This paper is published in the Journal of Refugee Studies

Renuka Mahadevan, Maneka Jayasinghe, Home away from home: Examining adolescent refugees' well-being in Australia, *Journal of Refugee Studies*, 2021;, feab065, https://doi.org/10.1093/jrs/feab065

Home Away from Home: Examining Adolescent Refugees' Well-Being in Australia

Renuka Mahadevan and Maneka Jayasinghe

Abstract

This paper examines the correlation of post-migration factors and in particular parental mental health with post-traumatic stress disorder (PTSD) and happiness levels of adolescent refugee migrants in Australia, with a special emphasis on associated age and gender differences. Data was sourced from the child module in the 2015-2016 Building a New Life in Australia data set. Results indicate that factors associated with happiness are quite different from those associated with PTSD and this varies across gender and the age groups of 11-14 and 15-17. For example, discrimination related to religion/culture and language have different correlation with boys' and girls' well-being measures. While father's education and mental state have no significant association with any well-being measure, mothers' education plays some role. Of concern is the intergenerational correlation of mother's PTSD with their daughters. The results in this study caution against a one-size-fits-all approach to intervention and suggests that a targeted focus on older and younger adolescents further differentiated by gender is likely to be more effective.

Key words: Mental health, Happiness, Adolescents, Refugees.

Introduction

The United Nations High Commission for Refugees (UNHCR) reports that by the end of 2019, 79.5 million individuals have been forcibly displaced worldwide as a result of persecution, conflict, violence or human rights violations. This was a record high with 26 million of them being refugees, and of great concern is that, around half of the refugees are children (UNHCR 2019). Pritchard et al. (2019) notes that this is one reason that researchers, practitioners and policymakers need to understand the consequences of forced migration on the integration of refugee children and youth in receiving countries.

Refugee children come from areas with ongoing war, armed conflict, persecution, immense poverty and may risk forced labor, sexual abuse, beatings, and detention during migration. As

a result of these stressors, refugee children comprise an especially vulnerable group for the development of mental disorder (Brown et al. 2017) and more so than those who are not refugees (Bryant et al. 2018, Fazel and Stein 2002). Article 22 of the 1989 UN Convention on the Rights of the Child tries to ensure that refugee children have the same rights as citizen children. Although there has been increasing research interest on the mental health of refugee children, there is a dearth in empirical research involving representative samples that investigate the psychosocial well-being of this vulnerable group within resettled families in high income countries (Lau et al. 2018).

In addition, empirical research on refugee children (see Fazel et al. 2012 for an excellent summary of studies) has mainly focussed on the post-traumatic stress disorder (PTSD) scores, child behaviour checklist, centre for epidemiologic studies depression scale for children, stressful life events, impact of events scale for children, and strengths and difficulties questionnaire (SDQ) amongst others. While these centre on psychological distress, there is value in examining positive mental health or flourishing measures such as satisfaction and happiness levels (Du Plooy et al. 2019, Yoon et al. 2013). Attaining a satisfactory level of well-being is a primary goal for most people, be they refugees or non-refugees.

Researchers (Keyes 2002, Westerhof and Keyes 2010) have argued that a dual continuum model comprising distress and flourishing measures can provide a more complete understanding of mental health. This model proposes that these measures are two distinct dimensions that are not mutually exclusive or perfectly correlated. Hence factors linked to distress may not necessarily be the same factors linked to flourishing.

Thus this paper uses both PTSD scores and self-reported level of happiness to provide a more holistic understanding of refugee children's well-being. Correa-Velez et al. (2015) have examined factors that are associated with happiness and self-reported health status for Australian refugee youth aged 11-19 while an earlier study Correa-Velez et al. (2010) did so including several domains of well-being for refugees aged 12-18 years. However, these studies did not disaggregate the analyses by age or gender. While previous studies including Fazel et al. (2012) have examined differences in gender and age of the child and adolescent refugees, this is mainly on the state of their mental health. More recently, reviews by Maehler et al. (2020) and Pritchard et al. (2019) note that a meaningful share of studies fails to distinguish between male and female children and younger and older adolescents in terms of factors linked with their mental health.

