions. Acculturation is the meeting of two cultures and the resulting changes that occur (Berry, 2003).

More and more, cultural transition is identified as both a psychological and sociological process, which has important implications for the mental health of people from refugee backgrounds (Pumariiega et al., 2005). The different cultural and social backgrounds between people from refugee backgrounds and members of their host community can create psychological and emotional stress in people from refugee backgrounds, including feelings of social isolation (Milner & Khawaja, 2010). Coping with cultural difference is a major challenge faced by many refugee young people from refugee backgrounds upon immigration to a new host country. Difficulties with acculturating to the new environment can contribute to the development of acculturative stress.

Acculturation and Acculturative Stress

Acculturation is defined as the process in which members of one cultural group adopt the beliefs and behaviours of another group (Berry & Sam, 1997; Marin et al., 2003). It refers to the cultural change that occurs when two or more autonomous cultural systems come in contact. This change is identified as the selective adaptation of value systems, the process of integration and differentiation, the start of developmental consequences, and the definition of role determinants and personality factors (Marin et al., 2003). People in voluntary contact are more likely to seek greater participation than those who are not in voluntary contact, such as refugees (Williams & Berry, 1991).

Acculturation affects cognitive and emotional interpretations of distress. It can further shape experiences of social distress. For example, Okazaki (1997) found that Chinese American college students who were less acculturated were more likely to report higher distress in social situations and more avoidance of social situations compared to peers with higher acculturation levels.

According to Berry (1997), four key outcomes may result from the acculturation process. “Assimilation” refers to an outcome whereby individuals reject their original cultural identity, and positive attitudes and relationships are cultivated with the host culture. “Separation” refers to the situation where individuals retain the original cultural identity and experience negative relationships in relation to the host culture. “Integration” refers to the

outcome where the individual maintains the cultural identity of the original culture and develops a positive relationship with members of the host culture. “Marginalisation” occurs when the individual does not retain their original culture or develop any positive relationships with the host culture.

Several factors affect the acculturation process. According to Berry and Annis (1974), individuals with an appearance that is particularly distinct from the dominant population have less of a desire to assimilate. These individuals are more likely to struggle with assimilation because of racism and discrimination related to their distinctive appearance. A common outcome of acculturation is distress at an individual level as social and cultural norms change. Acculturative stress occurs when an individual’s adaptive resources are insufficient to support adjustment to a new cultural environment. Stress is defined as environmental demands that are greater than the adaptive capacity of the individual, thereby increasing the risk for physical and mental health disorders. Stress exposure often involves a direct experience with the stressor or environment demand. Stress appraisal involves estimating the relative threat of a stressor through evaluating internal and external resources against the demands. This in turn affects the emotional, psychological, behavioural and physiological responses to the appraised stressor (Myers, Lewis & Parker-Dominquez, 2003).

In the context of acculturative stress, the pursuit of integration has been defined as the least stressful process (at least when integration is accommodated by the larger society), whereas marginalisation is the most stressful process. Between these two extremes are the assimilation and separation strategies (Williams & Berry, 1991). Berry, Kim, Minde, and Mok (1987) proposed the concept of acculturative stress as an explanation for the various mental health difficulties that have been observed and investigated among people from refugee backgrounds. The model stemmed from the work of Lazarus and Folkman (1984), on stress, including central experiences of psychological trauma and maladaptive behaviour.

Children and adolescents usually acculturate to a new society more rapidly than their parents, thus creating differences in behavioural and cultural expectations (Kirmayer et al., 2011). While parents attempt to retain the language and ways of their home culture, adolescents more actively explore new roles and behaviours of the host culture and gradually reshape their values and self-concepts. Parental confidence is inevitably undermined when they become too dependent on their children, who become proficient in the new language and

customs more quickly. In addition, parents may struggle to cope with children who identify with two cultures (Kaplan, 2009).

Research on acculturation and psychological distress is performed with a prior assumption that new immigrants, such as people from refugee backgrounds, experience significant acculturative stress, which predisposes them to psychological difficulties. This notion is one of the key premises of the immigration stress paradigm (Marin et al., 2003) whereby a negative relationship occurs between acculturation levels, psychological distress, physical health problems and psychosocial functioning. Research with Southeast Asian people from refugee backgrounds, including Vietnamese, Cambodians, Laotians and Hmong, have illustrated that acculturative stress can exacerbate or increase the risk for adjustment and other psychological disorders (Marin et al., 2003). Low English proficiency was found to be a predictor of depressive and anxiety symptoms for these groups.

Stress, Appraisal and Coping

Acculturative stress is influenced by the individual's appraisal of their situation, including coping resources. Lazarus and Folkman (1984) suggest that coping is a dynamic process, specific to both the presenting situation and to the stage of the encounter. Coping is significantly influenced by the individual's cognitive appraisal of an event. Cognitive appraisal is also considered to subsequently impact emotional arousal. Lazarus and Folkman (1984) proposed that psychological stress is an interactive relationship between the person and the environment, which is seen as potentially endangering to the individual's wellbeing. Two key factors mediate the relationship between person and environment. The first is cognitive appraisal, which is an evaluative process that determines the reason for and extent of the stressful transaction. The second is coping, which is the process whereby the individual manages the demand of the person-environment relationship and the subsequent emotions created by the situation.

Cognitive appraisal is the thoughts that an individual has in relation to an external event. There are three components to this process. The first, 'primary appraisal,' identifies the meaning of the event to the individual, and can take three forms: harm or loss (i.e., the damage the person has sustained), threat (i.e., the anticipated harm) or challenge (i.e., how the situation holds the potential for mastery or gain) (Lazarus & Folkman, 1984). The

‘secondary appraisal’ is a process where the individual assesses whether they can deal with the situation within the confines of their goals and other constraints. The final component is a ‘reappraisal’, which is an evaluation includes new information gathered from the environment and the person during the event. The factors that affect cognitive appraisal involve the person (general and specific beliefs of control, as well as learned helplessness) and the situation (familiarity, controllability, predictability and imminence) (Lazarus & Folkman, 1984).

Lazarus and Folkman (1984) define coping as “constantly changing cognitive and behavioural efforts to manage specific external and internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141). Coping encompasses a set of strategies or mechanisms utilised to manage specific situations. Coping may take two forms: emotion focused or problem focused. Emotion-focused coping is more likely to occur in situations where the individual believes that nothing can be done to modify the threatening conditions, and may include strategies such as minimisation or avoidance. Problem-focused coping refers to situations where the individual actively seeks out a solution to a problem or stressor (e.g., by learning new skills). Both emotion-focused and problem-focused coping strategies can be used concurrently or separately in response to stressful life events (Lazarus & Folkman, 1984).

How an individual interprets, appraises and responds to stressful events moderates the effects on their health as a result of exposure to chronic stress. Appraisal of resources available against the demands of the stressors affects the evaluation of the relative threat. The resources include personality variables (e.g., self-efficacy and self-esteem), demographic, and social variables (e.g., social support and financial resources). Different ethnic groups and individuals may respond differently to stressful racial cues, which will affect their responses to racially meaningful experiences and life stress. For example, ethnic minorities may minimise the significance of stressful events, which could represent a response bias (denial) or an aspect of defensive reappraisal (Myers et al., 2003). However, it could also be considered a habituation of chronic stressors where a coping mechanism has been developed to decrease the impact of the stressor.

Adolescents from refugee backgrounds and their families are often exposed to a wide range of trauma, violence and persecution throughout their refugee journey. How these experiences affect each individual will vary, and, the coping responses of each individual will

vary accordingly. While previous research has documented the impact of the refugee experience for adults, little is known about how refugee adolescents cope with these experiences.

Coping Strategies

Coping moderates the impact of exposure to chronic stress. Some refugees cope well with their challenges, while other refugees struggle. Coping strategies refer to the methods an individual uses to deal with demands perceived as taxing or in excess of one's available resources (Lazarus & Folkman, 1984). These methods can be one (or a combination) of cognitive, behavioural or emotional responses, and they can be adaptive or maladaptive. The effectiveness of a coping strategy is influenced by the type of coping (i.e., active versus passive), the type of stressor (i.e., controllable versus uncontrollable) and the relationship between the coping response and the type of stressor (e.g., availability of resources to cope with the stressor) (Myers et al., 2003). Active or approach-oriented coping relates to the engagement of cognitive, behavioural or emotional responses to change the nature of the stressor, or to moderate how one thinks about it. Avoidant coping strategies involve the use of cognitive, behavioural or emotional responses that remove or distance the individual from the stressor (e.g., using drugs or alcohol). Avoidant coping, such as distraction, has been found to be helpful in the short term for managing emotional reactivity. In the longer term, positive attitude, physical exercise and assertiveness have been found to be associated with positive physical health and psychological adjustment (Myers et al., 2003).

As refugee numbers have increased throughout the world, so too has the number of studies examining refugee coping strategies in the context of their vulnerability to developing psychological and functional difficulties related to their experience of exile and resettlement. A number of these studies, which outline the coping strategies young people from refugee backgrounds have endorsed or utilised throughout the spectrum of the refugee experience, are discussed below.

A qualitative study of 11 children from five torture-surviving families from refugee backgrounds were receiving treatment in Denmark identified four key coping strategies based on the dimensions of active versus passive problem solving, outer versus inner problem solving, and social interaction versus isolation (Montgomery, 2011). These four coping

strategies were (i) isolation and withdrawal, (ii) mental flight, (iii) eagerness to acclimatise and (iv) strength of will and fighting. Montgomery reported that the children were more likely to use one particular coping strategy that, while it may have been helpful in their country of origin, may not serve the same function or achieve the same outcome in their new country. Montgomery further stated that the active and extroverted coping strategy of mental flight and an eagerness to acclimatise appeared to assist with development and survival in Denmark. The more passive strategies were considered to facilitate self-preservation and thus survival in the traumatic context of exposure to torture. Inadequate support from their environment, particular from their caregivers, was found to hamper the development of better coping strategies (Montgomery, 2011).

Punamaki's (1996) study of Israeli Jewish adolescents who were still in the war zone found that ideological commitment can have a protective factor on mental health. The authors found that the stronger the young person's ideological commitment (their attitude toward war, peace, patriotism and the political enemy), the less anxiety, insecurity and depression identified. However, Punamaki cautioned that, while this appears to serve a possible protective role when the young person was faced with low levels of war exposure, the protective function decreased with higher level of war experience.

In another study with Lebanese children exposed to war violence, Macksoud and Aber (1996) found that children situated in more stable conditions (e.g., not having been displaced, separated or endured the loss of their loved ones) were more able to engage in planning or deliberate behaviour. Macksoud and Aber attributed this finding to the young person's attempt to gain a greater sense of control over their chaotic situation, including pain related to the trauma. Paardekooper, de Jong, and Hermanns (1999) also found that Sudanese children from refugee backgrounds still residing in refugee camps were more likely to use emotional-inhibiting strategies (e.g., "keeping quiet"), emotion-focused strategies (e.g., "spending time with others"), wishful-thinking strategies (e.g., "wishing things never happened") and prayer compared to 80 Ugandan children who did have experiences of war and flight. In other words, the children were more likely to use strategies that appeared to assist in distracting from their difficulties. The authors suggested that the living conditions of the camp likely constrained the form of coping strategy the children could use, for example, there were limited opportunities to use problem-focused strategies.

In Australia, Schweitzer, Greenslade and Kagee (2007) conducted a qualitative study

with 13 Sudanese individuals from refugee backgrounds to explore coping strategies used in the pre-migration, transit and post-migration phase. Findings suggested that social support, religious beliefs and personal qualities were critical factors that supported coping for the Sudanese refugees. Social support involved support from family and friends within their community, as well as friendships with members of the host community, and this assisted in providing information support, emotional support and as a form of distraction from current stressors. Religious beliefs in themselves were shown to be a source of emotional support; furthermore associations with members of the church appeared to facilitate social, practical and emotional support. Pertinent to the pre-migration and transition phase, personal attitudes were identified as a coping strategy. With reference to personal attitudes and beliefs, the quotes used in the article as examples of “giving up” as a strategy for coping could also be considered a form of acceptance in facing the situation and getting through. Schweitzer and colleagues further identified comparing with others as a coping strategy within the post-migration phase. Specifically, this technique of comparing with those less fortunate was reported to help Sudanese refugees gain perspective of their situation within a positive framework, and also to facilitate hope for the future. A consistent and critical source of support frequently reported by refugee adolescents was their peers, in addition to caretakers or other people who had taken them in (either the refugee camps or in the host country). Another means of coping with their ambiguous loss was acceptance or learning to live with the ambiguity (Luster et al., 2009).

In another qualitative study involving 23 Sudanese individuals from refugee backgrounds in Australia, Khawaja, et al. (2008) reported that their participants used reframing of the situation, including minimising and normalising difficulties experienced, to assist with maintain hope for the future. Khawaja et al. further found a greater reliance on the host government and government-related services within the post-migration phase for monetary, counselling and welfare support.

In an earlier study of 14 unaccompanied youths from refugee backgrounds from Sudan Goodman (2004) identified four key themes that reflected the coping strategies used to deal with hardship and trauma. These included (i) collectivity and the communal self, (ii) suppression and distraction, (iii) making meaning and (iv) emerging from hopelessness to hope. In terms of collectivity and the communal self, a sense of shared experience and collective coping enabled survival because the individual did not go through the experience

alone. The use of suppression was reported to facilitate individual and collective coping as the Sudanese youths tried to contain their worries and traumatic memories. Distraction was reported as a technique for avoiding distressing thoughts and feelings in the form of applying themselves to schooling and activities to avoid ruminating on feelings of disempowerment. Through occupying their minds, the opportunities to ponder on current and past challenges were reduced. In terms of making meaning, Goodman discussed how many of the youths attributed their life circumstances to God's will to make sense of their experiences.

Focusing more closely on coping behaviours in children from refugee backgrounds, Halcon et al. (2007) identified that men and women differed in their coping methods for sadness, in a study examining trauma history, immigration factors, problems and coping in 338 Somali and Oromo youth aged between 18 to 25 years old in the USA. Women were more likely to cope through grouping with other women, while men were more likely to display "fight or flight" responses. Additionally, the greater written and verbal English fluency of the men appeared to enable them to negotiate daily life more easily than the women. Common strategies for managing stress included prayer, sleeping, reading and talking to friends.

In a qualitative study with 117 Bosnian refugees, Weine et al. (2006) found that children tended to avoid talking about painful memories of traumatic events. However the authors identified that sharing happy memories and expressing feelings with one another (such as with their peers and family members) contributed to a healing process within the family. This was achieved through supporting the rebuilding of trust within the family.

In another study looking at coping strategies in 105 children from refugee backgrounds in Bosnia (Kocijan-Hercigonja, Rihavec, Marusic & Hercigonja, 1998), it was found that children from refugee backgrounds not only used less coping behaviours than non-displaced children, the strategies they did use were also less effective. Children from refugee background reported less use of coping behaviours such as watching television or listening to music. Kocijan-Hercigonja and colleagues argued that because the children from refugee background were from rural as opposed to urban areas, their existing coping strategies (e.g., taking care of animals or walking in nature) may not be as possible in an urban setting. Coping occurs within a context that is influenced by social factors based on gender, race, class, sexual orientation and age. These factors impact the appraisal of stressful situations,

including the judgements governing what resources are available (Myers et al., 2003). An individual's socioeconomic status and their environment can affect their resources and the particular coping strategies that are utilised (Taylor, Repetti & Seeman, 1997). Individuals of marginalised groups, either through social class, ethnicity and/or gender, may thus encounter particular challenges to active coping. A lack of knowledge and financial resources, as well as social, cultural or psychological barriers, may also deter active coping (Myers et al., 2003). For example, assertiveness is often perceived as arrogance or aggressiveness in minority populations, which may result in fear or punishment (such as "putting an individual in their place"). While passive compliance (such as "agreeing for the sake of agreeing") may help to avert threats, it can limit the achievement of desired outcomes (such as a pay rise).

Parental coping mode and functioning is also critical when considering coping in children. Almqvist and Hwang (1999) stated that young children are more able to cope with difficult adverse situations when their parent's stress-absorption capacity is not stretched. Once this capacity is exceeded, there is a marked and rapid deterioration in the child's development. Almqvist and Hwang stressed the importance of analysing coping in children within the context of family dynamics. With this in mind, they studied 39 Iranian children and their parents in Sweden. They found that parents were more likely to use problem-focused coping, while children were more likely to use emotion-focused coping.

There are many ways in which family, and family life, impacts on mental health. Family can act as a protective or risk factor that contributes to the development or perpetuation of mental health or mental disorders. According to the US Department of Health and Human Services (DHHS, 2001), family acts as a risk factor when there is overcrowding, family discord, social disadvantage or maternal mental health issues. Child abuse and neglect also contribute to the onset of mental illness, including suicide (Brown, Cohen, Johnson & Smailes, 1999). Examples of family as a protective family include smaller family structure, supportive relationship with parents and adequate rule setting and monitoring by parents (DHHS, 2001).

While there is evidence that adolescents from refugee backgrounds experience symptoms of stress at a cognitive, behaviour, physical and emotional level, Ahearn (2000) suggests that following their traumatic experiences, most people from refugee backgrounds are able to manage well. Rousseau, Said, Gayne and Bibeau (1998) also found in a sample of

unaccompanied Somali children from refugee background remarkable psychological strength and resilience, which they attributed to the cultural interpretations the children made of the traumatic situations they experienced and the use of coping strategies common within their culture.

Utilisation of Mental Health Services

Given the prevalence of mental health problems among youth from refugee backgrounds, including the growing number of refugee adolescents in New Zealand, mental health services are tasked with rising to the challenge of providing culturally-responsive services that are appropriate, accessible and effective. It is documented that refugee and immigrant children are less likely to access mental health services than non-immigrant children (de Anstiss et al., 2009; Ellis et al., 2010; Huang, Yu & Ledsy, 2006; Lustig et al., 2004). More than 92% of the immigrants and refugees identified as in need of mental health services do not receive the service they require (Birman et al., 2005). It follows that youths from refugee backgrounds may be even more underserved (Ellis et al., 2010). There are multiple factors contributing to poor access to, and utilisation of, mental health services. To provide effective mental health services for refugee youths, methods for engaging youth has to be integrated into intervention programs (Ellis, Miler, Baldwin & Abdi, 2011).

Barriers to seeking services are poorly understood (Ellis et al., 2010). However, practical experience of providers, including clinical observations, have emphasised particular barriers to refugee youth receiving mental health care (Ellis et al., 2011; Tribe, 1999). These include (i) distrust of authority and/or systems, (ii) stigma of mental health services, (iii) linguistic and cultural barriers and (iv) primacy and prioritisation of resettlement stressors (Ellis et al., 2011). Hodes (2002) and Raval (2005) have further identified parent and caregiver attitudes towards help seeking, as barriers to utilising mental health services in host countries. In many cases, carers will have their own culturally-defined understanding of impairment or distress, and refuse conventional Western methods of psychological intervention (Fung & Wong, 2007; Hodes, 2002). Furthermore, caregivers may not recognise psychological or behavioural distress in children because of their own emotional distress (Sack, Angell, Kenzie & Ruth, 1986; Zwaanswijk, Van der Ende, Verhaak, Bensing & Verhulst, 2005). Practical and structural factors, such as poor English fluency, limited awareness of available

services and difficulty in registering with general practitioners (Howard & Hodes, 2000), financial constraints and organisational structure of available resources (Barker & Adelman, 1994) also serve as barriers to referral and attendance at child and adolescent mental health services. In addition, refugees' experiences of discrimination from the host community, or from professionals holding similar prejudicial attitudes, can result in low confidence in healthcare providers and more ambivalence about service utilisation (Raval, 2005). Other factors influencing decisions to seek mental health included (i) level of psychological distress, (ii) social support and problem solving skills and (iii) socio-demographic and ethnic differences (de Anstiss & Ziaian, 2010).

Most of the available research in New Zealand on migrant and young people from refugee background has focused on secondary and tertiary students (Armstrong et al., 2005). Studies examining mental health need, prevalence of mental illness and utilisation of child and adolescent mental health services in youths from refugee backgrounds and their families are limited in New Zealand. While there are no specific data available for refugee youth access of mental health services in New Zealand, it has been suggested elsewhere that it is likely that youths from refugee backgrounds underutilise existing services because current services are (i) not available in their native language (Birman et al., 2008) and (ii) not congruent with their culture and values, or that of their families (Westermeyer, 1991). In terms of utilisation of mental health services, other studies have identified ethnic and linguistic minorities are generally underserved compared with members of the majority culture (Cheung & Snowden, 1990). Furthermore, it may be anticipated that the needs of people from refugee backgrounds are greater than that of the general population. Acculturative stress is commonly experienced by youth from refugee backgrounds and their families as a result of challenges integrating into a new culture and country, which may further impact their mental health (Berry et al., 1987). In addition, the presence of any psychological disorders developed prior to resettlement may complicate the young person's ability to adjust to the new circumstances, thereby compounding their adjustment difficulties. In managing poverty and economic survival, mental health may not be prioritised as important enough to seek mental health care for the young person (Westermeyer, 1991).

Mental health problems usually develop when there is a failure of coping strategies, or coping strategies are unhelpful. The coping strategies used by refugee adolescents may be a response to the demands of their environments as well as to cultural imperatives. Depending

on how a problem is perceived by the individual, the coping style is adapted to the demands. However, people also have a preferred way of coping with common forms of stress over time (Lazarus & Folkman, 1984). Furthermore, the relationship between coping and mental health outcome among children exposed to war and political violence is complex (Almqvist & Hwang, 1999; Punamaki, Qouta & El-Sarraj, 2001). For example, in a study examining whether cultural values and traditions impacted the development of coping styles between children living in Thailand versus USA, McCarty and Weisz (1999) reported that Thai children were two times more likely than USA children to report reliance on covert methods of coping, such as “not talking back” than overt behaviours such as “running away.” A direct, overt stance with a superordinate (elder) risk violating an important social rule that elders are to be respected. As parents and professionals such as doctors are considered elders, the authors noted that Thai children may be more inclined to use covert coping behaviours in stressor situations involving these superordinates. This supports the idea that culture effects on coping are more likely to be evident in contexts where culture specific norms and values are important. McCarty and Weisz went on to propose that the impact of culture on a child’s coping is best considered as an interaction between the culture and type of stressor, rather than one key form of coping across many different situations. Thus, depending on the situation, different coping styles are used.

The collectivist culture of many Asian cultures also means that having a mental illness can be seen a reflection on the person’s family and bring shame to the family (DHHS, 2001). For example, Sanchez and Gaw (2007) found that within Filipino culture, a person’s mental illness is considered as their family’s mental illness. In addition, individuals with a mental illness may struggle to achieve the academic and occupational successes that are valued in Asian culture, contributing to stigmatisation. Likewise, individuals with mental illness may be stigmatised because their behaviours reflect badly on their parents.

Barriers and Facilitators to Accessing Mental Health Services

An individual’s country of origin affects their exposure to different concepts of health and healthcare experiences. According to Helman (2007), every aspect of health, functioning and adaptation is significantly influenced by culture. This includes perceptions and interpretations of symptoms; explanations and understanding of illness; mechanisms of

coping and seeking help; following through on treatment; methods of expressing emotions and communication; and the relationship between clients, their families and service providers. Culture has been defined as the social context in which people share beliefs, values, language and social norms. It has been proposed that culture plays a role in (i) the prevalence of mental illness, (ii) etiology of disease, (iii) phenomenology of distress, (iv) diagnostic and assessment issues, (v) coping styles and help-seeking pathways and (vii) treatment and intervention issues (Hwang, Myers, Abe-Kim & Ting, 2008). In addition to culture, contextual factors are also thought to impact problem recognition and identification, and perceived needs (Cauce et al., 2002).

Choosing not to disclose or share difficulties may also be related to the cultural value of collectivism. According to Abdullah and Brown (2011), people of African descent have many shared cultural values, such as collectivism and kinship-like bonds. These two values are closely related to one another, as kinship-like bonds refers to having family-like relationships with members that are not a part of one's actual family. For example, "brothers" and "sisters" are commonly used as terms of endearment with others within the cultural group. Because of such cultural values, the behaviour of one person can be perceived as impacting on the whole group, which lead to the group reducing the association with the individual with mental illness (Abdullah & Brown, 2011).

Because of stigma, individuals with mental health problems are more likely to internalise public opinions and, through shame or embarrassment, will hide their difficulties and refuse to seek help (Wahl, 1999). In addition to decreasing access to resources and opportunities, stigma leads to low self-worth, greater social isolation, increased feelings of hopelessness (Penn & Martin, 1998) and negatively impacts family relationships (Ng, 1997). Cultural mistrust and adherence to Asian values were found to negatively impact attitudes towards seeking professional psychological help amongst students from a South Asian background in the UK (Soorkia, Snelgar & Swami, 2011).

The meaning of an illness relates to the attitudes and beliefs that a culture has about whether the illness is real or not; whether it is a component of the mind or body, or both; whether it deserves sympathy; how much shame or stigma is associated with it; what it could be caused by; and the type of individuals who are most vulnerable to it (Kleinman, 1988). Stigma impedes recovery from mental illness through acting as a barrier to seeking help for

mental health problems (Corrigan & Miller, 2004). Stigma is a barrier to gaining information about mental health problems, which limits identifying issues in a timely manner. Even when the mental health problem is recognised, stigma negatively impacts getting help for the problem (Abdullah & Brown, 2011). Across different racial and ethnic groups, ethnic minorities in USA were less likely than white to seek help from mental health services (Abdullah & Brown, 2011).

Furthermore, therapies within a Western model of care may not be appropriate for non-Western groups. To effectively treat clients, it needs to be recognised that constructs or understanding of illness is different among different groups (Misra, Connolly, & Majeed, 2006). Stressors and challenges are managed through using physical coping strategies, seeking social and emotional support from peers and family. Some also seek psychological or medical input because of a desire to talk to someone they can trust, who is external to their immediate support.

In a qualitative study of 11 individuals from refugee backgrounds exploring their experience in general practice, Bhatia and Wallace (2007) reported that challenges their participants encountered included difficulties registering with the general practitioner, difficulties making appointments because of language problems, refusal of an interpreter by the general practitioner, lack of continuity of care and perceived stigma and discrimination. Some of the impact of these experiences included using family members as interpreters and changing their help seeking behaviour by choosing to avoid going to the general practitioner. There was also a preference for doctors who they felt listened to their difficulties rather than rushed them through, including a preference for advice over medication. Bhatia and Wallace (2007) also hypothesised that concerns surrounding the confidentiality of professional interpreters might be exacerbated by anti-communal tensions within the country of origin. They further identified that individuals who accessed interpreters had a preference to have the same interpreter at each of their visits. It was suggested that this approach may be used in practice to manage client fears around confidentiality.

The culture of the clinician also contributes to the client's experience of mental health services. The culture is reflected in the language used by service providers, in how they conduct their assessment and where they focus their intervention. In addition to the professional culture, clinicians bring their own personal culture into the clinical environment

(Porter, 1997). When the clinician and client are from different ethnic or cultural backgrounds, cultural differences are likely to surface. The consequence is that clinicians may pay attention to what they deem important, but miss what the client deems to be important, or they may be less likely to understand the concerns and needs of their client. Each side may also hold very different perspectives on their understanding of the clinician's role, how the client should behave and what treatment type to implement. Because of this, the Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000) outlines the importance of understanding how cultural differences affect the relationship between the clinician and the client.

Mental Health Services for People from Refugee Backgrounds

Refugee youth mental health needs as discussed previously have specific implications for the fields of psychology and mental health in New Zealand. In the mental healthcare setting, culture influences how individuals communicate and label distress, their explanation of the causes of mental health difficulties and their perception of mental health providers (including how the person responds to treatment) (Gibbs & Huang, 2003). Sue and Sue (1999) identified that mental health services in Western countries typically operate from Western paradigm about mental health conditions, despite increasing exposure to clients of different groups and cultures from themselves. However, Guerin, Guerin, Diirive and Yates' (2004) study with Somali refugees found that Somali conceptions and expectations about mental health disorders and services were influenced by their particular cultural and religious beliefs. The Somali participants reported that direct causes of their mental health difficulties were related to preoccupation with reuniting with their families or other resettlement stressors, not necessarily related to the experience of trauma. Guerin et al. found that difficulties with translation, miscommunication, inadequate cultural skills and knowledge prevented adequate mental health treatment with the Somali population. In terms of both obligations to the professional codes of ethics and standards of practice, there is an expectation that mental health professionals will be able to accommodate cultural differences in their practices through incorporating cross-cultural and ethnic minority psychology's perspective on mental health issues and practices and including worldviews, beliefs, values and lifestyle components that are part of the individual's culture.

In regards to service delivery with Somali families, Guerin et al. stated that health professionals needed to spend more time with the Somali clients to find out about their family and community relationship, and to incorporate and facilitate Somali views on mental health, including traditional treatments, into their management plan. Surprisingly, in a study conducted in USA in Cambodian children and parents, Daley (2005) found that participants were open to the possibility of mental health services as a source of help, while also endorsing the usefulness of other sources of help. However, Daley stated that even though there might have been an apparent willingness among parents and youth to consider utilising mental health services, no less effort should be made to ensure that these services remain culturally relevant and are provided in a sensitive manner. In fact, mental health services need to continue to incorporate thoughtful evaluation of the congruence of these services with other beliefs about treatment that are held by Cambodian children and parents.

In recognition of these challenges for mental health service providers, a number of innovative approaches to service provision for young refugees have been piloted in the UK (Howard & Hodes, 2000). One innovation was the development of specialised mental health projects for young people from refugee backgrounds and their families, which provided pathways to care outside of the normal referral system. Those in favour of specialist refugee services highlighted the limitations of generic outpatient mental health teams, which were found to operate without particular expertise in addressing cultural or migration issues (Davies & Webb, 2000). Birman et al. (2008) suggested that clinicians must further address the context of acculturation and resettlement within families, schools and other settings of relevance to children from refugee backgrounds for young refugees and families to gain optimum benefit from specific evidence-based psychological interventions,. For this to occur, Ehntholt and Yule (2006) stipulate that a comprehensive model of service provision is adopted where case management, psychoeducation and the integration of culturally-appropriate concepts of distress and recovery become critical components of care in addition to psychotherapy. This model is schematically presented in Figure 1.

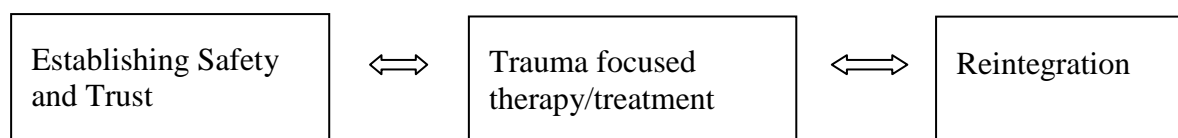


Figure 1. Diagram of a phased model approach to intervention. Sourced from (Ehnholt & Yule, 2006).

According to this model of service provision (Ehnholt & Yule, 2006) the first phase of treatment (“stabilisation”) should address the dual issues of safety from further harm and trust in the therapist. Stabilisation work typically involves liaising with agencies such as housing providers, schools, solicitors, health services and cultural organisations to ensure that basic needs are met and support networks created. Once trust has been established and the client has regained some sense of control over their life, specialised psychological therapy may be implemented. Thereafter, the final phase of treatment (“reintegration”) involves helping the client to identify and plan future goals, such as pursuing further education or finding employment.

While improving access to care is a key element in addressing the mental health needs of young people from refugee backgrounds, Ehnholt and Yule (2006) argue that these needs will remain unmet without the provision of evidence-based treatments focused on specific psychological problems and associated social impairment. Given the current lack of literature on clinical effectiveness of treatment in refugee mental health, clinicians must rely on careful case planning and formulation in order to successfully engage clients and deliver culturally and developmentally-appropriate interventions (Grey & Young, 2008). It is therefore important that clinicians and other professionals working with the client group are aware of the pre- and post-migration experiences of young people from refugee backgrounds. This should include knowledge of psychological risk factors that are especially relevant for youth from refugee backgrounds, such as traumatic loss and social isolation. Attention should also be given to identifying and strengthening individual and systemic factors that promote psychological resilience.

In the initial phase of work with people from refugee backgrounds, Pumariega et al. (2005) recommended an initial focus around symptom reduction by addressing feelings of impotence, emotional dysregulation and regressive behaviours. The second phase of intervention included addressing housing, education and employment concerns for the

individual and their family as part of the integration process. The author went on to recommend a third phase that focused on supporting the refugee family to continue communication and liaison between appropriate social services and mental health agencies. The final phase of the work recommended focusing on the cultural gap between the young person and their family.

Goldberg and Huxley (1980) have developed a framework to describe service utilisation for ethnic minorities and indigenous populations. The model details three filters between psychiatric morbidity in the community and clients attending specialist psychiatric services. The first filter involves the decision to consult a primary care physician which involves the study of “illness behaviour” in the community. Illness behaviour will be influenced by beliefs about symptoms and illness, access to and beliefs about lay healers, family structure, and access to primary care services. The second filter concerns the behaviour of doctors, and the accuracy with which they recognise psychiatric disorders amongst patients who consult them. This will be influenced by the patient's description of the symptoms (which may emphasise the somatic over the psychological) and interpretation problems. The third filter is the extent to which general practitioners refer patients to psychiatrists. Goldberg and Huxley (1980) states that the third filter will be influenced by the family's attitude toward psychiatric illness and treatment. Commander et al. (1997) found that there were ethnic variations in how people cross these filters and access specialist mental health services in Britain. However, it is unclear how these factors may influence the way young refugees reach psychiatric services.

According to Westermeyer (1991) a holistic family centred approach is required for the assessment and treatment of adolescents from refugee backgrounds and their family given the history of trauma, dislocation and disadvantage. This necessitates a comprehensive assessment of physical, developmental and psychological conditions. Alayarian (2007) argues that it goes beyond this, in that the only way in which we may successfully help those in our care who have suffered trauma, and who have consequently been affected by psychological instability and disorder, is through taking the person as a whole, their culture and history, their development process and their experiences prior to and after the trauma into account. To properly address the needs and issues of refugee adolescents, Miller and Rasco (2004) propose that an ecological and chronological approach to assessment with refugee children and adolescents is required. This model considers both the displacement-related events during the pre-migration, migration and post-migration phases of forced migration, in

addition to non-displacement factors.

The model proposed by Miller and Rasco (2004) is similar to the Bronfenbrenner Ecological Systems Theory (Bronfenbrenner, 1979). According to this theory, the child's development is affected by complex "layers" within his/her environment, and changes or conflict within a layer can have effects on the other layers. The interaction between the child's biology, immediate family and society affects the child's development.

According to the Ecological Systems Theory, if the relationships in the immediate microsystem break down, the child lacks the tool to explore other components in their environment. The child then looks for affirmations and attention in inappropriate places when this is not present in the child/parent (or other important adult) relationship. This deficiency presents itself in adolescents as lack of self-discipline, anti-social behaviours and inability to self-direct (Addison, 1992). Society and the culture of both the neighbourhood and the family have an effect on the child's perception of the family's position within the community. The family affects the community through its need for services (Miller & Rasco, 2004).

Blackwell (2007) argues that common therapeutic approaches with refugees, such as cognitive behaviour therapy (CBT), have a tendency to interpret the individual outside of the political, cultural and historical context. Blackwell states that the practitioner can present with presumptuous assumptions of "symptoms" which include insomnia, depression, nightmares and flashbacks, anger and irritability. In the therapeutic space, the service provider also brings with a professional discourse, theories, languages, practices and assumptions of how to ease or alleviate psychological distress or "symptoms." Just as the refugee's life is inextricably linked with his/her political and historical background, the clinician's life is also enmeshed in his/her own cultural, political and historical background, which informs their thinking and practice (Blackwell, 2007). Furthermore, the clinician's beliefs and assumptions about trauma and treatment have evolved historically and are influenced by political and cultural developments. Through one's own training and supervision, particular values and beliefs are instilled into the therapist, which further functions within a strong code of ethical and professional conduct. In a sense, a counselling culture is developed. Within this culture, there is the potential to "medicalise" political trauma, which can increase the refugee's distress and alienation through failing to address the political context of the client (Blackwell, 2007).

Culturally competent mental health services: Service providers' lack of cultural competency may be one of the biggest barriers to mental health service use for minority adolescents and their families (Sue, 1988; Takeuchi, Bui & Kim, 1993). Cultural and ethnic differences between service users and service providers are an important consideration for ethnic minority seeking and accessing mental health services. Mental health agencies may lack cultural competency for helpful and effective service provision. In turn, this may affect the refugee adolescent's decision to seek out or engage with the service, the meaning and satisfaction they derive from the service (the likelihood they remain with the service until the completion of treatment intervention) (Cauce et al., 2002).

When treating people from refugee backgrounds, it is extremely important to recognise that all forms of an intervention are value laden. Healthcare professionals have a responsibility to develop their knowledge about cultural and traumatic backgrounds, including their meanings to the client within the new environment. Björn and Björn (2004) suggest that "one has an ethical duty not to dismiss cultural sensitivities as evidence of abnormal behaviour and to avoid ethnocentric traps in the clinical assessment" (p. 194). Woodland, Burgner, Paxton and Zwi (2010) further note that when health services are sensitive to client's linguistic and cultural backgrounds, there is likely to be an improvement in service utilisation and clients perception of service quality.

A culture-centred perspective acknowledges the individual's cultural context as central and fundamental in controlling their lives and defining their reality (Pedersen, 2003). The culture-centred approach to counselling intervention is determined by the culturally learned assumptions that governs the person's behaviours, personality, and ways in which they manage difficulties in their lives (Pedersen, 2003). According to Wrenn (1962), cultural encapsulation assumes that reality is first defined by one set of cultural assumptions. Second, people normalise and become insensitive to differences between individuals and cultures and assume that their own view is the right one.

Pedersen (2003) states that "if culture is part of the environment and all behaviour is shaped by culture, then culture-centred counselling is a response to all broadly defined culturally learned patterns" (pg. 493). Sue and Sue (1999) argue that there continues to be a pervasive bias in knowledge and skills taught to therapists. They state that although multiculturalism is identified as important, there is a lack of evidence that indicates that

culture-centred knowledge is included in the learning program. They provide an example where cultural information is structured in a separate course rather than one that is integrated across the whole curriculum. In addition, a systematic method of teaching culture-centred counselling skills has not been implemented. This implies that culture-centred constructs are not recognised as common. Furthermore, there is a lack of consideration of culture in counsellor education material that has been developed for media-based training. Finally, there is a pervasive assumption that acquiring additional knowledge about other cultures is sufficient to achieve multiculturalism in counselling, without recognising the importance of developing knowledge about the underlying assumptions or skills that are required.

Cultural relativism: For many refugees, religion is an integral part of their culture. Culture, in turn, influences beliefs around religion, family, school and community life. For example, if independence is strongly valued in a particular culture, some members of society may believe that a critical component of success is individuality. Cultural beliefs are a foundation of a child's sense of self. As culture plays such a critical role in identity, this creates the potential for conflict between the different cultures within New Zealand. Although we exist together as one society, different cultural practices, such as religion, are maintained. The dominant culture may exert a message about their beliefs to other cultures. This can create crisis of identity in children (Seifert, 1999), which influences the behaviour of the child and others within their environment. A number of models have been proposed to conceptualise differences in racial and ethnic minority psychology. Universalism is a model that considers that any work in the psychology field is applicable to all populations at an equal level, even though it is established from a particular worldview (Potts & Watts, 2003). According to this universal model, cultural variations are marginalised. Universalism recognises that inequality and injustices are related to racism, and also that we may also become biased in our understanding of people based on their trauma rather than their cultural traditions. Focusing on traits including other differences at the individual level, runs the risk of attributing a problem associated with a group or social and political systems to being dysfunctions within the person (Potts & Watts, 2003). Out of oppression, people can still achieve at a creative level, or struggle with misery. For example, Sue and Okazaki (1990) proposed that high-achieving academic performance of Asian Americans, at a level greater than that found in their home countries, is conceptualised as part of a response to experiencing oppression in the United States.

According to African philosophy, rituals are considered the best mode to access historical memories, because these affirm healing and the individual's life purpose. A universalist worldview assumes that the key effects from an intervention are universal, and that through changing language as an example, external validity in the approach can be achieved. However, the underlying worldview and cultural ethos of the intervention has been translated may have stayed the same, which may in itself conflict with the culture of the client. A person-centred approach examines first the person's core values and worldviews before developing an intervention (Potts & Watts, 2003).