This paper sheds some light on the above identified research gaps using Australia as a case study to address the following research questions: 1) How different or similar are the factors associated with PTSD and happiness levels of refugee youth? 2) How do pre- and post-migration factors differ based on gender and age of this cohort? 3) In particular, what is the correlation of parents' mental status with the different age groups and gender of the refugee adolescents?

The Australian Context

Australia formally participates in the UNHCR resettlement programme accepting 12 000 to 20 000 refugees a year after their asylum claims have been processed overseas.[1] More specifically, the Australian Government has announced that it would increase the total Refugee and Humanitarian Program intake from 13 750 places in 2013/14 to 18 750 places from 2018/19 onwards (Kaldor and Kaldor 2020). The Community Support Program which began in July 2017 enables refugees (limited to 1000 places) to be resettled with support from individuals, community groups or business (ibid).

Australia is rather unique in that it is the only country with an established practice of detaining asylum seekers and immigrants without visas including children in detention centres for an indefinite period of time since 1992 (Mares 2016). Also, there is the additional threat of offshore processing of asylum seekers in Papua New Guinea's Manus Island and the Pacific Island nation of Nauru. This has been described as a manoeuver by the Australian government to evade legal obligations enshrined in refugee law and human rights (Everuss 2020). The facilities and conditions in Australian detention centres as well as abuse, self-harm and neglect of those housed both onshore and offshore are widely known and have received much criticism (Hedrick et al. 2019, Sanggaran and Zion 2016).

Currently, close to 300 children are in asylum-seeker detention.[2] The detention of asylum-seeker children has a long and brutal history in Australia and the separation of children from their families is not uncommon.[3] The scale of abuse of children in Australia's offshore

[1]Retrieved from Department of Immigration and Citizenship. Refugee and Humanitarian Program 2019, https:// immi.homeaffairs.gov.au/what- we- do/refugee- and- humanitarian- program/refugee- visas
[2] Retrieved from https://www.asyluminsight.com/#/statistics/
[3] Retrieved from https://www.ruralaustraliansforrefugees.org.au/australias-treatment-of-refugee-children/

detention[4] and the harsh practises in detention have led to child conduct problems (Hodes 2019, Zwi et al. 2020). Policies governing care and facilities and integration efforts to help refugee children and adolescents varies by states in Australia and there is little documentation in the public domain on many fronts.

Literature Review

The mental health of refugee children is said to depend on three stages of traumatic experiences (Fazel and Stein 2002) – in their native countries when they were forced to flee; journey to a country as they can be exposed to various threats and danger; and the final stage of finding respite in another country. The last form of trauma relates to integrating into the new society, feeling welcome, finding a peer group and settling into a new school to resume their disrupted education. Several studies such as Punamaki (1989), Mels (2010) and Eruyar et al. (2018) have highlighted the adverse impact of pre-migration experience of the first two stages on the final stage of trauma for refugee children. These include number of traumatic events experienced or witnessed before arrival, losing their parents, time taken for immigration status to be determined, period of time in refugee camp, physical health or malnutrition amongst other factors.

The majority of the literature on post-migration factors affecting refugee children centre around the individual child, parental and family factors, living conditions, and the external environment such as school and community. With the individual child, physical health impaired by past experiences and adversities (Hirani et al. 2019, Sandell et al. 2017), and inherent personality traits such as being an introvert/extravert or being more resilient by nature will affect how they deal with events in daily life (Hodes, Gau and De Vries eds. 2018).