"Etic" and "emic" are terms that are often used in social and behaviour science research, and refer to two different kinds of information regarding human behaviours (Marmol, 2003). "Etic" refers to theories, values and practices that are both normative and universal for all people. "Etic account" is a description of the behaviour by an observer. "Emic account" comes from the person within the culture and refers to values, practices and theories specific to a group, tribe or community. Traditionally, psychology considered many of its theories to be etic, but with the growing multicultural society, psychology has needed to become more sensitive to emic forms of practice (Marmol, 2003).

Until careful consideration has been made about the contexts within which the individual exists, including their particular settings, their behaviours cannot be adequately evaluated as adaptive or maladaptive (Case & Robinson, 2003). The pathologising and labelling of unfamiliar behaviours unique to a culture has contributed to misdiagnosis and inappropriate and, at times, unwarranted intervention (Case & Robinson, 2003). What may be considered maladaptive or dysfunctional in one culture may be attributed as resilient and adaptive behaviours in another. For example, a cognitive style referred to as "suspicious" within members of minority groups may be an adaptive approach to their historical experiences. Sue and Sue (1999) also reported that privacy and limited self-disclosure, which is valued in Asian-American culture may be interpreted by a Western (or non-Asian-American) psychologist as inhibited, repressed and unassertive, rather than as a mechanism that enables the individual to operate within the Asian-American culture.

A key concern with applying Western models of psychotherapy with non-Western cultures is its inappropriateness, including the potential harm it can cause by possibly alienating the client and perpetuating a form of cultural imperialism, which can endanger the

preservation of cultural diversity. Some clinicians who are mindful of this may purposely seek out more naturalistic or traditional forms of intervention that are embedded within the client's own culture. Blackwell (2007) cautions against such a radical approach, as he argues that it can invalidate any value within traditional psychotherapeutic approaches, while at the same time failing to contextualise the client's difficulties or the approach to address it. This can limit the client's access to possible valuable therapeutic skills and resources, and also disempowers the therapist and reinforces feelings of hopelessness and cultural ineptitude when working with such a population. Furthermore, if certain aspects of a human's response to trauma are assumed to be universal, a naturalistic or traditional approach may fail to address the trauma that the client has experienced.

Within the therapeutic encounter between the client and the therapist, it must be understood that the work is occurring between two individuals enmeshed in powerful and complex historical processes (Alayarian, 2007). With this in mind, the perspectives of both the service user and service provider need to be considered.

Refugees in New Zealand

Refugee Quota Programme

Since 1944, New Zealand has resettled more than 40,000 former refugees from conflict zones throughout the world. These include Cambodia, Laos, Vietnam, Myanmar, Iraq, Iran, Afghanistan, Ethiopia, Sudan, Somalia, Rwanda, Burundi, Nigeria, Eritrea, the Congo and Columbia. Although New Zealand has been accepting people from refugee backgrounds into the country since 1930, the Government formally established the annual quota for the resettlement of refugees in 1987. The Refugee Quota Programme is part of the Refugee Policy that falls under the International/Humanitarian stream. To be eligible for consideration of resettlement in New Zealand, the refugee must be recognised as one under the UNHCR's mandate, with the exception of applications who are dependent or nuclear family members of the principal applicant. Currently the quota is set at 750 new refugees per year with a focus on supporting people who fall in the subcategories of: Women-at-Risk, Medical/Disabled, and UNHCR Priority Protection subcategories (Immigration New Zealand, 2009). Additionally, a smaller number of refugee status claims are accepted for individuals who have arrived into the country as asylum seekers, including individuals from refugee-like

contexts/circumstances who have been sponsored under the Family Reunification category.

Between 1999 and 2008, 7823 people from over 56 countries were resettled in New Zealand under the Refugee Quota Programme. Of those, 60 percent were under 25 years of age when they arrived. This figure is not inclusive of refugees accepted into New Zealand under the refugee Family Support category, which allocates 300 places per year. The top 10 nationalities approved for residence under the Refugee Quota Programme between 1999 and 2008 includes Afghanistan, Myanmar, Iraq, Stateless, Somalia, Ethiopia, Iran, Former Yugoslavia, Sudan and Eritrea.

The highest proportion of quota refugees over this time were from Afghanistan, as a consequence of an increase in civil war conflict, the uprising of the Taliban movement, and war in Afghanistan after the 11 September 2001 attacks in the USA. The largest number of Afghan refugees to be accepted into New Zealand was 677 people in 2004.

In Myanmar, the increase in crimes against humanity by the ruling Junta led to a mass exodus of people from their homeland. Following the UNHCR's identification of refugees from Myanmar as a priority group in 2006, New Zealand resettled 572 quota refugees. They comprised the largest refugee nationality within that quota year. Ongoing civil war and the war in Iraq attributed to the steady number of refugees from this region to be resettled to New Zealand.

While the quota has a particular limit set, there have been times when the New Zealand Government has exercised exemption from the rule. For example, war crimes resulting from the Milosevic regime had forced many Albanians from Kosovo to flee their country and 404 Kosovo Albanians were granted refugee status on top of the quota in 1999 (Immigration New Zealand, 2009). Among the 15 percent in the other category, a large proportion was refugees from Bhutan who gained access to New Zealand in 2007 and 2008.

As noted previously, there are three main subcategories that quota refugees are accepted for residency in New Zealand. These include: Women-at-Risk (75 places), Medical/Disability (75 places), and UNHCR Priority Protection (which includes Family and Emergency subcategories) A further 300 places are allocated for family reunification and up to 35 places for emergency referrals (Immigration New Zealand, 2009). Any quota refugee who has not been identified under one of the above subcategories is still classified as a refugee quota refugee. The New Zealand Government must carefully balance New Zealand's capacity to

provide good settlement outcomes while still trying to assist refugees who are at the greatest need of resettlement.

On arriving in New Zealand, refugees accepted under the Refugee Quota Programme undergo an intensive six-week orientation programme at the Mangere Refugee Centre in Auckland. Services provided at the centre include Refugee Services; Refugee As Survivors; Housing New Zealand; Work and Income New Zealand (WINZ); Centre for Refugee Education (Auckland University of Technology); and the Ministry of Health.

Permanent residence is granted to all quota refugees, which entitles the people from refugee backgrounds to the same rights and benefits as any other New Zealand permanent resident in the areas of health, employment, education and social welfare. Once they have completed the orientation programme, people from refugee backgrounds are usually resettled in major cities includes Auckland, Hamilton, Palmerston North, Hutt City, Porirua, Wellington, Nelson and Christchurch.

Pertinent to this research is that a large majority of quota refugees accepted to New Zealand between 1999 to 2008 were under 25 years of age. Within this period 37 percent of the total quota refugees were aged under 15 years, with another 23 percent aged between 15-24. This means that at least 60 percent were aged under 25.

Issues Pertinent to Refugee Adolescents in New Zealand

In a report by the Refugee Group Action Group, Johnstone and Kimani (2010) with the assistance of Changemakers and Wellington Refugees As Survivors, documented a summary of difficulties faced by refugee youths in New Zealand. The age group they referred to included people aged between 12 and 29 years as they reasoned it was closer to cultural norms for refugee communities. Identified issues included challenges with access to youth services; experiencing difficulties with cultural identity and belonging; interrelated difficulties with secondary schools (dropping out of school early or leaving with low-level qualifications); requiring extra support to increase chances of achieving success at tertiary studies; struggling with long periods of unemployment; experiencing conflicts with their families; increased participation in petty crimes and gang activities; significant mental health and trauma issues, including difficulty and reluctance to access mental health services; living in over-crowded homes or conditions; lack of identification limiting access to social services

and community resources; language difficulties; feelings of discrimination and persecution; decreased opportunities to participate in sporting activities; social isolation and insufficient peer support; and difficulty accessing or engaging in youth development activities.

Rationale and Overview of the Study

This research aimed to build on the helpful, but limited, findings of previous research. It was an exploratory study that aspired to provide more information about stressors impacting on refugee youth and their coping strategies, including experience of mental health services in New Zealand. A total of two studies, using qualitative research methodology formed the basis of the current thesis. The two studies will be presented as two individual chapters, including the aims, methods, analyses and discussions. An overview of this thesis is first presented to highlight the relationship of the two studies.

The Current Research

The two studies were completed concurrently. That is, when adolescents were involved in focus groups or individual interviews, the focus groups with service providers were being conducted during the same period of time. All the components of the research were designed to complement one another. For example, the individual interviews were intended to explore themes that had been identified in the focus groups in greater depth. Focus groups with service providers were intended to clarify the psychological needs of the young person, while hopefully also providing insight into the barriers to service utilisation for young people from refugee backgrounds.

Aims of the Study

This study first aimed to address the limited information available in New Zealand about refugee adolescents and their coping mechanisms in response to their stressors, including their experience of mental health services. Second, the study aimed to identify how service providers understand or make sense of refugee challenges, and how this then influenced their approach to working with the young person and their family. An emphasis was placed on examining the similarities or differences in adolescents' and service providers' identification of refugee adolescents' needs and issues, in the formulation of their experiences and the

intervention received or provided. It was hoped that this information would further help to identify whether current practices appropriately address the needs of the refugee individual or changes could be made to increase utilisation and promote helpful interventions to support refugee adolescents to lead a successful and meaningful lives in New Zealand.

Study One focused on psychological needs and coping mechanisms in youth from refugee backgrounds who have and have not accessed mental health services in New Zealand. Focus groups with young refugees explored how they had coped with the adversity of the pre-migration, transit and post-migration stress and whether they access mental health services or not, including their experience with these mental health services if they were accessed.

The focus groups were followed by individual interviews which explored in more depth the issues and challenges refugee adolescents experienced across the refugee journey. It further provided the opportunity for the young person to discuss topics or issues they may have felt uncomfortable discussing in a focus group discussion where confidentiality is limited (Hayes, 2000). A semi-structured interview schedule was developed based on themes identified in the focus groups for the individual interview. Interviewees ranged in age from 13 to 18 years, although more than half the participants were aged 16 years or older. Thematic analysis was completed with the transcribed recorded interviews.

Study Two explored the practice and provision of mental health services in working with refugee young people. The objective of Study Two was to gain a greater understanding of mental health professional experience in working with refugee adolescents to gather insight into ways in which professional practice could be modified to enhance the efficacy and meaning derived from the interaction when working with a refugee young person. Specifically, the inquiry focused on how the service provider understood the young person's difficulties, the types of treatment modalities they used and their rationale for using their chosen approach with young people from refugee background. It is believed this knowledge will provide a basis from which strategies to improve the quality of the experience of mental health services can be enhanced for young people from refugee backgrounds and their families.

Researchers on the mental health needs of people from refugee backgrounds have generally formed their conclusions about access barriers to mainstream services based on the

perception of the refugee, and have not considered the perspective of service providers. It is likely that the barriers identified in previous studies reflect limitations of mainstream services; however, some of the conclusions may be misguided without consideration of other factors that contribute to the perceptions. In addition, if barriers to access are considered by service providers, health professionals or services may be able to identify strategies to decrease or ameliorate these barriers. Therefore, focus groups with service providers assist with ensuring that information obtained from adolescents from refugee background about their experience with mental health service providers is validated through also examining opinions and perceptions of service providers.

CHAPTER TWO

Methodology

Qualitative Approach

This chapter presents the general methodology of the two studies in this thesis. The specific details of each study are described in Chapters Three and Four.

A qualitative approach using semi-structured interviews with focus groups and individual interviews was used. This approach was chosen in consideration of the potential benefits that a qualitative methodological approach can contribute to understanding the stressors affecting refugee adolescents, how they cope, and their attitudes toward and experience of mental health services.

Qualitative research enables both the exploration and elaboration of a phenomenon, including the possibility of generating tentative explanations. It further contributes to new levels of understanding, such as understanding the importance of local context, values, opinions, behaviours and social contexts (Ahearn, 2000). In relation to this study, qualitative methodology enabled the exploration and elaboration of the refugee experience. Critically, qualitative research provides complex detailed descriptions of individuals' experiences. Therefore, the "human" aspect of an issue, such as contradictory beliefs, opinions, relationships and behaviours can be recognised and acknowledged.

A further benefit of a qualitative approach is that the form of inquiry (such as using focus groups and interviews) is not dependent on a questionnaire that has pre-established assumptions about the range and depth of topics covered. Thus, a qualitative approach is more helpful in research with under-researched phenomena, such as stressors affecting refugee youths and how this affects their wellbeing (Miller et al., 2002).

Much of the earlier research on refugees has focused on mental health status and has utilised symptom checklists and structured interviews which recorded psychiatric symptomatology (Miller et al., 2002). While the focus on psychiatric symptoms has enabled the documentation of recurrent and long-term patterns of distress often associated with people from refugee backgrounds communities, it has nevertheless limited the understanding of the psychology of exile, the range of stressors experienced by people from refugee backgrounds, and how these may interact with ongoing post-migration stressors to cause or perpetuate high

levels of distress (Miller et al., 2002). Firstly, if distress is mainly understood in regards to psychiatric symptomatology, it does not assist in supporting greater understanding of patterns of distress related specifically to the refugee experience. For example, viewing refugee distress in terms of psychiatric symptomatology poorly captures how the experience of forced migration, including exposure to violence, can significantly challenge an individual's stance on meaning, faith and identity (Silove, 1999). An inductive approach, as attended in qualitative research, enables participants to identify and explore forced migration in their own words, so that key features of their experience, including patterns of distress that may not be integrated within conventional diagnostic categories, can be made known.

A qualitative approach also enables the historical and comparative aspect of the refugee experience to be captured, giving insight about effects of the past on the present situation. The refugee experience occurs across a period of time, rather than one event (Miller et al., 2002). This means that the refugee experience and its influence on a person's wellbeing cannot be fully comprehended without consideration of the person's life before he/she became a refugee (Miller, 1999).

Semi-structured interviews in focus groups and individual interviews enable significant domains of particular experience to be examined in greater depth. How young refugees perceive, experience and cope with pre-migration and post-migration stressors, including their experience of mental health services, can thus be better understood. The implication is that future therapeutic work or intervention with refugee communities can address variables that are of significance to them.

Thematic Analysis

The fundamental qualitative method completed in the two studies in this research was thematic analysis (Braun & Clarke, 2006). Depending on the theoretical position and the aim of the researcher, thematic analysis is a flexible technique that can be utilised across a range of qualitative research (Braun & Clarke, 2006).

The six phases of thematic analysis as described by Braun and Clark (2006) were used to guide the analysis in both Study One and Two. All interviews were recorded and transcribed. Phase 1, "familiarising yourself with your data", involved repeated readings of the transcribed interviews to search for meanings and patterns, including developing a list of

ideas of what were in the data. Phase 2, “generating initial codes”, involved identifying codes in the data. A code is a word or sentence that represents a particular idea or statement in a meaningful way regarding the phenomenon (Braun & Clarke, 2006). In Phase 3, “searching for themes”, the codes are sorted into broader “themes”. A theme will include related codes. Reviewing of the themes was completed in phase 4, wherein themes were either collapsed into one another or further divided into separate themes, and in addition, subthemes were often developed. For example, in Study One “discrimination and bullying” was initially considered a theme on its own. However, during the review process, this theme was incorporated into a broader theme of “making friends is difficult”, and “discrimination and bullying” was presented as a subtheme. The tables containing potential themes and subthemes were shown to the primary supervisor as well as another colleague with a background in qualitative refugee studies, in order to provide validation of the coding process and derivation of themes. They were asked to identify if the text provided corresponded to the themes and subthemes identified. When they disagreed with the codes or themes identified, this was discussed with the researcher. Changes were then made to themes in consideration of their feedback. Phase 5 relates to “defining and naming the themes”; for example, “school is hard”. Once this was completed, phase 6, “producing the report” involves bringing together themes and placing this information within the context of the narrative provided in the relevant chapter.

Semi-structured Interview Schedule

Semi-structured interviews were used in all interviews. The interview questions were derived from the literature review and considerations of the specific aims of Study One and Study Two. Semi-structured interviews enable a balance between flexibility and control. According to Morse and Field (1996), the semi-structured interview enables the participants the freedom to discuss the topic in their own words, while still allowing the researcher to obtain the information required. In the present research questions were organised under a series of headings to help keep the conversation focused on the topic of interest. This is consistent with van Manen’s (1997) position that one of the researcher’s roles is to keep the participants focused on the investigated subject.

Semi-structured interviews enable the exploration of subjective meaning, such as, what

the topic of the interview really means to the individual participant (Banister et al., 1994). The open and flexible nature of the semi-structured interview allows the opportunity for the researcher to follow up concerns or issues raised by the interviewee, including those not considered or anticipated before the interview. Therefore, it enables the documentation of perspectives not envisaged by the researcher or not usually represented. Subsequently, the approach can validate and publicise the views of marginalised or disadvantaged groups, empowering the group (Mishler, 1986).

In relation to the thematic analysis used in this research, certain issues were defined in the semi-structured interviews (see following chapters) which became categories within which first codes, then themes, were described. For example, in interviews with mental health professionals, “Barriers to engagement” was identified as an issue and questions addressed this. Particular codes and then themes were grouped according to this topic or category.

Focus groups and Individual Interviews

A focus-group methodology was used as a data gathering method for Study One and Study Two as it enables the investigation of group-defined attitudes and experiences (Krueger & Casey, 2000). Historically, focus groups have been used to develop group-generated information on a wide variety of issues. The focus group is considered an efficient qualitative data collection technique because it enables a greater range and amount of information to be gathered through interviewing people simultaneously (Berg, 2001). Participants are exposed to other issues they may not have considered if interviewed on their own, and respond to the issues accordingly. One advantage of using focus groups is that they help to decrease any potential power differences between the participants and the researcher when the common language and culture of the group is used. Furthermore, they help to investigate the significance and/or consensus on any given topic (Krueger, 1993). For example, a focus group would provide insight into the participants’ shared understanding of acculturation issues, and experiences of mental health services. In this particular research, focus groups also had the advantage of identifying issues for the subsequent individual interviews conducted in Study One. Through the focus-group process, participants can feel empowered and be given the opportunity to be valued as experts. Finally, compared to using individual interviews alone, the focus group allows the opportunity to collect a large amount of

information over a shorter period of time (Berg, 2001).

While there were a number of advantages to using focus groups, there are also disadvantages to using this form of data collection. For example, it is difficult to support participants to maintain confidentiality and anonymity within a group setting. Individual interviews allow participants to share their experiences in a confidential context. For this reason, it was decided to use a combination of focus groups and one-on-one interviews in the interviews with young people.

Reflexivity

Reflexivity requires the researcher to examine the ways in which his/her involvement with the study or research informs, influences and impacts the research (Nightingale & Crombie, 1999). This means that the researcher needs to be aware of his/her own personal influence on the contributions of participants, and the interpretation of such data from the beginning to the end of the research process. Furthermore, it involves the researcher being aware and acknowledging that it is not possible to remain “outside of” the subject matter while completing the research. Reflexivity extends from designing the research questions, and identifying and setting up the interviews with interviewees, to the interview itself (including one’s role, how one is being perceived by the interviewee, and one’s own reflections on the process), in addition to the work completed to convert an interactive experience into a piece of written work (Banister et al., 1994).

Reflexivity takes two forms: personal reflexivity and epistemological reflexivity (Willig, 2001). Personal reflexivity involves looking at the ways in which the research has been shaped by one’s values, interests, personal commitments, experiences, beliefs, goals in life and social identity. This process is reciprocal as it also involves reflecting on how one has possibly been changed or influenced by the research as a researcher and as a person. Epistemological reflexivity involves reflecting on the assumptions (about knowledge and the world) that one has made in the course of the research, and to also consider the implications of such assumptions for the research and its findings (Willig, 2001). It thus requires the researcher to connect with the questions that have been used, such as: “How has the research question defined and limited what can be ‘found’?” “How have the design of the study and the method of analysis ‘constructed’ the data and the findings?” “In what ways could the

research question have been investigated differently? To what degree would this have led to a different understanding of the phenomenon being investigated?” (Willig, 2001).

The following is a brief account of key life experiences that I feel may have influenced the phenomenon being researched, through questions asked and the interpretations of those findings.

More than 250,000 Laotian refugees have been resettled in other countries, the majority having been accepted into the USA. In October 1986, my immediate family and I arrived in New Zealand as refugees from Laos. In the two years prior, my family and I had lived in two separate refugee camps in Thailand, along with hundreds of thousands of other refugees from Laos, Cambodia and Vietnam. The conditions in the camps barely met basic needs. Toilet and washing utilities had to be shared, food was sparse and expression of distress assaulted one's senses across a lot of levels.

My parents never retrained in their original profession. They stayed on the factory floors. Their sacrifice is more than the hours of factory labour; it is also their family and the way of life as they knew it. In my teens I felt a responsibility (and sometimes a burden) to make something of myself and of my life; otherwise their sacrifice would have been in vain. I have often questioned whether other youths from refugee backgrounds have experienced similar or different responsibilities and subsequently, how have they managed these responsibilities.

In 2005, I graduated with a Postgraduate Diploma of Clinical Psychology. During my clinical experience post training, I have worked primarily with children, adolescents and their families. I have also sought work with refugee children, adolescents and their families who have experienced psychological, emotional and behavioural problems from their pre-migration and post-migration experiences. My training as a clinical psychologist gave me a rich opportunity to learn and be exposed to many refugee stories and experiences, and worldviews. Such experiences have, however, also influenced the epistemological assumptions brought to this research. The limitation of my professional training background is a tendency to consider the phenomenon being investigated from a problem-focused approach. To control for this, there has been a conscious review and analysis of the questions identified for the focus groups and one-on-one interviews to examine the meanings rather than just the content of the experience.

As part of a clinical team, I often wondered what the experience of accessing a mental health service means to the refugee young person, and how they made sense of the services they received. I thus have never been “outside of” the subject matter. This has implications in terms of having to be even more mindful during the research process. While I might know of the refugee experience from my own perspective, as well as understand the different perspectives put forth about the refugee experience, this does not mean that I know what the experience of adapting, coping with stressors and mental health services is like for all refugees. As such, I have had to take great care to not confuse my stories, my experiences, or any previous refugee client’s experiences of mental health services, for the participant’s stories and ultimately what it has meant for them.

The validity of the participant’s response may be questioned because of other factors such as trust in the researcher. Despite being from a refugee background, to the majority I likely had outsider status to the ethnic group and their community. Furthermore, social desirability in face-to-face interactions may threaten the validity of the response. Last, but not least, many refugees are likely to be unfamiliar with the idea of research, which itself can affect their participation and responses in a number of ways.

In this study, many of the young refugee participants asked about my background and they were subsequently informed that I had arrived in New Zealand as a refugee child. While self-disclosure can have a number of drawbacks, such as influencing the thoughts and opinions of the participants (Jackson, Daley & Davidson, 2008), Davies and Dodd (2002) argue that when participants request advice or information, this impacts on the area of researcher involvement and is considered an issue of ethical consideration. Choosing to not respond to the questions asked by participants can adversely impact the flow of the interview (Jackson et al., 2008).

Reflexivity also includes thinking about the researcher’s motivation in the research activity and considerations of whom the researcher is accountable. I had aspired to represent the young people’s stories and that of the service providers honestly, respectfully and with integrity. Finally, in acknowledging positionality, it requires careful considerations in terms of “How can I best represent the voices of the youth participants and service providers?” “Who does the research benefit the most?” and “Will this work make a difference in the lives of refugee youths?” Ultimately, my hope was that the outcome of this research would help to

make a difference to the lives of young people from refugee backgrounds in enabling them and their future generations to flourish in the post-migration environment.

CHAPTER THREE

Study One

Refugee Youths: Stressors, Coping, and Experience of Mental Health Services

The steady increase in the number of people from refugee backgrounds in New Zealand over the last 70 years has brought a wealth of ethnic diversity, culture, religion and beliefs into the New Zealand community. As described in the literature review in Chapter 1, many people from refugee backgrounds have likely been exposed to political violence, displacement and war-torn conditions, however, the adverse effects of such exposure include a loss of social networks (which often leads to social isolation), loss of social roles and role-related activities and unemployment, as well as poverty-related stressors. In addition, other adverse effects include a lack of environmental mastery, discrimination, separation from loved ones and concern for loved ones, including in terms of intergenerational differences in rates of acculturation (Miller & Rasco, 2004). These impacts are likely to be present in the lives of adolescents from refugee backgrounds, just as they may be with their parents.

The increased number in people from refugee backgrounds brings challenges to mental health service providers in terms of mental health provision. Consequently, there is a need to review existing provision and access of quality mental health care to people from refugee backgrounds and conduct research that examines the accessibility of such services to those in need.

This study had two aims. The first was to explore what types of issues or challenges young people from refugee backgrounds experienced in resettling in New Zealand and how they have coped with their issues and challenges given their refugee experience. The second aim was to explore young people from refugee backgrounds' experiences of and beliefs about, professional mental health services that may assist them. It was anticipated that this research could provide insight into ways in which mental health professionals can modify their practice when working with young people from refugee backgrounds.

This study had two components: a focus-group study, followed by individual interviews with a different set of individuals from the focus groups. It was decided to include two components because some participants may have been deterred from full participation in the focus groups due to concerns about confidentiality and social acceptance. Furthermore, individual interviews allowed the opportunity to explore initial issues identified in the focus

group in more depth.

Initially, focus groups were only planned to include service users. However, as the research progressed, it was decided that the experiences of non-service users needed to be explored too, with the goal of identifying the barriers to adolescents from refugee backgrounds' access and use of mental health services.

Method

Focus Group Participants

A total of 37 refugee adolescents between the ages of 13 and 18 years participated in one of nine focus groups. All participants who met the criteria for inclusion were included in the focus groups. They were recruited in the Auckland and Hamilton regions, as these two regions, have the highest number of refugees in New Zealand. Five focus groups were conducted with mental health service users, while another four focus groups were conducted with non-service users. The number of participants within these focus groups ranged from two to six. The service-user focus groups included eight females and twelve males, with a mean age of 16 years (see Table 1). In terms of ethnic representation, nearly half of the participants in the service user focus groups classified themselves as Somali. The participants in the non-service user focus groups included twelve females and five males, with a mean age of 17 years. In terms of ethnicity representation in the non-service user focus groups, over half classified themselves as Columbian (see Table 2).

Individuals were assigned to focus groups according to whether they had accessed services, as well as by their age. Service users and non-service users were separated because the literature had stated there was a lot of stigma related to accessing mental health services. As such, the participants who had accessed services needed to be protected from potential discriminatory or stigmatising attitudes from non-service users. Those aged from 13 to 15 years were grouped together, and those aged from 16 to 18 years were grouped together, so that younger and possibly shyer members of the group were not limited from sharing their experiences. Furthermore, there was consideration that younger participants could possibly be intimidated by older participants.

In terms of cultural considerations, individuals from a Muslim background were further separated according to gender to respect cultural expectations and parental concerns about

mixing genders. For participants from non-Muslim backgrounds, parents did not make

Table 1.

Demographics of service-user focus groups (Total n=20)

Focus group	Ethnicity	Gender	Mean age	Venue of group meeting
A (n=3)	Laotian (n=1) Vietnamese (n=1) Cambodian (n=1)	All female	16 years	McDonald's
B (n=5)	Somali (n=3) Afghan (n=2)	All female	16 years	School
C (n=4)	Afghan (n=2) Burmese (n=2)	All male	15 years	School
D (n=6)	Somali (n=6)	All male	17 years	School
E (n=2)	Egyptian (n=1) Pakistani (n=1)	All male	15 years	School

Table 2.

Demographics of non-service focus groups (Total n=17)

Focus group	Ethnicity	Gender	Mean Age	Venue of group meeting
A (n=4)	Somali (n=3) Columbian (n=1)	All male	18	School
B (n=5)	Somali (n=5)	All male	17	Library
C (n=2)	Columbian (n=2)	Male (n=1) Female (n=1)	16	Home
D (n=6)	Columbian (n=6)	All female	17	McDonald's

specific request to separate genders during the focus group when signing the consent forms for their child's participation. As such, participants from a non-Muslim background were not

grouped into separate gender groups.

Individual Interview Participants

Following the focus group discussions, a total of 16 refugee adolescents, all service users, participated in the individual interviews (See Table 3). All individuals who agreed to participate were included. Like the participants in the focus groups, the adolescents, aged between 15 to 18 years old were recruited in the Auckland and Hamilton regions. Adolescents aged from 13 to 14 years were also sought, but recruitment with this age group was unsuccessful.

Table 3

Demographics of participants in the individual interviews (Total n=16)

Participant	Ethnicity	Gender	Age (years)
1	Afghan	Female	15
2	Afghan	Female	15
3	Somali	Male	16
4	Somali	Male	16
5	Cambodian	Female	18
6	Laotian	Female	17
7	Somali	Female	18
8	Cambodian	Female	18
9	Somali	Male	16
10	Laotian	Female	18
11	Vietnamese	Female	17
12	Laotian	Female	17
13	Burmese	Female	16
14	Burmese	Female	17
15	Burmese	Female	16
16	Burmese	Female	17

Interview Schedules

Focus group interview schedule and process. The semi-structured interview (see

Appendix A) used in the focus groups were conducted with a protocol to ensure that four areas of primary interest were discussed. These included: (i) life prior to New Zealand and stressors encountered, (ii) stressors/adjustment experience following resettlement, (iii) coping mechanisms used and (iv) experience accessing and not accessing mental health services and the meaning of these experiences.

The questions within each primary area of interest were open-ended to facilitate the flow and direction of discussions, to follow participant's answers. This interview methodology is based on the voice-centred relational interviewing technique developed by Brown and Gilligan (1992) whereby participants primarily determine the course and content of the interview. For example, when asked "What was life like before coming to New Zealand?", participants' answers were wide ranging in both content and depth. Follow-up questions helped to explore participants' statements in greater depth, for example, "Why did you not want to leave?" The discussions/interviews were then modified to the unique stories and perspectives of the participants, for example, "Tell me about your life in Ecuador?" The questions were also modified for the dynamics within the group. Advantages of this approach are that it enables participants to share experiences that are most salient to their lives and allows exploration of all primary areas of interest to be covered within the duration of the focus group.

A number of participants sought agreement or acceptance by posing such statement as "You know what I mean." This suggested an assumption from the participant about the level of knowledge the writer possessed on the matter. In providing a timely response to the questions posed during the focus group discussions, the interview encounter was enhanced (Britten, 1995).

Individual Interview Schedule

The semi-structured individual interview (Appendix A) was in part based on the issues identified in the focus groups, and schooling, friendships and mental health service experiences more closely considered. The questions within each focus area were open ended so the interview flowed. The following topics concerning life and experience of mental health services were also covered in the individual interviews:

-
- Memories of life before arriving to New Zealand and pre-migration expectations or knowledge of what life in New Zealand may be like.
 - Challenges or difficulties before arriving in New Zealand and life in New Zealand. Interviewees were prompted to discuss challenges in relation to school, friends and family.
 - Coping with the difficulties and challenges.
 - Experience of mental health services, including what was helpful and unhelpful.
 - Recommendations for improving mental health service provision.
 - Recommendations for other young refugees settling into New Zealand.

Procedure

The University of Auckland Human Participants Ethics Committee (UAHPEC) approved this study in November 2008 (Reference 2008/369).

Recruitment and focus group process. Participants were recruited using a purposive sampling method. This is a deliberate and non-random method of recruiting participants who had accessed or not accessed mental health support (whether at the schooling, primary healthcare or tertiary healthcare level). An email was first sent out to Child and Adolescent Mental Health Services (CAMHS), non-government organisations (NGOs), key stakeholders, high schools and other community organisations in Auckland and Hamilton likely to have come in contact with refugee adolescents. The email contained a brief introduction about the researcher, the focus group participant information sheet (see Appendix B), and contact reply slip. It also included the request to disseminate the information to their contacts within the organisation to help advertise to potential participants.

An agency that was thought to be particularly relevant to recruitment was RASNZ, a mental health assessment and treatment agency for all United Nations quota refugees entering New Zealand. An initial meeting within this agency was established for two reasons. The first reason was to introduce the researcher and discuss purpose and objectives of the study. The second reason was to formally request assistance from members of the community link

facilitators group of RASNZ to inform their own ethnic community about the study. Participant information sheets for refugee adolescents, including contact reply slips (Appendix C), were given to the individuals at the meeting. The community facilitators queried what remuneration participants would receive for their time and involvement in the study and were told that the participants would be given movie tickets as a token of gratitude. The facilitators further queried how the outcomes of the study, or participation in it, could improve the mental health services received by refugee adolescents and their families, and were given information about how the study outcomes would be disseminated to inform and improve services.

A second means of recruitment involved contacting key stakeholders such as community leaders from refugee backgrounds about the study. On receiving an email about the research, one stakeholder from the Somali community invited the researcher to attend a weekend school assistance programme for Somali refugee youths funded by the community. They wanted the opportunity for leaders of the community, people running the group and Somali students to meet with the researcher before deciding whether to participate. They stated that they were wary of being over-researched and reported that their community had not always been treated respectfully when participating in previous research projects.

Focus group participants were given a range of options as to where focus groups could take place. This included rooms at a school, at the public library, at the Refugee Migrant Services building or at a local McDonald's restaurant. Five focus groups were completed in schools, while two were completed in a room at McDonalds (see Table 1 and 3). One focus group was completed at the library of a tertiary campus, and one completed within a home with two siblings. Attempts were made to be flexible about the venues as they had to complement the adolescents' commitments, be easily accessible, and feel safe enough for the adolescents to discuss their experiences. All focus groups except for one were completed in English. The exception was a focus group with two siblings who were from a Columbian background and who asked to have an interpreter present.

Once potential participants contacted the researcher via text, phone or email to indicate their interest in participating in the research, they were given the opportunity to discuss the study further, including any queries they might have had about the research. For youths under 16 years of age, their parental consent was required to participate in the focus group. This

meant that if a young person under the age of 16 years had contacted the researcher indicating a desire to participate, parental consent was sought in the first instance. If the young person chose to not gain their parent's consent, they were not able to participate in the study. If the parent or caregiver of the young person under the age of 16 refused to provide consent, they were also not able to participate in the study. Mindful of the cultural consideration in which parents of youths from refugee backgrounds liked to be informed and make decisions for their children about activities the young person participated in, participants over the age of 16 were encouraged to share their participation in the research with their parents.

At the beginning of each focus group, an introduction was given by the researcher, including an explanation of the framework and specific purposes of the study. This was followed with a discussion of possible risks of participating in the study. For example, if they were to become distressed in the middle of discussing their experience, the focus group discussions would be stopped to allow the young person to have a break. The young person could choose to stop participating in the study at any time without any negative judgement or consequences. The young person would be further followed up straight after the interview to examine his/her levels of distress and the type of support required, for example, a follow-up referral to a mental health service.

Following a discussion of the risks, the benefits of the study for the participants and for society were discussed. The adolescents were given the opportunity to raise any questions or concerns. This was followed by an explanation of how confidentiality would be maintained, and how the transcript of the interview would be stored and secured in a locked cabinet held on the University of Auckland campus. If the adolescents remained willing to participate in the study their signature was obtained on the consent forms.

At the end of each focus group discussion, the participants were thanked for sharing their time and experience with two movie vouchers. They were additionally given the opportunity to share any additional thoughts, questions or feedback they might have on the subject matter or the discussion process. Written permission was received to enable the researcher to contact the participants if the transcripts needed clarification.

In regards to role differences (e.g., clinician/academic, refugee youth/adult), careful considerations were given to the power imbalance that can occur in interviews (Fontana & Frey, 2000). This meant listening carefully to the participants' responses to show interest and

respect in regards to their lived experience. The participants' contribution to the study was also acknowledged.

Recruitment and individual interview process. A purposive sampling method was also used to recruit participants for the individual interviews. As with the focus groups, emails were sent to Child and Adolescent Mental Health Services (CAMHS), high schools, and NGOs. The participant information sheet (Appendix D) and contact reply slip were attached to the email. Participants in the focus groups were also asked to share the research with their peers and contacts who might be interested in participating in the individual interviews.

Individual interviews were completed in the participants' homes. Interviews were completed in English. Participants were informed of the opportunity to access an interpreter; however, none requested this.

At the beginning of each interview, the content of the participant's information sheet was reviewed with the participant. Following this, the consent form was discussed and signed before commencing the interview. Participants were reminded that they had the right to withdraw at any stage, that they did not have to answer any questions that they did not want to answer and that they could change their mind about participating at any time without fear of any negative outcomes or judgement from the researcher. Furthermore, they would still receive two movie vouchers as a small token of gratitude for their participation in research.

Ethical considerations. An extended discussion on the ethics has been provided because adolescents are a vulnerable population in research (Ahearn, 2000). The cognitive and reasoning capacity of a young person is still developing as compared to an adult participant. Younger adolescents' capability in effective reasoning is likely to be less than that of older adolescents, which thus influenced the decision to structure focus groups in Study One in age groups. Secondly, an interview experience in the research setting may trigger memories of prior interviews as part of their refugee experience. The triggered memories can activate cognitive, physiological, emotional and behavioural responses associated with the trauma. Another point is that the stressful circumstance of resettling for more recently-arrived refugee adolescents can adversely decrease their reasoning capacity, which may affect their decision to participate, or their responses in the interviews. With these points in mind, the relevant ethical issues specific to this project and the techniques employed

to address concerns are outlined below.

The two key ethical considerations when using focus groups are that (i) it can be intimidating, especially for inarticulate or shy members, and (ii) focus groups may discourage some people from trusting others with sensitive or personal information. To address these points, the participants were given clear explanations at the beginning of each focus group of the purpose of the research, use of the outcomes and possible implications, including any discomfort that might be experienced. The participants were further given the opportunity to participate in the individual interview if they did not wish to participate in the focus group. If they chose to participate in the group and experienced trauma as a result of the issues discussed, they were supported to access counselling as soon as possible. At the onset of the research, it was decided that the focus group session would stop if a participant became distressed and the participant would be supported immediately to minimise further traumatisation.

Clear protocols were also established from the outset about how the researcher could minimise or moderate the possible impact of traumatising or re-traumatising the potential refugee participants. This was based on using a sensitive and reflexive approach to facilitate the focus groups. As the facilitator of the focus group discussions, the researcher had a responsibility to be honest and informed the participants about the topics and expectations of the group. The participants were encouraged to share, but never pressured to speak if they chose not to.

One community link facilitator also raised the concern about parental consent not being required for young people from refugee backgrounds over the age of 16 years who chose to participate. They stated that some parents of Muslim background believed they had the right to be informed about what their children were engaged in, irrespective of the age of the young person. Furthermore, these parents believed they had the final say in what research or activity their children chose to participate in. It was acknowledged that it was understandable that parents may be interested in what their child was engaged in, even when the young person was over the age of 16 years as it enables them to be involved in their child's life on a number of levels. It was also acknowledged that some parents may want to have the final say in whether a young person over the age of 16 years was allowed to participate. It was recognised that a number of non-Western communities value the concept of the family as a

whole, rather than as distinct individuals. This, in turn, influences their desire to be kept informed, and to have a say in their children's activities, in the sense that the children's participation in an activity reflects the participation of the "whole". This presented a dilemma in a New Zealand research setting, specifically, usually young adolescents in New Zealand have the right to not inform their parents of their participation in activities, and if they were to participate in this study the researcher would not be able to inform their caregiver or parents of their participation because of confidentiality consideration. The young person however would be informed that they had the right to share or discuss their participation in the group and what the research was about, although this would not be able to discuss the contents of the discussion or disclose who else had participated. They also had the right to withdrawal from the study following the focus group or interview, and have any information they shared omitted from the analysis.

Informed consent. All elements of the research were openly, honestly and fully disclosed before any focus group discussions or formal interviewing could take place. In the disclosure, the position and involvement as the researcher in the issue and purpose of the research was discussed, as well as what the research involved, how it would be conducted, the number of participants the researcher hoped to recruit, the time it was likely to take and what would happen to the material gathered. Only when potential participants were fully involved were they considered to be able to give informed consent. It was further reiterated with the participants that they had the right to withdraw at any time in the research process, even six months after the interview. If they chose to, the material gained from their participation would be destroyed. The contact details of the researcher and the primary supervisor (including a postal address, phone numbers and email addresses) were provided on the participant information sheet so that if participants chose to withdraw, or if they had any concerns or queries, these could be responded to quickly and respectfully.

Protecting participants. The aim in trying to reduce any possible harm to participants is to equalise the power relationship so that exploitation does not occur. Thus, from the first point of contact, the researcher disclosed her refugee, clinical and PhD student background to locate herself firmly within the research issue. Another aim with this disclosure was to support participants to understand the researcher's position as a PhD candidate with a clinical psychology background. A limitation to this researcher's role is that involvement with participants must occur as a researcher and not as a clinical psychologist, despite one's

qualification to offer professional help.

The researcher was mindful from the outset of the research that although it was possible in asking participants to discuss mental health service experiences that they would also recall negative thoughts and emotions related to the experience. This had the potential to re-traumatise the participant if their experience of the services had been difficult or challenging. If a participant was observed to become distressed, the discussions or interview would be halted, and the tape recorder would be switched off to allow the participant an opportunity to deal with the uncomfortable emotions. If participants asked for advice such as who to turn to for professional support/therapy for their difficulties, names, addresses and telephone numbers of appropriate mental health agencies such as Refugee As Survivors New Zealand (RASNZ) or Child Adolescent Mental Health Services would be provided to them. Again these were strategies considered to reduce the power differential between the researcher and the participant. Having stated that, the researcher is mindful that it is not possible to achieve complete neutrality and equality between the researcher and the participant, because it is the researcher who sets the process in motion, identifies the research issues and framework. Furthermore, the final analysis that is visually scrutinised by the public is ultimately the researcher's perspective of reality.

Confidentiality and anonymity. Confidentiality and anonymity relate closely to the issue of protection for participants. In dealing with personal information, there is always the potential for harm, particularly if the information is made public. In publishing quotes from the participants in this thesis, all efforts were made to anonymise the information. This is challenging in qualitative research that in deals with personal experiences, as the personal details required for understanding the experience increases the risk of the participants being identifiable to those who know them. Thus, great care was required to ensure that potential identifying details were not included in the write up.

From the outset, participants were informed that each person's contribution would be shared with the others in the group as well as with the researcher. They were encouraged to practice confidentiality. The researcher has also anonymised information from group members in this publication to protect their identity as much as possible. In regards to the participants' ability to provide informed consent for the focus group discussions, an interpreter was used with the Columbian participants to translate the consent document to

them. The interpreter was also required to sign a confidentiality agreement.

Data Analysis

All focus group discussions and individual interviews were recorded and transcribed verbatim. Consent forms (Appendix E), and hard copies of the transcripts are stored in a locked filing cabinet at the University of Auckland. Electronic versions are stored on a secure server at the University. Where words were unclear, or where there were overlapping conversations, the discussions were replayed as often as required to clarify the word and content.

The step-by-step guide to completing thematic analysis as outlined by Braun and Clarke (2006) and as discussed in the methodology chapter, was used to guide the analysis process for both the focus groups and the individual interviews.

While the analysis for the focus groups and individual interviews were completed separately, the data are presented together in this chapter as they relate to the aim of identifying refugee adolescent stressors, coping mechanisms and experience of mental health services. The data were combined because of the shared purpose, and because considerable overlap was found. The findings are presented according to the four categories: life prior to New Zealand; resettlement; coping mechanisms; and experience of mental health services/barriers to engagement.

Analysis of Interviews: Focus Groups and Individual Interviews

Life Prior to New Zealand

Multiple changes and challenges impact on young people and their families as they go through the refugee process and adjust to living in the host country. Youth participants were asked to discuss their life experience prior to New Zealand. Most focus group members and individuals who arrived during early to late adolescent years were able to report experiences that they had been exposed to prior to re-settling in New Zealand. The key theme that emerged from this discussion was “exposure to violence, hardship and corruption”.

Exposure to violence, hardship and corruption. The experience of violence and

corruption was a key theme in the primary area of interest of “life prior to New Zealand”. More than half of the participants in the focus groups with service users discussed experiences of violence and corruption in their life prior to resettling in New Zealand.

I didn't, not really problems here, but in Karachi, you know, these days, there is so many other things going on. Fighting, killing, and things like that. (Focus group C, service users, Afghan)

Of the individuals, more than half had arrived in New Zealand as infants or young children, therefore they “didn't have any memories of their parents' homeland.” However, some were able to share what life prior to New Zealand had been like for their parents. A few participants in the individual interviews were also able to share their own experiences of the difficult circumstances they experienced pre-migration.

The soldiers made our lives horrible. (Individual interview, Participant 15, Burmese)

Hardship occurred in their immediate homeland, and also in places where they sought refuge, whether legitimately or illegally. In these environments, there was the risk that the young person and his/her family's identity in regards to nationality could be exposed. This was often accompanied with the potential threat of being sent back to where they came from.

So it's very difficult. Because unless if you go city, and for shopping and things like that, it will be risky. To them maybe tomorrow, maybe one day they will take you and send you back to Afghanistan. (Focus group C, service users, Afghan)

Another risk that refugee adolescents and their family faced was being subjected to bribery and financial corruption in order to maintain their status of hiding within the country of refuge. Violence related to discussions of fighting and killing, and also to economic violence. Related to the economic violence were further threats of expulsion if the individuals did not pay in order to remain living in the country.

My dad paid money and gave all our family's gold so the smugglers would not inform the camp about sneaking us in, and allowing us to stay in the camp. My family couldn't risk going back as we could be shot trying to get back into our country. (Focus group A, service users, Laotian)

The experience of violence was reported to occur both directly and indirectly towards the

individual. For example, a service user participant reported witnessing a girl being raped. Furthermore, the experience of fear was common with concerns about safety and welfare. Within this experience was also recall of a sense of powerlessness in not being to act or intervene during the traumatic experience. The adolescents stated that they will “never forget it.” It is unclear if the adolescents struggled to forget what they witnessed, or how they behaved in the situation, or both. The “not forgetting”, as either a conscious action or a subconscious action, possibly suggests that the experience continues to impact on their thinking, and potentially their functioning within their present context.

I watched a girl being raped and I couldn't do anything because I was too scared they might do something to me. I will never forget it. I still keep thinking about it. (Focus group D, service users, Somali)

Another experience of violence as discussed by other focus group members (in both the service-user and non-service user focus groups) related to losing their loved ones as a result of violence, for example, through an explosion. An adolescent who lost his father in this way continued to be influenced in his present context through finding it hard to cope. Others also struggled with how their loved ones died. Because of these experiences, the adolescents continued to worry about the safety and welfare of friends and family back in their homeland, subsequently affecting their ability to cope or adjust to the present situation.

I worried about family and friends back home. An explosion also killed my father. That's the hardest thing to deal with here. Not having my father.
(Focus group D, service users, Somali)

Participants' discussion about their experience in the transit camps/countries suggested there was a state of limbo in the transit camps and lack of certainty about the future. For example, an individual interview participant reported that many individuals had nowhere to go. They were unable to return back to their country of origin, and there were uncertainties about their future.

There were lots of people there from Burma, Cambodia, Vietnam and Laos. Some people had been there all their lives. The people that had been there a long time looked sad because they had nowhere else to go. They couldn't go back to their country, and no other country had accepted them. I felt sorry for them. (Individual interview, Participant 13, Burmese)

Participation in common behaviour practices such as shopping was limited and carried with it a risk of identification, being bombed, shot at or killed. Thus, even in the country that the refugees had sought refuge before arriving in New Zealand, ongoing threat to their safety persisted.

Yes. Risk was like there was, because you are Afghani you are foreign people, you know, there are so many robberies, and so many corruption. You see it's in our everyday bombing in the cities. So you could be one of those victims passing by, and you have no clue, and then something happen in the street and then the shot and things like that. So it's just one of those victims could be, every day is people like dying and aren't interested because of it.
(Focus group C, service users, Afghan)

Many of the participants were not able to report on the conditions of life in their home country prior to New Zealand because they “had never lived there” (Individual interview, Participant 1, Afghan), had been born in the refugee camp or had arrived in New Zealand at a very young age.

I was only three at the time we arrived in New Zealand. (Individual interview, Participant 5, Cambodian)

It was identified in the focus group discussions that life prior to resettlement included exposure to hardship and violence. Similarly, many participants in the individual interviews who had arrived in New Zealand at an older age reported a number of difficulties, such as experiencing physical violence or living in conditions that were “dirty, smelly and poor” (Individual interview, Participant 14).

Compared to New Zealand, we had no money and were very poor.
(Individual interview, Participant 8, Burmese)

They captured my family and beat us. We escaped in the night and kept running. (Individual interview, Participant 14, Burmese)

Of those who could recall early experiences, one participant chose not to share because she stated that she “don’t want to talk about it” (Individual interview, Participant 16, Burmese). The conditions discussed were not all negative, however several participants talked about friendships they had established or the fun experience they recalled in the transit

environment. For example, two Columbian siblings reported that their memories of life in Ecuador were “fun” even though their “house was smaller” and people and traditions were different.

Because we were so young it was fun for us. It was good even though our mum had to work and provide food. We went to school and it was good.

(Focus group C, non-service users, Columbian)

Their young age, similar language and cultural similarities may have contributed to the ability of the Columbian refugees to adapt to living in Ecuador as a family. Describing life as fun in Ecuador may suggest that the environment they were exposed to provided some form of stability. Conversely, perhaps the participant’s approach to their new setting in Ecuador was to continue to have fun in spite of the changes in conditions. This may indicate a more resilient personal quality of being able to have “fun” in the midst of what others may have viewed as difficult conditions.

Resettlement

To adapt is to adjust oneself to new conditions or environment. Focus group and individual interview participants discussed a wide range of issues they coped with in adjusting to the new environment. The themes identified under the resettlement primary area of interest included: dealing with loss and worry about people left behind, learning a new language was difficult; money is a worry; making friends is difficult; adapting to the new culture; school/work; and managing parental expectations.

Dealing with loss and worry about people left behind. The experience of loss was identified as a key theme across focus groups with service users, non-service users and individual interviews. Participants discussed the loss of their culture and a familiar environment. The other key loss that participants discussed related to loved ones who had been left behind because (i) they were too young or too old; (ii) the family was separated in the fleeing process; (iii) the people had been missing for some time; (iv) there had not been enough provision in the last country they resided in to provide resource for all the immediate family members; or (v) they had purposely chosen to stay behind because the fear of the unknown was greater than the political violence and war conditions they had become accustomed to.

We got separated...it's been hard. The biggest challenge at the moment is not having our father here. So that's eclipsing everything else happening in our lives. And so my mother's life is revolving around how she is going to sort this problem out. (Focus group B, service user, Somali)

For participants who had arrived to New Zealand in their teenage years, many discussed key losses in family and friendships from their home country, or friendships/relationships that had been established in the refugee camps or places they had resided before immigrating to New Zealand.

In our village back home, I had heaps of cousins to play with, and aunties and uncles and grandparents. It's only my family here. We don't have anyone else. My parents used to worry that if we did anything wrong we would be sent back. They worried a lot about doing the right thing so that we could stay. I didn't want to live here in the beginning because I missed my friends and family back home. (Individual interview, Participant 13, Burmese)

According to focus group participants, worrying about family and the experience of loss are exacerbated by struggling to cope with not knowing where family members are; or what has happened to their loved ones.

My family and I still find it hard living here because we don't know where my father is or what has happened to him. (Focus group C, service users, Burmese)

Participants reported that the experience of "not knowing" makes it "hard" to adapt to living in New Zealand.

No. My family thinks he might have been killed, but we can't be sure. Sometimes we'll get information that he might still be alive, and then nothing. It's hard when this happens. If we knew that he died, maybe easier. Not knowing what has happened to him makes it hard for us. (Focus group C, service users, Burmese)

One focus group discussed that it was hard not having a key family member around because the absent person helped to protect and care for the family. The family's support network was thus reduced through having a critical figure absent and the ability for family members to work was compromised when there was a lack of support to care for younger family

members.

Our whole family struggle to adapt because it's hard not having our father around. He protected us and looked after us. The family is still very sad without dad. Mum is not able to work because there's nobody to help her. Mum still cries a lot. I sometimes think it might have been better if we had stayed back in our country. At least mum still has people back there to help her. (Focus group C, service users, Burmese)

Care within the family also extends to caring for those with a disability. There are fewer resources to call up on to help care, and also greater loading on those available to take on responsibility of care.

My dad had back surgery and was collected and couldn't get up. So if we had my aunty or somebody really close to you it will [be there] but at that time if you need somebody...they are far away. Very, very painful. (Focus group A, non-service users, Somali)

Four of the participants in the individual interviews indicated that they had been born in the refugee camp, and had lived in the camp for all their life before coming to New Zealand. The loss for these young people was not for their homeland or the conditions their parents might yearn for, but rather for the refugee camp conditions that had inadvertently become home to them.

Some focus group members reported that adapting to the new environment was difficult. In the individual interviews, parental struggle with adapting to the host country was more evident and, as a consequence, adolescents yearned for the familiar conditions back home. Several focus group participants further reported a desire to return back to the country of origin as participants felt "homesick".

I feel homesick two days after I came to New Zealand. Everything was different and it took a long time to get used to it. I still feel homesick and I wish to go back. (Focused group B, service users, Somali)

In more than half of the focus groups, participants discussed concerns about the safety and welfare of family members left behind. Worry or concern for separated family members appeared greater when the person remaining had a physical or emotional difficulty.

Family is really important to us. Our first wish is to be together as a family. So I was especially, and I am worried about my oldest brother, because he hasn't got good health. So he has got a weakness that I am worried. Even though he is married, but he is not like other people. He's not normal, he's not like others. It doesn't mean that he is harming somebody, or hitting someone. Not like that. He always is a kind of a depressed. He always sort of cries and gets upset. And those sorts of feelings he had. So I am worried about him. (Focus group E, service users, Pakistan)

In many focus groups, participants reported leaving family members and loved ones behind, for example, "we left the rest of my family, my grandparents." (Focus group C, non-service users, Columbian). With the separation, many families appeared to experience a longing for, and missing of, family members and the culture in the country of origin.

My parents missed the family back home though. They missed the culture, they missed the food, the weather, they missed a lot of things back home. They missed it even though there was a lot of violence. (Individual interview, Participant 16, Burmese)

Some families are able to maintain contact with other family members on Skype or by telephone, while others do not know the location of family members and their current context or whether they are still alive.

Since we left Ecuador we haven't seen them. Sometimes we see them in the camera. (Focus group C, non-service users, Columbian)

For many families, a member of the direct family was not with them. Focus group and individual participants discussed a number of challenges in not having a family member present. For example, the role of providing education, food and accommodation, and caring for the family's welfare becomes a greater responsibility for family members that are present. This can impact the young person's ability to focus on other areas of his/her life, which can result in negative outcomes. For example, having to care for younger family members means that less time and attention can be given to studying. This then impacts academic performance, which can affect the young person's acculturation experience, sense of achievement and self-worth, potentially having a negative impact on their mental health.

It's hard work trying to take care of my younger brothers and sisters when I

have a lot of homework from school to complete. Often I don't get it done and then I don't do so well in school. (Individual interview, Participant 12, Laotian)

Both the focus group discussions and individual interview accounts indicated that being separated from family members had a negative impact on the family's wellbeing.

I mean Mum does a lot for us. Providing us with good health, education, food, accommodation, all that. But she thinks we don't appreciate any of that, because we don't have our father here. And it's having a negative effect on the family's wellbeing, of course. (Focus group B, service users, Somali)

Participants further reported how "painful" it was to "wait a long time being apart from your family" (Focus group C, service users, Afghan) until they could one day be reunited. Sufferings on mental and emotional levels were also discussed in terms of worrying so much about the welfare of loved ones, including concerns about whether they will be reunited. Several focus group participants discussed the "hard work trying to get family to New Zealand to be safe." (Focus group C, service users, Afghan)

I want to say, it was painful, because you have to wait for a long time being apart from your family. You have no idea will they going to accept that, or not. So sort of like keep you in the room, lock you in the door, and you don't know when you will be free. Just like that. It's a freedom. Sort of when you are thinking about something, you are under pressure all the time. So you will be mentally and emotionally, everything will be under pressure. Because one is suffering. (Focus group C, service users, Afghan)

Another consequence of separation from loved ones included feeling lonely, which was reported to affect a person's happiness. These narratives suggested feelings of inadequacy at being unable to speed up the process of being reunited.

I think people become a bit lonely because they can't do anything. Loneliness really affects people's wellbeing; you can't go out because you don't feel very happy. If your family is back home and they are suffering and you're suffering because you can't do anything to speed up the process to be together. People in the community became depressed and were diagnosed with depression. They can't do anything; they think

they need to go back. It's quite hard, it affects their whole lifestyle. (Focus group D, non-service users, Columbian)

Learning a new language was difficult. Many members of the focus groups reported that migration at a young age appeared to assist with quick language acquisition compared with coming to New Zealand at a high-school age. From the individual interviews, language difficulty was identified to limit the young person's ability to access and function in many aspects of their life. For example, using public transport is inhibited when the young person is unable to communicate his/her needs to transport staff, and cannot understand communication from transport staff.

I couldn't speak any English, and I found it hard to travel on the bus because I could not understand the bus driver, or instructions. (Individual interview, Participant 15, Burmese)

Language difficulties further negatively affected the young refugees schooling through primary, intermediate and high school. Not having relevant language was experienced as a disability and once language was developed, more opportunities were open to the young person. Language is a key facilitator to developing social networks, forming supportive relationships, developing and learning new skills, making oneself understood, getting one's needs met and assisting the family with one's adjustment needs.

I had to learn the language because I couldn't understand anything. My parents couldn't understand or read or write in English either. So I had to work hard to learn English because my family needed me to. We didn't have anyone to help us. (Focus group D, non-service users, Columbian)

Language also supported the young person to actively facilitate the family's adjustment to the new environment.

My family needed my help. It felt good when I could read the letters and translate for them. I could see they were working hard to care for us. This was a way I could help them out. (Focus group D, non-service users, Columbian)

For others, language difficulties were not reported as a problem because they had been exposed to the English language from a young age, some as young as infancy. However, this

did not mean that language difficulties were not experienced by other members within the family which may have impacted the young person. The majority of refugee children and adolescents arrive in New Zealand with either one or both parents. The following adolescents did not express any difficulties with language because she was a “baby” when she arrived in New Zealand; however, she did report that her parents struggled with the language initially, and that her mother has continued to do so.

My parents had lots of language problems, and still do. My mum still doesn't speak much English. (Individual interview, Participant 6, Laotian)

Notwithstanding, there are negative outcomes that can occur when the young person develops their language skill quickly. For example, they may be called, or relied on more heavily to act as interpreters or the spokesperson for the family.

Maybe it might have been helpful to have an interpreter for my parents so I don't feel stuck in the middle. (Individual interview, Participant 15, Burmese)

Many of the focus groups participants reported language difficulties as a key challenge faced in adjusting to living in New Zealand. Some discussed that language difficulties was the only difficulty they experienced, while others identified it as one of multiple challenges that they or their family faced.

Only the English language, the friends were fine. (Focus group C, non-service users, Columbian)

Others participants stated that, although English was “really hard to learn” (Focus group B, non-service users, Somali), many refugee adolescents developed their English skills faster than their parents. It was reported that parents sometimes expressed frustration when the young person spoke English rather than their native language.

And another thing, my parents have struggled to pick up the language. They get frustrated with my brothers, sisters and I when we speak English, and they want us to speak our language. (Focus group A, service users, Vietnamese)

Language difficulties were often discussed as an ongoing challenge for parents, which were identified to negatively impact the parents' social life, their interaction with their children and

their participation within their community. Because of language difficulties, focus group members stated that they “suffered a lot” (Focus group E, service users, Pakistan).

Language is still a problem for my parents. And was very big problem at first. Still a problem at the present for them. It hasn't been solved yet. There is no social life here for them. I have my own friends. What I mean by social life is like you know visiting relatives and neighbours and mates. At all times, we don't have people with our kind of mentality here to mix with them continuously. That's a big gap. (Focus group B, service users, Afghan)

As language facilitates almost every aspect of adjusting, engaging and participating in the new environment, the struggles to learn it may act as a barrier that limits the ease with which the adolescents are able to adapt and participate in their community. This can contribute to an increased sense of frustration, which may reinforce feelings of ineptitude and inadequacy. These feelings can further add to the challenges of adjusting to a new country, which may increase the adolescents' vulnerability to developing mental health difficulties.

Money is a worry. Another theme under the resettlement primary area of interest related to concerns and worries about money. Money facilitates the opportunity to have a “good education” or a “good life”, therefore a lack of money may mean that such goals are not accessible.

Problems become worse because...mother worries about family, money, us getting a good education, having a good life here. She worries about nearly everything. (Focus group C, service users, Burmese)

Focus group participants discussed parents working hard as a means of managing their money anxiety. Some also discussed parents attending the casino and gambling away the money they had earned, which led to disputes and tension within the household. This contributed to feelings of frustration for the adolescents, which may have occurred towards the loss of household money, their parent's gambling behaviours, or the increased fighting within the household. Irrespectively, money concerns and worries were a pertinent issue for refugee adolescents.

My parents have started gambling away a lot of the money they made in the bakery when the casino opened. They ended up going bankrupt. It caused a lot of arguments in the house because Mum and Dad were always blaming

one another. It was both their fault for going to the casino. I was angry with them. (Focus group A, service users, Laotian)

Money worries may be related to pre-settlement conditions as focus group participants discussed that “life is very difficult and poverty is deep” (Focus group D, non-service users) prior to moving to New Zealand. Therefore, having lived in such an environment beforehand, money concerns may continue for many refugee families despite New Zealand’s welfare system established to provide basic living necessities such as shelter, food, and access to healthcare.

The living conditions back in their homeland, where people are dependent on agriculture for survival meant that money was sent by some refugee families to support families in their country of origin to buy food. The “pressure” felt to send money home may be external, or internal to the individual.

People depend in agriculture and at times there are no rain they cannot plant and all this and that so the money that we sending from here will help buy food and maintain their families. So this is putting quite a lot of pressure on us...so it makes us quite busy. (Focus group D, non-service users, Columbian)

In some focus groups, discussion indicated that sending money back home was not an option, but a necessary behaviour in the support of both immediate and non-immediate family members. This then impacts the remaining financial resources available to the adolescent and their family to enable them to start a new life in New Zealand.

I think for us we value family so much. As I have explained we look at it not surrounding you and your family members only. Other relatives that are close - uncles or aunties - they are all your family. And as a result they expect so much from us because back home we all live together. So the little you do, whatever work you get, what little money, you keep on. You keep on sending, taking a bit of it. You have to send money back home. Not only to your family members but all the others that are your family. You have to support them. You can't ignore it. (Focus group D, non-service users, Columbian)

Exposure to poverty was reported to impact on how the adolescent or their family applied themselves to the task of creating a new life. Through the experience of significant financial

hardship and poverty in their homeland and in the refugee camps, the majority of refugee families arrive in New Zealand with limited or no financial resources. If they were accepted under the Quota Refugee category, they are entitled to basic benefits such as the unemployment benefit or housing supplements; however, many families may be very strongly motivated to work and earn money as part of establishing a new life for themselves. This can reduce time and availability to the family or the children, which can further affect the adjustment process to the new environment.

Being a refugee youth meant that I didn't see much of my parents growing up because they were always working. It meant that we were still poor for a long time in the early years. It meant that my parents tried to push us hard because they had made so many sacrifices for us. It meant that a lot of my relatives can't be with us, so we have less support from extended family. I know that I live a very different life from other Cambodian children in Cambodia. My parents tell me this all the time. (Individual interview, Participant 8, Cambodian)

In some focus groups members discussed how in the early days of living in New Zealand, family members chose to all live together in one household, perhaps because of money worries. This meant sharing of resources and facilities, such as sharing one toilet. It was reported that many individuals living within a small household contributed to constant fighting within the home, with some individuals choosing to move to a different place.

In the early days at first everybody lived together. But the house that we live in we only have one toilet for nine people. So there were constant fighting, and troubles. Everyone fighting, young and old. So family decided to move out, and be in a different place. (Focus group B, service users, Somali)

Making friends is difficult. Focus group members who arrived in New Zealand at a young age reported few difficulties in making friends. This may have been due to exposure to the norms of the society, which enabled them to develop adaptive behaviour.

I grew up here, so I've been a Kiwi from like a young age. (Focus group B, non-service users, Somali)

This is a significant contrast to experiences of difficulty in making friends reported by

adolescents who had arrived in New Zealand more recently. For these participants making friends was reported to be a challenging experience, which was negatively compounded by lack of English proficiency.

Making new friends and learning a new culture hasn't been easy. There's lots of new culture in New Zealand. I didn't know there were so many. (Focus group C, service users, Burmese)

Members of several focus groups discussed a reliance on connecting with other forms of social supports, such as a classroom teacher. However, when the classroom teacher acted as a mediator to support the extension of friendship with other youths, they reported feeling that the friendship felt "forced" and that perhaps there was a lack of genuineness to the friendship gesture. Learning and understanding language was reported to help develop and make new friendships.

I used to, I had a teacher that spoke Spanish, so I hung out a lot with her and she saw that I was alone without friends so she would then tell the other students to hang out with me, but it wasn't the same because it was like they were forced to do it and it wasn't like they wanted to do it. But after it was easier to understand English it was easier to make new friends. (Focus group C, non-service users, Colombian)

Not speaking English and coming from a particular country (i.e., Columbia) were identified reasons why other individuals may not interact or initiate friendship with some participants. Other participants also suggested that "I'm not that friendly" (Focus group C, non-service users) as another reason why making friendships was difficult.

I think that because I don't speak the language, because I'm from Columbia they don't want to talk to me. So, they're not that friendly in that school, they are only a girl's school and there are over a thousand of them and only five of them are friendly with me and they behave friendly with me in the class but the rest of them aren't. (Focus group C, non-service users, Colombian)

Many participants in both the focus groups and individual interviews discussed challenges with developing new relationships within the host community. As a consequence, there were increased feelings of loneliness and social isolation.

I struggled with making new friends and starting school and not feeling like I belong. I used to feel really lonely, and didn't speak much in class. That's when I was sent to talk to somebody in school. (Individual interview, Participant 14, Burmese)

The desire to fit in may, however, come at a cost to the young person as it may require forsaking or compromising the values of their own culture. It can further impact the focus in other domains in their life, such as academia. A poorer performance with their studies can affect their job opportunities and the overall quality of life they are able to lead.

I tried hard to be popular and gave into peer pressure. It's not worth it. Don't try hard to impress anyone. Stay true to who you are your values and don't forget where you've come from. (Individual interview, Participant 5, Cambodian)

Adolescents may prioritise the desire to be accepted by the new community, in addition to his/her status within the host society, as more important than other aspects of his/her life. The prioritisation of friendships may also place the adolescent's physical and emotional safety at risk, which can negatively affect their perception of themselves and others.

Something happened to me when I was younger. I didn't care much about school work. All I cared about was being popular, socialising and hanging with my friends. I cared too much about my social life and my status. I didn't care about my academics. None of my teachers picked up my learning difficulties or led me onto the right way. They would have picked me as the kid most likely to fail in life. (Individual interview, Participant 5, Cambodian)

Discrimination and bullying: While the experience and challenges of discrimination was mentioned in several focus group discussions, this subtheme was discussed in more depth in the individual interviews. Furthermore, within this subtheme, experiences of intragroup and intergroup discrimination were identified. In relation to intergroup discrimination based on being a refugee, some participants felt that other people in the host society expected them to fail, or that they were perceived and discriminated against as a "bad person" because of their refugee background.

The hardest thing being a refugee is that people expect us to fail and not be

the best we can. That is why we wanna prove them wrong. Some people expect you as a bad person and they judge you before they know you.

(Individual interview, Participant 2, Afghan)

Young people felt that other people's perception based on their physical features or religion changed the way that others behaved towards them. For example, they felt that others in the host community changed the way they communicated with them, or bullied them because of their differences. It was implied that, because they did not look like the mainstream population, that they would struggle with the language, which resulted in feeling treated differently by people in the mainstream culture.

They, New Zealanders, see me as a Chinese girl. They talk to me like I don't understand. I'll then start to speak in English, and they'll say, didn't know you knew how to speak English. (Individual interview, Participant 6, Laotian)

People judging me because of what I look like. And teachers assuming I don't speak English. (Individual interview, Participant 7, Somali)

In the quote below, the young female reported a struggle she had in New Zealand related to "fitting in" because of her clothing. As a Somali female, her physical features not only distinguish her, but also her cultural dress code. Rather than being accepted as a unique individual, it further highlighted her difference from the mainstream population.

Fitting in because of my clothing. In our culture, the women always cover their hair and body. (Individual interview, Participant 7, Somali)

Differenced in clothing can increase the refugee's vulnerability to being judged and discriminated against. It was further identified that young people from refugee backgrounds with features that are markedly different from the host society appeared to experience challenges with discrimination more than individuals from ethnic backgrounds who share more common physical features with the mainstream society.

Experiences of bullying by both individuals from the mainstream culture and individuals from other minority ethnic groups resulted in feelings of distress, despair and anxiety within the young person. It contributed to avoidance behaviours of social situations in which they were bullied.

There was this time when I was on the bus going home, these Māori girls

thought I was looking at them, so they pulled my hair and started pushing me. I was so scared and I started crying on the inside. My mum saw me cry at home and I told her what had happened. She and Dad bought me my car so I could get to school because I was too scared to get on the bus again.

(Individual interview, Participant 6, Laotian)

In terms of intragroup discrimination, individual participants described feeling bullied by members from other refugee groups.

When I first went to Girls' High, I got picked on by Somalians. They'll say ching chong and go back to your own country. I get annoyed how they say go back to your own country. (Individual interview, Participant 6, Laotian)

Despite their own refugee experiences, direct or indirect bullying behaviour by different refugee groups towards other refugee groups may suggest a lack of acceptance, tolerance, compassion or understanding. Another possible reason for such behaviour is that these young people are the subject of discrimination related to their own physical features, as highlighted in the quote below.

The hardest thing being a refugee is they're mostly from Africa. People just know if you are refugee because of your features. (Individual interview, Participant 3, Somali)

Subsequently, those bullied may become the bully towards even more vulnerable minority members within the refugee population. Irrespective of the reasons for why it occurs, the observation that this does happen may require psychological intervention or support for the young person on the receiving end of the behaviour.

Skills help build friendships. Under the theme of “making friends is difficult” was the subtheme of “skills help build friendships”. Older participants reported that having skills in particular recreational, sporting or musical areas in particular facilitated the development of friendships. For example, one focus group reported that that being able to play the guitar or ride a skateboard appeared to assist with managing the language barrier to developing friendships.

I'm a fun person, I make lots of friends because of what I do, I play the guitar, I sing and I also ride a bike and the skateboard. (Focus group C, non-

service users, Colombian)

These associations with peers from the host culture facilitated English language development and proficiency, may have helped to accelerate the acculturation process further.

Adapting to the new culture is hard. For other refugee adolescents, especially those that came here as babies or toddlers, “fitting in and adapting to the culture” continued to be an issue, even when language skills were well developed.

Well the language wasn't an issue for me, but ah, maybe like fitting in, and like trying to adapt to other cultures and that kind of stuff. (Focus group C, non-service users, Colombian).

The challenges with fitting in for some of the participants included having to explain themselves, their cultural ways, their country of origin and even their religion.

Like most people wouldn't know about like, well being Muslim, my religion and being Somalian, it's like two things you have to explain as well, so like most people didn't know about that. (Focus group C, non-service users, Colombian)

Although they may have been exposed from a very young age to the cultural norms, values and beliefs of the host country, this did not appear to decrease perceived difficulties with fitting in. Many refugee families work hard to maintain their native language, cultural beliefs, values and customs. The multiple losses they have experienced may explain this behaviour. When so much is gone in terms of physical possessions, family connections, relationships and a world of familiarity, the values and beliefs of their culture may be the only intrinsic entity that they have left.

I think it's like, I see things differently from my parents. I get where they're coming from, but we're not back home, we're here, and there are different ways of doing things. It's like they're stuck in some sort of time warp about when we came. I've moved on, so why can't they? (Focus group B, service users, Afghan)

The family may place great effort and importance on preserving these aspects of their own culture. They may also try to maintain some connection with values and behaviours that are familiar. This can, however, limit their ability to develop and integrate.

Within the theme of “adapting to the new culture is hard”, three subthemes were identified: generation disparity, intergeneration conflict and gender expectations.

Generation disparity: There may be an assumption that fitting in is a unidirectional, process of adapting to and being included in the host community. However, fitting in with members of the original community who had resettled in New Zealand was also discussed as an adaptive challenge. Several adolescents, especially those more recently settled (i.e., under two years) reported problems with developing relationships with members from their host community. Some even went so far as to report feelings of being ostracised by members of their original community. Some described how hurtful this felt, given their assumption that members from their original community would be a source of support and guidance. They were also observed to struggle to make sense of this experience and appeared somewhat confused and distressed. Focus group members who had lived in New Zealand for more than 10 years referred to newly resettled members from their community as “FOBS” (meaning “fresh off the boat”) because their behaviours and dress likely suggested their more recently resettled status.

Like they wear like long stuff, so we call them FOBS. We’re used to it, growing up here, so we know like the dress code and stuff. But like when you see them it’s like they’re lost. (Focus group B, non-service users, Somali)

For those individuals who have lived in New Zealand for more than 10 years, interacting with those “fresh off the boat” may be perceived as a negative association and may adversely affect their social status or position with their current group of peers. To associate with people who appear “lost” may imply that they themselves are lost and contribute to isolation or rejection from the society that they have grown up in. Therefore, they may remain distant from recently resettled individuals as a means of protecting their current status.

Growing up in New Zealand was identified as a mediating factor in regards to possible challenging experiences related to acculturation difficulties. Growing up in New Zealand meant that the individual obtained a Westernised education from the primary or preschool level. Furthermore, they had the opportunity to be exposed to social norms, rules, behaviours and the environment from a young age.

Maybe like growing up through primary school, knowing people, that kind of stuff. (Focus group B, non-service users, Somali)

Although growing up in New Zealand was identified as supporting acculturation, and thus minimising acculturation difficulties, focus group participants discussed the fact that their parents “didn’t grow up here” (Focus group B, non-service user, Somali) was a challenge.

Oh, one difficulty would probably be parents actually. Because if you grow up here, you do have a Western culture part of you, and they don’t understand that because they just have the Somali culture, and they haven’t experienced it. (Focus group B, non-service users, Somali)

Intergenerational conflict: Intergenerational conflict takes many forms. These include conflict over supporting family by caring for younger family members; engaging in activities with family members, such as going to church; keeping traditions such as taking off the shoes before entering the home; or speaking the original language with family members. These factors were reported as resettlement stressors.

My Kiwi friends were allowed to go out at night to the movies or to each other’s house. I was not allowed because my parents are very strict. I used to argue a lot about this with my parents because they weren’t treating me fairly. They were treating me like a little kid. (Focus group C, service users, Afghan)

Contributing to the intergenerational conflict may be differences in values held by the adolescents and their parents, as highlighted in the quote below. These differences can influence the behaviours, rules and assumptions that each individual holds, which can create conflicting scenarios between the adolescent and his/her parent or caregiver.

I wanted to be allowed to go out and do the same things as my friends. My parents wouldn’t have it, especially my dad. (Focused group C, service users, Afghan)

In some focus groups, members discussed their expectations that their parents adapt to the new environment, because the adolescents themselves had been able to. Added to this was the frustration that parents were unable to acculturate at the same level, or to the same degree as their children, which subsequently affected how the parents lived their lives and what traditions/religious practices continued to be maintained for the family. This then impacted on the adolescents’ ability to “do stuff” or participate in activities more freely.

It's hard to explain how different our cultures are but it's a struggle to know they're completely different and some people don't accept that. It is very difficult because my family is so traditional and religious. Then it is hard to do stuff. (Focus group C, service users, Afghan)

In many focus groups, members reported a desire to be given the same opportunities to engage in behaviours consistent, similar or equal to that of their peers, for example, being given permission to "go out" and socialise during the day, night or weekends. When this behaviour was not permitted, participants reported feeling unfairly treated and frustrated by their parents' decisions.

I grew up here as well. I have lots of problems with my parents, too. They don't want me to go out with my friends, but what do they expect me to do? Stay home and hang out with them? Nah. (Focus group A, service users, Cambodian)

As noted above, avoiding conversations is a tool for managing parental expectations. In instances where the adolescent is aware of the cultural differences and expectations of their parents, choosing to keep secrets or not informing parents, family members or others of the same community group about the activities that they are engaging in is another coping strategy for managing expectations and intergenerational conflict.

I want to spend time with my boyfriend, but my parents would kill me if they found I had a boyfriend. This is all confidential right? If we ask our parents if we could go out with our friends our parents would say no because they come from different backgrounds and they do different things. So, sometimes, I don't tell them what I'm doing. (Focus group A, service users, Cambodian)

Avoiding conversations or keeping secrets may be because participants felt they would not be heard by their parents, that is, their parents would not listen to them or understand their challenges.

When I have tried talking, they don't even listen. They always think they're right. It's like you know in our culture we're not suppose to talk back to them or argue with them. (Focus group A, service users, Laotian)

Alternatively, another explanation provided by focus group participants was that according to

their culture, children did not argue or talk back to their parents. This means that there are clear defined rules about listening and obeying parental decisions and demands rather challenging them.

That we shouldn't argue back with them. They're our parents and we're supposed to listen to them. (Focus group A, service users, Laotian)

Gender expectations: Members of the focus groups also discussed that adjustment to the new culture was influenced by gender expectations, that is, parents' expectations on achievement were dependent on whether the individual was male or female. Furthermore, males were expected to do well academically and in their career, while females were expected to marry and not develop their career aspirations.

When I talked about the traditional part, my parents expect my brothers to do well, but they expect me to get married and to not want much of a career. I deserve it too. My friends talk about what they want to do, and I have plans. I want to go to an Early Childhood training program. I don't know how to talk about it with my family. It's not what they would traditionally expect or want of me. (Focus group B, service users, Somali)

In managing expectations around other areas, such as the carer's role within the family, some participants discussed simply doing what is expected. This was more frequently discussed in the focus group discussions with females in both the service user and non-service users groups.

My parents, especially my father, worked hard all the time to find a good job for us. He became a taxi driver, but it's not what he wanted to do. Mum ended up getting a job too, so it's my responsibility to look after my younger siblings. It's hard work because I don't always know how to deal with them, and I've got my own issues too. I do it, like take care of my brothers and sisters because it's when my parents expect of me. (Focus group B, service users, Somali)

In relation to gender expectations, in one focus group with female service users from Muslim backgrounds participants reported on how the different attitudes within her community about men and woman affected the family's adjustment experience in New Zealand.

In our community, the male is more respected, so not having my Father around means that it's much harder for my family (Focus group, service users, Somali).

School is hard. Many focus groups discussed challenges and struggles with school or a fear of failing at school. Some reported that a lack of help and support from both family members and teachers contributed to learning difficulties. For some participants, their parents were not available for support because they work hard “all the time”, rather than a lack of interest in their children's schooling.

Like I was saying, because my parents worked all the time, they were not able to help with the school work. I struggled because Mum and Dad made us speak Vietnamese at home and I didn't do well in my schoolwork. I wish my parents or teacher had been able to help me more. (Focus group A, service users, Vietnamese)

In other focus groups, members discussed putting a lot of effort into their school work, but feeling that their parents did not acknowledge or recognise the effort. In several groups, talk was about a strong dislike of school because they “find it hard to read and write” and they “feel stupid because the work is hard” (Focused group D, service users, Somali).

They have no idea what's wrong with me and I work hard at school but they don't think that, which makes me sick about my family. I'm a teen that wants to get her own life (Focus group B, service users, Somali)

Some focus group participants reported wanting to leave school because of their struggles with learning, while others reported feelings of failure if they did not do well in school, as they felt that was expected of them from their parents.

Yeah, it's the parents and their expectations. I said it once to my mum, and she said that she doesn't say it out loud, but I know it's there. If I don't do well in school, I feel like a failure. (Focus group A, service users, Laotian)

In addition, a fear of disappointing their parents by underachieving at school work was reported to negatively impair the adolescents' quality of sleep. Sleep was also affected by worries about causing parental distress through a possible lack of academic success. This places a significant sense of burden and responsibility on the refugee adolescents to succeed

academically.