Parental factors such as education and employment (Fazal and Stein 2002, Zwi et al. 2016), their PTSD (Bryant et al. 2018, Hodes 2019), their English language proficiency (Beiser and Hou 2016, Zwi et al. 2018), and family composition (Zwi et al. 2016) are linked to their children's mental health. Parenting behaviour related to child-adult relationship could either be

[4] Retrieved from https://www.theguardian.com/australia-news/2016/aug/10/the-nauru-files-2000-leaked-reports-reveal-scale-of-abuse-of-children-in-australian-offshore-detention

supportive if there is warmth or problematic if hostile (Anstiss et al. 2019, Lau et al. 2018). For instance, there could be conflict associated with children's pursuit of a more western lifestyle and there can be a disconnect between home and host-culture rearing practices. Parental mental health, particularly in mothers is an important protective factor of children's mental health (Fazel et al. 2012). Bryant et al. (2018) however observes that the evidence of an association between parent and child mental health status is mixed and a major limitation of the studies on this issue is the reliance on small and non-representative samples, which restricts confidence in the validity of the findings.

Living conditions related to poverty and hence household facilities and inability to afford recreational activities and opportunities have been found to have negative outcomes for refugee children (Allsopp et al. 2014, Montgomery 2011). Others such as Beiser and Hou (2016) do not find poverty to be significantly associated with children's emotional problems.

With regards to the external environment outside the family, several studies have examined refugee children's involvement in community groups based on ethnicity or religion. Some studies (Sujoldzic et al. 2006, Bhui et al. 2012) have found these to reflect the importance of social capital and connections to have a positive correlation with mental health while others such as Lau et al. (2018) and Wilkinson et al. (2017) have found limited or no association. Arguments around these results are varied and complex. For instance, community groups can be effective as a platform for troubled refugee adolescents to seek advice outside their immediate family or have peer groups to discuss some issues and feel that they belong (Moensted 2020). At the same time, these groups may not be the right forum for refugee adolescents to air troubles for fear of being shamed or gossiped about (Dhanji 2009, Moensted 2020). The lack of appropriate professional expertise and service in these groups to deal with mental health problems is another concern.

As schools are one of the first and potentially most influential services that refugee children engage with, the school context plays a pivotal role in the socialisation and acculturation processes in the host country (Horswood et al. 2019). By and large, the extent of adjusting well in school and doing well at school has a positive correlation with the well-being of refugee children (Bang 2017, Lau et al. 2018).

In addition to attending school, Fegert et al. (2018) note that learning the language of the host country was the most common need of refugees minors as access to education offers a much needed daily structure and an opportunity for integration into society. Beibert et al. (2019) show that language competency matters for social inclusion of refugee adolescents. The importance of language also manifests itself in the form of children who may have to assume adult roles as a vital language link with the outside world for their family (Fazel and Stein 2002). It has been noted that language brokering for parents can be highly stressful for refugee children with low host language competency (Kam and Lazarevic 2014).

Lastly, being bullied and the experience of discrimination adversely affect the mental health of refugee children (Correa-Velez et al. 2015, Samara et al. 2020). Some studies such as Beiser and Hou (2016) considered a range of questions related to different types of discrimination and summed the effect in their analysis.

Methods

Data and sample

Data for the analysis in this paper were drawn from a population-based cohort representative sample of refugees from the Building a New Life in Australia (BNLA) data set compiled by the Australian Government Department of Social Services and the Australian Institute of Family Studies (see Edwards et al. 2018 for details). The refugee cohort has permanent humanitarian visa and about 87% of the sample have been residing in Australia for 2 to 3 years. The data on refugee children was a one-off collection undertaken between October 2015 and February 2016. It was obtained from a face-to-face survey that was nested within a broader study on adult refugees.

To date, Bryant et al. (2018) and Lau et al. (2018) have used the same data set and examined some factors that affect the SDQ of refugees aged 5 to 17 years. The former study used structural equation modelling for the path analysis on four aspects (emotional, conduct, hyperactivity and peer problems) of the SDQ while the latter study used multiple regression analysis on the total SDQ score. Both these studies on the influence of the factors do not differentiate between the age groups of the adolescents or undertake explicit analysis for boys and girls in different age groups.