It's mainly around how sometimes I don't sleep well because I worry about failing at school and then my parents are going to get upset and be really disappointed in me. (Focus group A, service users, Laotian)

Because of a keen awareness of the sacrifices that their parents had made in leaving their country of origin, many adolescents discussed parental pressure to succeed and make something of themselves. Their application of themselves at school was influenced by this pressure, which can have a number of consequences, such as feeling pressured to study or excel in particular subjects, even though it may not relate to their area of interest. Even if the adolescents were able to achieve in the subjects that their parents desired for them to excel in, their pursuit of an area that is not necessarily important or meaningful to them can affect their physiological and psychological wellbeing.

Yes. It's very important for me to do well so that I can get a good job in the future. I feel pressured to do well mainly in Science and English. (Individual interview, Participant 7, Somali)

If a young person dislikes a particular subject, or is disinterested in the curriculum or school *per se*, this not only has implications in his/her performance, but also likely impacts his/her relationship with family members.

I found Maths was hard. School was fine. I hated computers. It's not my thing. PE and sport, it's not my thing; hate it so bad, not a sport person. School isn't that important to me. School doesn't really concern me right now. I'm over it. NCEA level 1 and 2 will get me into the course I want. I can't get into uni because I don't have enough Maths credit. Just want to work at the airport as a check in person. (Individual interview, Participant 6, Laotian)

In particular, if the young person's academic achievement is not consistent with parental expectations this can result in the young person experiencing disappointment, shame and remorse, and lead to increased conflict within the household.

Focus group participants discussed feeling pressured by their family to be grateful for the chance to study, particularly when other individuals from their country or of similar

backgrounds did not have the opportunity to do so. For example, in Cambodia, many academics were killed during the Pol Pot regime. In some focus groups, participants repeatedly discussed the perceived lack of fairness in having such a burden of responsibility to succeed academically, particularly if they were struggling to cope or succeed in their academic work.

The parents talk about where they come from and what they went through, you know with the killing fields and Pol Pot stuff, but I don't remember any of it. They're like you should be grateful you get to study because lots of people were killed in Cambodia. It's just not fair to put the pressure to like study. Not everybody can be good at it. (Focus group A, service users, Cambodian)

Managing parental expectations. Related to challenges with school work was the subtheme of “managing parental expectations” in regards to academic achievements and other areas of the adolescent’s life, such as speaking their native language in their home environment or caring for younger siblings. Some participants provided the insight that parents held particular expectations because they did not want their children to follow a particular pathway in terms of their career, for example, working in a restaurant. However, in spite of a recognition and understanding about why parents might exert the pressure to achieve in particular areas of their life, many participants also reported the desire to have a choice in how they lived their lives, and what they chose to do with it.

My parents also speak Khmer to us all the time. For me, there was heaps of pressure to do well in school. The oldies don't want us to end up working in the restaurant or bakeries with them, but it should be our choice what we do with our life. It's not their choice. (Focus group A, service users, Cambodian)

Coping with parental expectations for some focus group participants involved avoiding conversations with parents because they did not want to hear the reasons behind the expectations. The narratives suggested that the adolescents may have heard the reasons about the sacrifices made and the struggles the parents have endured on many previous occasions. Through not talking to their parents, the participants avoided these discussions, including the possible distressing emotions or conflict that may occur.

Can't talk to the oldies. Always going on and on about how hard they had it

and the sacrifices they've made. I never asked them to make the sacrifice. It's feels like I owe them something, but that's not right. (Focus group A, service users, Vietnamese)

For many focus group participants, there appeared to be a struggle with managing parental expectation. Some reported feeling “stink” about how hard their parents worked, but then also angry that the parents have “put that” back on them in regards to the sacrifices that have been made.

My parents talk about what they've given up, and how hard they've had to work to care for us. I do feel stink, but also angry. I didn't ask them to make the choice to leave Laos. They made the choice. They can also go back, but they say that it's too hard for them now. I couldn't help it that they had to work hard to take care of me and my siblings. They sort of put that on me though, that, that makes it worse. (Focus group A, service users, Laotian)

Coping Mechanisms/Dealing with Difficulties

This primary area of interest explored participants' coping mechanisms and how they coped with the stressors in their lives. Six themes were identified in the analysis related to this area: “coping is private”, “religion helps coping”, “physical activity is a coping mechanism”, “peers and family support coping”, thinking strategies affect coping” and “problem solving strategies assists coping”.

Coping is private. Several focus groups talked about the “private” aspect of coping, that is, participants reported that they preferred to cope with problems “privately”. This was attributed to a number of reasons. For example, in some cultures, the norm is to keep those problems to oneself in order to limit shame and humiliation on the individual or his/her family.

At primary school, if I didn't figure something out, I would give up. I felt I couldn't talk to anybody because it's not the done thing.

Interviewer: What do you mean by that?

My family says that we should keep things to ourselves. We have a saying that's like, loss of face. If I share my issues with other people in my community, I can lose face, and so can my family. It's always about

maintaining face. (Individual interview, Participant 5, Cambodian)

I keep a lot of things on the inside. It's not our way to go around talking about our problems or our family's problems. (Focus group B, service users)

Alternatively, some participants from the individual interviews discussed coping on their own as their ability to manage or control their responses.

I just want to stay in my room by myself and listen to loud music. I can do what I like with the music. It normally makes me feel better. (Individual interview, Participant 10, Laotian)

For others, coping privately enabled them to avoid feeling awkward about sharing with other people.

It's just awkward, if you see them around, like a school counsellor and you tell them about your problems and your feelings. (Focus group B, non-service users, Somali)

By contrast, others talked about choosing to manage problems on their own as a result of negative experiences when they had attempted to access external sources of support. For example, members of the focus groups identified that when they did seek support from their parents, they felt that the parents did not listen or did not understand them. They also felt unable to challenge parental perspectives because, at a cultural level, participants commented that young people do not talk back or argue with their parents. Subsequently these experiences may have reinforced a private way of coping.

When I have tried talking, they don't even listen. They always think they're right. It's like you know in our culture we're not suppose to talk back to them or argue with them. (Focus group A, service users, Cambodian)

As part of coping privately, members of the focus groups discussed the idea that one's problems are a burden to others, particularly in relation to their parents. The adolescents expressed concern that telling their parents about their problems would unduly burden the parents, especially when they already had many worries associated with the war and resettlement. Others mentioned parents not understanding, or responding in ways that were not seen as helpful.

Religion helps coping. Seven focus groups had discussions about turning to God or

their religion for support as a method of coping with problems. For them, God was accessible at any time, in their language, and something they had been raised to place faith and trust in. Religion may have also been an acceptable method of coping, compared with other methods of managing stressors and difficulties, such as seeking support from a mental health service or professional.

For my case I think I put my faith and my trust in God. So coming here again, this is now a foreign land, far away from home. It would have been more difficult if I didn't know the language. But because I was fluent in English, my communication with the people was easy. Anything I want I could ask for it and I could get it. So my communication with people was okay. So that also with time, I gained some confidence but I would say it's, I believe that God was what brought me here and not going to let me suffer. That kept my faith. (Focus group D, non-service users, Columbian)

Physical activity is a coping mechanism. Being active in response to stressors was another coping mechanism. All of the focus groups and at least a third of the individual interviews discussed using different forms of physical activity to cope.

When I started playing soccer it helped. I kicked the ball hard, and pretended it was somebody bothering me. (Focus group B, service users, Somali)

The thing that makes us feel better is we listen to music, study, walk or go for a run. Go swimming, talk with friends, go out with family, play sports and think positive thoughts.” (Individual interview, Participant 1, Afghan)

Playing sport I guess. (Focus group B, service users, Somali)

The male focus group discussions appeared more dominated by sporting activities as physical coping strategies, while less physically strenuous activities were reported by the female groups, such as going to the movies or listening to music.

Swimming, going to the movies, screaming at others. (Focus group D, service users, Somali)

Um, like if I feel like things are getting too much, I like having alone time by myself. I like reading. I go for walks. But not so much now, I used to go for

walks. (Focus group B, non-service users, Somali)

I think like maybe going out more, doing activities and spending your time wisely helps with that. (Focus group B, non-service users, Somali)

Peers and family support coping. Many members of the focus groups identified accessing friendship as a source of support to cope with challenges in their life. More than half of the participants in the individual interviews discussed talking with friends or “spending time with friends” (Individual interview, Participant 4, Somali) as ways in which they coped with their difficulties. Friends were identified to be easily accessible, that is they were “always there”, and furthermore, they were identified as more understanding of the young person compared with other sources of support, such as from family members.

When I’m angry or sad, I call my friends. It’s easier to talk to my friends than to my family sometimes. My friends are always there for me. I feel like they understand me better than my family. (Individual interview, Participant 12, Laotian)

Participants commented on a number of distracting and active activities that likely had a positive effect on their mood, which then likely improved their appraisal of their ability to cope with difficulties they encountered. For example, playing the guitar or spending time with friends.

I have really good mates that I can talk to.” (Focus group A, service users, Cambodian)

Hanging out with mates, eating shopping, doing teen stuff together normally makes me feel better. (Focus group B, service users, Somali)

Also talking to my friends and doing fun stuff together. (Focus group D, service users, Somali)

Although talking to God, peers, and engaging in physical activities was more frequently reported in the focus groups as a coping mechanisms, several focus groups did discuss “talking to my parents” (Focus group D, service users) to help with their difficulties. If they didn’t choose to talk to their parents, talking to somebody they “trusted” (Focus group B, non-service users) was important to them.

Several members of the focus groups who accessed mental health services felt that it

was difficult to talk to their parents because they were different, in the respect that the young people wanted to be more like their Kiwi counterparts, and felt that their parents did not understand this.

Don't think Somali kids can talk to their parents. Maybe like problems that they have to be involved with. The little problems I don't think they can tell their parents . . . Because Kiwi kids and Somali kids, it's not like they're different but their parents are different....You know, [Somali kids] want to be like Kiwi kids. But the parents don't understand that. (Focus group B, service users, Somali)

Thinking strategies affect coping. Different thinking approaches as a coping strategy was reported by six focus groups. There were subthemes of “positive thoughts” and “distraction” as mechanisms for dealing with difficulties.

Positive thinking strategies: Choosing to focus on the positive aspects to life was identified as a critical method of coping with life's difficulties. Participants reported that negative thoughts only reinforced more negative thoughts, which would further adversely affect the individual's feelings. A conscious decision to focus on the positive was attributed to keeping the individual “okay”. Continuing to think negatively was also reported to affect people's vulnerability to becoming “mental” which can have many negative consequences for the individual.

Like there are so many people I know, they have become mental. Because why? Because they are thinking negative. I mean, every human is like that. Sort of for me, why I kept all this positive is because it's life like that. If you think one negative, the other negative will go on the top of that. Because daily life you have so many problems, every day. (Focus group C, service users, Afghan)

Recognising that everybody, even powerful people have difficulties enabled normalising of the experience, but perhaps also minimalised the experience.

Doesn't matter who you are. Doesn't matter who you are. Even if you are a President of the country. Still you have problems. So if you thinking of your today you are upset, and another daily based problem comes on top of that one, and tomorrow is the same, so you keeping negative. You are thinking

about negatives, you are not thinking about positive. This is how to top up. And then the end of that you are broke. So many things is going on in the world just because of that. So I thought of that. No, throw the negatives and keep the positives only. And just thinking of everyday, if there is a problem, look at the positive side. So this is how I keep myself okay. (Focus group C, service users, Afghan)

Participants further stated that the brain ceased to function appropriately when it was engaged in negative thinking. Conversely, participants discussed that positive thinking enabled the brain to function and “work better”. Furthermore, focus group participants reported that trying to see the positive aspect of an experience helped with coping with life stressors.

Because see that's the thing, if I thought negative, my brain didn't work. What am I going to do? Because sort of like when you are upset, your brain doesn't work at all. But if you try to be positive, and that positiveness is makes you to think like more positively as like more, it works better. I experienced that one. If you think like that. So sort of and right way. So and then that's how it works for me. Because I always try to push myself to say okay, if this one didn't happen, maybe some good things will because of some good things, and what other positive things I can do to actually like reverse it and do the job? (Focus group C, service users, Afghan)

Distraction strategies: Focus group participants discussed forgetting about their difficulties, or engaging in coping behaviours to distract their mind, helped them to manage their moods. For example, they reported that “listening to music so my mind gets distracted” helps them to “forget everything.” (Focus group C, non-service users, Columbian)

When I feel sad, I try to distract my mind and do things I enjoy doing, play guitar or ride my bike. (Focus group C, non-service users, Columbian)

Problem solving assists coping. Participants also discussed using problem solving strategies with their difficulties. For example, participants stated they coped with their problems by “going to school and studying” (Focus group D, service users, Somali).

Experience of Mental Health Services

When asked about their access, engagement and utilisation of mental health services, participants' themes were grouped under two headings of "barriers" and "facilitators". Themes identified under the "barriers" heading included cultural difficulties, which had two subthemes of "different understanding of an issue", and "interpreters". The other two themes identified under "barriers" included "stigma" and "fear of privacy not being maintained". Themes identified under the "facilitators" headings included "positive experience supports engagement", "confidentiality supports engagement", "established long-term relationship supports engagement", "feeling accepted and not judged supports engagement", "good listener contributes to a positive experience", and "receiving support on many levels support engagement."

Barriers to Engagement:

Under the heading of "barriers to engagement", five themes were identified: cultural difficulties, different understanding of an issue, interpreters, stigma and fear of privacy not being maintained.

Cultural difficulties affect engagement. Several focus groups and individual interviews identified cultural difficulties as a barrier to engaging with mental health services. Within this theme, two subthemes were identified, that of challenges with understanding and the relevance of interpreters.

Different understandings of an issue: In relation to perceived lack of understanding from service providers, members of a focus group attributed the doctor's lack of understanding as being related to the fact that the professional was not from the same cultural background.

My parents found it especially hard trying to make the doctor understand from their perspective why as a family we were struggling so much. They felt the doctor didn't understand because he was not from the same culture as us. (Focus group C, service users, Afghan)

Other focus group participants also reported a concern as to whether their difficulties or challenges could be fully comprehended because they assumed the service provider to not

have experienced a journey equal, or similar, to their refugee experience.

I don't know if they will completely understand. It's not like they've gone through what we've gone through. (Focus group C, service users, Afghan)

Interpreters: Several focus groups commented that interpreters were sometimes required to assist with communicating their difficulties and needs to the service provider. Even if not required, several focus group members felt that the option of having interpreters should be available, including being able to access information in their native language.

I think some interpreters should be availablealso information in our language. (Focus group D, service users, Somali)

Having interpreters from the same cultural background as the person accessing the mental health service was identified to not necessarily be helpful. Some of the members of the focus groups and individual interview participants discussed concerns that the interpreter may break confidentiality and share their private information with others in the community. Furthermore, youth participants reported feeling negatively judged by interpreters and stated a preference to have an interpreter external to their community.

The interpreter was from my community, an older person and it was like they were judging me. Would have preferred someone else outside of the community, because you know, they could go and share my problem and stuff. (Focus group B, service users, Somali)

Stigma limits engagement and access. Many members of the non-service user focus group discussed stigma of accessing and using mental health services as a barrier to engaging with services. That is, the decision to not access mental health services appeared to centre strongly on themes of negative associations or stigma about people who had accessed these services. Many participants reported that individuals who had accessed mental health services were “crazy” and also mental health services only worked with “crazy” individuals. This in turn was reported to affect the adolescent's behaviours towards individuals who had accessed mental health services, for example, choosing to distance themselves physically and socially from these individuals. As members in one focus group reported, they would “not hang out with them” (Focus group B, non-service users). They were identified as people who they interpreted as being “weird” or “crazy”.

Well I wouldn't judge them, but I would keep my distance if I don't know them. (Focus group B, non-service users, Somali)

From the focus group discussions, perceptions of psychiatric symptoms, social-skills deficits, physical appearance and labels related to people accessing mental health services contributed to the stigma. Subsequently, this appeared to reinforce the stigmatising attitudes of participants who chose not to access mental health services. For example, when a focus group was asked, "How do you know if somebody is not psychologically well?" they stated "You can tell by talking to them." (Focus group B, non-service users, Somali). When asked further what they would be saying or doing, the participants reported, "You can just tell when people are weird." (Focus group B, non-service users, Somali)

Interviewer: Really, do they have like particular facials?

Participant K: Yeah, like, they'll say random things, or they'll give off a vibe.

Participant N: You can tell.

Interviewer: Oh OKay. What about you? How can you tell if somebody is psychologically unwell?

Participant S: The way they're walking probably. (Focus group B, non-service users, Somali)

These stigmatising reactions may have stemmed from observations or experience of more severe forms of mental illnesses such as psychoses, where inappropriate affect and behaviours manifest themselves as indicators of psychiatric illness. Poorer social skills stemming from mental health problems can also contribute to stigmatising perceptions of mental health service users. Furthermore, the individual's appearance as alluded to by the described interaction may contribute to the negative associations surrounding mental health service users, and the fear of being labelled or perceived as such if they were to access the services themselves. Stigma may also arise from ongoing prejudice and discrimination of mental health service users based on the misattribution that only "crazy" people use mental health services and that mental health services only works with "crazy" people.

Despite the clear stigma identified surrounding the access of mental health services, individuals who had accessed mental health services reported that through accessing mental health services, this supported them to learn that they were not alone in their experience and

that others had also experienced similar difficulties.

It might help them, like it helped me today to know that other guys have problems, too, and sometimes they have similar problems. So that person won't feel as if they're going through it on their own. (Focus group C, service user, Afghan)

Fear of privacy not being maintained. Some members of the individual interviews highlighted that, even when they accessed help, they were fearful that confidentiality would be breached, particularly in relation to their parents. One participant in particular reported that she felt paranoid that the material she discussed could be shared with others, and sought reassurance from the service provider that it would not be shared.

I get paranoid a lot that the stuff I talk about will be shared with others. I often ask them that it's confidential because I don't want my parents to find out. (Individual interview, Participant 6, Laotian)

Facilitators to Engagement:

Several participants from the focus groups with service users and individual interviews commented that they had a good or great experience when they accessed or utilised mental health services. As part of their positive experience, several themes were identified that contributed to a positive engagement with service providers. These included “confidentiality”, “established long term relationship”, “feeling accepted and not judged”, “good listener”, and lastly “receiving supports on many levels.”

Positive experience supports engagement. Participants from the focus groups with service users highlighted that being able to share and discuss their feelings and difficulties helped them to feel better. Some focus group members reported accessing mental health support when they felt guilty or unhappy. Others discussed different agendas in accessing help; for example, to gain formal validation of their struggles to cope without family members or to ‘prove’ or legitimise their suffering to support their application to be reunited with their family. In one focus group, members talked specifically about how they felt about the practical assistance given by service providers to help facilitate family reunification.

When [x] at Refugee As Survivors helped the family with our application for

my brother and his family to be with us, we were really happy. (Focus group E, service users, Pakistan)

Confidentiality supports engagement. It was suggested by some of the members of the focus groups with service users and individual interviews that when mental health services were accessed, it was helpful being able to discuss materials they felt unable to discuss with other key individuals in their lives. This could mean that what was helpful was the confidentiality upheld by service providers, other than in instances of high safety concerns. It could also mean that talking to a person external to the problem was helpful.

My experience with my GP has been great because he is very helpful and I can talk to him about some stuff that I can't always talk to my family or friends about. (Individual interview, Participant 3, Somali)

Established long term relationships supports engagement. Participants identified that an established relationship with the service provider supported a positive perception of the providers they engaged with, including the service they received.

I like my GP, he's a good doctor. I like Dr [x] the most coz he treats me well. He listens to me whenever I go to him with any problems about my family. He already knows everything about me. When I worry about something that makes it hard for me to sleep, I like that my GP listens to me instead of judging me. (Individual interview, Participant 6, Laotian)

Feeling accepted and not judged supports engagement. In regards to traits or characteristics that the adolescents may have found helpful in the service provider, the participants reported that it was useful to be able to talk with an individual who they perceived to be kind and where they "didn't feel judged" (Focus group B, service users).

I liked seeing my counsellor. She was nice. I didn't have to go to see her for long, but it helped just being to talk to somebody about the problems at home. My parents never found out. (Focus group A, service users, Cambodian)

Sweet...because somebody to talk to. I couldn't go to my parents, because they were part of the problem. The counsellor was easy to talk to. I didn't feel

judged. (Focus group A, service users, Cambodian)

Some focus groups felt that being able to discuss their problems enabled them to view their difficulties from a different perspective. For example, the issues “don’t seem so big”.

You see we have been going through different circumstances, you know having troubles in the family, and worries. And all these things. And RAS have been coming and doing sessions with us, and the family. And so when we talk about these problems, they don't seem so big. And the continued to support is just great. (Focus group B, service users, Afghan)

Although they may have had apprehensive or fearful feelings about seeing a counsellor, participants commented that being encouraged and able to ask questions of the service provider helped. They also noted that having the service provider answer questions resulted in them feeling more at ease within the environment and the therapeutic relationship.

Going to a counsellor or a GP felt scary but at the same time they encourage you. I would ask any questions and they will answer it. I got along with them. (Focus group D, service users, Somali)

In contrast to struggles with service providers’ lack of understanding, some focus group members reported feeling understood by the professionals they accessed, irrespective of whether the person was from the same culture or not. They also felt that the service provider gave care they needed.

The only professional person I’ve ever gone to when I’ve felt down is my GP. She’s a good person. My GP seems to understand whenever I explain the effects of when I get sick or unhappy, and she provides me with the right medicine. (Focus group D, service users, Somali)

Good listener supports engagement. Many members of the focus groups with service users, and individual interviewees highlighted that feeling well listened to by the service provider contributed to a positive experience of seeking help for their problems.

I’ve had really good experience with my GP when I was feeling stressed. He listened really well. (Focus group D, service users, Somali)

I think my counsellor is very nice. She is good at listening. She gives good

advice. (Individual interview, Participant 13, Burmese)

Receiving support on many levels supports engagement. Several members of the individual interviewees commented that being supported within the community, such as having the physical presence of the service provider at critical meetings or having support letters, contributed to a positive experience of engaging with mental health service providers, not only for themselves, but also for their families.

Since our parents have been in New Zealand, the GP and counsellor have helped a lot. For example, the guidance counsellor has been to one of our family court cases. The GP has helped by writing letters to the people involved with our problems. (Individual interview, Participant 1, Afghan)

Discussion

The refugee population in New Zealand continues to steadily increase with each refugee quota intake. Because of the stress and trauma that many refugees have experienced, they struggle with, or are at increased risk of, developing mental health problems. Furthermore, they are less likely to access or utilise mental health services compared with other ethnic groups.

This study examined youth from refugee backgrounds stressors during pre-migration, transit and post-migration; their coping strategies; and their experiences of mental health services. Focus group discussions were completed with 20 mental health service users and 17 non-service users. An additional 16 individual interviews were completed with service users to gain insight into mental health needs of refugee adolescents, their coping, and, critically, their experience of mental health services.

The focus groups and individual interviews were analysed using thematic analysis. In relation to stressors experienced by youths from refugee backgrounds, there were two categories of themes. The first primary area of interest, “life prior to New Zealand” had one key theme which was “exposure to violence, hardship and corruption”. The second primary area of interest, “resettlement” included seven themes. These were “dealing with loss and worry about people left behind”, “learning a new language was difficult”, “money is a worry”, “making friends is difficult”, “adapting to new culture”, and “school is hard” and

managing parental expectations. In relation to the primary area of interest of coping mechanisms/dealing with difficulties, six key themes were identified. These included “coping is private”, “religion helps coping”, “physical activity is a coping mechanism”, “peer and family support coping”, “thinking strategies affect coping”, and problem solving assists coping.” In the third primary area of interest of experience of mental health services, “barriers” included “stigma”, and “fear of privacy” not being maintained’. Facilitators that supported access and use of services engagement included the themes of “confidentiality supports engagement”, feeling accepted and not judged supports engagement”, “good listener supports engagement” and “receiving supports on many level supports engagement.”

Before discussing the results in light of previous research examining stressors, coping and experience of mental health service by youths from refugee backgrounds, the differences and similarities between groups are discussed. In talking about stressors experienced, participants in the individual interviews appeared to share more stories about sensitive challenges that were not raised in the focus groups. These included experiences of abuse and discrimination. Limitations of confidentiality may have prevented focus group members from discussing such issues or focus groups members may not have experienced these challenges. Across the focus groups and individual interviews, irrespective of ethnicity, age or gender, challenges with the family dynamics were a reoccurring difficulty as part of the theme of “adapting to a new culture.” Similarly, across the focus groups and individual interviews, accessing friendships to share difficulties or to engage in an activity appeared to be the most common methods of coping. While physical activities were discussed by both genders as coping mechanisms, males reported engaging in sporting activities more often, while females reported watching movies or listening to music. This may be because male youth participation in sporting activities is encouraged more than female participants in particular cultures.

While participants in the focus groups were grouped according to age, rather than the number of years they had lived in New Zealand or the age at which they had migrated to New Zealand, language difficulties were reported by many participants who had arrived to New Zealand at an older age; that is, participants who had arrived after 10 years of age reported more language difficulties as compared with participants who had arrived at an earlier age, in particular, preschool age. It was further identified that some of the participants who had arrived at the preschool age, engaged in discriminatory behaviours towards more newly

arrived members of their own community, such as the attitudes and behaviours they discussed in reference to “fresh off the boat” individuals.

Diverse range of Issues, Challenges and Stressors

As identified in previous mental health research with people from refugee backgrounds conducted internationally (Lustig et al., 2004), and nationally (Ho, Au, Bedford & Cooper, 2002) this study found that exposure to violence, hardship and corruption is a common stressor experienced as part of life prior to arrival in New Zealand. Furthermore, these experiences continue to impact on the families from refugee backgrounds as part of challenges to adapt to New Zealand, for example, dealing with the loss and worry about people left behind.

Some of the adolescents in this study reported a low level of direct exposure to the political violence, war or trauma in their homeland because they were either very young at the time or had been born in a refugee camp. An implication is perhaps these children were less vulnerability to developing psychological symptoms of distress. However, in their study with Cambodian youths from refugee backgrounds, Rousseau et al. (1999) identified that parents’ experiences of trauma after the child’s birth was associated with anxiety and depression in the child. They hypothesised that this may have been related to the “extreme closeness” between the female Cambodian participants and their parents so that when parents became distressed over their memories of the traumatic experiences, so too would the adolescent. Thus, pertinent to this study, even if the young person is not directly exposed to the trauma, they can still experience vicarious trauma through witnessing their parent’s struggle with the memories and effects of their own experiences and sufferings. In turn, this may affect their vulnerability to developing mental health difficulties.

Although quota refugees and their families are given permanent residency status on arrival into New Zealand, which grants them the same rights and privileges to social, health, and education services as New Zealand citizens, the majority of adolescents from refugee backgrounds and their families are still faced with significant demands of adapting to the new social, environment and cultural settings, while trying to establish a new life for themselves. Participants’ accounts of settling in both the focus groups and individual interviews confirmed common challenges identified in other research with refugee children and

adolescents (Lustig et al., 2004; McCarty et al., 1999; McMichael, Gifford & Correa-Velez, 2011; Westermeyer, 1991; Williams & Berry, 1991). These included difficulties with language, making friends, adapting to schooling, managing limited finances and adjusting to the new environment and culture.

Youth participants identified that, while language difficulties were initially a stressor for some of the youths who had arrived to New Zealand at an older age, their desire to fit in and belong appeared to facilitate their commitment to developing their English skills as a key priority. As a result, their accounts suggested the young people were able to navigate language difficulties more quickly than their parents. Language difficulties negatively impacted the young person's life and that of their parents or the family as a whole across many functional domains. It hindered education and employment opportunities, which decreased the ability of the young person and/or their family to achieve their goals and expectations in starting a new life in New Zealand. This can result in increased difficulties to adapt to the new setting, which may subsequently increase the young person's vulnerability to acculturative stress.

Struggles with language can affect information processing, including understanding other people's behaviours. The interpretation of other people's body language is also likely to be culturally bound, in that body language exhibited by an individual raised within a different set of beliefs and values from the adolescent from refugee backgrounds can be interpreted within the cultural norms and values of the refugee young person, rather than within the cultural norms of the person exhibiting the behaviour. This can influence how the adolescent from refugee backgrounds feels about themselves and the actions of others around them. If the young person is already struggling to communicate verbally because of language difficulties, his/her interpretation and attributions of other people's behaviour may be negatively biased, which may further reinforce his/her perception of being a "minority" and his/her struggles to adapt to the host environment.

Different rates of acculturation and language development were highlighted to result in frustration within the young person and/or their family. Parents' frustration may be a result of their own struggle to understand the language of the host country, and they may feel excluded from participation in the conversation with their children or members of the local and wider community. This potentially creates a context whereby the parents are dependent on the

adolescents for social input, including increased supports, which places more responsibility on the young person. There are a number of reasons why parents may have continued to struggle with language. For example, Choummanivong (2003) identified that many Laotian mothers from refugee backgrounds stayed at home to care for their children while their husbands worked, which affected these women's opportunity to learn and develop their English skills.

Youth participants noted that a critical challenge of adaptation was adjusting to the new culture, particularly in relation to generation disparity and managing parental expectations. Female participants in particular appeared to report, more than male participants, difficulties with managing parental expectations for them and their role within the family context. This was evident across all the ethnic groups that participated in this study. Participants perceived their peers in New Zealand as having higher levels of freedom, and their experiences of parental control are considered within this cultural context. Many wanted to spend time with their peers and engage in similar behaviours to them. This contributed to conflict within the family unit when the young person's behaviours were not in line with those expected by their family. This suggests young people from refugee backgrounds may be afforded different degrees of freedom and autonomy as their New Zealand peers. Both male and female participants reported a desire to be given more opportunities to participate in similar behaviours and activities as peers within New Zealand. However, female participants discussed feeling restricted by their parents on the basis of their gender in what they were able to participate in. Different gender cultural expectations may thus persist from the native cultural background, and this may exacerbate intergenerational conflict between the young person and parent in the context of the larger New Zealand society. This finding is similar to other research involving young people from a refugee background that has reported young people's difficulty with their parents in their push for independence and autonomy (e.g., McMichael et al., 2011).

In addition to coping with changes in the family unit, youths from refugee backgrounds discussed having to cope with being separated from loved ones. Family separation has been associated with anxiety and depression (Luster et al., 2009), including long-term trauma (McMichael et al., 2011). Participants in both the focus groups and individual interviews frequently discussed worrying about loved ones back in their country of origin, including efforts to care for or to reunite with separated family members. Thus, loss, change and

adaptation are characteristics of the environment for young people and their family (McMichael et al., 2011). Because family provides a critical source of support (including a reinforcement of a sense of self and cultural identity), separation from family members may also lead to a decrease in a representation of a meaningful purpose in life (Schweitzer et al., 2006), which may further contribute to increased risk of developing mental health difficulties.

In addition to struggles with separation from loved ones, participants discussed poverty as an ongoing difficulty that both directly and indirectly affected their quality of life and wellbeing. A direct consequence was having to share resources, such as living in cramped conditions with many family members in one house. An indirect consequence of poverty was that parents had to work harder or longer hours to provide for the basic needs of their family. As a result, there are reduced opportunities to receive the attachment, love and quality interaction that young people need as part of their development. It has also been suggested that parents may focus on economic, academic or material success for them or their children as a means of compensating for the sense of isolation and disconnection from the mainstream society (Pumariega et al., 2005). Irrespective of the reasons why parents may not be physically or emotionally available to the young person, the absence means that youths may turn their attention and focus to seeking relationships with peers or other members within the host society. Some may be able to establish relationships easily, but for many this task is hindered by language and cultural differences as discussed earlier. Not being able to develop new relationships as easily can contribute to greater feelings of loneliness, isolation, frustration and low mood. If the young person struggles to cope with these difficulties, they may subsequently require mental health input.

Adolescents from refugee backgrounds have to participate in many social networks that are at times at odds with one another. These social networks include their peers and that of their family or community. Each network may have very different sets of expectations of behaviour from the young person, some of which may be very contradictory to one another and may exert very different sets of demands on the young person for them acceptance and support from the group. Focus group participants discussed the frustration experienced in wanting to participate in similar activities to their peers or with their peers, and the challenges they encountered when these behaviours were incongruent with parental expectations of appropriate or acceptable behaviours. According to the 1993 National Conference proceedings for the New Zealand Federation of Ethnic Councils (1993) in which panellists

had to consider intergenerational matters related to migration, a “culture clash” occurred between the generations in the immigrant household as the young person adapted to the host culture, while their parents stressed the importance of traditional cultural behaviours and values. The report further stated that conflicting pressures from both sides affected the young person’s sense of identity and contributed to feelings of marginalisation and guilt. Struggles to cope with feelings of guilt were reasons participants accessed mental health services.

In negotiating the new environment, participants had to negotiate relationships both with new members from within their community and people external to their community. The adolescents’ behaviours and attitudes towards “fresh off the boat” members from their own ethnicity could be seen as a struggle to manage the tension between their need for validation and similarity with others, with the need to be perceived as different. According to Brewer’s (1991) theory of optimal distinctiveness, social identity is seen as a reconciliation of opposing needs for assimilation and differentiation from others. Youths in this study discussed the tension in being asked or expected to adhere to their ethnic culture, while also developing an identity that is considered acceptably acculturated in order to fit in with the dominant culture. In addition to dressing in some traditional clothing, refugee youths not “fresh off the boat” modify their outfits and behaviours to “fit” within the new environment, thereby achieving optimal distinctiveness. Identities and identity symbols help to negotiate status within the dominant culture. It assists in socialising peers towards desirable and acceptable behaviours. Social identity is both an outcome of the cultural and ethnic identities of refugee adolescents. To maintain a commitment to some of their traditions, adolescents may find unique ways to express their ethnic membership while also finding ways to adapt to the dominant culture throughout the acculturation process.

Young people reported a struggle to make friends, to fit in and be included. In addition, some experienced peer pressure to conform. If the young person did not adapt to the new setting, they risked being socially isolated and discriminated against. This outcome supports the findings by Sobrun-Maharaj (2002) that significant intimidation is experienced by young people in visible ethnic minority groups in New Zealand. The implications of such intimidation are poorer physical and mental wellbeing for the victims of bullying and intimidation. As the New Zealand population expands with increased numbers of migrants, asylum seekers and people from refugee backgrounds, the pace at which different physical features, food, language and culture permeates New Zealand’s society is gaining momentum.

This is juxtaposed with the time and opportunity for members of the host community to adjust. This may subsequently lead to increased levels of overt and covert discrimination within New Zealand society towards members of the non-dominant cultures. Discrimination is recognised more and more as an adverse mental health risk (Pumariega et al., 2005). Consequently, youths from refugee backgrounds may require input from mental health services to cope with experiences of discrimination. For instance, amongst minority youths, a strong relationship has been found between discrimination and poorer mental health outcomes such as depression and psychological distress (Fisher, Wallace & Fenton, 2000). The behaviour of being “picked” on or bullied can reinforce feelings of anxiety, insecurity, annoyance and distress within the young person. These feelings can trigger traumatic memories or similar responses to previous traumas encountered related to discrimination along their refugee journey.

While discrimination can occur at any age, some youths, appeared more aware of discrimination as they got older. This may be because differences are less significant at the younger developmental stage or alternatively the young person may be less aware of what was going around them. However, as peer pressure increases to conform to acceptable or fashionable means of dress, behaviours or looks in society, being different means the young people from refugee backgrounds may be more likely to experience discrimination. This has reinforced the idea that discrimination is a learnt behaviour as the individual develops, they are taught and become more aware the “norm” within society. Older young people from refugee backgrounds are also more likely to be cognisant of discriminatory behaviours. To have features, beliefs or mannerisms inconsistent with the norm thus increase their vulnerability to being discriminated against or being “picked” on.” These young individuals and their families are often those already discriminated against in their country of origin for their particular beliefs, religion and political views. Therefore, the experience of discriminatory behaviours towards them may trigger trauma responses that may warrant mental health intervention.

In the migrant or refugee setting, it is recognised that the young person’s position within their family is complex (Department of Labour, 2009). The academic and career aspirations of their parents, grandparents and community are often carried on their shoulders. To achieve such expectations, youths from refugee backgrounds must successfully engage with the education system, which is likely foreign to their parents. The analysis suggested that the

education system is also foreign to some young people and is not always easy to navigate. This can make it difficult for the young person to engage with their studies. Lack of familiarity with the education system also likely makes it difficult for parents to assist with their child's schooling through assisting with homework or making time available to support them in their endeavours.

As noted previously, poverty affects parents' availability because parents have to work to meet the financial responsibilities within the household, or to create the life they had likely envisioned for themselves and their children. Participants' reported struggles with their academic studies support the findings of Humpage's (1998) study with Somali adolescents.

One important observation in Study One was that the age/development stage at which the young person migrated to New Zealand, combined with the number of years they had lived in New Zealand, was likely to have affected the perceived difficulties discussed in the context of the pre-migration, transit and post-migration experience. Participants who had arrived in New Zealand at a young age reported fewer difficulties in acquiring English, making friends, negotiating schooling and negotiating the environment. Migrating at a young age may serve as a protective factor for acculturation difficulties, which in turn reduces vulnerability to mental health challenges.

Many participants were too young to remember the pre-migration setting or the transit experience. For participants who were old enough to remember, some reported feeling hopeful about starting a new life in New Zealand, while others were not. When asked about whether they had wanted to migrate to New Zealand, several non-service user focus group participants responded "no" and that the family or caregivers had made the decision for them. They reported that they had established a new life and a good group of friends in the transit country. The move to New Zealand thus represented another disruption to their lives. It also created greater physical distance between themselves and their loved ones. For example, a number of Colombian focus group participants who had spent time in transit in Ecuador reported that, prior to migrating, their families could still cross the border between Columbia and Ecuador and so the ability to still physically connect with family members was more readily available. The consequence of having decisions made for the young people that are inconsistent with their desires may result in a reluctance or ambivalence to exert any effort to the task of resettling. Therefore these individuals may become at risk of marginalising

themselves and experiencing isolation and greater distress than expected during their acculturation process.

The task of adapting to a new country occurs as a two-way process through which different social and cultural interactions impact on the adolescents and their families (Weine et al., 2006). This includes a consideration of how the trauma related to forced migration and political violence interacts with the transitions related to life as a refugee (Weine et al., 2006), and the person's experiences within multiple social spaces such as life before war and political conflict, schools, with organisations and within the family. Participant accounts of family challenges underscore the impact of resettlement challenges, ongoing changes to family structure, family separation and cultural adaptation. Participants repeatedly discussed challenges their family and parents encountered post migration. These stressors build up and can result in decreased family cohesion and support, included a reduction in coping resources. Parental emotional and physical wellbeing, including peer relationships, can alleviate or exacerbate difficulties or challenges experienced by the young person (Almqvist & Broberg, 1999).

The challenges and disruption that youths from refugee backgrounds experience as discussed above can have diverse and profound effects on the developing young person. While some youths are resilient, others develop transient difficulties related to acculturative stress, such as difficulties making friends, difficulties adapting to changes in family roles and dynamics, schooling difficulties and making the adjustments to the new environment. While on their own, these events may be small and irrelevant; however, the cumulative effects of minor life events (e.g., fighting with a friend, not performing well on a school exam) appear to be as significant as major life events when considering an adolescent's subjective wellbeing (McCullough, Huebner & Laughlin, 2000).

Coping Mechanisms

Relevant to coping mechanisms (defined as coping strategies used to manage personal and interpersonal difficulties, or to reduce stress levels) youths from refugee backgrounds reported that coping is often private. According to Parkinson, Fischer and Manstead (2005), there are cultural rules about the public expression of distress. Participants from a range of ethnic backgrounds discussed how talking about emotions was not appropriate in their

cultures. In a qualitative study using extracts from interviews and focus groups with over 100 people from Ethiopian, Eritrean, Sudanese and Somali backgrounds to examine their understandings and experiences of “depression”, Tilbury (2007) noted that many of the participants in the study reported “hiding their problems” or not speaking about their difficulties. While it was not identified in this study, other members of Tilbury’s (2007) study raised the concerns that discussing distress could be viewed as complaining by others around them. The fear of stigmatisation of serious mental health problems may also contribute to this. For example, both youths from Columbian and Somali backgrounds in the focus group with non-service users expressed their concern that if someone within their community identified them as having a problem, they would be termed “crazy”. This would result in feelings of shame and embarrassment, which may further support the attitude and belief that “coping is private”. Coping privately possibly reduces potential exposure to distressing feelings of shame and embarrassment.

Keeping quiet about their struggles as an approach to managing stressors has further been identified in other studies with refugee families as a method to focus on the future and carve out a new life. For example, Rousseau (1993) reported that parents from refugee backgrounds in Canada felt that it was important to forget the past and focus on the future as a way of coping and forging a new life for themselves. To support forgetfulness, traumatic events would not be discussed, and when family members attempted to discuss these events, it was greeted with disapproval. Rousseau (1993) goes on to suggest that keeping quiet as a style of coping with a traumatic experience was transferred to the children. Thus the keeping quiet strategy evident in participants’ accounts as a coping behaviour may have been transferred to them by their parents.

The second coping strategy described by participants included the use of religion. Religion is an important aspect for many refugees, such as those who hold Muslim, Catholic or Buddhist beliefs. In turn, using their religion is likely a culturally accepted form of coping amongst many adolescents from refugee backgrounds. Importantly, God is readily and easily accessible at any time. Furthermore, accessing religion supports coping privately, which limits exposure to discrimination and negative stigma related to seeking help from external sources. There are no linguistic or cultural barriers to accessing religion, particularly if it is the same one the young person has been raised with. In addition, given its ease of accessibility, this method of coping does not distract from prioritisation of other resettlement

needs.

Youth participants described the third coping strategy as physical activity. Both genders reported using physical activities, such as engaging in sports, walking, or playing a musical instrument, to manage their distress and cope with their problems. Physical activity as a coping strategy is often free (or low in cost); it is easily accessible, it can occur (within reason) any time of the day; and it is likely a common form of coping across cultures, thus making it a culturally-acceptable form of managing problems. Using physical activity to cope allows the young person to be autonomous in their coping without having to rely on others for assistance. Culture influences people's coping behaviours with day-to-day stressors, and extreme forms of stressors and adversities. Within particular Asian American groups, not dwelling on distressing thoughts, or the avoidance of outward expression of distress are common coping mechanisms (Cauce et al., 2002). Furthermore, there is a greater emphasis placed on suppressing emotions (Kleinman, 1987) with some individuals preferring to rely on themselves to cope with distress, rather than relying on other people (Narikiyo & Kameoka, 1992). On the other hand, refugees from Sudanese backgrounds have been reported to have a tendency to take an active approach to managing personal difficulties, rather than avoidance. They are further more inclined to rely on religious or spiritual support to manage distress and adversities (Khawaja et al., 2008).

The fourth coping strategy described by participants was accessing peers and parents as sources of support. The pivotal role that support plays in coping for people from refugee backgrounds has also been documented by authors such as McMichael and Manderson (2004). In their exploration about how the loss of social relationships as a result of civil war and displacement contributes to Somali females and refugees' distress and sadness they found that individuals who used established social networks were in a better position to access material and social support. Furthermore, they were less likely to suffer from sadness, distress, depression and anxiety. The social support networks seemed to facilitate the sense of belonging within the community for people from refugee backgrounds while enhancing access to practical resources such as food and housing. Gorman et al. (2003) note that family and community support provide young people with the ability to maintain their identity and a feeling of stability and self-esteem when faced with a dominant culture very distinct from that which they are familiar with. However, these resources can also be the foundation for conflicts of culture and expectations that can place the young person in a vulnerable and

difficult position of trying to engage with the dominant culture without negative recrimination from their primary cultural attachment.

The role of peer, familial and social support may be even more relevant considering that young people from culturally and linguistically-diverse backgrounds to the dominant culture are more likely to seek support from those around them, rather than to access help from the formal health and welfare sector (Yeh & Inose, 2002). Several studies of families and migration have identified families as critical to overcoming barriers in the new society and facilitating positive mental health (McMichael et al., 2011; Portes & Rumbaut, 2001). The analysis also identified that while the majority of young people trusted their parents, they felt that their parents did not trust them. The participants attributed this to parental loss of everyday bearing and lack of familiarity with new surroundings. Participants also considered their parents as being too strict, which caused feelings of frustration because of lack of autonomy. This can contribute to high levels of stress and difficulties with adjusting to the new culture.

The fifth coping strategy employed by adolescents from refugee backgrounds related to thinking strategies. Two key strategies included positive thinking and distraction techniques. These results support a study in the USA, whereby qualitative interviews with 14 unaccompanied male Southern Sudanese Dinka youth from refugee backgrounds (aged 16–18 years of age) found high levels of resilience were maintained using cultural coping mechanisms such as suppression, distraction, finding comfort in the collective experience of loss, constructing meaning from suffering and focusing on the hopefulness of resettlement (Goodman, 2004). Positive thinking related to focusing on the positive aspects of a situation. Alternatively, the individual could compare and contrast their situation to optimise perception of the problems, for example, in Study One, one participant observed that even the President of the country has problems. Distraction involved forgetting or engaging in behaviours to redirect their minds. According to some cultures, at the basic level, there is a belief that avoidance of thinking about the problem is the best way of managing the problem (Cauce et al., 2002). As discussed above, within some Asian-American groups, it was identified that not focusing or dwelling on upsetting thoughts and events was best for the individual. These strategies have been observed in other coping studies with people from refugee backgrounds (Goodman, 2004; Gorman et al., 2003). The strategies reported by youths from refugee backgrounds in this study also support Colic-Peisker and Tilbury (2003) active and passive

coping styles identified with people from refugee backgrounds.

While the research focused on experiences of mental health services, there was evidence of strength and resilience in the adolescents' coping. Some participants sought help from family and friends from within, and external to, their ethnic community. Resilience (positive self-esteem and self-efficacy), secure attachments and protective factors (family, religion, community and cultural practices) have been found to mediate how young people manage their challenges and struggles (Whittaker, Hardy, Lewis & Buchan, 2005). Despite the challenges with school, some youths worked hard to achieve in that environment. Previous studies have found that Cambodian mothers place the burden of succeeding at any cost in order on their children to restore dignity lost by the family who had lived through the Pol Pot regime (Rousseau et al., 1999). As in Rousseau's et al.'s focus group with refugee Cambodian adolescents, the participants in this study confirmed that they were keenly aware of the burden of carrying the weight of their family's expectations. Striving for academic success could be an overcompensation behaviour on the part of the youth whose parents or grandparents survived significant atrocities. As such, they inherit the implicit obligation to succeed for those who had passed on (Rousseau et al., 1999).

Of interest, a few of the participants discussed limited or no difficulties with their refugee experience. The implications of their perceived limited adjustment difficulties perhaps lends itself to greater resilience to cope and adapt to the new cultural, social, and political context within the New Zealand environment. In reporting few adjustment difficulties, it does not necessarily mean they had few difficulties. It may be that their appraisal of the situation and of being open to new "experiences" had supported them to adapt to the conditions more easily than others who may find the language and social context difficult to manage. It may also be another reflection of the attitude that coping is private, therefore, it also means that it does not get discussed in any context.

Experience of Mental Health Services

Attitudes toward mental health services, stigma tolerance and anticipated negative responses from others, including self consciousness, have been found to affect seeking and utilisation of mental health services (de Anstiss & Ziaian, 2010). This study found that cultural differences, stigma and fear of privacy not being maintained were the major barriers

to help seeking with mental health services.

When individuals did access mental health services, cultural differences (in particular, language) and different understandings of an issue were two key issues identified in their experience. Dependent on the service utilised, trained interpreters may not be readily available, which limits understanding for both client and the service provider. It further limits the service that the young person receives as providers will likely be hindered in providing the most helpful form of care if they cannot understand what the young person or his/her family is trying to communicate. The finding of differences in cultural understanding of difficulties supports other researchers, who have found that different understanding and attributions of mental health problems exists across different cultures (Guerin et al., 2004).

In relation to fear of privacy not being maintained, several focus group members articulated the importance of confidentiality, with a particular concern about whether their parents, caregivers or other members of their community would be informed about the issues for which they had accessed mental health services. This appeared to be related to another barrier to seeking help from mental health services, which was the fear of being stigmatised as “crazy” or being seen as unable to cope. The implication was a fear of being treated negatively by other individuals if they obtained access to their information. In effect, youths feared a negative response from their own family members or community. This could be related to how mental health and mental health services are perceived within their communities. For example, in many East Asian cultures, feelings of shame and “loss of face” are commonly identified when seeking help from support outside of the individual or family unit (Takeuchi et al., 1993).

In addition to the role of culture on mental health seeking, Cauce et al. (2002) suggest that developmental issues associated with adolescents also play a role in mental health help seeking. The authors identify adolescents’ need for privacy, their drive for self-reliance and autonomy, and self-identity as influencing help seeking, even from peers or family members. Furthermore the authors also noted that concerns about confidentiality and believing that problems are too personal to share with others negatively influence help seeking.

The characteristic of the problem is another important factor that affects help-seeking behaviours with adolescents, than other interpersonal problems (Boldero & Fallon, 1995). However, young people in Study One, particularly in the individual interviews, discussed

seeking help because of feelings of frustration and difficulties related to family conflict.

Focus group participants reported that the form of assistance sought from mental health services was more pragmatic, rather than psychological or emotional support (for example, assistance with completing an immigration document). According to Au (2002), it is not uncommon for migrant youths to present to mental health services for practical assistance rather than for mental health problems. This may be because discussions around practical challenges are easier. Assisting with pragmatic challenges is a problem-solving approach that can have a fast positive outcome on the functioning of the young person and their family.

This study also found that when youth participants did access mental health support, they did find it “helpful”, “good” or “great”. Several factors were identified that contributed to these positive experiences, including feeling listened to. Talking about the traumatic event can be helpful or unhelpful; for example, in a study with Bosnian children from refugee backgrounds in Sweden, Angel, Hjern and Ingleby (2001) reported that when children were able to discuss their war experiences, those who had experienced less stress had fewer difficulties adapting to the new environment while those who had experienced extreme stress had more difficulties adapting to the new environment.

Summary

The aims of Study One were to (i) explore issues and challenges that youth from refugee backgrounds experienced in adapting to living in New Zealand and how they coped with stressors and (ii) to explore the young person’s experience and beliefs mental health services that may assist them. In examining their stressors, seven themes were identified under two categories of “life prior to New Zealand” and “resettlement”. The first theme of “exposure to violence, hardship and corruption” highlighted the enduring impact of the pre-migration trauma on the young person or their families. The theme of “loss and worry about people left behind” discussed the ongoing stress of losing or being separated from loved ones. During resettlement, learning the English language was difficult for some adolescents or parents, which may have affected their ability to adapt to or acculturate to the new environment. The theme of “money is a worry” noted that financial limitations and poverty affected the young person’s and their family’s wellbeing and quality of life. In addition to these stressors, making friends was difficult, and young refugees were subjected to the experience of

discrimination and bullying. At times, having musical or athletic skills, however, helped to facilitate the development of friendship. The theme of adapting to the new culture highlighted generational disparity in rates of acculturation and its contribution to intergenerational conflict. Furthermore, this theme noted that parents held different expectations of the young person, dependent on their gender.

In relation to coping mechanisms and dealing with difficulties, the theme of “coping is private” highlights refugee youths preference to cope with difficulties on their own as opposed to seeking help for their problems. The theme of “religion helps coping” discussed the accessibility of religion for the young person, which may suggest the importance of making mental health services easily accessible to young people. The next theme of “physical activity is a coping mechanism” enables the young person to cope by becoming engaged in activities that may be culturally appropriate and again, easily accessible. The theme of “thinking strategies affect coping” discussed the effects of positive and distracting thinking strategies as a coping mechanism. Finally, peer and family support were identified to support coping, as was problem solving. Themes identified in the experience of mental health services were structured under the headings of “barriers to engagement” and “facilitators to engagement”. The barriers to engagement included cultural difficulties, stigma and fear of privacy not being maintained. Facilitators to engagement included having a positive experience, being reassured of confidentiality and having an established relationship with the service provider. Furthermore, feeling accepted and not judged, having a good listener, and receiving support on many levels also facilitated adolescents’ engagement with mental health services. Having these factors highlighted, it is therefore important to also examine service providers’ insight into working with refugee youths and their considerations on future engagement and interventions with this population.

CHAPTER FOUR

Study Two

Service Provider Experience of Refugee Youth Mental Health

As clients of mental health services become more diverse, it is increasingly important for practitioners in Western countries to direct attention to culture. Contextual factors are critical to understanding the challenges experienced by clients. The significance of the young people from refugee backgrounds' culture of origin has been stressed as a major influence on the acceptability of mental health treatment. As such, there is a need for mental health professionals to be aware of their client's culture, family system, and view of previous traumatic events (Lustig et al., 2004).

Study One focused on youth from refugee backgrounds challenges across the pre-migration, transit and post-migration experience, their coping mechanisms, and their experience of and attitudes towards mental health services. Study Two aimed to explore the practice and provision of mental health services in working with young people from refugee backgrounds. Specifically, the focus of inquiry was (i) How the service provider understands the young person's difficulties; and (ii) What types of treatment modalities are used and the rationale for using particular approaches with young people from refugee backgrounds. Study Two also sought to identify the difficulties experienced by providers in working with this population, and sought suggestions for how service provision could be enhanced. It was hoped that this study, along with Study One, could provide a basis for the development of strategies to improve the experience of mental health services for young people from refugee backgrounds and their families.

Previous researchers on the mental health needs of people from refugee backgrounds have generally formed their conclusions about barriers to access to mainstream services based on the perception of the people from the refugee backgrounds, and have not considered the perspective of mainstream service providers (Boldero & Fallon, 1995). The barriers identified by people from refugee backgrounds to engagement with mental health services include stigma, language, cultural traditions and cultural differences to the mainstream service providers.

In this study, focus groups were conducted with service providers to firstly identify commonalities or differences in their experiences and views compared to young people's

experiences. Secondly, service providers can offer a unique perspective on the young person's experiences. Third, service providers can provide insight into strategies that have worked with refugee adolescents. Finally, service providers are able to suggest what is possible in terms of future engagement and intervention with youths from refugee backgrounds.

Method

Participants

Participants were 20 service providers who had extensive experience of working with adolescents from refugee backgrounds and their families in New Zealand. The participants came from a range of professional backgrounds including psychologists, social workers, general medical practitioners and school guidance counsellors (Table 4). Four of the participants were men, while 16 were women. They ranged in age from 25 to 65 years. The ethnicities of the participants were variable. Three of the participants identified themselves as Indian, and one each as Māori, Iraqi, Greek, Somalian, Scottish and Ethiopian, respectively. The remaining of the 11 participants identified themselves as New Zealanders of European descent. On average, the participants had over 10 years of professional experience in their field (range, 3 to 25 years).

Table 4.

Professional backgrounds and genders of focus group participants (Total n=20)

Professional background	Gender	
	Male	Female
Psychologist	2	6
Social worker	1	2
School guidance counsellors	1	5
General practitioners	0	3
Total	4	16

Four focus groups were completed. Groups A and B consisted of four service providers each, Group C consisted of seven providers, and Group D consisted of five providers (Table 5).

Table 5.

Service provider focus group composition (Total n=20)

Focus Group	Profession	Number
A(n=4)	Clinical psychologist	4
B (n=4)	Social worker	2
	General practitioner	2
C (n=7)	Clinical psychologist	2
	Social worker	1
	Educational psychologist	1
	School counsellor	3
D (n=5)	Clinical psychologist	1
	General practitioner	1
	School counsellor	3

Focus Group Interview Schedule

An interview schedule was used with predominantly open-ended questions. A broad descriptive question was used to start the focus groups to help place the group in the context of the participants' experiences of working with refugee young people. This involved asking each focus group member to describe their experience of the key issues that youths from refugee backgrounds had presented with. According to McCance and Mcilpatrick (2008) asking the participants to share a particular experience at the beginning of the interview is a common approach.

The areas covered in the interview included:

- 1) What key issues/problems have refugee youths presented with?
- 2) What factors do you think contributed to the development and or maintenance of these problems?

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- 3) What treatment strategies or interventions have been used to address these problems?
 - 4) How much does the assessment/treatment of the youth's problems take into account their refugee backgrounds?
 - 5) How much does the assessment/treatment of the youth's problems take into account their cultural backgrounds?
 - 6) What assessment/treatment methods have you found to work well or not well with refugee youths, and why do you think this is so?
 - 7) What would help in the future to assist your practice with refugee youths?
 - 8) What kind of services have you provided to refugee youths with mental illness?
 - 9) What are the gaps in mental health services in refugee youth with mental illness and their families? Prompts included:
 - a. Early intervention services
 - b. Acute and sub-acute care
 - c. Rehabilitation and ongoing support.
 - 10) What does your service need to do to increase its responsiveness to refugee youths affected by mental health problems? Prompts included:
 - a. Building policy
 - b. Creating supportive environments (e.g., information, education and services, networking)
 - c. Strengthening community action (e.g., mental health or generic groups)
 - d. Developing personal skills (individuals with mental illness, caregivers)
 - e. Re-orienting mental health services (accessibility and provision of services).
 - 11) What are the gaps in knowledge and skills within your service to achieve the above?
 - 12) What do you see as the strengths and resources within the refugee community that can be mobilised to cope with mental health problems?

Prompts were used to clarify responses in order to gain more depth on the issues being discussed. Probing questions were managed with care during the focus groups to reduce the risk of developing bias and making participants feel uncomfortable. Prompts were also used to support the participants to share their knowledge on a specific area. This was done through

rephrasing or repeating the questions, or offering examples.

Procedure

Ethical approval for the study was gained from the University of Auckland Ethics Committee. Participants were recruited via an email sent to the mental health service providers within the District Health Boards, primary health services, public health services, social service agencies and community-based health organisations in Auckland and Hamilton. This email introduced the research and its aims and included a request to forward the information to the staff within their organisation. Emails outlining the purpose of the research and the request to disseminate the participant information sheet were also sent to other relevant organisations and individuals such as the Auckland Refugee Councils and Forums, Refugee Coordinators for secondary schools, District Health Boards' cultural interest groups, the coordinator of the school guidance counsellor network group, and the chairman of different refugee communities. A contact reply slip was attached to the email so that potential participants could reply to the email to indicate their interest in participating in the research. When replies were received from the participants by email or by phone, each individual was followed up with a telephone call or email to arrange a convenient date and time for the focus groups to take place. When interested service providers contacted the researcher to indicate their interest in participating, any queries or concerns they had about the research were answered. All individuals who were contacted consented to participating in the study.

Focus groups with service providers were conducted concurrently with Study One. All of the Study Two focus groups were completed in work settings. The focus groups lasted between 1 and 1.5 hours. Consent was obtained to audio-record all of the focus group discussions. Notes were not made during the focus group as it was considered a possible distraction for the participants.

Before commencing the focus group discussions, the participants were again reminded of the purpose of the research and what was expected of them as a participant in the research, including the estimated time needed to participate. The risks and benefits of the research were then outlined to the participants, including the fact that their participation was voluntary and that they could withdraw at any time, or withdraw their comments, without any negative

consequences. Furthermore, participants were informed how confidentiality would be maintained. If the participants had any questions or problems related to the research, they were reminded of the name and contact details of the researcher and encouraged to make contact if the participants were uncomfortable about contacting the researcher, the contact details of the researcher's primary supervisor were also provided. Finally, the contact details of the University of Auckland Ethics Committee were provided should they have any queries about their rights as a research participant. All these details were included in the participant information sheet (Appendix F), which was also given to the participants to take away with them. Written consent (Appendix G) was obtained from each participant before the focus group commenced. On completion of the focus group interviews, service providers were provided with a meal. If they were unable to participate in the refreshment, they were offered a movie voucher as a token of appreciation.

Data Analysis

The recorded interviews of service providers were transcribed verbatim before being sent back to the participants to review for accuracy and to clarify any areas that had been hard to understand during the transcribing process. The participants were also given the opportunity to add to their responses or to withdraw a comment. The analysis was an adaption of the thematic analytic method described by Braun and Clark's (2006) thematic analysis method. This enables the identification, analysis and reporting of themes within data gathered.

Analysis of Focus Groups - Results

Mental Health Problems with Youths From Refugee Backgrounds

Service providers were asked to briefly outline and describe the issues or challenges that refugee youth had presented to them with. Two key themes were identified under the primary area of mental health problems with refugee youths. These were "young people have a range of problems, and there are "differences in gender presentation of difficulties".

Young people have a range of problems. People from refugee backgrounds present with a range of psychological and behavioural issues. Most service providers reported youth

from refugee backgrounds challenges as a function of “multiple ongoing stressors, for example, learning a new language, adapting to a new culture and a new life would be immensely hard for anyone, but especially more so for refugee families” (Focus group A). Participants commented that youths presented with what was commonly described as “adjustment difficulties” and challenging behaviours within the school, family or community; suicidal ideation and threats of self harm; anger; depression; drug and alcohol use; and sexuality issues.

Both of them with suicide ideation and threats of self harm. (Focus group B)

My work has been focused on challenging behaviours...if they are at school they are causing problems within school and with the families and in the community. (Focus group D)

Mine was referred for anger problems and behaviour difficulties in school. (Focus group A)

We’ve got anger, anxiety, depression, drug and alcohol use, sexuality issues. (Focus group D)

Differences in gender presentation. When asked to elaborate further on behaviours, some service providers’ discussions suggested that male adolescents were more likely to exhibit their difficulties externally while female adolescents were reported to internalise their problems. When behaviours were exhibited externally, this included physical violence, fighting, throwing chairs, verbal abuse towards others and anger towards themselves and others. Participants also reported that adolescents were not just the initiators of such actions, but also the observers or receivers of anger from peers, family and community. This likely contributed to the “psychological issues” the young person presented with.

Demonstrated mostly with the young boys, it’s externally, or with young girls, it’s internally. So the boys think the acting out in school, the physical violence, fighting, throwing chairs, verbal abuse, parents, teachers, siblings, community, self-anger, harming themselves the whole range. And also being exposed to that sort of anger from peers, family, community and also psychological issues. So trauma backgrounds as well. (Focus group D)

Beliefs about Factors that Contribute to Youth from Refugee Backgrounds Mental Health Problems

Following queries about stressors and challenges, participants were asked to share their beliefs about factors that contributed to refugee youth mental health problems. Ten themes were identified from their discussions. These included trauma and the lingering impact, clash of cultures, missing relationships, lack of meaningful activities, poverty, different rates of adaptation, family health and wellbeing, parent's expectations, and lastly, family's attitude about mental health and mental health services.

Trauma and the refugee experience continue to impact. Service providers' accounts of the young people from refugee backgrounds' difficulties highlighted the enduring effect of the refugee experience on the young person and/or their family's ability functioning. Participants discussed efforts to "factor in their [the young person's] refugee background...because it's a different kettle of fish" (Focus group A). Many service providers recognised that young people with no prior schooling opportunities struggled to adapt to the structure and behaviour required within a classroom environment. They discussed how young people with a refugee background continue to engage in behaviours related to the refugee experience, such as hoarding food, and attributed this to the young person's uncertainty of the next meal or next opportunity to access food.

Service providers also discussed concerns that other professionals may be lacking in understanding the child from refugee backgrounds' behaviour within the context of their refugee experience. Thus, the young person's behaviour is judged according to the dominant or development expectations of a child at that age that had been raised within the New Zealand context. This leads to conflicting situations for the young person and, likely, their family. The quote below illustrates this. While service providers were encouraged to share their experiences specifically in relation to refugee adolescents, some also discussed experience with younger children in relation to the lingering effects of trauma.

Some teachers, they just read the behaviour as naughtiness, you know, think of little kids, five, six, seven years old who have no schooling experience going into a classroom. Um, and teachers thinking, why won't they sit on the mat? Why won't they do that? Or a little girl we've just had through here who had a very flexible view of what was hers and what was

somebody else's and if she saw somebody else's something, that was fine to put into her pocket, or to hoard food for instance. Take five biscuits and not one because I don't know when I will get a biscuit again. And imagine that in a class room with school lunches. You know potentially it's quite a conflict ground from the start, if the teachers don't understand. (Focus group C)

Service providers commented that these experiences affect the young person's sense of control and his/her sense of the world, including his/her role and position in the world. When the young person has been "badly damaged" or traumatised throughout his/her life, this has an effect on his/her ability to adapt and to cope within the new environment.

Steeped in trauma from when they were refugees or other issues which have come along. Similarly with the school so they're trying to find some control, making some sense of the world and how they fit into it. So those are the things that have happened and some of the young girls have been badly damaged in other ways. (Focus group D)

Clash of cultures. On the issue of adjustment, many service providers also discussed a clash of cultures as a key factor for the distress and challenges reported by adolescents from refugee backgrounds. Service providers likened the adjustment to New Zealand's environment, social, political and cultural context as "a completely different experience" (Focus group C) in which the young person and their family are "being beamed onto Mars" (Focus group C), especially for groups from a rural background who have had little exposure to city life. The new environment is thus "an alien sort of place" (Focus group C) that is unfamiliar and completely foreign to the resettling family.

It's just the change and stuff. It's so profound, it's like being beamed, being beamed into Mars in some cultures. There's some cultures that aren't too different from ours like the urban, urban people that kind of get New Zealand much more quickly, and so the transition, isn't, say if you've lived in a city before, you kind of get it. But if you're rural, you don't. (Focus group C)

Making the adjustment to the differences between cultures was posed as a challenge, not only to the young person, but also his/her family.

With one other family there was some issues about the daughters wants some more freedom, like a Muslim teenage girl wanted to have a sleep night at her friend's house which is quite common in Kiwi culture and the mum's she – sleepovers yes, going out during the weekend and mum was very freaked out. (Focus group D)

When the adjustment to the difference between the two cultures is so significant, particularly for the family members, this itself becomes another problem for the young person to deal with.

So I think the big issue is when the refugees come over here there is a big difference between their culture and the way Kiwi culture is. Culture I am talking in terms of everything, not only in terms of language, culture in terms of policies, privacy act and generally everyday living. There is a big difference with that and with my experience there are very few families who have, refugee families who have the migration of both of the cultures. That is where there is a problem. That is a problem among refugee youth according to me, the family hasn't been able to migrate both cultures. The difference between the two cultures is vast. (Focus group D)

Service providers discussed that in adjusting to the new environment, the young person must constantly navigate two different worlds. Within his/her home environment or family context, he/she may be expected to continue engaging in the cultural and religious practices. However, when he/she goes to school, he/she has to change his/her behaviours to fit in or avoid being teased or bullied.

The difficulty is that they are living in two different worlds. When they come home there is an expectation of a religious family bond and practice every day and they want them to go and put a high value on education and things like that. When they go to school and try and fit with the mainstream, it is like they look up to the other kids, the way they look, the way they talk, the way they think. So it's very difficult either way, when they go to school, when they come home it is very difficult. So that's how easily we lose our young kids between home and school as there is no way they can participate easily as they come over because they don't speak the language fluently and

they tease them and they laugh at them so they really get upset and not want to go to school. (Focus group D)

Service providers suggested that the length of time that the young person had resided in New Zealand contributed to these adjustment difficulties, in that adolescents from refugee backgrounds are under the pressure of immense stressors in the early months or years of adjusting to the life and environment within the host country.

The referral said PTSD, but it was more about adjustment issues. The family had only been in New Zealand for eight months and were still under lots of stressors in terms of adjusting to so many new things in New Zealand. (Focus group A)

Service providers also noted that schooling adjustment was hard for participants, particularly for older adolescents. Participants discussed that a lack of exposure to academic structure and curriculum was hard for adolescents to cope with. In addition, there were unrealistic expectations from the young person about his/her ability to adapt and adjust to the new environment that he/she are faced, which affected their psychological wellbeing.

And the other one I think that's quite common is ah, them coming as teenagers especially with um not much in the way of academic background or poor English, and just having no idea about the school system that's just about to confront them, and often unrealistic expectations about how quickly they will adapt to be successful. (Focus group C)

Self identity is affected by the refugee experience. A subtheme of clash of cultures was “self identity is affected by the refugee experience”. Throughout the refugee experience, the young person’s self identity is shaped, as is their sense of belonging. The young person’s understanding of himself/herself may be significantly challenged in his/her struggles to manage the new environment. This leads to feelings of devastation and inadequacies. One service provider in particular recognised how important it was to be mindful of the impact of acculturation difficulties on the young person’s development, especially in terms of self identity. Furthermore, the service provider stressed the importance of working with the young person to recognise and negotiate the consequences of such impacts.

Yeah, their identities have been compromised, their sense of belonging, all sorts of fundamental things. (Focus group C)

Yeah, and that thing that they talk about more, more with adults sounds fancy, but this developmental asynchrony. Where you know in your own culture if you were reasonably confident as a 15 years old in the society, knowing the language and how society works. Then coming here as a 15-year-old and being devastated by not speaking, not knowing the culture, feeling essentially like you're a two or three years old. (Focus group C)

It's so vital to how it affects people and just helping them to identify that and work with that. I mean it's a hard thing, but it's a huge thing. (Focus group C)

A significant change within an environment can have an enormous impact on an individual's sense of belonging. There is pressure to conform and adapt quickly to the new behaviours and attitudes within the host country in order to be included and accepted. The risk of not conforming to behaviours is to be excluded, or bullied. Service providers discussed that the desire to normalise, be accepted or fit in with the members within the host society can lead to mental health issues for the young person.

There's also, the peer pressure for these young youths is quite huge in school. Most of them behave differently because they want to fit in a circle at school. Otherwise, they were left out. Like, if there are a few kids smoking, in order to get into that circle, you have to be a smoker or you have to be into some kind of a drug or something in order to get in, to just behave differently. And wants to be part of them, or they just want to normalise themselves and that also leads to some of these mental health issues as well. And even parents want to say something, but they say, and everybody's doing. Like I came across the issue, they say, everybody's smoking. I remember in school, they're going out or doing something, otherwise, they will call you names or they bullying you because you're studying too much or you're too good. (Focus group C)

What is alluded to is that conformity behaviours may be engaged in as a mechanism to reduce the risk of being harmed further, as that which may occur if the young person is subjected to bullying.

Missing relationships contribute to stress. Service providers' discussions suggested

that another key reason that refugee youths struggle in the new environment is because of missing key relationships and people in their lives. Participants reported that adolescents miss family members, such as parents, or siblings, and also peers. The physical absence of these family members was considered to be an enduring issue for many adolescents from refugee backgrounds.

Missing relationships is the key one for me in the children I've seen, followed closely by trauma issues. So missing relationships in that they might just miss their teenage girlfriends back in Syria or wherever they've come from. Or they're missing a parent or um a dead sibling, or siblings left behind and the gaps in the family with the left behind or the dead people. Um, and then, yeah, that, that for me is a key enduring issue, um for the children, um and trauma, trauma issues for the things they have witnessed or have had happened to them. (Focus group C)

Service providers' discussions highlighted the absence of family or friends contributed to a loss of a potential source of support. Compounding the issue of missing relationships was communication difficulties with people who were absent, as a result of lack of finances, practicality or access to technological resources.

For me, just a lack of support. Most of them, like recently, I had a one of the Nepalese client, and she was a school student, year 8 or 9 and she came here and just missed that lack of support that she had back home from her friends, school mates. And coming here, not having enough money to contact them, or sending a letter is not quite practical from here to there so that was quite big for them. (Focus group C)

Some service providers felt that missing relationships also contributed a lack of role models for the young person. As a consequence, the young person ends up isolated or interacting with the "wrong crowd" which engages in antisocial behaviours and may then lead to increased conflict within the household, particularly with the parents.

A role model, someone they can actually look up to from their own community, that says this person has succeeded, then I should follow through, there is not many of them within the communities and when they end up in the wrong crowd they also get isolated within the community as

well. Let's just say that they start doing drugs or alcohol or things like that ... and the parents straight away don't support what the children are doing and the communication with them, so they punish them whichever way it is.

(Focus group D)

Not only do adolescents struggle with separation from loved ones, but so do their parents. Participants observed that, despite being in New Zealand for a long period of time (e.g., more than 10 years), some refugees continued to struggle with the “disconnect” from their family and country of origin.

So mum was struggling with the disconnect from her country I think, from her family and so on. (Focus group B)

Participants noted that disconnection from missing family members affected parents' interactions with, and responsiveness towards, their children and their needs.

Lack of meaningful activities. According to half of the focus groups, adjustment difficulties the young person presented with were related to a lack of meaningful activities to participate in within the young person's community. This led to the young person becoming “restless” and gravitating towards the use of drugs and alcohol, or associating with antisocial peers and engaging in antisocial behaviours. The quote below suggests that the service provider assumes that if the family was able to occupy the young person with meaningful activity, there would be less of a risk of engaging in the unhelpful behaviours mentioned. However, this would also require a family to be functioning “well” post-migration, which, as other service providers argue, is not always the case.

I think if they keep occupied as they are growing up or you can see that they become more restless. As they become more restless all of the negative things keep attracting them more, like drugs or alcohol, getting into the wrong company but I think if they are kept occupied by their parents some of the girls introduced are going back to refugee families, most of them are on benefit and because of the benefit they can't access those resources outside of there. So in the end you are left without doing anything because they are alone and they get in the wrong kind of company and that's where things get a bit out of hand, a bit out of control. (Focus group D)

Poverty affects choices and opportunities. Service providers described their

understanding of how poverty limited a young person's participation in activities that would otherwise facilitate their socialisation and interaction within the community.

Sport, most people love their kids to do sports but unfortunately in New Zealand it's quite expensive, not all of the schools provide kids with sport activities so if you go for private then you have to pay for the clothes, have to pay for the membership, private coaching and all of this and somebody needs to provide them with transport every Saturday and Sunday for matches and games and these things are way beyond the capacity of most of these families. (Focus group D)

Furthermore, one focus group noted that a fear of increasing family debt, and lack of understanding of how the student loan system operates, hindered families from developing English skills. This impacted family's ability to acculturate and adjust to New Zealand's society.

Yeah, the adult that I talk to, about the need for learning English, they understand that learning English is critical, but they're really paranoid about taking on any debt. Having arrived in the country with nothing, so in that they don't fully understand the student loan scheme, how it works, you know. What happens if I die, will my children get the debt, and they don't. All these sorts of fears. (Focus group C)

Different rates of adaptation between generations. While the change in environment may be profound for the young person and his/her family, service providers also reported that through going to school, refugee adolescents were able to make friends. This provided the young person with the opportunity to become more familiar with the new community and to learn strategies to fit into the new community. However, parents from refugee backgrounds do not always have such opportunities. Instead, some parents continue to socialise more frequently with members from within their own community. Through not interacting as much with the new community as their children, parents may start to lag behind in their adaptation practices. They may also struggle to understand the new behaviours and attitudes the young person may start to exhibit. The resulting outcome is increased conflict between the parent and young person.

I think part of problem is that young people go to school here, that they make

other friends from New Zealand and they're probably not just from south Auckland, but from a variety of cultures. They kind of, within New Zealand, within the community, they get to know their community more often than perhaps their parents do. Their parents will still mix with their own communities. They don't kind of extend, and I think that's where a lot of the problems are. The young people will fit into the New Zealand way of things, but actually the parents aren't really aware of what that is. In part, I suppose it's because they've kept themselves closed. Closed isn't the right word, but the kids go to school and they learn English and learn to communicate with the community much better than the parents who don't perhaps have that support of education and how to fit it into the community. It leads to, and helps maintain the difficulties, but it also leads to conflict. (Focus group B)

Adaptation/acceptance of new culture. Under the theme of “difference rates of adaptation between generations”, a subtheme of “adaptation/acceptance of new culture” was identified. Service providers felt that because of parents’ lack of interaction with members of the host culture, they have limited opportunities to challenge their assumptions about the “Western culture”. Thus, there are fears the children may be negatively influenced by the new culture, particularly if there is a significant difference between values and behaviours from their culture and that of the new country. Such differences in perception and engagement with the new community ultimately results in a “huge clash” between the generations.

Especially in the Islamic base culture, fearing you know all the bad side of western culture is going to corrupt their children, the drugs, the sex and the alcohol, and the disrespect for elders. And um, it's all of those things, but I think that's common to many cultures. (Focus group C)

And beyond just a sexual thing, it's the whole freedom thing of you know, of Western culture and high school culture, tertiary education culture, where they, you know, kids are expected to have adult freedom from about 16 or 15 years onwards. That huge clash with the parent culture. (Focus group C)

Different rates of English language learning. Another subtheme in relation to generation differences was reported as relating to parent's limited ability with English language. Through limited access to education opportunities because “there's no entrance to

the education system” (Focus group C), many “adults are going out and sitting in their community. Just sitting in their houses with no English, not developing it, not getting a job because of their low English, and just being stuck....It impacts the whole, rest of the family, self esteem of the adult” (Focus group C). Language difficulties were identified to limit a parent’s ability to take to take an active role in their children’s life, such as children’s performance in their school environment.

I have had a family, a woman who came in about three or four years ago, a lot of trauma and all that and surprisingly – she came through a lot of trauma from Africa and surprisingly she’s had a lot of English in the first year from her children. The woman, she began learning English and started mixing with the Kiwi community. After she started doing that she started dealing with, she has five children, she was able to deal with her children’s issues much better because she was even able to go to the school for the parent teacher meeting which often our refugee families cannot go because of the language aspect. (Focus group B)

Family health and wellbeing. Service providers’ accounts highlighted the functioning of the family unit pre- and post-settlement as having a critical influence on the youth’s ability to settle into New Zealand and his/her wellbeing. Irrespective of the family’s ethnicity or country of origin, service providers discussed that the baseline interaction and relation of the family unit, including parent’s coping mechanisms, affected how they treated the young person, which in turn also affected the family’s overall functioning. For example, if some family members used drugs to cope, or were struggling with their own psychiatric difficulties, this adversely impacted on the family’s ability attend to their children’s needs, settle or “do better” on a number of levels within the host country.

Another issue for the young kids is sometimes The cases, I mean the case that I’ve worked with, the one case, um, the young person, um presented with suicidal ideations, um, low mood, um and low mood, and in this case a lot of stemmed from her, her mum who was a mental health patient with chronic depression, severe depression, and she felt emotionally neglected, and the family also being so engaged in their activities of daily living, that she felt really isolated from her family. (Focus group B)

Family functioning. While poor family functioning was identified as having a negative impact on the young person's functioning, some service providers also identified it as a protective factor. For example, service providers talked about the structure and nurturing within the family unit as a mediating factor that supported or negated the acculturation process, which mitigated the possible effects of acculturative stress on the young person. For example, if the young person had previously existed within a household where parents used drugs and were physically or emotionally unavailable to them, it was discussed that these individuals would likely have a harder time adapting to the new environment. However, if the young person had been nurtured and raised within a structured environment, this acted as a protective factor to facilitate adjusting better to the new environment, irrespective of where they had come from.

The other thing is the quality of family life prior to settlement. I think that if a family has been a, kind of a reasonable family in whatever culture you've come from, but if your parents are drug addicted, drug dealing people who abandoned you at three and a half, you're going to have a much harder job settling in. So, families that have had a structure, and where the children have been well nurtured and looked after, it doesn't seem to matter where they're from, will do better. (Focus group C)

Service providers discussed their concerns surrounding parents being unable to provide emotional or physical support to the young person because some parents were thought to lack in ability to understand their children's needs.

The children don't get anything from the parent in terms of emotional support. That's not always true, but some kids just don't get any input from their parents whatsoever. They're kind of here but there's a lack of ability sometimes on the parent's part to actually understand that their kids have emotional needs and as well as like, and sometimes they're quite neglected, um physically as well as emotionally. So there can often be cases of quite severe neglect. They're here and so their parents think they've got them here, but the kids may not be warm enough, they're wandering about unsupervised. We saw a lot of that recently, unsupervised children. Children do dangerous things when the parents not caring. I think that's a profound issue sometimes.

(Focus group C)

According to service providers, when parents struggle with emotional or physical health difficulties, the young person is expected to assume the responsibilities of the parents within the household. The multiple stressors that refugee youths struggle with in caring for family members and changing roles in the new environment is a significant issue.

She's also taking on a maternal role herself in the household. Um, relationship issues with her siblings and the parents lack of understanding around that. (Focus group B)

Sometimes when you've got parents with quite significant mental health issues, the adolescent is actually the parental figure. Yeah, in the family. Not only in taking care of the young people but actually the one that's kinda got the future orientation. And that's quite a responsibility. (Focus group C)

Parents' lack of familiarity with the role. In some focus groups, discussion included that even when the parent's functioning has not been compromised by their own traumatic background and/or struggle with English acquisition, some may struggle to parent because parenting may not have been their role in their country of origin but the role of other family/village/community members.