Our study not only fills the research gap on gender and age by undertaking separate regression analyses on these groups but unlike these studies, two different well-being measures given by PTSD and happiness levels are also used. In addition, our focus is on those aged 11-17 years as only those who are eleven years and above were allowed to answer questions themselves. Thus there was no mix of self-reported and parent-reported responses on their well-being in our sample. Parent-reported assessment on their children is said to have high intrinsic error (such as wanting to please the researcher) and this may be amplified in the refugee setting as parents may view their children's state as a reflection of their family and community and potential impact on their immigration status (Zwi et al. 2016).

Our research also considers a slightly different set of factors from Bryant et al. (2018) and Lau et al. (2018). Unlike their studies, ours includes the frequent use of mother tongue and English, discrimination experienced and each parents' education and mental state. Data on these variables for our analysis were available for 356 adolescent refugees for our sample.

Measures

There are two well-being measures used as dependent variables. With the happiness variable, a Likert scale response ranging from 1 (strongly disagree) to 5 (strongly agree) is recorded for the question of how much one agrees with the following statement: *In general, I am happy with how things are for me in my life right now.*

With the PTSD variable, we used two different measurements. One is a pre-determined binary valuation of 'unlikely to have PTSD' and 'may have PTSD'. Documentation on the BNLA data set explains that if all (any) the 3 subscales' criteria were (not) met, the PTSD value was set to 'may have PTSD' ('unlikely to have PTSD). The subscales are Intrusion, Avoidance and Hypervigilance. The criteria for indicating the presence of PTSD for each subscale was applied following Hansen et al. (2011). The second measure is the PTSD score derived using confirmatory factor analysis with a principal components extraction method based on a Likert scale ranging from 1 (not at all) to 4 (most of the time) for the following eight PTSD related aspects: recurrent thoughts or memories, feel the event is happening again, recurrent nightmares, feeling jumpy/ easily startled, feeling on guard, avoiding activities, avoiding thoughts or feelings, and sudden emotional/physical reaction when reminded of event.

The Bartlett's test for factor analysis rejected the null hypothesis that variables are orthogonal (χ^2=1963.7, degrees of freedom =28, p=0.000) and hence data is appropriate for factor analysis. The Keiser-Meyer-Olkin (KMO) value of 0.905 indicated that the sample is adequate and 90% of the variance in the data can be explained by the eight factors. When applied to the eight variables affecting PTSD, the principal component extraction resulted in a 1-factor solution with eigenvalues equal to or greater than one. Cronbach's Alpha statistic for internal consistency of 0.866 indicates the extent to which the separate questionnaire items measure the same underlying construct. As suggested by Allen and Bennett (2010), anything above 0.7 is acceptable and hence the data on the eight items are reliable to obtain the PTSD score. The higher (lower) generated PTSD score indicates a presence of higher (lower) level of PTSD.

Independent Variables

Apart from gender and age, potential pre-migration experience related to safety of the adolescent refugee was considered by the Yes/No response to the following question: '*Have you ever had something happen in which your safety or life was badly threatened?'*. A binary variable (Yes/No) that indicates the potential exposure of children to traumatic events based on the question: '*Have you been exposed to traumatic events?*' was also used. Questions relating to post-migration experience include the number of days of physical activity in last seven days and the list below.

<u>Parental factors</u>

: Whether both parents are in Australia (0=no; 1=yes)
: Any parent in paid work (0=no; 1=yes)
: Mother and father's education (decile ranging from 1=lowest to 10=highest)
: Mother and father's mental health (Kessler score from 6 to 30, higher score denotes more distress)
: Caregiver has a warm relationship with child (given by the sum of Likert scale responses to five types of questions - reported by parent; 1= never/almost never to 5= always/almost always)
: Caregiver has a hostile relationship with child (given by the sum of Likert scale responses to five types of questions - reported by parent; 1= never/almost never to 5= always/almost always)