Gosh I think even some of those, some of those Afghanis, this woman comes from a village in the middle of a valley and you know she never had to watch her children, you know, all of that. Whereas if you've lived in the city you watch your children. (Focus group C)

Poor parent mental health. Parents with emotional, psychological, cognitive or physical disabilities present particular threats to young peoples' adjustment. Included within New Zealand's refugee quota of 750 per year is a specific category that accepts highly vulnerable people, for example, individuals who are "themselves quite disabled" (Focus group C), at times to a very significant level. Some service providers speculated that these individuals with physical disability were likely to be better supported by people within their original community.

Here, in parents, we see parents make, do, bad behaviour, like, give me a gun, I kill myself now, stuff, you know all of that drama. Things, children aren't

necessarily protected from that extreme emotion that families are experiencing. There's a family, [X] and I have been working on a family where mum will get up in the middle of the night and go outside and make complaining noises, and all this, and the kids all have to get up and stand with her. (Focus group C)

Also major health issues in families can affect the children's wellbeing. By either if mum's either HIV positive, raped or whatever. And say there's a single mother, you know the future for the children is quite uncertain, in the respect that chronic health issues that some people come with. We take quite a few medical cases in, and they have chronic health issues that need sorting out. It's a bit like the disability thing, but that can impact on future settlement I think. (Focus group C)

Service providers discussed that if parents who are emotionally unavailable or disengaged affected the young person's behaviour and ability to plan ahead. Participants felt that one of the consequences for refugee adolescents of not having a parent who was emotionally available to them was to feel emotionally neglected.

The reasons for neglect, sometimes, they haven't needed to. They've come from communities where you don't, everybody, sort of, you know, safe village where kids can roam about, but I still think some children are really quite neglected. (Focus group C)

So, all the stresses around that, and one of the major things was how mum was not being emotionally available for her because she was mentally ill herself and being um hospitalised, so she really felt emotionally neglected in that sense. (Focus group B)

Parents' expectations for the young person. With resettling into New Zealand, the service providers noted that parents often held many expectations for the young person across various domains in their life, such as their academic performance, and role within the family unit. For example, older adolescents within the family were expected to take on a greater caring role for these individuals with disability because of lack of support in New Zealand.

So, in their community, probably those disabled people were supported more by the people around them. But as soon as they arrive here, the expectation of

older adolescents is to provide more of a care. (Focus group C)

So a lot of, you know, a lot of children, young or older children being caregivers. In some societies, like you know, like some of the Arab societies, yes, it's normal for six years old to carry one-year-old around. That's not what I'm talking about, but they all love doing it and that's fun. But I'm talking about the burden of caring for people with disabilities. (Focus group C)

A few participants also raised their concerns that the caregiving roles expected of some adolescents were excessive and may become a possible abuse of power and position within the family. They noted that the young people were required to engage in a vulnerable caregiving position, although the family member with disability was able to manage the task independently. Participants felt that some adults were not concerned enough about the welfare of the young people.

Caregivers, a lot of caregivers, adolescent caregivers. Like washing. We, we had to do changing adult nappies basically, and all sorts of caregiving roles. A couple of young girls in a family recently were having to shower a man, a disabled uncle, who in fact was perfectly capable of showering himself. But it had fallen upon these girls. They, he was even, they found him sleeping in the same room as them because he needed looking after, and the other adult males couldn't be bothered. (Focus group C)

Service providers discussed that an extension of the caregiving role for the adolescent included the burden of responsibility to find a job and financially support the family. Participants felt that this limited the young person's choices if he/she wanted to pursue education or other goals.

But even those without disabled parents, often it's about the onus is on them to go out and get jobs instead of going on, going on with tertiary education. So the parents and families are expecting them to go out and earn some money rather than to be able to continue expecting them to continue their education. Not with all cultures, but with quite a few cultures which is a sad problem. The teenagers get really upset by that because say, they feel that they have no choice because of the cultural demands, but their whole future is

kind off on hold, long term. (Focus group C)

Service providers discussed parental expectations of youths to marry young, for example, “in some communities is the pressure to marry very young, especially for girls” (Focus group C). They further identified that these expectations were more likely to occur in Muslim communities and occasionally the Burmese community.

Young girls. Yes, the young girls are expecting to be married. Probably the more, from the Muslim communities, but occasionally the Burmese community as well. I think Burmese, not so much the Bhutanese, they seem to be, have higher education stuff, but the young Muslim girls from cultures where they haven’t, they haven’t got that history of education. So much in this current, sort of generation. (Focus group C)

Service providers felt that this expectation occurred with girls particularly when they approached the age to have boyfriends and sexual relationships because in some cultures premarital relationships are forbidden. To prevent the young person from being “corrupted”, they are encouraged to marry young.

And also to avoid them from having boyfriends. If you’re getting to that age, from having any kind of sexual relationship before marriage, which is quite forbidden within the culture as well as the religion. (Focus group C)

Service providers’ discussion on their understanding of the young person’s difficulties also highlighted the impact of parents’ excessive and unrealistic expectations, where “the benchmark is too high, which it often is” (Focus group D) on the young person.

And the cultural thing is a big factor but it can also come to play in parental expectations of their children generally. In many cultures in New Zealand in many ways but particularly Pacifica and Māori. But also as a general thing among young people, their ideas of what they can do at a certain age and what their parents’ views are, are different. Those things are the same sorts of things in a lot of ways, they’re sort of magnified a little bit in terms of the cultural expectations and the schools don’t necessarily understand it. (Focus group D)

Service providers believed that family expectations extended to the young person achieving

high grades at school in some cultural groups. The expectation however places a great amount of pressure on the young person, particularly when they have limited ability and knowledge to achieve within the schooling environment.

Sometimes, parents want the kids to get, obtain a high level of education, but kids they don't have the ability or they don't have enough knowledge that also puts the young kids under enormous amount of pressure. (Focus group D)

However, other service providers were cognisant that many refugee parents may set the standards too high for the young person to achieve on an academic, career or personal level. This affected the parental interaction with the young person, and vice versa, which in turn affected the quality of their relationship.

Like music is, like back in Afghanistan music is belong to a particular group of people, even they have their own small town, all of the musicians are there so they grew up there so their grandfather, themselves, their children for generations, those people have their special names and other people they don't want to, apart from just hire their music, or buy their cassettes or CD's they don't want to have any kind of involvement with them, even it terms of dealing or asking for their daughters or son's hand or something these things are never take place. Those people are a group of quite, they have their own community. So somebody else from a respectful or from a decent family to go in for singing or something like that it's very odd. Very, very odd and they just can't accept this aspect. (Focus group D)

The young person will however not always follow the expectations of the family, in spite of a strong cultural assumption that the expectations will be followed. As a result of having different desires and expectations for their lives, service providers noted that youth from refugee backgrounds' behaviours contributed to increased conflict between them and their parents.

There was also, um, some cultural conflict around her need to pursue her education from her family's perspective and her need to engage in artistic pursuits, so like the music that she was involved in. There was a clash you know between her family's expectation and her expectation around this area.

(Focus group B)

Family's and adolescent's attitudes about mental health services impacts access.

Service providers discussed that family's attitude about mental health and mental health services affected the young person's mental health problems. Furthermore, it affected access for the young person, including the type of intervention implemented. Service providers commented that what they considered would be most useful in regards to the therapeutic approach for the young person were not always accepted by family members.

She would have preferred some medication, we thought maybe a bit of both would be useful. So um, we um, we ah, suggested medication, but the family was resistant to it. (Focus group B)

Service providers also noted that initial lack of participation with agencies increased the risk that agencies would cease following up the case, meaning that the young person fails to receive the input they require.

I can think of a young girl who was referred to a CAMH [Child and Adolescent Mental Health] service from here and because her father steadfastly refused to take her to appointments and he was a bit obsessive about her anyway, in a rather icky way... I'm not saying there was anything sexual but it wasn't good. It was very poor and the CAMH service just gave up on it. Whereas I thought it was a child protection issue actually. (Focus group C)

Some service providers thought family behaviours were influenced by their negative perceptions and stigma surrounding access and utilisation of mental health services. Lack of collaboration and parental consent resulted in lack of input from services, despite services recognising that even short-term intervention would have been beneficial to the young person.

And in terms of the matter, there are so many families down there in terms of the community link workers and facilitators talk about who ah, they've got large, major problems, you know the whole lot of them. But there are cultural inhibitions in terms of seeking help. You know, the embarrassment, loss of face. (Focus group C)

It is for young people, most of the time if they need just a short intervention, most of the time parents are not willing to follow up with their referrals. In the past we have some referrals from the school counsellor for problems with some of these young refugee children but the family refuse to collaborate with us in working with these young kids. Because we need parental consent to work with them as they are young and without that we can't do it. So parents are not quite happy as you know there is a stigma involved around being involved with mental health so they don't want their children involved. (Focus group D)

Other service providers also thought that family prioritisation of mental health issues was less than that of education. Therefore, even if the young person struggled with psychological, emotional or behavioural difficulties, this would not warrant any intervention from an agency as it was not related to the young person's education.

Most of the time their focus is on their education so they don't think that being involved with mental health is a priority, even if children suffer from lack of sleep or some nightmares, bad dreams. They just need to study, and putting a lot of pressure on children to succeed but they don't think about these things. (Focus group D)

In addition to family concerns surrounding the stigma attached to accessing mental health services, service providers noted that the young person's fear of bringing shame and embarrassment to their family limited the form of intervention that could take place, for example, being able to engage with, and work with the wider system.

Um, and he also talked about like the embarrassment to him, the embarrassment and shame that would come to his family and to him if they knew he was in a mental health service as well, so he was very much against the family even knowing. Um, so it was very much individual work, but working with the wider system would have been really helpful too. (Focus group B)

Although most service providers discussed work with the wider family unit or system as helpful or, in some cases, critical, they were mindful of the culturally-specific implications of working with the whole family unit. The advantages of engaging the whole family, such as

the opportunity to support and facilitate the sharing of unexpressed emotions or difficulties were tempered by the problem of possibly “losing face”.

And sometimes they think of you as mother figure, or an older sister kind of figure. They come for a quick fix, if they have a quick issue like they’ve had in the past and they went to a wife or old lady or somebody in the community. They just come for one off and when you go back the next week and want them to come, they’re surprised and they think everything they have told you and there’s nothing else to talk about. (Focus group C)

Service providers suggested that family perceptions of mental health services are influenced by their experiences of how individuals with mental health issues are treated in their country of origin. Those fears continue to persist and influences behaviours in the new setting, and influence behaviours in the new environment.

The older siblings and the parents and I think the family just felt, cause this girl had been quite psychotic, such relief at the treatment here, because if it had happened in Vietnam, she would have gotten left, kind of on the side, there would be no treatment for her in Vietnam. They were initially ashamed and embarrassed, but they actually engaged quite well. (Focus group B)

In summary, in their work with adolescents from refugee backgrounds, service providers have noted that young people from refugee backgrounds have a range of problems, in which there are sometimes differences in gender presentation. In relation to beliefs about factors that contribute to youth mental health difficulties, discussions with service providers highlighted that trauma and the refugee experience continue to impact the young person and their family. In resettling into New Zealand, the clash of cultures contributed to youths from refugee backgrounds’ distress and challenges, and their self identity is further affected. Furthermore, missing relationships, the lack of meaningful activities and ongoing struggles with poverty were found to contribute to the young person’s distress. The themes identified also highlighted that the different rates of adaptation between generations and the family’s health and functioning, including parental expectations, also affected the young person’s mental health and functioning. Finally, family and adolescent attitudes about mental health services influenced their access to these

services, which can exacerbate the young person's challenges in the post-migratory context.

Service Provision: Types of Therapy

Service providers were asked to discuss the forms of interventions or treatment they used with the young person and their family. Under this primary area of interest, five themes were identified. These included: "wide range of models and therapy intervention", "family therapy", "education and skill development", "working with agencies", and "challenges with diagnosis".

Wide range of models and therapy interventions. In all the focus groups discussion included using a diverse range of interventions, based on many types of models, with the young person and their families. In some focus groups, it was acknowledged that the young person "just want you to listen, from the time they come, talk, and then they just move on.... what they're after is that we listen to them really carefully. We don't judge them, it's all the basic stuff, we should respect, be friendly and hospitable" (Focus Group C). In contrast other providers reported that their input was longer, and occurred at not just the individual level, but also at the family and systemic level.

An ecological model, a psychosocial model...with the family complex, the extended family and the community and school and all the supports around what the government provide...around supporting young people, around supporting refugee people. (Focus group D)

In addition to supporting families to develop insight about their challenges, "the first thing we do is, well what we're trying to do here is to mitigate whatever distress they have. And that sort of counts foremost in some ways" (Focus group C).

As part of supporting the young person and his/her family to develop insight, some service providers discussed the importance of normalising the young person's experience.

Just help them focus on things that will, that are achievable in the short term which will enhance their sense of competency in the new culture and the new community. (Focus group C).

Then explain, explain to them what it actually is that they're feeling. You

know what happens to every, normalise it and explain it a bit more. (Focus group C)

Service providers believed normalisation was an important part of their role because “if they feel stuck, and still stuck at that developmental level where they’re at a two or three years old, and see no way where they can graduate themselves up, in terms of competency, they just lose hope and their self esteem gets destroyed” (Focus group C).

Other service providers identified their role as building bridges to connect the young person with supportive resources in the community because, for many people from refugee backgrounds, seeing a tertiary mental health service carried with it “the environment of embarrassment” particularly as “there’s some culture like Middle Eastern and Iraqi cultures that the adults themselves often comes with huge, you know trauma issues” but they struggle to share “because of loss of face” (Focus group C).

Most focus groups members reported that “communication and trying to understand where they are, which country they’re from” (Focus Group D) was a core component of their work. Furthermore, service providers noted the importance of keeping the family informed at each stage of engagement and to utilising interpreting services when required to assist with communication with family members. Participants reported that they completed “psychological assessment and intervention” (Focus Group A), including “psychoeducation” (Focus Group D).

Examples of intervention included the use of “testimonial therapy” (Focus group A), graded exposure therapy where the client undertakes “exposure to a graded hierarchy” (Focus Group B) or family therapy. Testimonial therapy is an individual psychotherapy for survivors of torture and other types of organised violence that involves the narration of survivors’ traumatic experience. The stories are recorded, jointly edited by the therapist and the survivor, and compiled into a document. Exposure to a graded hierarchy is a form of therapy in which the individual is exposed gradually from the least anxiety-provoking stimuli to the most anxiety-provoking stimuli. Exposure involves remaining in the situation long enough for the anxiety to subside. Non-talking therapies were also mentioned, such as sand play, dance therapy and expressive art. In one focus group it was described how these non-talking therapies enabled youths to communicate their experiences and challenges using a different (non-talking) medium.

Sand tray work, people with adolescent years are quite excited too, I've borrowed the sand box occasionally when I've been working with teenagers and um, sand tray work is really useful. Quite, because it's non verbal until they explain it, so they can work on it and express and show like before and after. Before everything went wrong what was the, what was going on before it was wrong. It's kind of a, that can sort of be like, it's assessment, but also therapeutic as well. (Focus group C)

Because young people were perceived as gaining excitement and participation in the non-talking therapies, it was identified that it potentially helped them to "open up". This means that they may be more open to participating in a talking therapy later on.

Another thing that's really important for the adolescents is the expressive art opportunities that they have. Because they have a huge amount of fun opening up, so it's not a long-term talking kind of therapy but they, they, you see them open up and they have just enjoyment. And it's the first time they seem to really relate as a group and have enormous fun together. Really enjoy it. (Focus group C)

Family therapy. Most focus groups acknowledged that understanding the young person within his/her system was critical to their work. Through family therapy sessions, service providers described that it gave the young person and their family "the opportunity to talk, to express their feelings ... so just facilitate the session, and let them, one at a time to speak or express their feelings" (Focus group C). Many discussed conducting family therapy with the young person and their family because "family therapy has been found to work really well, especially using reframing with them" (Focus group A). Family therapy sessions provided an opportunity to advocate for the young person, which was identified as having positive outcomes.

She felt that we were advocating for her and I think that helped to shift her mood. Also advocated for her regarding acculturation issues, her needs to meet her own desires in terms of music and those sorts of things. Also expressing to her the need for accountability to the family in terms of concerns about her safety and arriving home late at night. So, it helped to shift her family, that helped to shift her mood as well. So she's no longer

suicidal, she's in a much happier state than what she used to be. (Focus group B)

In one focus group, members went so far as to argue that not including the family could be considered malpractice when working with a young person.

I would very rarely treat a child on their own for very long without family work happening at the same time. I just think it's malpractice to um not include the family in treatment. (Focus group C)

Furthermore, it was felt that working with the family supported the family to establish their life within New Zealand society.

Most of the times if you can help or work with parents and it makes it much easier for them to set up quite nicely in New Zealand society. (Focus group D)

In their work with family, a focus group discussed using a "genogram with the family" as "it helps to give an idea of what's missing in their life, but also point out possible available support resources" (Focus group A).

I do a fair bit of family therapy work. For the families that come here with just mother and children, sometimes the male children don't listen to the mother, so that causes lots of arguments. (Focus group A)

One focus group felt that while there were many positives to working with the young person and his/her family, they were concerned that major issues of concern would not be raised in the family setting, particularly if there was a risk of loss of face with sensitive issues such as violence and abuse.

But then of course if there is a major loss of face issue, they're not going to be raised. I mean the more minor issues are going to be raised but you know issues of violence and abuse and stuff are not going to get raised in that session. (Focus group C)

As identified further down, service providers discussed that work with adolescents from refugee backgrounds took time. If time was available to build a trusting relationship with the young person, other service providers felt that this would enable helpful work to occur in a family context as the individual would be more willing to share and discuss major issues.

But then there is trust. I've been to those meetings. If they trust you and you work with them for a long time, then slowly slowly they will open up, there will be an opportunity. (Focus group C)

Education and skills development. A core focus of most service providers' input with refugee adolescents appeared to involve education and skills training, such as "stress management and if possible squeeze a lot of the help in around problem solving" (Focus Group C). Skills development further involved teaching parenting skills.

You can do a lot of goal, sort of setting. You can do quite a bit of information, you can encourage parents to be more a parent to the kids, to help them out. (Focus group C)

Education was thought to support greater understanding and awareness of the challenges for both the young person and his/her family members. Furthermore, it helped family members to modify their interactions with the person who was not coping.

Asking her, um, asking her about how she would like to or want to address and then we brought in her sister into the situation and did some psychoeducation around depression and self harm stuff and the suicidal thinking which her family was not aware of. (Focus group B)

Did some psychoeducation around where she was at in terms of her mental health status and so on. And that shifted the family a little bit in terms of how they related to her. (Focus group B)

Most focus group accounts suggested that skills development enables the resourcing of individuals who "at the end of the day have to learn their own strategies around problem solving and conflict resolution to find out where they are in themselves" (Focus group D), and enables them to learn that they can resolve or manage the issues in their life. It was discussed that while it is helpful to work with the systems around the young person, the young person also needs to be resourced. The work with the refugee young person is thus "a multi-element thing" (Focus group D).

Working with agencies. Working with the system occurred at both a micro and macro level to the young person. At the macro level, work involved case coordinating, liaising with other agencies and advocacy for the young person and their family. Members of some focus

groups discussed case coordination as a significant part of their job. As part of case coordination, liaising with other agencies was seen as another important part of the role, for example, “make sure this service enjoys good relationships with other services, and therefore you get traction when you want to persuade other people into doing this” (Focus group C). This was in order to increase knowledge and awareness within other agencies about key issues when working with refugee adolescents from a particularly region, cultural or ethnic background. Thus when other services were required to work with the young person, the response would be more ideal in terms of what was needed. Furthermore, without case coordination, it was argued that “if you don’t get that, you might as well kiss it goodbye really” (Focus group C), which implies that the work and input identified for the client will not be available to them.

But we can go and will go to the schools and talk with them about refugee needs and in general and not honing in on anyone in particular and so we can encourage the schools to understand the groups within the school not just the ESOL[English is a second language] teacher. More than that and in an on-going way so they have access. There is support in some senses through the refugee education coordination centre but it’s limited. We can tap into that service for funding but we need to be Okay with the funding that’s available from the ministry, so that the schools can access it. But our role is that we can go into the schools, and we will. (Focus group D)

Community advocacy was also described as another big part of their job. The accounts indicated that “if you don’t do advocacy, they will never come back, so on many occasion, I’ve put them in my car and take them to Unitec or AUT [Auckland University of Technology], introduce them to the student advisor, help them to fill their forms, and once that’s been done, they just quickly move on. And I think it’s quite useful” (Focus Group C). The advocacy role could be seen as sometimes an extension of the “phone card cure” (as discussed later), a pragmatic and quick solution to the identified needs of the young person.

Challenges with diagnosis. Many service providers discussed a reluctance to diagnose or use diagnostic terms with refugee clients, but felt pressured to do so by the organisation or the Government. Participants discussed that some service providers still worked within organisations that are driven by a “medical” model, which thus impacts their practice. One

focus group argued that the medical model of assessing and treating was not solely relegated to the organisation level, but that it came from the Government. As such, some participants were mindful of the need to modify their practice with consideration of the potential impact or usefulness of the diagnosis for the young person and his/her family.

Often you have one or two hours to do the assessment, with the service asking you quickly afterwards, what's the diagnosis? Even if you're reluctant to do diagnosis, you're forced to because you work in an organisation that requires it. Or we still work in an organisation that operates from a medical model. (Focus group B)

It's not just the organisation is it, but it's the whole system, it's the whole Ministry of Health that requires it. (Focus group B)

Participants noted that they managed the tension between using a diagnosis or not through omitting it from their discourse with the client. However, within the restraints of their responsibilities as an employee, they continued to use the diagnosis, such as when they classified the client's difficulties into the organisation's system. They further used the diagnosis within letters or communication to other professionals (e.g., the general practitioner), despite never having discussed the particular "label" with the client.

But that doesn't mean that you have to work with clients with diagnosis. Like with the guy I was working with PTSD. I talked about in terms of what were his symptoms and behaviours and so we were working to help with the stress that was caused by those and avoided using the PTSD label, even though, diagnostically, I put it into our system and wrote to his GP with that, but I didn't use it with him. (Focus group B)

Service providers further discussed using the "provisional diagnosis" or "not otherwise specified" (Focus group B) as a method of managing the dilemma to diagnose a client or not.

I have come across that experience when I was working with the Asian community. Ah, I tried to avoid classification, mental illness classification. I found out that families really like when I used the term emotional difficulties. They seemed to prefer that, I really avoided to put DSM-IV when I was working with the Asian community. They seemed to like it. Other colleagues of mine used to go with traditional diagnoses and this was met with resistance

from families. Some of them still wanted to apply the traditional. I was always trying to find a compromise between that and the Western case. I was not successful with the majority of cases, but there were some cases where it worked. (Focus group B)

Service Provision: Process Issues

Under “service provision”, participants were further asked to discuss issues and challenges in relation to working with refugee adolescents. Five themes were identified under this primary area of interest. These included “language difficulties and the use of interpreters”, “cultural understanding”, “pacing the work”, “flexibility in approach” and “resilience”.

Language difficulties and use of interpreters. With English as a first language for many service providers, and English being a second language with the majority of refugee youths and/or their families, language was a significant barrier in both assessment and treatment of refugee youths.

For the majority of the staff, English is our first language. We can’t, most of the time do assessment and treatment in the first language. There’s a barrier, if we could, we would, and then we would have to go through an interpreter. (Focus group B)

Language difficulties made it difficult to gain even the most basic of information from the client, but also to provide information to the client.

It was a very difficult procedure to interview a family without an interpreter. Sometimes we’re lucky and one of the refugees or asylum seeker would speak English, so he would translate for his group. Because these people come in group, they have a couple of people who can speak the language or some other language. So if we are lucky, we can use, but most of the time, it was very difficult process to get the basic information. (Focus group B)

Many service providers were mindful that language and its meaning varied across cultures. Thus, careful considerations were required in terms of how to ask and frame questions, and to simplify terms into basic elements in order to increase understanding and comprehension with

refugee youths.

When I see somebody from Africa, I realised that I would probably need to ask in very basic ways. For example, somebody might ask, how do you do business in your family? You know, who's the boss in your family? But a refugee coming from that country whatever, may not interpret it as you being the boss but they just know that it's a patriarchal system, and that you know, dad's kind of like the household you know whatever. But the concept of boss may not be understood by them, you know. So, how do you go about that, how do you have sensitivity in asking that sort of question. (Focus group B)

Language difficulties further influenced the ability of service providers to provide the culturally-sensitive approach they desired with their clients. Using an interpreter limited the "delicate" management of the issue with the client. Secondly, there were no guarantees that the interpreter would be able to explain what was being discussed, or to explain it with the sensitivity and consideration required.

I've experienced working with refugee adolescents with psychotic backgrounds, and it has been challenging to explain from hallucinations to delusions. For some culture, to hear voices and to see things is such a normal part of their thinking and their ways, and it's trying to explain that when it's possibly going to cause harm to themselves to other individuals, that's when you might have to do something. But if it doesn't impact them, and they continue to sit beside those things well, then it doesn't become as much of a concern. But it's trying to explain that delicately, and culturally appropriately to the family has been an issue, and then having to use interpreters, and being unsure if the interpreter is able to explain. (Focus Group B)

Service providers also discussed language difficulties impacting on the most basic things in therapy, for example, understanding of appointment letters and difficulty getting "literal translations".

I guess it's not just phone messages, but written materials they would struggle to understand, for example, appointment letters. (Focus group B)

Because of language difficulties, interpreters were often required. However, many community places, including schools and primary health organisations lacked funding or

budget for interpreters. More specialised mental health services, such as CAMHS, were considered to have funding for interpreters. As a result of language difficulties, or having to use interpreters, the sessions or work with youths from refugee backgrounds would also take longer. Although this reality was recognised by many service providers, there was also the added frustration that the funding provided for services to youths from refugee backgrounds was based on the assumption that language difficulties would not increase the length of time required to implement service.

What, well they're still seen as being literate aren't they. I think for example a session takes twice as long anyway. (Focus group C)

Because everything's being done through the interpreter but somehow, the funders don't quite understand that somehow. Six sessions for a European or an English speaking person should automatically be 12 sessions. (Focus group C)

Work with adolescents from refugee backgrounds takes time when interpreters are required because of language difficulties. It further takes time to coordinate and liaise with different agencies and to fully understand and appreciate the young person's difficulty at a contextual and relational level.

This was the first time that the client had the opportunity to listen to hear from her kids and then we slowly, slowly started working on those issues with some positive parenting, working on the depression. (Focus group D)

Some service providers felt they were unable to perform their role and provide health or counselling services to the capacity they hoped to because of being unable to communicate clearly with their clients. Lack of access to trained interpreters meant that some professionals had to rely on untrained individuals from members of the same community as their client, or on the client's family members to interpret on their behalf.

One of the GPs, she is very close to the office. She just basically asked one of the customers to come and do the interpreting, and client rejected. And I told her, it's against the law. (Focus group C)

Using members of the community or family as interpreters challenges ethical standards, and also limits confidentiality. When a general practitioner used a community member to

interpret members in one focus group felt such actions warranted complaint to the Medical Council.

You can't do that, everything is quite confidential here. (Focus group C)

This is the doctor doing it? Outrageous, a complaint to the Medical Council that one. (Focus group C)

While a number of issues were identified in regards to using family members as interpreters, service providers also noted that family members were preferred to interpreters from the same community. Furthermore, using family members as interpreters appeared to place less “strain” on the session and the session flowed better. However, in other focus groups, it was reported that sometimes when family members were used as interpreters, not all of the information would be interpreted.

I was going to say too, the other issue with working with interpreters with other cultures is often not wanting to have an interpreter, because it's often from the same culture and families often wanting one of their younger family members who knows both languages to do the interpreting, which of cause doesn't work. That's often quite a big issue too. (Focus group B)

Participants sometimes experienced difficulties with involving the family in the care of the young person. They felt that using an interpreter made it increasingly difficult to gain the family's story and to build a relationship with the family.

I think, certainly, the difficulty in engaging families. Um, it's okay in developing some level of rapport with the young person was okay. But it was getting the parents involved, and understanding. In my case I had to use an interpreter, and that makes the whole thing difficult...to um, to get the whole story and to develop a relationship. (Focus group B)

Where interpreters were available, their skills and expertise in interpreting were important to many service providers because “when you get a good one, you remember the name and you get that person again” (Focus group B). Despite the most skilled interpreter, one focus group discussed concerns about accuracy in translation.

Currently there's no control over which interpreters we get. Some interpreters are really good, while I have doubts about the skills of other interpreters.

(Focus group A)

You're never quite sure what's been translated. It's a tricky issue. (Focus group A)

Another challenge related to using an interpreter was having to counsel the interpreter who became traumatised by the contents of the client's discussions.

There's also the ongoing issue of interpreters re-experiencing some of the trauma during the session, and how much support they get is at the discretion of each clinician. (Focus group A)

Cultural understandings affected service provision. Most service providers discussed the importance of being mindful of the young person's cultural background. They were cognisant that the cultural background impacted the young person's experiences and their presenting issues, including their understanding of the problems.

Part of considering the young person's cultural background is also considering their cultural backgrounds and how this impacts the experience, presentation and understanding of their problems. (Focus group A)

Service providers also made efforts to modify their practice to include the principles, ideas and values of the young person's culture.

For example, when I was using CBT [cognitive behaviour therapy], I would try to let's say, to fit the concepts into the specific traditions of the people. To give an example, negative thoughts for someone who comes from central Africa, negative thoughts would be, let's say described as a voice from an evil spirit. If I was trying to work with the negative thoughts, I would make it like an evil spirit was talking to him. It's the same process, I would use with other culture.

Interviewer : So with the evil spirit, is that an example you would bring in, or would you ask them to provide an example?

Both ways, I could get it myself, or I would ask them to give an example about how the spirit sometimes talk because it some sense, in African, and South African communities, now they still have the Shama, you know the

holy man, so for me the fear would be the presence of one of the bad spirits. But that was done when it was really needed and when it was effective. Most people were really, for most people it was important to deal with the immediate situation. (Focus group B)

Although there was the recognition of the role that culture could play, one participant queried whether service providers with very different cultural backgrounds from that of the refugee young person would have an understanding of the cultural context, including the impact of the refugee experience, or what it might mean to be a refugee.

You know, sometimes, the reality, I think the majority of therapists within those team are Pakeha and you know, do they understand the cultural context from within which these families come from? Um, the kind of struggle, the kind of pain they've had to endure as refugees, you know. The struggles they've encountered in their own country, you know. (Focus group B)

Other participants also raised the point that this consideration should be applied to all young people who accessed their service, that is, cultural background was relevant across all ethnicities and background, not only to refugees.

Considering the young persons' cultural background should be a priority, not only with refugees, but with all the young persons we see. (Focus group A)

Despite the awareness of the impact of culture, two of the focus groups raised concerns that models of practice, analysis and intervention was still significantly informed from a Western perspective.

And some of the models that can be applied there within the sessions can be so structured, their analysis and their thinking in terms of Western perspective, in terms of technique and all that kind of thing. (Focus group B)

Therefore, there was a lack of consideration to providing cultural support workers to support families engaging with the service, and to support professionals working with the young people. This was thought to possibly contribute to low treatment efficacy with youths from refugee backgrounds.

At our workplace, there's no cultural support worker or the equivalent of a Maori or Pacific elder to help provide cultural consultation and support for

our work with refugee families. I feel like I'm working in the dark sometime, and I wonder why treatment efficacy has been so poor with the work I have done with refugee youth to date. (Focus group A)

Other service providers negotiated the lack of cultural support workers through encouraging the family to bring in a support person from their community. They reported finding it helpful to perform rituals from within the community in the session or changing a non-mainstream technique to fit with that of the mainstream culture as opposed to the other way round.

If I had someone from an African background, I would have someone from Africa with me. We would start the session by a prayer for the ancestors. It's something they do here in New Zealand as well with Maori and Pacific Island people. So this was something I had used. Usually I found it really helpful to bring a member of the community, to have a ceremony. Or if possible, I would try to modify an Eastern technique to fit the Western culture. (Focus group B)

While benefits to having support workers were identified some service providers also perceived this as a barrier to encouraging youths from refugee backgrounds to share their experience.

In one instance, while the parents may have found the support person from refugee services helpful, I felt that the young person may have hesitated to share her story about what was contributing to her poor school work at school, and I wonder what's the impact of sharing the story with not one, but two other persons whom you don't know very well. (Focus group A)

Pace, slow, go with the flow. As part of developing rapport and engagement with refugee adolescents, service providers discussed the necessity of being flexible with the approach and slowing the process of engagement and assessment down, including keeping an open mind and 'ear' to what is being shared when working with refugee adolescents. Critically, the discussions reflected a cautiousness to be respectful to the client's presenting issues, while trying to minimise any additional trauma or harm, such as unintended experience of shame.

Yeah, go with the flow. I agree with that [X]. (Focus group C)

So with a lot of them, you have to have very open ear. (Focus group C)

As part of the experience of working with adolescents from refugee backgrounds, participants repeatedly discussed “going with the flow” and taking a “long” time to get to know the young person and his/her story. Part of “going with the flow” also included openness and willingness to change the course of inquiry, as well as discussing what was salient and meaningful to the young person.

It’s really quite difficult to be directive with interviews, so you really have to listen, and ah, be prepared to slowly shift the oil onto a new course. (Focus group C)

Where formal assessments were required, service providers discussed what modifications were made to the process and content. For example, an assessment tool might be used in a “conversational” manner rather than systematically followed as instructed by the guidelines for using the instrument. Again, there was recognition of the deviation from the standard method/guidelines when using a particular tool or instrument.

In a conversational way as it were. You know obviously not as a checklist going through it. (Focus group C)

Many service providers discussed the importance of pacing the assessment and allowing for flexibility in the discussions. The reason given was the importance of establishing credibility as a professional and as a person. Furthermore, there was consideration of the impact of shame on the young person or their family if the issues were approached in a directive manner in the first instance. Discussing a “sensitive” topic before a therapeutic relationship and credibility could be established may jeopardise the building of the credibility, including the ability of the service provider to help. In other words, an “incredibly careful and cautious” approach was taken.

Yeah, just go with the presenting issues and show that you can actually help them, and then once you’ve got some credibility, once you’ve got, yeah once they see you can be helpful there. I mean, you have to go really slowly with that stuff and if you’re suspecting family issues which are often there, usually session three or four that you scoot around that stuff and all of that kind of not wanting to shame the family, that’s a huge issue to try and get to the bottom of what’s going on with the family. And often I just do the thing of,

you know some other teenagers I've worked with from your culture, these are the sort of things that they've talked about. You know, there's this one that's a little bit relevant to you, but just being incredibly careful and cautious with that. (Focus group C)

Experience of working with adolescents from refugee backgrounds did not appear to be solely relegated to assessment or treatment, but also to the experience and ability to develop rapport with the service users. Despite the best efforts to develop engagement, this did not guarantee that the young person would engage or choose to discuss their challenges. The unwanted attention could then result in a possible deportation, as may have been experienced throughout their refugee journey. The young person may thus not engage as a mechanism of protection or pressure from the family.

And they don't want to talk about it because they are under pressure from these people, from their mother/father figures if you talk, and you put us in trouble then you will be in trouble and they will send you back. All of these things can play in their minds. (Focus group D)

There needs to be exposure for the clinicians in terms of education on how to engage refugee families. (Focus group A)

Importance of engagement. A subtheme of “cultural understanding affects service provision” was the “importance of engagement”. All focus groups highlighted that engagement was critical for any work to occur. That is, for meaningful and helpful assessments and intervention to occur, the service providers discussed the importance of developing good rapport, connection and engagement with refugee adolescents and or their families.

Whereas, sometimes, it's, it's just about the connection, the empathy, the relationship, the connection, and questions may not necessarily have been answered in any particular models, style or whatever. And it may be a natural flow, you know and therapist relationship you know, that can make a difference, in actually the therapeutic shift. Um, so family therapy clinic may not necessarily be the answer to working with refugee families. (Focus group B)

Whereas in the refugee case, that community is not so strong, so the actual relationship they have with their clinicians and the mental health centre must be that much more important in so the ways of continuity. (Focus group C)

Friendliness and a relaxed attitude and behaviour, including a recognition of interests that might help to bridge the cultural, professional, gender, social, political and historical distance between the service provider and refugee adolescents, were identified as factors that facilitated a positive engagement. Furthermore, in the development of rapport, a mindfulness to pace the seriousness of discussion issues with more light-hearted topics was also noted.

Just being friendly and relaxed and informal too is very important. Talking to the guys, you know just talking about their favourite soccer players and musicians and that kind of stuff. Just a lot, kind of, you know talk about the serious stuff for a little bit then, but then back off and talk about some fun stuff, then serious. It's just kind of, in and out, gently, in and out without charging through a checklist. (Focus group C)

Although there was likely to be cultural and age differences between the service providers and adolescents from refugee backgrounds, an understanding of youth culture appeared to also be important to developing a therapeutic alliance. Thus, being able to discuss interests that may be more salient to "youth culture" appeared to aid the development of the therapeutic engagement.

With the girls, you know they all like toe nail painting, finger nails, you know it's amazing you can fashion stuff, you know girlfriends left behind. (Focus group C)

Many service providers appeared to be very conscious failure to take the time and effort to engage the young person or their family would limit their interaction with the young person, including the assistance they might be able to provide. To facilitate the role and service they were able to provide to refugee adolescents, several service providers also discussed clarifying the referral, including any particular refugee issues they had to be aware of when working with the case.

Can't do much if we can't engage the family. Engagement is the key thing. Before seeing the family, I had had a long discussion with the referrer about the referral and any refugee issues I had to be mindful of. (Focus group A)

Flexibility/fluidity in approach. The theme of fluidity in roles encapsulates both fluidity that service providers had to adapt to in regards to their professional roles, and also in the way they worked with young people from a different cultural group. In particular, this involved making efforts to ensure the work is culturally relevant and specific to the young person and their family.

But how you undergo that family work is absolutely essential. It's so cultural specific too. (Focus group C)

In terms of being flexible with professional roles, some service providers recognised they had to “adapt yourself to fit” (Focus group C). However, other service providers appeared to struggle with the adaptation as they ended up having to do something that they felt related more to the scope of other professions.

Even though I'm a psychologist, I also end up doing a fair bit of social work like role with the family. For example, assisting them with their WINZ [Work and Income New Zealand] benefit. (Focus group A)

I found that I was doing more of a social work role. With getting into schools, I made phone calls to different schools and enrolment policies. (Focus group A)

In terms of being fluid in the manner they worked with refugee adolescents, service providers felt that “the jargons used in assessment or treatment don't always help. For example CBT, diagnostic terms, schizophrenia, asperger” (Focus group A) contributed to families disengaging. Thus they were mindful of modifying or simplifying the terminology that they used.

I agree that the family disengage from the service in part because of the technical jargons. (Focus group A)

Sophisticated or complex terminologies were felt to limit the opportunity to connect with service users, whereas the use of basic terminology was identified as likely to be more helpful in developing rapport and bringing about positive changes for the family.

Sometimes where you've worked in third-world conditions as a therapist you might be better to understand why you need to ask questions at a more basic level, in a different way, or the need to establish relationships. The different

ways you need to connect, gel with the family in a very simplistic way to achieve an outcome with them. (Focus group B)

Practical approach. “The phone card cure” was coined by a participant in Focus Group C to describe using therapeutic interventions either through a practical solution, or helping the family to implement pragmatic outcomes to their issues and challenges. While the service provider queried the ethics behind the practice, the pragmatic solution was considered the most effective and helpful to bringing about an immediate resolution to either big or small concerns to the service user.

Well, it’s probably, you know questionable in terms of ethics, but sometimes you can, you just know that something will work. And I just said, oh for goodness sake I’ll buy her a card, so I did. She needed it. I mean, I’ve spent a bit of money occasionally. The other week there was one of those, it was a pregnant woman, and they were going to Christchurch, and there was this big thing going on. And [pointing to another focus group member] you were going to leave home and drive them over there to the airport. [x] was going to drive to the other half to the airport. So I said, just get a shuttle, here’s you know, how much will it cost. It must be \$15 dollars to get money for a shuttle. I mean, you know, I’m not saying everybody should spend money because there’s a lot, it’s just occasionally everything quietens down and it’s done. It’s gone. (Focus group C)

One focus group in particular clarified that their key role with many adolescents from refugee backgrounds and their families was assisting with “practical needs meeting” (Focus group C).

And going slowly, like um, you know going with the presenting issues and showing that you’re prepared to help them with practical things. (Focus group C)

Resilience. Despite the challenges, most of the participants felt it was a “humbling” (Focus group C) experience to work with adolescents from refugee backgrounds. They believed the young people were “remarkable” and recognised that “it takes a lot of time to open up, if at all” (Focus group C). Participants further found that the stories they heard were “heart breaking”, and that they themselves needed supervision to help them deal with the work.

Sometimes heart breaking, heart breaking the lives that they’ve led. I, you know, find, you know you really need to use supervision I think to deal with the way you feel about your, all you can feel, and get some distance away. Like working on the empathy and, but making sure you keep yourself unburdened and don’t take it home. But occasionally the stories that you hear, with the young, with everybody, but the young people are exceptional.
(Focus group C)

Most of all participants were in awe of the resiliency that adolescents displayed in order to survive the journey along the way.

And I marvel at the resiliency of the people and their inner strength and what, what makes a difference sometimes. You know, just how they survive, I find it astonishing really, heart breaking and astonishing in the same sentence.
(Focus group C)

In summary, under the category of service provision, types of therapy and process issues were examined. With types of therapy, service providers reported using a wide range of models and therapy in their intervention with adolescents from refugee backgrounds. Some of the core interventions included family therapy, education and skills development and working with agencies. Service providers also experienced dilemmas and challenges in relation to providing diagnoses for refugee clients. Language difficulties and the use the interpreters had a significant impact on service provision with youths from refugee backgrounds, as did cultural differences and understanding. Service providers discussed pacing their work, and being flexible in their approach with youths from refugee backgrounds. Finally, despite the trauma and hardship that refugee youths had experienced, service provider discussions highlighted the resilience identified within the young person to cope with the refugee journey throughout the pre-migration, transit and post-migration stages.

Recommendations for Service Development

Participants were asked what recommendations or changes they believe are required to improve the services provided to refugee adolescents and their families. Many participants discussed that any significant service development had to occur within the community and be inclusive of community members, from planning through to execution and delivery of the service. There were suggestions that members within the community could develop mental health resources for their own communities.

Forging partnerships. Because of time constraints within a number of organisations, in terms of how long service providers were able to work with the young person because of other demands on the provider's time, the work that was able to be conducted with the young person was limited. As a result, most focus groups identified that development of mental health services/interventions with adolescents from refugee backgrounds needed to occur within the community.

There's not much more we can do here I don't think that given the amount of time. I mean if, you know, we run groups for children, we run groups for adolescents, there's child specialist working with them. We've got other expertise that sits in house. [x] and um [y] and [z] and [a] and I, we all see young people as well. We've all got expertise with young people in one way, shape or form. So, it's not like there's only one person who can do it here, and but we don't have them long enough to do any better or any different given, given the competition for time for them while they're here in the program. I think it's in the community that it needs developing really. (Focus group C)

Service providers suggested that such service development needed to incorporate input from community members, for example, "the highly educated people within the refugee community can develop resources, like mental health resources for their own communities" (Focus Group A). Furthermore, it was identified that development of resources and services could benefit from drawing on the resilience factor that enabled the families and cope.

The other thing is with many refugee young persons and their families, they've been through a lot of trauma and they've been able to get through, so

there's a resilience factor within a number of these communities that continues to keep surviving and coping. How could this host country and our service draw on those resilience factors to develop our service? (Focus group B)

In addition to developing mental health services, service providers noted the importance of employment and adequate housing in supporting families from refugee backgrounds to cope with their trauma. Thus, developing social services focusing on supporting these young people or their families to access employment and housing may also support positive mental health.

Usually, when they can get a job and when they can get housing they leave the trauma behind. The necessity of the family to get through the new situation keeps the family very close together. So usually, even if the child has quite severe mental health problems, the family sticks together. (Focus group B)

At a broader level, developing other organisations to better support refugee families was mentioned in several focus groups, for example, churches, or places within the community where refugees are settled.

Maybe we can also help develop services that refugees access, for example, churches to assist them to better support refugees when they seek help from them. (Focus group B)

For refugee young people, there are groups in the community they can access. They can feel comfortable about joining in, where they can go to and speak to somebody about their what their acculturation struggles are, to feel comfortable, to gel with other students, to access culturally appropriate counsellors, you know, that might be more empathetic to their needs and feelings. I think intervention needs to happen before they get to a moderate to severe level. That could happen within the school, in the community, within areas where refugees are settled. How do we get these groups and so on going? (Focus group B)

Service providers identified the concept of developing a relationship or a consult liaison with refugee agencies as a strategy to address the lack of mental health service access by

adolescents from refugee backgrounds.

What about a liaison worker with refugee services? I can see so much potential in terms of development within this organisation, you know, but I see it's not happening. (Focus group B)

Participants felt developing relationship with other organisations increased the likelihood that the young person being referred into mental health service was able to access the identified help required earlier.

We've formed a relationship with CAMHS where we can get someone into one of their acute appointments often the same day if somebody is unwell or psychotic.... Kids who've needed maybe medication or whatever, we've managed to get them into those services really quickly. (Focus group C)

Building relationships with refugee agencies was seen as an extension of working with the wider system involved with refugee communities. Participants identified that access would be supported through developing other agencies' knowledge about what services were available to refugee adolescents with mental health difficulties.

I was thinking on the issue in terms of access. We're possibly not seeing, in terms of the numbers and so developing some sort of relationship or consult liaison with the refugee services so the dialogue is there, so they're aware of what is provided. (Focus group A)

A collaborative relationship with other agencies would further help to ensure "a proper handover from the refugee centre". (Focus Group A). Moreover, it would enable the specialist organisation to help link appropriate support people with the family. For example, "if people are going to be referred, RMS [Refugee Migrant Service] volunteers need to match up support" (Focus Group A). Participants further identified that ongoing consultation would be required between the agencies.

I know, but still, I mean in an ideal world, you would have people from this service providing ongoing consultation and support, and it would be required of them that they check in. For example, on a monthly basis, or run things past us if they're not sure of. Because at the moment, they don't know what they don't know and there's no, kind of, there's no system, there's no

structure for them to deal with the danger of not knowing what they don't know. (Focus group C)

As part of the list of ideas provided to enhance or develop interagency collaboration, the role of a coordinator was proposed to link those in need of support with key individuals or organisations that might be able to help.

Or having someone act as a coordinator who is aware of what group there is out there, and begin linking with key individuals. Because if those organisations exist, they have their own little pockets, and the need for information sharing and transparency for the different organisations. It's not about the organisations, it's about the consumers accessing their service. (Focus group B)

Select appropriate resettlement locations. Because change is so profound, some service providers talked about the need to more carefully consider where specific families from refugee backgrounds are placed within New Zealand. For example, placing refugee families/individuals from an urban background into an urban environment might not be as "alien" a change as it would be for a family/individual from a rural background. Conversely, it might be helpful as part of the resettling process to place individuals from a rural background into a rural setting where they may have more opportunities to engage in familiar behaviours, such as gardening.

And in my view, or in families who have got some sort of urban background will do better than people who come from the foothills of Columbia or you know, the back of Bhutan and stuff like that, that people who live in cities will do better. And we don't think about that. In Australia, they settle some people in the country, out in the country where they can do market gardening and kind of they feel better sort of. You know we would be better sending some people off to Pukekohe actually, or areas where they could garden. They could dig farms." (Focus group C)

Improving access to services. Service providers discussed a range of strategies aimed at targeting the service level. These included increased training with and about other cultures in order to increase cultural awareness and more culturally-appropriate practices. Modifying work hours and communication strategies were also suggested. Furthermore, providing more

youth-friendly facilities was also highlighted as a strategy that could be modified to enhance youth participation at the service level.

And even if they are taken up by CAMHS when they're out in the community, I'll say there's the obvious thing that you know, that the Clin Psych [Clinical Psychologist] or the psychiatric nurse, or whoever is working with them, is just so unlikely to have much background experience in working with people from that culture, from that background so how do you ensure, I mean all the knowledge. (Focus group C)

Facilities: Two focus groups discussed the lack of an appropriate facility in which to see adolescents as a barrier to engaging and working with them, particularly in terms of lack of privacy. For example, while the office was accessible to people from within the community, anybody could come in and identify the young person there. This meant that young people may prefer to engage at cafes or other venues.

I don't know here, but from the mobile team's point of view, our office is not suitable to treat young people. Like it's in the middle of quite a busy place, that any minute, probably somebody from their community comes in. There is no privacy and we have a young boy, year 12 or 13 from school. And he didn't want to come to our office. He would prefer to go to a cafe, like a shop or somewhere. So when you take the young boys or girls to those kinds of places, they would expect you to somehow treat them with like cup of coffee or a chocolate cake, or something which unfortunately we didn't have the budget for it. And that was, and also they didn't like you to go to their house or see them at school. So first of all the premises has a BIG thing to do with their treatment and also inside the rooms itself. It's not youth friendly environment. (Focus group C)

Extended hours: Service providers felt that extending the time available for appointments was important as "time is another barrier" (Focus Group B). For example, offering evening clinics provides refugee youth and their families with the opportunity to access services at a time that fits in with their own priorities and demands, such as work and schooling commitments.

But coordinating it with the availability of everybody makes the job difficult.

And, the working environment sometimes doesn't allow for that flexibility of working on a Saturday so you can meet the migrant needs. (Focus group B)

I think you also maybe need to work after hours, you know. Um, you've got to have a day when family can come in the evening, you know and service needs to be more accessible. (Focus group B)

Service providers identified that income generation is essential to families from refugee backgrounds. Thereby, if they have to attend an appointment or bring their young person to an appointment, it represents a loss of income for the family. Allowing families to access services during a time that did not negatively affect income generation was more likely to improve access and service utilisation.

The reality is, families, refugee families are working really hard you know, and income is absolutely essential for them. Um, and if we're going to be calling them away from their work schedule, that's a loss of income for them in order to attend these appointments. (Focus group B)

Extending office hours would also allowed for service providers to contact families during a time they were more likely to be available to answer calls.

From my experience, it was the work commitments of the family. They worked long hard hours. Trying to even reach them within my work hours was hard, and leaving a message on the phone to family that doesn't even speak English, was quite hard. (Focus group B)

According to some participants, extending the clinic hours available meant that families might be more likely to engage with services earlier. Service providers would then be able to intervene during the critical period for the young person when assistance was required.

If we intervene in a time when it's really essential, they're more likely to engage, more likely to be committed to some form of change, you know, and committed to something in the therapeutic sessions. Whereas if it's like six weeks down the line, it may no longer be relevant, you know, to them. (Focus group B)

Pamphlets: In addition to physical barriers that hampered access to mental health services, mental health professionals reported that “not having very good English language

skills, and just not knowing the system were huge barriers to accessing help” (Focus group C). In addition, anxiety was reported as a barrier. To address some of these issues, service providers discussed that pamphlets could be developed using the native language of users to outline the role of the organisation and the services.

I think there would probably be some anxiety about that, about how to do it, physical barriers and so on. I wonder if the pamphlets for the services were written up in their language, that they’re here to support you and if you give them a ring somebody could come to you. (Focus group B)

The participants were further asked why they thought those suggestions had yet to be implemented within the service they worked in. While the majority of focus groups discussed financial constraints, one focus group described the lack of empathy for cultural challenges as influencing how they engaged and worked with individuals from a refugee background.

I think we have a very Pakeha dominated management who have not experienced, um, experienced culture from a different perspective. And who don’t have empathy for the cultural challenges, um, that clients experience here and they apply Western models of thinking and of managing stuff. (Focus group B)

Increase staff training on working with refugees and other cultures. While one focus group noted that significant movement had occurred in terms of mental health services making attempts to “get culturally up to date, and that there are a lot of people doing CALD [Culturally and Linguistically Diverse] training or have done, or are working with cultural consultants in lots and lots of places” (Focus group C), two other focus groups felt that more training would be undertaken to increase cultural responsiveness to refugee adolescents and their families. For example, some participants discussed concerns that not enough training or support had been given to working with other cultures and ethnicities. As one participant stated, “We’re required to attend the Treaty of Waitangi training when we start at our workplace. However, there’s been no support for training to work with people from other ethnicity and culture” (Focus group A). These trainings are required because it is not always easy for professionals working with refugee youths of another culture to access peers or colleagues who can provide cultural input or advice on the case.

You learn things with experience, and your practice. That some of your

learning and understanding works across culture. And it's by asking people, what is the cultural norm, but you're relying on that information to be correct. Sometimes you have members of staff of different culture, and you can ask them, but you don't always have that. (Focus group B)

Furthermore, service providers felt that best practice guidelines for working with refugees, in addition to training with other cultures would enable them to provide a service that was sensitive and responsive to the needs and cultures of adolescents from refugee backgrounds.

One of the best ways I see to address all the issues you mentioned, is to have some kind of training with other cultures. So for example here, we have the best practice guidelines for Maori, for Pacific Islanders. I would love to see some training with the Asian or African communities, or with people coming from Afghanistan or Iraq. So for example, a training course in refugee issues will be something that will address all the questions. It would also allow the service to have a better sensitivity and responsiveness to work with those problems. I don't think in terms of cost effectiveness, this will be a big issue for the Government to do that. (Focus group A)

Educating families from refugee backgrounds about mental health services available. In half of the focus groups, it was suggested that refugee families new to the country needed to be better informed about what mental health services were available, what they did, and where the family could access the services for help or assistance. Service providers were mindful that “not knowing what sort of help there was” (Focus Group B), resulted in some families from refugee backgrounds being seen at crisis point rather than at an earlier opportunity.

The other thing I was wondering about, the refugee services are involved with the family for about six months, and I guess it's about the case load and the demand. Are these families informed about where they can access services if things go wrong, you know mental health services, child and adolescent mental health services? Um, because you're a foreigner coming into the country and you don't know about these things. Um, like at the outset when they come, the termination will be in six months whether with their social worker or their key worker. So you know, these are things that are

available to you, this is where it's located in your area, because when you're so new, you don't know who to access, how to access and what to access there, and what those services are. (Focus group A)

Discussion

This study examined service providers' beliefs about the factors that contribute to young people from refugee backgrounds mental health problems and the types of therapy and intervention provided, including process issues. Five focus group discussions were completed with a total of 20 service providers. The discussions were transcribed and subjected to thematic analysis informed by IPA in relation to the primary areas of interest. Themes that were identified are discussed further in the following section.

Mental Health Problems Presented and Attribution of Causes

Consistent with earlier studies, service providers reported that girls were more vulnerable to internalising problems, while boys were more likely to develop externalising problems (e.g., Derluyn & Broekaert, 2008). In other studies, conduct disorders were diagnosed twice as often in children from refugee backgrounds compared to children from non refugee backgrounds. However, the authors thought this could be a result of a lack of information gathered about the child's social environment, given that the family's acculturative stress could be contributing to the conduct problems, as opposed to the conduct difficulties being intrinsic to the young person (Guarnaccia & Lopez, 1998). Previous studies have further found a link between externalising behaviour problems and traumatic exposure (Bean, Eurelings-Bontekoe, Mooijaart & Spinhoven, 2006), while internalising problems has been found to be related to daily stresses (Ellis et al., 2008). Thus the externalising and internalising difficulties reportedly experienced by adolescents from refugee backgrounds may be related to trauma experienced, including daily stressors as identified in Study One.

Service providers reported that youth from refugee backgrounds difficulties were related to both the impact of past events (especially within the country of origin) and the transit process and the post-migration stressors. This finding is common to other mental health related research in adolescents from refugee

backgrounds (Ajdukovic & Ajdukovic, 1998). In line with recent studies, participants in Study Two identified separation from family members and poverty as having negative effect on mental health (Henley & Robinson, 2011; Lustig et al., 2004).

Service providers noted that poverty and lack of financial resources negatively contributed to the young person's mental health on several levels. It was further noted that individuals may feel a burden to support family first financially, rather than pursue education or other personal goals within the community. This may limit them from developing skills and knowledge that supports environmental mastery, which can have detrimental effects on the young person's mental health in the long term. Poverty further limits the young person's ability to access resources to connect with key supports. Therefore, the young person's ability to draw on coping strategies that they may normally utilise, such as leaning on friends, is reduced. It further has implications on their access to mental health services, in regards to ability to afford care and follow up. Lack of financial resources has been documented as often present in many refugee families living in Western countries (Khawaja et al., 2008). Moreover, when parents are under stress and not coping in challenging situations, such as poverty and lack of supports, it has been found that parents become harsher and less warm towards their children (McLoyd, 1995).

Service providers also attributed young people from refugee backgrounds difficulties to the clash of cultures experienced in settling into a new country. In addition to adjusting to the clash in culture, in which service providers likened the family to being "beamed into Mars", young people from refugee backgrounds and their families had to also adjust to differences in rates of acculturation between the young person and older members of the family. Service providers' discussions highlighted that English learning and the faster rate of adapting to the new culture contributed to significant parent-child conflict and psychological distress for the young person. These results are consistent with Kaplan's (2009) findings that adolescents usually acculturated to a new society at a quicker rate than their parents, which results in differences in cultural and behavioural expectations. When young people develop language at a faster rate than their parents, parents may come to rely on their children as interpreters, and as a bridge to interact with the host society where language is required.

Participants' accounts also highlighted acculturation difficulties as impacting on developmental asynchrony and self identity. A sense of continuity in understanding "who we are" is recognised as an important part of our understanding of the self and is closely related to the knowledge of one's personal history (Povinelli, Landau & Perilloux, 1996). The "profound changes" within the new environment was thought to affect developmental asynchrony, whereby the individual's development at an intellectual, emotional and physical level is not occurring at the same rate that would be expected of that developmental stage. When development occurs out of sync, such as having to learn a language again, the growth of confidence and mastery over the new setting may affect the individual's sense and understanding of who they are (Povinelli et al., 1996).

Central themes that were identified about factors that contributed to youth mental health problems related to family health, functioning and wellbeing. According to service providers, parents' lack of familiarity with the parenting role, their general functioning and poor mental health negatively impaired their ability to parent and attend to their child's needs. This consequently limits the care and support the young person receives to manage his/her stressors and challenges, which may further exacerbate their difficulties. Service providers reported that parents struggled to cope with being separated from family, the "disconnect" from their country of origin, adjusting to a new life and adjusting to changes in family roles and dynamics. The young person had to thus cope with parental distress and poor functioning in the new setting as well as significant change in environment.

It has been reported that children and adolescents are particularly vulnerable within these situations because parents are often overwhelmed and struggle to appropriately recognise, interpret and respond to the young person's emotional needs (Pumariega et al., 2005). For example, it has been reported that parental emotional difficulties with previous trauma can be reactivated through psychological distress experienced many months or years after the events (Pumariega et al., 2005). The importance of parental functioning and coping modes for coping in children who have been exposed to adverse experiences has been highlighted by several authors (McMichael et al., 2011; McMichael & Manderson, 2004; Rousseau et al., 1999). According to Almqvist and Hwang (1999), as long as parents are not pushed beyond their stress absorption capacity, the young person will continue to cope. However, if the stress absorption capacity is exceeded, the young person's development begins to deteriorate quickly and significantly. Parents may further become less sensitive to

their child's distress. When a greater burden of care is placed on family members, it has been identified that this influences the parent's subjective needs. Thus, parents who are managing more responsibilities are less likely to recognise psychological challenges in their children or adolescents (Brannan, Heflinger & Bickman, 1997).

Although the young people in Study One identified family members as a source of support, the discussions with mental health professionals suggest that family members may not always be in a position to perform this task. For instance, each member of the family faces the challenge of processing his or her traumatic events, which means that his/her ability to be aware and respond to other family member's experience may be compromised. During their formulation of the cases they had worked with, many service providers raised the importance of considering the difficulties the young person presented with within the context of the family.

For many communities around the world, there is an expectation that younger members within the family will care for older or disabled members. This has implications in regards to the burden of responsibility placed on the adolescent while already juggling multiple challenges experienced in acculturating, as identified in Study One.

Service providers were cognisant of the effect of parental experience of trauma on the parent's ability to attend to the young person's needs. The lack of resources within the parents to care for their children appeared to trigger or exacerbate difficulties experienced by the young person. Sleeping difficulties in children may be related to struggles with letting go of the need to be in control, which Montgomery (2011) argues can only occur when the young person feels a certain amount of security within their environment, as usually provided by their caregiver. Young people from refugee backgrounds who have had a history of repeated exposure to violence may have little trust in their parents' ability to protect them, which can further affect anxiety-related sleep disturbance. Parents' mental and physical health issues have been reported to be related to sleep disturbances in children. In a follow-up study looking at mental health and integration of young people from refugee backgrounds from the Middle East, Montgomery (2011) reported that parents' attention towards their children can be reduced through their own somatic or psychological difficulties because of the struggles to cope with challenges of daily life. As traumatised youth from refugee backgrounds may have parents with psychological or physical difficulties, this has clinical

implications when these youth are referred for assessment and intervention (Montgomery, 2011). Therefore, they are less able to engage with the young person in their new environment, for example, visiting with school to discuss how the young person is coping.

Service providers described excessive expectations by parents about their children's role within the house, including (at times) parental abuse of power. However, the community or family may not view the behaviour as anything outside of the cultural norm. If this is the case, another issue can arise where the clinician's rules and assumptions of appropriate and inappropriate behaviours within a family governs his/her interactions with the young person. For example, if the young person was to be educated that the behaviours and roles they are carrying within the family are inappropriate, they may then challenge their family, which can result in increased conflict in the relationship between the caregiver and youth. This can lead to reduced supports for the young person and exacerbate the stressors likely already operating on the family. The clinician's input, while likely well intentioned, can have detrimental effects on the relationship stability within the household, affecting the young person's psychological functioning.

As mentioned above, fulfilling expectations can limit the young person's opportunity and potential to participate in a wide range of activities that are possibly more consistent with their dreams and goals for themselves. When the practical demands of the family on the adolescent for language, physical, financial, transportation or social support is great (and yet) at times inconsistent or in excess of what the adolescent can provide, this can lead them to feelings of distress, hopelessness and despondency. Furthermore, there may possibly be great shame involved in accessing help from other sources. Additionally, young people from refugee backgrounds may not be aware of support resources available to them, or struggle to access support services because they have difficulty understanding and expressing their problems. In spite of the harrowing experiences that many young people from refugee backgrounds have been exposed to, service providers recognised their resiliency and ability to recover from the psychological and emotional impact of their adverse experiences to carve out and adapt positively to the host society.

The factors that contribute to youth mental health problems are outlined in 10 themes. The first theme, "trauma and the lingering impacts" highlighted the ongoing impact of trauma on the young persons, and particularly his/her parents' mental health and functioning. The

second theme “clash of cultures” discussed the significant cultural differences that youths and their families are faced when adapting to the host society, including the impact on self identity and developmental asynchrony. The third theme, “missing relationships and loss” highlighted the impact of loss of potential sources of support for the young person and their family, including the loss of role models and the effects of disconnection from missing supports. The fourth theme, “lack of meaningful activities” discussed the vulnerability of young person associating with peers who engage in antisocial behaviours as a result of limited meaningful activities to participate in within the new community. The fifth theme, “poverty and lack of financial resource”, addressed the impact of financial limitations to participate in activities that facilitated socialisation and interaction with the new community. In addition, fear of increasing debt hindered the adaptation and acculturation process. The sixth theme, “different rates of adaptation” discussed the different rates of acculturation for the young person and their family contributed to conflict within their relationship and interactions. Within this theme were two subthemes that included “adaption/acceptance”, and “different rates of English learning” that were critical influences to the different rates of adaptation. The seventh theme, “parents’ lack of familiarity with the role” noted that parental struggle with the parenting role impairs their ability to attend to, and provide for, the needs of the young person. The eighth theme, “family health and functioning” highlighted that the family’s interaction, relations and coping baseline continued to affect present interactions within the family. Under this theme were two subthemes of “family function” and “poor parent mental health”. The subtheme of “family function” discussed that structure and nurturing within the family unit is a mediating factor that affects the acculturation process. The “poor parent mental health” subtheme highlights the impact on the young person when parents struggle with significant mental health problems, such as the young person having to assume increased responsibility within the household. The ninth theme “parent’s expectations” discussed the negative impact on the young person’s mental health when parental expectations are unrealistic or unachievable. The last theme in this primary area of interest, “family and adolescent attitude about mental health services impacts access” addressed the stigma associated with seeking help from a mental health service, including the type of help that is culturally acceptable.

Service Provision: Types of Therapy

Service providers described using a wide range of therapeutic approaches inclusive of CBT, exposure therapy and testimonial therapy. The process of sharing the story within a clinical environment is itself considered as having a positive therapeutic effect on the individual (Watters, 2001). According to Turner and Herlihy (2009), sharing of the traumatic story firstly enables the processing of the emotion that it is related to and secondly, is the initial stages in creating a new story that facilitates a different understanding of historical experiences, while enabling the creation of hope for future to come. However, within a predefined context or clinical environment in which refugee voice is presented, the experiences are likely to be viewed through clinical eyes.

Service providers discussed process issues and challenges in their practice with youths from refugee backgrounds. For example, some service providers were mindful of how they approached particular topics with the young person as they were aware of the “shame” that young people may experience when particular topics are discussed too soon in the assessment or therapeutic process. Other service providers felt that the young person likely had concerns of disclosing or opening up in the therapeutic setting because of fears of getting in trouble with their family, or getting their family in trouble. As identified in Study One, some participants had experiences in which they risked being sent back home to their country of origin if they shared too much information about themselves and their families. Those fears may continue to persist and affect the young person’s ability to engage with service providers or to share their experiences..

According to Watters (2001), the examination of broader levels with the refugee in regards to what they may require or want from in-house services, or the opportunity to examine this with them, is very rare. For example, a study conducted with mental health services for refugees in Europe undertaken in collaboration with the World Federation for Mental Health reported that, of the 18 European countries they examined, only two had clearly developed methods for listening and examining the voices of refugee service users (Watters, 1998). However, participants in Study Two appeared cognisant of key issues and needs for young people and their family. Accordingly, service providers responded in kind, even if it challenged conventional understanding of practice, for example, buying phone cards for young participants because the key need for the young people was to connect with family

and friends. While the phone card cure practice may not have scientific validity to support its efficacy, it appeared to address the young person's need at a very quick and effective level.

Service providers were both inspired and humbled in their work with adolescents from refugee backgrounds. Within this particular context, many service providers recognised that refugee challenges need to be considered in a social, political, historical and cultural context. In some focus groups, concerns were however raised that clinicians were still primarily operating from a Western dominant model. A consequence of a Western dominant approach in working with refugees is that the refugee experience is reduced to what is considered to be of clinical significance. The experiences and challenges of the young people from refugee background are thus vulnerable to being understood according to a model with an underlying Western approach.

Through a lack of opportunity to share their experiences in their own ways and to determine their own priorities in regards to service provision, people from refugee backgrounds may be the unwilling participants in service responses that are impacted by stereotypes. This may further reduce a rich and complex group of individuals into one homogenised group (Watters, 2001). It is argued that this creates an environment in which the needs of many people from refugee backgrounds are ignored. The responses to people from refugee backgrounds are thus service led as opposed to user led. Furthermore, the voice of the refugee is only considered through a pre-defined and compartmentalised context (Watters, 2001).

Under service provision, there were two main areas of findings that included types of therapy provided and process issues experienced. The themes relating to the "types of therapy" included: "wide range of individual therapies", "family therapy", "educating and skills development", "working with agencies", and "challenges in diagnosis". Under the theme of "wide range of individual therapies", it was noted that service providers utilised a wide range of models and therapeutic approaches with the young person. These interventions helped to develop insight with the young person about their difficulties, facilitated the mitigation of distress and normalised the young person's issues and challenges. The wide-ranging forms of intervention further helped to support the young person to connect with supportive agencies from within their community as a way of reducing stigma that came with the potential loss of face in accessing a tertiary-level mental health service. Interventions

mentioned, included talking therapies (such as testimonial therapy) and non-talking therapies (such as sand play or dance therapy). The non-talking therapies were seen as methods to support the development of a trusting relationship that might facilitate the young person to be “more likely open up”. “Family therapy” was identified as a theme on its own because many service providers considered it a core intervention that would be considered “malpractice” if not completed with refugee adolescents. Using reframing as part of family therapy was found to work well with youths from refugee backgrounds, including genograms, which supported the young person to identify supports available to them. While there were general agreements as to the benefits of using family therapy, it was noted that particular sensitive issues around violence and abuse may not be raised in the family context, which supports the importance of using a flexible approach when working with adolescents from refugee backgrounds. The theme of “educating and skills development” outlined the importance of providing skills and knowledge to young people from refugee backgrounds and their families struggling to cope in the new environment. These included teaching parenting skills and stress management strategies, which also supports modifying family interactions with one another. Education was further identified to serve an important role in resourcing the individual to assist with adaptation and coping within New Zealand. The fourth theme, “working with agencies” related to the importance of case coordination, and liaising with other agencies, including advocacy for the young person and their family. These behaviours were thought to contribute to increased traction for the young person’s case and increased awareness and knowledge with other agencies about the key issues when working with young people from refugee backgrounds. The last theme under this primary area of interest, “challenges with diagnosis”, discussed service providers’ reluctance to diagnose. Therefore, efforts were made to modify practice with consideration of the impact or usefulness of the diagnosis to the young person.

Service Provision: Process issues

Service providers experienced cultural differences between themselves and the service user as having an impact on their practice and engagement with youths from refugee backgrounds and their families. The impact of cultural differences and understanding on practice with adolescents from refugee backgrounds also posed diagnostic challenges for service providers. The conception, manifestation, subjective experience, diagnosis and

prognosis of mental disorder can be significantly affected by cultural factors (Minas & Silove, 2001). Cultural factors further affect family and community responses, including help-seeking behaviours towards traditional and professional remedies (Minas & Silove, 2001). Service providers were mindful of challenges related to giving a diagnosis of the young person's challenges. Several authors have commented on the challenges of giving a diagnostic label to problems presented by refugee populations. For example, it has been reported that attributing a person's struggle solely to anxiety, depression or a PTSD diagnosis may unjustifiably medicalise a problem, while neglecting and disempowering the social and family network (Rousseau, Measham & Nadeau, 2013). Additionally, a diagnosis may be stigmatising as it may suggest the problem is within the individual, rather than in the society, even though the symptoms likely occurred from adverse conditions (Miller, 1999; Miller & Rasco, 2004). Lastly, within communities where mental illness holds a lot of shame and stigma, being diagnosed by a clinician may be construed as an indicator of weakness, which can be a foundation for shame and humiliation.

Despite these limitations of diagnosis, sociologists have argued that the construction and use of diagnosis supports resources to be directed to developing programmes that can address such disorders in the refugee population (Watters, 2001). Therefore, a diagnosis can serve a critical purpose in mobilising resources into social and mental health work with refugees. However, such behaviour also highlights ethical and practical challenges that relate specifically to the acquisition and allocation of resources. In addition, diagnosis enables financial or professional assistance to be directed according to established clinical needs. Without doing so, many services concerned with the social and health welfare of people from refugee backgrounds may fail to achieve funding or resources that enable them to provide a service to the refugees.

Because of ethnic, cultural and language differences, service providers needed to pace their engagement, take their time and be flexible in their assessment and intervention approach. Critically, service providers stressed the importance of focusing on developing a positive rapport and relationship with the young person and other key people. According to Warr (2010), establishing trust in therapy with people from refugee backgrounds may take longer given the socio-economic and political conditions, and potential threats to their psychosocial and biological wellbeing. This backdrop facilitates hypervigilance to scrutinising and analysing potential threats, which may make the task of developing trust

harder and take longer. If the therapist is able to foster an environment of understanding and empathy, this supports the development of a therapeutic sanctuary (Warr, 2010).

There were five themes under the primary area of interest of “service provision: process issues”. The first theme, “language difficulties and use of interpreters”, noted that language difficulties contributed to gaining and providing information to youths from refugee backgrounds and their families; affected the service provider’s ability to provide culturally sensitive services and increased the need for interpreters. Access to interpreters was not readily available to all service providers. The use of interpreters further did not guarantee increased understanding with the family, however it often further often added more time to working with refugee adolescents. The second theme “cultural understandings”, highlighted the importance of the impact of culture on the young person’s experience and their presenting issues, including their understanding of the problem. In spite of this understanding, concerns were also raised under this theme that models of practice with adolescents from refugee backgrounds continued to be influenced by Western perspectives. Cultural support workers were considered both helpful and unhelpful for engagement because having additional individuals could deter the young person from disclosing information that might be critical to the service provider’s input with them. The third theme, “pace, slow, go with the flow”, discussed the importance of flexibility with the approach and slowing the process of engagement, assessment and treatment. A subtheme included the “importance of engagement” because service providers identified that engagement was critical for any work to occur. The fourth theme, “flexibility and fluidity in approach”, is closely related to the third theme, however, it highlights the fluidity required in the role as a professional, including the way they work with the young person. Under this theme was the subtheme of “practical approach”, in which quick and pragmatic solutions, such as the “phone card cure” can resolve immediate stressors to the young person. The fifth theme in this primary area of interest relates to “resilience”, which discusses the humbleness that service providers experience in their work with refugee adolescents. Importantly it also discusses the heart-breaking challenges that this work brings to a service provider and the need to access supervision in order to support service providers to deal with their work with the refugee young person.

Recommendations by Service Providers

The recommendations made by service providers at both the service and societal level to improve responsiveness in provision of care to people from refugee backgrounds groups are similar to recommendations made by different authors (Birman et al., 2005; Ehntholt & Yule, 2006). Service providers noted that extending practice hours, developing a youth friendly environment, providing pamphlets in the service user's native language and providing assistance with transportation may be helpful in regards to improving access and mental health services. In terms of service delivery, staff training about other cultures was also considered as needed and helpful. At a societal or broader level, the study found that forging partnerships across agencies and placement considerations needed to be factored to support positive acculturation.

The most effective approach has been proposed to be one in which specific cultural characteristics of the individual or their group are acknowledged, and that strategies or efforts are made to support the individual's cultural identity. Consistent with the model proposed by Goldberg and Huxley (1980), supporting positive social relationships and reducing social challenges enables targeting individuals in such a way as to decrease their vulnerability to mental health problems.

Culturally sensitive services often support efforts to include appropriate cultural support staff to participate in engagement, assessment and intervention; however, this may hinder rather than promote access and participation in the service. The roles of community link workers or consultants within the community may be more critical in supporting and advising professionals from a different culture background to the adolescent, while promoting and increasing awareness in cultural understanding. Outreach services that focus on supporting wellbeing rather than specifically dealing with psychiatric problems may provide an avenue to connect services and community, which in turn may help to establish trust and relationships.

Key recommendations for service development are outlined in five themes. These include: "forging partnerships", "selecting appropriate resettlement locations", "improving access to services", "staff training" and "educating refugee families to increase awareness of mental health service available". The theme of "forging partnerships" highlighted that the development of mental health services needs to occur within the community. Furthermore,

these developments need to incorporate views from the community could be based on the resilient factors that enabled youths from refugee backgrounds and their families to cope. This theme also discussed the development of social services to support families from refugee backgrounds to access housing and employment, as this was identified as critical to their positive adjustment to New Zealand's setting. Finally, the theme discussed forging partnerships with other agencies as important to the provision of mental health services to youths from refugee backgrounds. Under the theme of selecting appropriate resettlement locations, the importance of matching the environment post settlement to the environment that families from refugee backgrounds were used to pre settlement was discussed. The third theme, "improving access to services", noted that training with, and about, other cultures and about refugee issues was needed in the provision of mental health care and support to refugee adolescents. Pertinent to this theme were three subthemes of "facilities", "extended hours" and "pamphlets" that could be modified or adapted to increase refugee youth and engagement with mental health services. The fourth theme, "staff training" highlighted that some service providers identified the need for more training about working with CALD clients, either for themselves or their colleagues. Last, but not least, the fifth theme, "educating families from refugee backgrounds about mental health services available", highlighted the need for refugee families to be better informed about what services were available to them, what these services did and where the family could access these services for help or assistance.

Summary

In exploring the perspectives of service providers in New Zealand, it was found that adolescents from refugee backgrounds present with a range of problems to mental health services and that multiple factors are thought to contribute to their mental health difficulties. It was also found that mental health service providers provide diverse forms of models and therapeutic intervention, while encountering multiple process issues.

The factors that were seen to contribute to youth from refugee backgrounds mental health problems included trauma and the lingering impact, clash of cultures, missing relationships and loss, lack of meaningful activities, poverty and lack of financial resource, different rates of adaptation, parent's lack of familiarity with the role, family health and functioning and parent and adolescent attitudes contribute to accessing mental health.

Under service provision, there were two main areas of findings that included types of therapy provided and the process issues experienced. The themes relating to the types of therapy included a wide range of individual therapies, family therapy, educating and skills development, working with agencies, and challenges in diagnosis. While the themes related to the process issues included language difficulties and use of interpreter; cultural understandings; pace, slow, go with the flow; flexibility and fluidity in approach; and resilience.

Key recommendations for service development are outlined in five themes. These included forging partnerships, selecting appropriate resettlement locations, improving access to services, staff training and educating refugee families to increase awareness of mental health service available.

CHAPTER FIVE

Conclusions and Recommendations

This study investigated young people from refugee backgrounds adjustment and coping with stressors. It further investigated mental health service provision to youths from refugee backgrounds. The study had two key objectives. The first objective was to identify stressors and challenges experienced by adolescents from refugee backgrounds, together with their coping skills and experience of mental health services. The second objective was to identify how mental health service providers understood adolescent from refugee backgrounds difficulties, including their approach to working with the young person and their family. Two studies were carried out. Study One aimed to explore what types of issues or challenges youth from refugee backgrounds experienced in resettling in New Zealand and how they have coped with their issues and challenges given their refugee experience. The second aim with the Study One was to explore young people from refugee backgrounds experiences of and beliefs about, professional mental health services that may assist them. The first study used both focus groups and one-to-one interviews with youths from refugee backgrounds who had, and who had not accessed mental health services. Study Two aimed to explore the practice and provision of mental health services in working with young people from refugee backgrounds. The second study employed focus groups with mental health service providers. Thematic analysis was used in both studies to identify key themes relevant to the research question and objectives.

The context for this research is that much of the international literature with children and adolescents from refugee backgrounds has identified that pre-migration, transit and post-migration experiences affect mental health status and wellbeing (Lustig et al., 2004; McCrone et al., 2005; Westermeyer, 1991). Between 2006 and 2009, 874 young people under the age of 18 years were accepted into New Zealand under the different refugee quota intake categories. This number continues to steadily increase with each new intake. In spite of the steady growth in the population of refugee adolescents in New Zealand, there is a paucity of information regarding stressors and challenges faced by this group within New Zealand society. In addition, there is limited documented research about the coping mechanisms that refugee young people in New Zealand utilise to cope with stressors. Finally, despite the identified higher risk of mental health difficulties with refugee populations, it has been

anecdotally reported that very few adolescents from refugee backgrounds access mental health services.

This chapter examines the results of both Study One and Study Two in light of previous research into youth from refugee backgrounds experience of mental health services, and strives to integrate the findings in order to reach conclusions and make recommendations. The implication of this analysis is also discussed for the provision of care and service to refugees, together with future research directions and research limitations.

Youth From Refugee Backgrounds Stressors and Challenges

Both Study One and Two identified that adolescents from refugee backgrounds and their families are often exposed to multiple difficulties and challenges through the pre-migration, transition and post-migration experience to adjusting to a new country. Youths from refugee backgrounds described that in the pre-migration context, they and their families were exposed to violence, hardship and corruption, while service providers noted the lingering impact of exposure to such experiences and other traumas. Some indirect effects of pre-migration trauma, particularly exposure to conflict, appeared to be mediated by the set of post-migration difficulties such as the English language barrier and poverty. These factors were identified to increase resettlement stress and difficulties with adapting to the new environment. It is not known whether or not such struggles with English language and adaptation to a new environment is worse for people from refugee backgrounds than other migrants (such as voluntary migrants); however, it seems likely that exposure to trauma may impair the capacity of individuals to manage stressors and difficulties effectively in the post-migratory context. For example, Study One identified that adolescents desired the opportunity to interact with their peers, to participate in the same or similar activities as their peers, and to access their peers as an important source of support. However, some youths experienced difficulties with making friendships, which may lead to feelings of sadness, frustration and increased difficulties with adapting to New Zealand society.