<u>Community</u>

: Regularly attends activities in religious group (0=no; 1=yes)
: Involved regularly in team sports, music, or ballet (0=no; 1=yes)
: Recognised for achieving a community award for sports/music/arts/dance/drama (0=no; 1=yes)
: People in neighbourhood are friendly (reported by parent; 1= strongly disagree to 4= strongly agree)
: Neighbourhood feels safe (reported by parent; 1= strongly disagree to 4= strongly agree)

: Support was given from religious or ethnic community (reported by parent; 1=no, 2=sometimes, 3=yes)

Language
: *I often use English for communication* (e.g. talking to friends/family, reading books, television, internet) (1= strongly disagree to 5= strongly agree)
: *I often use the language spoken by my family for communication* (e.g. talking to friends/ family, reading books, television, internet) (1= strongly disagree to 5= strongly agree)

Discrimination (3 types of unfair treatment are considered separately)
In the last 6 months have you been treated unfairly or badly because of your language or accent; skin colour; religious beliefs/cultural background (0=no; 1=yes for each type)

School
: Overall achievement in school (reported by parent; 1= well below average to 5= excellent)
: Number of times skipped school in the last 12 months.

Statistical analysis

Data was collated and estimations were undertaken using STATA Version 16. As meeting the criteria for PTSD variable is binary, a binary probit model was used and with the PTSD score generated, ordinary least squares (OLS) model was used. With the happiness variable, an ordered probit model was used. The interpretation of a positive coefficient estimate in the PTSD binary model relates to an increased probability of suffering from PTSD symptoms. A positive coefficient estimate of PTSD in the OLS model indicates an increase in the level of PTSD symptoms.

In the first stage, descriptive statistics of the variables used are provided and a comparison of gender by age (11-14 and 15-17 years) is seen for the two measures of well-being. To date, there is no consensus as to what the cut-off age for younger and older adolescents should be (Pritchard et al. 2019). The chosen age categorisation in this study produced a more equal sample size in the two groups for analysis. In the second stage, regression analysis was undertaken for the full sample using both well-being measures. This was followed by separate regression analyses for boys and girls and younger and older adolescents and a combination of these. The correlation coefficient between the independent variables (available upon request) were all below 0.28 and do not pose any confounding associations when entered in a single multiple regression model.

Results

Table 1 shows the summary statistics of the variables used. The gender ratio of the sample is fairly equal and the proportion of younger adolescents aged 11-14 years (56%) is slightly more than the older adolescents aged 15 – 17 years (44%). It appears that only 15% of the youth may be suffering from PTSD and more than half the sample strongly agree that they are happy with their life.

[Table 1]

A much higher proportion (78.4%) of refugee youth agreed to using English often compared to those who agreed to using their mother tongue often (57.5%) for communication. While 67.4% of them had both parents with them, 17.7% felt that their safety was threatened and a very high proportion of them (more than 85%) have experienced some form of discrimination. About 21.7% of them indicated that they have been exposed to traumatic events. Lastly, the father's mean education level was significantly lower (t-statistic of -3.26) than the mother's education and the father's mean Kessler score was also significantly lower (t-statistic of -2.07), than the mother's, indicating that the mental state of mothers is worse than their spouse. The average PTSD score (from factor analysis) for refugee youth was 0.61with a minimum of 0 and a maximum of 2.19.

[Table 2]

Table 2 shows the breakdown by age and gender for the two well-being measures. With PTSD, there is hardly any gender difference in the percentage of those who have PTSD symptoms. This was reinforced with the happiness variable where gender difference was not statistically significant for the full sample and neither was it the case across the two age groups. However, within the boy and girl cohorts, there was a higher percentage in the younger adolescents who have PTSD symptoms compared to the older groups. But the mean happiness level of the younger adolescents is higher than the older ones for both boys and girls. The difference in the happiness levels of the age groups within the (boys) girls' cohort showed (weak) statistical significance.