In addition to adapting to the new environment at a social, psychological and cultural level, both studies reported that youths from refugee backgrounds and their families also experienced difficulties with adapting to the physical environment. Youth participants reported that families have to manage living in overcrowded homes with little space and

limited privacy. Furthermore, service providers identified that the young person and his/her family may have limited opportunity to engage in meaningful and rewarding activities. For example, families from a rural background have little or no opportunity to engage in gardening or other behaviours that they would have been familiar within their country of origin when placed in an urban setting. An implication is that youths from refugee backgrounds and their families may be prevented from participating within the new environment as effectively as they could, given that the skills and behaviours they have for coping in a particular physical environment may be poorly matched to the environment that they have been resettled in.

Both the young people and service providers identified that young people were often expected to take greater care-giving roles in the post-migratory context. The roles that youths from refugee backgrounds are expected to perform within their families likely impacts the intergeneration difficulties reported, which may also adversely impact the young person's mental health and then warrant psychological, medical or social intervention. Developing language faster than their parents also means that the young person is more likely to be exposed to, and have different understandings of, the customs, behaviours, attitudes and cultures within the new context, which may be incongruent with those held or practiced by his/her parents. This can further contribute to intergenerational conflicts if the young person chooses to integrate aspects of the new culture that are not acceptable to the family into his/her attitudes and behaviours.

Youth participants and service providers also described missing relationships with people left behind, and coping with loss and worry about people left behind, as significant issues that continued to impact on their emotional and psychological health. It has been proposed that individuals who miss their home, or who may have lost a lot in the process of migrating may hold extreme positive attitudes about their culture or country of origin, which can lead to greater psychological and somatic stress (Davies & Webb, 2000). As a result of missing relationships or grieving for lost relationships, groups in both studies noted that refugee youths and their families strived hard to reconnect with old established relationships and connections from their country of origin, as well as make new connections in the new community. Furthermore, refugee youths reported experiencing both inter-group and intra-group discrimination and bullying, which may also lead to psychological distress. It has been suggested that the task of developing a cohesive sense of self may be more difficult for

refugee young people experiencing discrimination because discrimination may be related to internalised negative self images, which in turn may lead to depression (Ellis et al., 2008).

Service providers discussed that lack of support and role models in the host country negatively impacted the young person's choice in peers and conduct. Separation from loved ones and loss of support was also identified by refugee youths. This has implications for the young person's wellbeing as other research has identified that social support when present can reduce refugee isolation and loneliness (Bhui et al., 2006), and it can also increase refugee feelings of sense of belonging and life satisfaction (Stewart et al., 2012). Furthermore, social support has been found to facilitate integration into a new society and mediates the stress of discrimination (Stewart et al., 2012). Service providers considered that reduced social supports may increase feelings of loneliness and isolation in young people from refugee backgrounds and increase the stress of discrimination, which may contribute to developing unhelpful connections or relationships with peers that engage in drugs, alcohol or antisocial behaviours.

Participants in both studies highlighted that inherent to the post-migration experience were difficulties related to acculturating to the new culture and country. Specifically, youths from refugee backgrounds identified difficulties of learning a new language, managing money/poverty concerns, experience of discrimination and bullying and difficulties making friends. Developing language skills faster or acculturating more quickly than their parents has implications in terms of the young person's self identity and the relationship dynamic within the family. Different rates of language acquisition between parents and youth was further identified to contribute to increased feelings of frustration by the adolescent. In resettlement, a major theme identified across both studies was the struggle to adapt to the new culture. Both studies highlighted that youths from refugee backgrounds experienced different modes and rates of acculturation compared with their parents. Specifically, their rates of acculturation to New Zealand society and development and acquisition of the English language often occurred faster than their parents/caregivers. The generational disparity in different modes and rates of acculturating appeared to contribute to intergenerational conflict. This finding is consistent with Stewart et al.'s (2012) assertion that intergenerational conflict and language difficulties impede the ability of people from refugee backgrounds to mobilise or use social supports through highlighting the role in which different rates of acculturation impact on intergeneration conflict.

When comparing the two studies, adolescents identified their parents as the cause of their problems, while service providers identified that parents from refugee backgrounds themselves had many psychological and physical health problems. To elaborate, adolescents discussed parents' expectations about them and their roles in the household, such as caring for the young and the disabled, when they were to marry, and how they achieved academically in New Zealand as contributing to their difficulties. Youths from refugee backgrounds further highlighted that parental expectations differed according to the gender of the youth, although this was not reported across all ethnic groups. In line with other research, having escaped the danger, people from refugee backgrounds often have high expectations for their new lives and their family, which influences a drive to rebuild their lives in the host country (Dona & Berry, 1994). The findings from Study One suggest that such expectations may impair the young person's ability to rebuild their lives rather than support them with this task. The service providers provided further insight of intergenerational conflict in noting that parents themselves were struggling with many difficulties negatively impacting the functioning of the family. Furthermore, service providers identified that often parents' lack of familiarity with the parenting role and poor parental health impaired their ability to provide the necessary care, guidance and support for their children. This is consistent with the observation by others that parental mental health increases children's risk of poor coping in adverse situations. For example, when investigating the association between psychological distress in Vietnamese parents and their children after 23 years of resettlement in Norway, Vaage et al. (2011), reported that a significant negative paternal predictor for the children's mental health was the father's PTSD at arrival in Norway.

Service providers in Study Two further identified that because of parents' unfamiliarity with the caregiver role, or because of parental mental health issues, adolescents were required to take on these roles. Because of this, there were concerns that youths could be exploited within particular communities in which they were required and expected to perform roles that challenged them physically, emotionally and psychologically without having adequate resources or sources of support to manage these tasks.

Coping Mechanisms and Service Provision

Youths from refugee backgrounds in Study One outlined many coping strategies they

employed including religious beliefs and practice, physical activity, using different thinking strategies and accessing family and friends for support. The coping strategies identified with youths from refugee backgrounds in Study One are consistent with coping strategies identified in other studies on youth from refugee backgrounds and coping. For example, Khawaja et al. (2008) reported that utilising a wide range of coping strategies and supports is common amongst migrants and people from refugee backgrounds. Halcon et al. (2004) also identified that turning to God for support is a key coping strategy by Somali and Oromo refugee youth, while Gladden (2012) reported that East African people from refugee backgrounds use social support and cognitive reframing of the situation to cope. Brune et al. (2002) further cited that traumatized individuals were assisted in their coping when they held a strong belief in faith or politics. Positive thinking as an emotion-focused coping strategy has also been reported as invaluable to the young person's wellbeing, as is play and the use of distracting behaviours (Khawaja et al., 2008).

For the youths in this study, keeping private about their problems was important. Youth participants may choose this coping strategy because they fear being perceived as “crazy” if they were to access mental health services. Subsequently, this deterred them from accessing mental health support. Youth participants further discussed that if they identified someone acting or behaving in such a way that was considered a deviation from the norm, they were more likely to engage in social distancing or avoidance of the individual. The behaviours reported are consistent with the findings that mental illness is strongly connected with a desire for limited social interaction with the individual with mental illness (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999).

While the young people in this study came from a variety of different ethnic backgrounds, many also came from the Southeast Asian region, such as Burma, Laos and Cambodia. Keeping quiet as a coping behaviour may also relate to the cultural traditions for these young people. Like African cultures, despite the heterogeneity, there are many common values within Asian cultures. According to Kim, Atkinson, and Yang (1999), these values include conformity to norms, emotional self control, collectivism, family recognition through achievement and filial piety (respect to one's parents and ancestors). Because of the importance placed on conformity to norms, behaviours that do not conform (such as mental illness) would not be valued, increasing the risk of stigmatisation. Furthermore, in cultures where emotional self-control is valued, displays of emotional behaviour can be perceived as

poor emotional regulation or aggression and may be interpreted as a mental illness, or a person of a “weaker character”, thereby again leading to stigmatisation (DHHS, 2001). Moreover, accessing help through counselling involves emotional expression; this may increase the likelihood of stigmatisation for someone who has accessed mental health support (Abdullah & Brown, 2011). The implication is that because of the stigma attached to a person who does access mental health service, this limits them from receiving the mental health care or support they may require. Another factor that may contribute to youth from refugee backgrounds coping privately as identified in Study One was that adolescents feared confidentiality would not be maintained.

Both studies identified language difficulties and lack of access to interpreters as factors that contributed to barriers to engagement and process issues when working with youth from refugee backgrounds and their families. Study One also highlighted that cultural difficulties, particularly in relation to different understandings of an issue, were a barrier to accessing and engaging with mental health services. Service providers in Study Two recognised that cultural difficulties negatively affected their service provision with youths from refugee backgrounds and their families. Because of these difficulties, service providers identified the importance of slowing and pacing their engagement and intervention with youths from refugee backgrounds. Service providers also discussed how critical it was to be flexible and fluid in their work while trying to navigate the challenges discussed above and in the preceding chapters.

Implications for Mental Health Services

Youths from refugee backgrounds in Study One identified that having a positive experience of mental health services facilitated their engagement with these services. Contributing to this positive engagement, adolescents discussed having a trusting relationship, through which confidentiality is respected by the service provider. Establishing trust has previously been identified as an important component of the approach to working therapeutically with traumatised clients (Gorman et al., 2003). It is supported by the theme of flexibility and fluidity in assessment and intervention as identified by service providers in Study Two, in which service providers also discussed in depth the process of developing a strong therapeutic relationship with the adolescent. Service providers discussed pacing and

taking their time with engagement and service provision. Across the different mental health services available, for example in primary care practices or at tertiary level services, there are reported anecdotal accounts of time constraints within practice. However, the findings from the two studies suggest that service providers may require more time to enable them to build the trusting relationship that adolescents identify as being helpful.

When youths from refugee backgrounds did access support or assistance, youths from refugee backgrounds and service providers identified that the input they sought was often related to present and practical challenges, such as connecting with friends or assistance with immigration paper work, rather than historical difficulties. The “phone card cure” as identified by service providers is an example through which services have tried to meet the needs that youths from refugee backgrounds present with. However, it appeared that these services were being funded personally by the service providers rather than the organisation they worked in. There are several implications. Firstly, current services may need to modify service provision to fund different inputs for the client, such as for phone cards. Secondly, current services may need to have greater knowledge about social services that may be able to support clients to meet these needs, and to support these clients onwards. Thirdly, the Government may need to factor in the importance of social supports for people from refugee backgrounds as part of an orientation pack to support these individuals to connect with family members or friends who are unable to be with them.

In addition to a trusting relationship, youths from refugee backgrounds identified having a good listener, feeling accepted and not feeling judged as factors that facilitated a positive experience of mental health services. These themes highlight the importance of placing time and energy into developing therapeutic rapport when youths from refugee backgrounds access mental health services. Service providers discussed making efforts to engage the youth in conversation that may be salient and relevant to the youth, with topics including sports or makeup. These findings support the stance that therapeutic success very much depends on the rapport and on the clinician’s grasp of the issues, social supports, self-esteem (DHHS, 2001) and opinions about the treatment received as shaped by both individual and societal stigma (Abdullah & Brown, 2011). It also highlights the importance of service providers’ understanding and awareness of activities and interests that may be salient to the youth culture, in order to build a therapeutic relationship.

What the findings in both studies indicate is that once the youth access current mental health service, they generally have a positive experience of the service. However, as the coping discussions highlighted, fear of stigma and concerns with confidentiality limits access by refugee youth. Thus, more efforts may be required to reduce the stigma within this population to support them to access mental health services when they need support. Service providers discussed forging relationships with other agencies and community organisations such as churches or groups that refugee youths can access to support them in their role. It also presents service providers with the opportunity to develop outreach programmes in other facilities or other organisations that refugee youths are already accessing. Through modifying how and where they provide their service, service providers may be more able to meet the needs of youths from refugee backgrounds.

As discussed above, youths from refugee backgrounds and service providers identified that language difficulties and differences in cultural understanding of the issue impacted the engagement and provision of mental health services. These are important factors to note as they relate to cultural competence in working with clients with different ethnicity and culture. Being sensitive to the client's cultural and linguistic background increases the opportunity to "improve access and equity, health literacy, communication, patient safety and quality of service provision" (Woodland et al., 2010, p. 564). Individuals are more likely to participate in treatment and experience better outcomes when therapy is culturally responsive, and it further increases family's understanding and adherence to treatment (Sue & Sue, 1999). Service providers in Study Two not only recognised the challenges with language and different cultural understandings in working with young people from refugee backgrounds, but they also recommended that increased staff training was needed, with and about other cultures. The implication is that current mental health services may need to encourage and provide opportunities for staff members to attend training opportunities that helps to educate and enhance practice with CALD clients such as the CALD training currently being offered by the Waitemata and Counties Manukau District Health Boards.

There is a strong emphasis on verbal communication within the mental health field. Diagnosis and treatment is informed largely through verbal communication between the client and service provider. However, miscommunication and misunderstanding can occur, even when the clinician speaks the same language as the client, thereby leading to misdiagnosis and poor adherence to treatment plan (DHHS, 2001). These issues are

magnified when both parties do not share the same language. Service providers in Study Two identified the challenges with using interpreters including concerns about confidentiality, particularly if the interpreter comes from the same community as the client. Nevertheless, service providers acknowledged the important role of interpreters in addressing the language difficulties that impeded their service provision. These findings support other work with refugees that have reported that the use of professional interpreters, rather than *ad hoc* translators (e.g., family members, children, friends and community members) significantly improve communication and decreases differences in use of a wide range of medical services. In using professional interpreters, there are still areas to be mindful of. For example, Ong (1995) cautions that because professional interpreters are likely trained according to the Western concept of health, their interpretation of the client's difficulties may not be an accurate reflection of the client's issues, but rather an attempt to fit the issues into models and concepts that are understood by the service providers. Service providers also noted that there were times when interpreters became traumatised and needed therapeutic support themselves. The training that interpreters currently receive may need to increase education on how interpreters can manage the distress witnessed or discussed in sessions. There may also be a need to provide extra supervision and debriefing opportunities for interpreters after the interpretation session.

It has previously been reported that when mental health services are accessed, people from some ethnicities prefer therapists of the same race or ethnicity. Such preference has supported the development of ethnic-specific programmes that match the client to a clinician of the same culture and ethnicity (Sue, 1988). However, the participants in Study One did not want to engage with service providers of the same ethnic background because of fear of confidentiality being breached within their community. Consistent with other mental health related studies with ethnic minorities, fear of confidentiality not being maintained or mistrust has been identified as a barrier to receiving mental health treatment amongst many racial and ethnic minorities (DHHS, 2001). Thus, while matching ethnicity between the service user and service provider may be seen as a method for increasing cultural competency, in some cases it can have a deterring effect on the young person's decision to access help and to continue follow-up. It may be more important to make a case-by-case clinical judgement and consider the young person's preference in service providers allocated, particularly someone who may

have an understanding of the influence of culture and context on their difficulties and challenges.

To support youth from refugee backgrounds to cope with their difficulties and challenges, service providers in Study Two discussed using a wide range of individual therapies and family therapy. When working with the family, service providers can support families to reinterpret roles in a positive way that recognises strengths within the post-traumatic reconstruction. For example, “parentification” with children is often perceived as a burden; however, it could be reconstructed as a role that has a purpose and mission. It can thus serve a protective function. An implication with the findings of both studies is that considerations need to occur about the provision of care that will be available to these families, and how easily they will be able to access support services. There must also be consideration about what may prevent or limit the families from accessing available sources of support, otherwise there may be a greater sense of expectation and responsibility on the care-giving role for refugee youth. As participants in both studies have reported, many young people from refugee backgrounds are vulnerable to difficulties in adjusting and adapting to the new culture, without these expectations adding more stress.

As part of therapy, service providers also highlighted education and skills development as another important component of their input with youths from refugee backgrounds. In addition, youths were referred to other agencies that supported artistic pursuits, sports or engagement with other activities that enabled the continuity with meaningful aspects of the young person’s life.

Youths from refugee backgrounds in Study One discussed how when they did access help, they were more likely to access their GPs or school guidance counsellors. This highlights the importance of educating and equipping these professionals so they are able to identify and respond appropriately to the psychological/behavioural/personal needs of the young person. According to Hodes, Jagdev, Chandra and Cunniff (2008), schools may provide mental health services for children and young people from refugee backgrounds who otherwise may not be able to access assessment or therapy through having a primary mental health professional situated within the school environment. However, this may not always be feasible. As service providers identified in Study Two, increased liaison and relationship building with schools will help to achieve a collaborative approach with gatekeepers within

these organisations. Furthermore, liaison with these agencies will support these agencies to continue providing support and input with adolescents from refugee backgrounds, particularly when the young person's difficulties are not the functional impairment that warrants formal mental health input. Current services may thus need support to develop these liaison roles or positions.

The challenges facing youths and families from refugee backgrounds as identified in both studies suggest the importance of developing programmes and services that are comprehensive and multicultural in nature. It further supports the suggestion of Birman et al. (2008) that components of outreach are required to assist with engaging populations that encounter barriers to accessing service. The wide range of stressors identified by participants in both studies also supports the need for a holistic approach to working with adolescents from refugee backgrounds. Culturally informed care would factor in challenges with stigma, the social functioning and the role of the family, traditional healings and beliefs about medication and language and cultural understandings (Fancher, Ton, Le Meyer, Ho & Paterniti, 2010). The findings from both studies suggest that while youths from refugee backgrounds and their families have complex needs, they can be successfully engaged in mental health services that are mindful of their needs. Such services need to have links and relationships with community agencies and other resettlement, education and social services that work with young people from refugee backgrounds and their families.

Limitations of Research

The findings of the present research must be considered in the context of a number of limitations. One of the primary limitations was the small sample size in the focus groups with service users, non-service users, service providers and in the one-to-one interviews with service users. While considerable efforts were made to recruit youth participants and service providers from various sources, recruitment was challenging. As in much qualitative research, the convenience voluntary sampling and small sample size restricts the generalisability of the data.

Several issues may have contributed to the small and perhaps selective sample. Participants in Study One were recruited from Auckland and Hamilton, areas that are known to be highly populated by people from refugee backgrounds. However, the sample cannot be

considered representative of the wider national refugee population to which they belong. Furthermore, the nature of the study inevitably restricts the sample size because it is a qualitative as opposed to a quantitative study. In addition, asking youths from refugee backgrounds to participate in a study about experiences with mental health services can have stigmas attached in itself, which may have negatively impacted their interest in participation.

Secondly, within a focus group setting, it is possible that participants experienced inhibition and reported only superficial or general concerns. This was at least partially accounted for by completing one-to-one interviews, where participants were found to discuss more serious issues such as discrimination and abuse. Contributing to this may have been that by interviewing participants at their home (although it may have been chosen as an interview setting by the participant), the ability to control for the presence or interruption of family or other members may have affected their ability or decision to disclose particular experiences. Furthermore, the use of an interpreter in the one of the focus groups, despite the reassurance of confidentiality, may have also affected the participants' ability to share more traumatic experiences. The use of interpreters in research work further affects the translated meaning of the discussions.

The information gathered for this study was collected in a specific relational or interpersonal context. That is, young people from refugee backgrounds from a wide range of ethnic backgrounds were asked to share very personal accounts to a female Laotian researcher also from a refugee background. During the first few focus group interviews, the researcher was mindful of disclosing her refugee background in case it biased the participants' responses. For example, the young participants might choose to limit their sharing if they held the assumption "she should know what it is like". As the research progressed, the researcher disclosed in the focus groups and one to one interviews when appropriate as a method of prompting responses from participants. For example, in one youth focus group, participants reported they had not experienced any difficulties. The researcher consequently gave brief examples of the difficulties she had experienced in adjusting to living in New Zealand. The young people in the group reported they had in fact experienced those things. However, the fact that the participants did not initially report their experiences has several possible interpretations. Firstly, they might not have perceived their experiences as a challenge; secondly, the experiences may have been perceived as a norm, rather than a unique or different perspective/experience to living and growing up in New Zealand; and

thirdly, they may have perceived the experiences as challenging but did not want to be seen as youths who had struggled with difficulties in adapting.

It is unknown to what degree and in what ways the participants may have modified their responses in relation to their experience of the relational context. With this in mind, the data set represents a unique context of researcher participant relationship that invariably means that if some other researcher (for example, perhaps one from the participants own ethnic background) was to ask similar questions, the stories captured may be different to that obtained within the conditions of this research. By the same token, a relational context applied to the research with service providers, given that mental health professionals were asked to share their experiences with a researcher from a clinical psychology background, may have shaped their responses by concerns about how their intervention and practice with young people from refugee backgrounds may be viewed or interpreted by a researcher who is both a health professional and from a refugee background herself.

The service provider group may also not have been representative of the mental health service provider population in New Zealand. While this study sought to include voices of service providers from the education sector and primary, secondary and tertiary level healthcare, there were a greater proportion of service providers from the tertiary sector and a greater representation from psychology than any other professional background. The education the participant received in working with people from different cultures (particularly from traumatised background) and the type of support they received in regards to their work may be different across professions. Each profession's training aspect was not examined in this particular study to identify the possible relationship between training received and the experience perceived in working with youth from refugee backgrounds. Mindful of the greater representation of psychologists, comparative studies among school counsellors or general practitioners working in the same area might also determine how working with the youth from refugee backgrounds population affects them, which may help to highlight the type of support and resources they require in their work.

Another limitation in this study is that, with the absence of a control group of non-refugee migrant group, it is difficult to identify the extent to which the issues presented in both studies are related specifically to the refugee experience.

Finally, a limitation in this study relates to reflexivity in research, which has likely

impacted how the researcher constructed her interpretation of the data gathered across both studies. As a formal refugee youth resettled in New Zealand from a young age, and as a Clinical Psychologist who has worked with young people from refugee backgrounds, these experiences have likely shaped her construction of knowledge and has likely further influenced the planning, conduct and writing up of the research.

Future Research

There are many areas in which future research needs to be conducted in terms of the understanding of mental health needs and service provision to people from refugee backgrounds in New Zealand. Firstly, future studies need to be undertaken to develop a conceptual model to enable an understanding of coping and adaptation within the New Zealand context. In terms of its implication, new groups of people from refugee backgrounds arriving in New Zealand would particularly benefit through the facilitation of appropriate interventions that focus on supporting resilience, wellbeing and a sense of community in what is commonly identified as an at-risk group within our society. Stemming from this research, potential questions to consider in terms of future research include: (i) What is the exact mechanism of increased risk for psychological distress, and (ii) in regards to the experience and shaping of coping behaviours, are certain cultural health and coping beliefs more salient than others.

Secondly, future research could include the perspectives of youths from refugee backgrounds and compare these with youths belonging to other ethnic groups in New Zealand, such as those from migrant backgrounds and youths from the mainstream society. Through including comparison groups, it would help to identify barriers common to all youths versus those specific to refugee youths and shed light on the areas that require input to reduce barriers to access and engagement.

Thirdly, participant reports from both studies in regard to intergeneration conflict that is contributed (but not limited) to by changes in family roles and dynamics, different rates of acculturation and language acquisition, parental expectations and poor parental mental health suggest that future research could research the efficacy of family therapy with youth from refugee backgrounds.

Fourthly, youths from refugee backgrounds indicated that they are more likely to access primary health practitioners and school guidance counsellors for support than access help from tertiary level mental health services because of possibly fewer stigmas attached to these supports. Therefore, research examining the impact of increased education and support to primary health practitioners and school guidance counsellors in terms of working with young people from refugee backgrounds and their families would also be helpful.

Conclusion

To the researcher's knowledge, this is the first youth from refugee backgrounds study in New Zealand to have examined young people from refugee backgrounds adaptation stressors, coping and provision of care with youths from refugee backgrounds and mental service providers. The findings demonstrate that youths from refugee backgrounds experience a wide range of stressors across the refugee experience from the pre-migration to the post-migration phase. Furthermore, youth from refugee backgrounds access diverse coping mechanisms to manage their stressors. The two studies have highlighted youth from refugee backgrounds needs and stressors in New Zealand, but more importantly, they have shed light on coping by adolescents from refugee backgrounds in the face of difficult circumstances throughout the refugee experience. It has further shed light on some of the challenges in delivering accessible and needs-led mental health services for youths from refugee backgrounds.

The complex social and psychological needs of youth from refugee backgrounds and their families place demands on mental health services and an integrated response is required from a range of community agencies and services. These include the ability to develop close liaisons with other agencies when required, including an awareness of the complexity of the client's issues and challenges. Practical issues (e.g., providing information in the client's native language, changing hours of service and interpretation services) are also important, although they inevitably place further demands on budgets, human resources and organisation structure. These factors are important considerations for social and health planners when services are being developed, especially in areas with significant refugee populations.

Although improving access to care is a crucial component in addressing the mental health needs of youths from refugee backgrounds, without the provision of evidence-based treatments that target specific mental health problems, and related social impairment, these

needs will continue to be unmet. Because of the limited information available about clinical effectiveness in young people from refugee backgrounds mental health, service providers need to carefully formulate and plan their input in order to successfully engage with youths from refugee backgrounds and their families, and provide both culturally and developmentally-appropriate interventions. Therefore, it is critical that service providers are aware of the impact of the pre- and post-migration experience of youths from refugee backgrounds. The psychological risk factors identified in this research relevant to youths from refugee backgrounds include the enduring impact of trauma, loss and significant challenges in acculturating to the new environment and adapting to changes in family roles and function. Consideration is also required in recognising and strengthening the individual and systematic factors that promote psychological resilience within the youth and their family unit.

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Appendix A.
Refugee Youth Experience of Mental Health Services in New Zealand

Individual Interview Questions with Refugee Youths

Pre-migration history and experiences:

- Do you remember leaving your homeland?
- What types of things do you remember?
- What was it like to stay in the refugee camp?
- What expectations did you have about life in New Zealand?

Early adjustment experiences in New Zealand

- What types of things did you find most difficult when you first arrived in New Zealand?
- Is this still a problem?
- How did you manage to solve this problem?

Adjustment problems specific to school life

- Do you experience any difficulties in school? If so, what types of difficulties have you experienced?
- How important is it for you to do well in school?
- Do you feel pressure or expectations to do well in school?

Family and social relationships

- How is your relationship with your parents?
- Are there any values that you and your parent(s) share/disagree on?
- What types of friends do you have, for example do you have friends mainly from one culture or a lot of culture
- How do you think other New Zealanders see you?
- What kinds of struggles do you see yourself as having as a refugee youth?

Coping

- How do you cope with your problems/difficulties?

Experience with the health services

- What type of difficulties have you accessed mental health services for?
- What has been your experience with the mental health service you have accessed or are accessing?
- Would there be any reasons why you would not talk to a doctor or counsellor when feeling stressed/worried or sad?
- What type of support did they offer you?
- How did you feel about the service and why?
- How can your experience be improved e.g. interpreters or cultural workers available?

Appendix B.
Participant Information Sheet
For Youth Focus Group Interviews



THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND
HEALTH SCIENCES

Investigator: Chaykham Choummanivong
Department of Social and Community Health
School of Populations Health
The University of Auckland
Private Bag 92019
Auckland

Title: Refugee Youth Experience of Mental Health Services in New Zealand

My name is Chaykham Choummanivong. I am a Laotian postgraduate student at the University of Auckland, enrolled for a Doctor of Philosophy Degree in the Department of Social and Community Health. As part of my doctoral thesis, I am conducting a study to examine refugee youth experience of mental health services in New Zealand.

Why is this research happening?

There are an increasing number of refugee youths in New Zealand. A number of these youths have experienced significant problems adjusting to living in New Zealand, which may require input from mental health services.

You are invited to participate in a group discussion with 4 or 5 other youths. You will be asked to discuss a number of topics including the issues that refugee youths have presented with, and what assessments and treatment models have been utilised with refugee youths. Following the focus group discussions, some of you may be asked to participate in individual interviews with the researcher to discuss in more depth the difficulties that you have experienced adjusting to living in New Zealand and the impact this has had on your mental health.

Group discussions will be conducted in English, at a place and time convenient to you, and are expected to take approximately 60 to 90 minutes. If required, interpreters will be available. I will take notes during the group discussions which will also be audio-taped. The tapes may be transcribed for further analysis.

If you do wish to be interviewed please let me know by filling in the Contact Form, and then either posting the completed form to me at the above address or emailing me at chaykham@internet.co.nz.

In recognition of the time you've given to take part in this research, I will offer you a \$20 supermarket/petrol voucher or a movie pass.

How will the findings of the research be used?

Data from this research will provide in-depth information on a wide range of issues that refugee youths experience in acculturating to New Zealand's society. This information will help organisations and professionals to assist and hopefully provide better care and services for the problems identified.

Confidentiality

Your confidentiality is very important. If the information you provide is reported or published, this will be done in a way that does not identify you as its source. If you choose to take part in this study, you may refuse to answer any particular question, and ask any questions about the research at any time.

Should you find the interview or questions upsetting and wish to talk with someone, please contact the researcher who is a trained clinical psychologist. She, along with her supervisors will support you to access appropriate assistance.

A summary of research findings will be sent to the funding agency and other stakeholders, and will be made available to participants at their request.

Any Questions?

Thank you for your time and help in making this study possible. If you have any queries or require further information, please contact the researcher, Chaykham Choummanivong.

My supervisor is:
Associate Professor Peter Adams
Department of Social and Community Health,
Health
School of Population Health,
The University of Auckland
Private Bag 92109
Phone: 3737599
Email: p.adams@auckland.ac.nz

The Head of Department is:
Associate Professor Peter Adams
Department of Social and Community
The University of Auckland
Private Bag 92109
Auckland
Phone: 373 7599
Email: p.adams@auckland.ac.nz

For any queries regarding ethical concerns please contact:

The Chair, The University of Auckland Human Participants Ethics Committee,
The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland
Phone: +64 9 3737999 Ext 87830

“APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 3/11/2008 for three years from 10/11/2008 to 10/11/2011 Reference Number 2008/369”

Appendix C.
Contact Reply Slip



THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND
HEALTH SCIENCES

Centre for Asian Health Research and
Evaluation
Social and Community Health
School of Population Health
Tamaki Campus, University of Auckland
Morrin Rd, Glen Innes
Private Bag 92019, Auckland,
New Zealand
Phone +64 9 3737599
Fax +64 9 3737624

Title: Refugee Youth Experience of Mental Health Services in New Zealand

Researcher: Chaykham Choummanivong

I would like to participate in the study and I would like to be interviewed. Please contact me to
arrange an interview date and time:

Name of Participant:.....

Daytime phone Number:.....

Evening Phone Number:.....

Email:.....

Signature:.....

Date:

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COMMITTEE ON 3/11/2008 for three years from 10/11/2008 to 10/11/2011 Reference
Number 2008/369”**

Appendix D.
Participant Information Sheet
For Individual Youth Interviews



Centre for Asian Health Research and
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Investigator: Chaykham Choummanivong
Department of Social and Community Health
School of Populations Health
The University of Auckland
Private Bag 92019
Auckland

Title: Refugee Youth Experience of Mental Health Services in New Zealand

My name is Chaykham Choummanivong. I am a Laotian postgraduate student at the University of Auckland, enrolled for a Doctor of Philosophy Degree in the Department of Social and Community Health. As part of my doctoral thesis, I am conducting a study to examine refugee youth experience of mental health services in New Zealand.

Why is this research happening?

There are an increasing number of refugee youths in New Zealand. A number of these youths have experienced significant problems adjusting to living in New Zealand, which may require input from mental health services.

You are invited to participate in a one on one interview. You will be asked to discuss your experiences of mental health services (this includes General Practices (GP), School Guidance Counsellors and other services such as Child and Adolescent Mental Health Service.

The interview will be conducted in English, at a place and time convenient to you, and are expected to take approximately 60 to 90 minutes. If required, an interpreter will be available. I will take notes during the interview which will also be audio-taped. The tapes may be transcribed for further analysis.

If you do wish to be interviewed please let me know by filling in the Contact Form, and then either posting the completed form to me at the above address or emailing me at chaykham@internet.co.nz.

In recognition of the time you've given to take part in this research, I will offer you a \$20 supermarket/petrol voucher or a movie pass.

How will the findings of the research be used?

Data from this research will provide in-depth information on a wide range of issues that refugee youths experience in acculturating to New Zealand's society. This information will help organisations and professionals to assist and hopefully provide better care and services for the problems identified.

Confidentiality

Your confidentiality is very important. If the information you provide is reported or published, this will be done in a way that does not identify you as its source. If you choose to take part in this study, you may refuse to answer any particular question, and ask any questions about the research at any time.

Should you find the interview or questions upsetting and wish to talk with someone, please contact the researcher who is a trained clinical psychologist. She, along with her supervisors will support you to access appropriate assistance.

A summary of research findings will be sent to the funding agency and other stakeholders, and will be made available to participants at their request.

Any Questions?

Thank you for your time and help in making this study possible. If you have any queries or require further information, please contact the researcher, Chaykham Choummanivong.

My supervisor is:
Associate Professor Peter Adams
Department of Social and Community Health,
Health
School of Population Health,
The University of Auckland
Private Bag 92109
Phone: 3737599
Email: p.adams@auckland.ac.nz

The Head of Department is:
Associate Professor Peter Adams
Department of Social and Community
The University of Auckland
Private Bag 92109
Auckland
Phone: 373 7599
Email: p.adams@auckland.ac.nz

For any queries regarding ethical concerns please contact:

The Chair, The University of Auckland Human Participants Ethics Committee,
The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland
Phone: +64 9 3737999 Ext 87830

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Appendix E.
Consent Form
For Youth Participants



THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND
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Private Bag 92019, Auckland,
New Zealand
Phone +64 9 3737599
Fax +64 9 3737624

Title: Refugee Youth Mental Health

Researcher: Chaykham Choummanivong

This Consent Form will be stored for six years in a locked cabinet on University premises, before it is destroyed.

I have read the Information Sheet and have had the details of the research explained to me. My questions have been answered to my satisfaction, and I understand I may ask further questions at any time.

I understand that my name will not be used in any reports or publications arising from the study. I agree to provide information to the researcher on the understanding that my name will not be used.

I understand that the researcher cannot ensure confidentiality of the information shared in a focus group discussion, as it requires everyone who takes part to keep the information confidential. I agree to keep the information shared in the group discussions confidential.

I understand I have the right to withdraw from the study at any time without giving a reason and to decline to answer any particular question before the 10th of April 2009. I also understand that if I withdraw from the study, any comments I have provided within a group discussion will be unable to be identified and withdrawn from the project.

I agree that the discussion will be audio taped. I understand that the audio-tapes will only be transcribed by the researchers if needed and erased after the completion of the project.

I request/do not (please circle one) request for a summary of the key research findings.

I agree to take part in this research under the conditions set out in the Information Sheet.

Name: _____

Postal address: _____

Signed: _____

Date: _____

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Appendix F.

Participant Information Sheet For Professional Focus Group Discussions



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Phone +64 9 3737599
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Investigator: Chaykham Choummanivong
Department of Psychology
The University of Auckland
Private Bag 92109
Auckland

Title: Refugee Youth Experience of Mental Health Services in New Zealand

To: The participants of mental and community health professionals focus group discussions

My name is Chaykham Choummanivong. I am a Laotian postgraduate student at the University of Auckland, enrolled for a Doctor of Philosophy Degree in the Department of Social and Community Health. As part of my doctoral thesis, I am conducting a study to examine refugee youth experience of mental health services in New Zealand.

Why is this research happening?

There are an increasing number of refugee youths in New Zealand. A number of these youths have experienced significant traumas prior and post migrations, which may require input from mental health services. There are currently very little information about what problems these youths present with to mental health services (which broadly include services provided by General Practitioners, School Guidance Counsellors and Health professionals in Tertiary Sectors that include Psychotherapist, Clinical Psychologist and Psychiatrist) in New Zealand, and how these problems are assessed or addressed.

Who and what will the research involve?

This research will involve Refugee youths who have accessed or are accessing 'mental health services' in New Zealand. Participants will be recruited from within Auckland. I would also like to invite Mental and community health professionals who have had experience with refugee youths to participate in my research.

You are invited to participate in a group discussion with 4 or 5 other professionals. You will be asked to discuss a number of topics including the issues that refugee youths have presented with, including what assessments and treatment models have been utilised with these youths.

Group discussions will be conducted in English, at a place and time convenient to you, and are expected to take approximately 60 to 90 minutes. If required, interpreters will be

available. I will take notes during the group discussions which will also be audio-taped. The tapes may be transcribed for further analysis.

If you do wish to be interviewed please let me know by filling in the Contact Form, and then either posting the completed form to me at the above address or emailing me at chaykham@internet.co.nz.

How will the findings of the research be used?

Findings from this research will provide in-depth information on a wide range of issues that refugee youths experience in acculturating to New Zealand's society. This information will help to assist and hopefully provide an effective culturally appropriate model for addressing the difficulties they present with.

Confidentiality

The researcher cannot ensure confidentiality of the information shared in a focus group, as it requires everyone who takes part to keep the information confidential. Participants will be asked to keep the information shared in the group discussions. Your name will not be used in any reports or publications arising from the study. If you choose to take part in this study, you may refuse to answer any particular question, and ask any questions about the research at any time. As all information is anonymous, any comments you provide within a group discussion will be unable to be identified and withdrawn from the project.

Potential Risks

Should you find the focus group discussions or questions distressing and wish to talk with someone, please contact the researcher who is a trained clinical psychologist with over four years experience in working in the mental health field. She, along with her supervisors will support you to access appropriate assistance.

Transcriptions of group discussions and any other information will be kept by the researcher in a locked cabinet on University premises for up to six years after this research for future reference if necessary. After this period the transcriptions will be destroyed by shredding and the audio-tapes of group discussions will be erased by the researchers after completion of the project.

A summary of research findings will be sent to the funding agency and other stakeholders, and will be made available to participants at their request.

Any Questions?

Thank you for your time and help in making this study possible. If you have any queries or require further information, please contact the principal investigator, Chaykham Choummanivong.

My supervisor is:
Professor Fred Seymour
Department of Psychology,
The University of Auckland
Private Bag 92109
Phone: 3737599
Email: f.seymour@auckland.ac.nz

The Head of Department is:
Dr Douglas Elliffe
Department of Psychology
Private Bag 92109
Auckland
Phone: 373 7599
Email: d.elliffe@auckland.ac.nz

For any queries regarding ethical concerns please contact:

The Chair, The University of Auckland Human Participants Ethics Committee,
The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland
Phone: +64 9 3737999 Ext 87830

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COMMITTEE ON 3/11/2008 for three years from 10/11/2008 to 10/11/2011 Reference
Number 2008/369”**

Appendix G.
Consent Form
For Mental and Community Health Professionals



THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND
HEALTH SCIENCES

Centre for Asian Health Research and
Evaluation
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Tamaki Campus, University of Auckland
Morrin Rd, Glen Innes
Private Bag 92019, Auckland,
New Zealand
Phone +64 9 3737599
Fax +64 9 3737624

Title: Refugee Youth Experience of Mental Health Services in New Zealand

Researcher: Chaykham Choummanivong

This Consent Form will be stored for six years in a locked cabinet on University premises, before it is destroyed.

I have read the Information Sheet and have had the details of the research explained to me. My questions have been answered to my satisfaction, and I understand I may ask further questions at any time.

I understand that my name will not be used in any reports or publications arising from the study. I agree to provide information to the researcher on the understanding that my name will not be used.

I understand that the researcher cannot ensure confidentiality of the information shared in a focus group discussion, as it requires everyone who takes part to keep the information confidential. I agree to keep the information shared in the group discussions confidential.

I understand I have the right to withdraw from the study at any time without giving a reason before the 10th of April 2009. I also understand that if I withdraw from the study, any comments I have provided within a group discussion, will be unable to be identified and withdrawn from the project.

I understand that the discussion will be audio taped. I understand that the audio-tapes will only be transcribed by the researchers if needed and erased after the completion of the project.

I request/do not (Please circle one) request for a summary of the key research findings.

I agree to take part in this research under the conditions set out in the Information Sheet.

Name: _____

Postal address: _____

Signed: _____

Date: _____

“APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 3/11/2008 for three years from 10/11/2008 to 10/11/2011. Reference Number 2008/369.”