[Table 3]

Table 3 shows that the common factor that affects both PTSD and happiness for the entire youth cohort is the unfair treatment related to religion/culture. Unfair treatment due to language/accent is associated with the increased PTSD score. Safety threats and exposure to

traumatic events related to pre-migration experience are correlated with both the PTSD score (from OLS model) and the probability of having PTSD (from the binary model) while parental hostility is only correlated with happiness. An increase in school achievements is associated with lower PTSD levels but has no association with happiness. While high frequency of communication in English and one's mother tongue has no correlation with the likelihood of having PTSD, communication in English, however, appears to be negatively correlated with the PTSD score. Both English and mother tongue have significant positive association with happiness.

The regression results also show no association of mother's education with adolescent PTSD or happiness and this was the same with the variables associated with the father (which are not shown here but are available upon request). Another result that is not significant is the association of parents' paid work. Similar to Lau et al. (2018), community related variables have no correlation with the probability of having PTSD or happiness of adolescent youth. Nevertheless, community involvement has a significant association with the PTSD score.

[Table 4]

The above results vary quite considerably when the analyses are undertaken by age and gender. For example, Table 4 shows that mother's depressed mental state is associated with only the older girls' mental state (model 6) while mother's education can be a protective factor against older boys' PTSD score (model 3). Having both parents live with them provides good support for older girls but not necessarily for the boys. Trauma is only statistically significant for older but not younger boys or for girls regardless of whether they are younger or older.

Doing well in school (that is, school achievements) has a negative association with the PTSD of older boys and girls but is statistically not significant for the younger cohort. The result on safety threatened is seen to be correlated with the PTSD of older boys. This is possible due to the older cohort of 15-17 year olds being more likely to be travelling on public transport independently than younger adolescents and therefore are likely to be exposed to opportunities for safety to be threatened. Similarly, exposure to trauma also appeared to increase PTSD scores of boys, in particular those of older boys. Discrimination related to religion/culture and language on the other hand is correlated with only the younger boys' PTSD while the latter is correlated with only the younger girls' PTSD. While discrimination due to skin colour is

associated with the PTSD scores of younger girls, it has no association with the PTSD of the older girls or boys. Warmth of caregiver has a significant negative association with the PTSD scores of younger boys.

[Table 5]

Table 5 for the happiness results also shows some varying results from column (2) results on the full sample in Table 3. For example, communicating often in one's mother tongue and discrimination related to religion/culture has an association with happiness in the full sample in Table 3 but in Table 5, they have differing associations. It can be seen that the use of mother tongue is associated with increased happiness of older boys and girls, and seems to be consistent by sex. But discrimination with respect to religion/culture is significantly correlated with only boys' (both younger and older) happiness and not girls. In addition, caregiver hostility and safety threatened are negatively correlated with only the older girls' happiness while use of English is correlated with the happiness of both boys and girls, younger and older. Mother's education on the other hand is associated with the happiness of older boys and younger girls.

Discussion

This study used nationally collected cross sectional data and regression estimations to show two important results. First, factors associated with happiness are quite different from those associated with PTSD. For instance, obtaining good results in school helps coping with PTSD but for refugee youth to be happy, this is not relevant. This result is consistent across gender and the age groups of 11-14 and 15-17. Doing well in school is important as this provides a sense of control and ability to influence their lives through a potential sense of belonging and integration at school (Chen and Schweitzer 2019). However, significant results for the negative association with PTSD is only found in the older cohort aged 15-17 years of both boys and girls. It could be that for the older cohorts, there is greater peer respect or acceptance at school by their classmates when they do well in their studies. Or achieving good grades gives the refugee youth greater confidence and makes them more resilient against other negative factors in their lives. These explanations are postulations that need to be tested but are beyond the scope of the present dataset.

While many studies have examined the association of language proficiency in mother tongue and host country main language with PTSD, this study focused on the frequency of using these languages in communication. This reflects ability and possibly comfort levels of refugee youth in reaching out socially and staying connected to the mainstream population and their own family and community. Familial bonds and community relations and values related to their religion or country of origin are supportive factors in the resettlement of refugee adolescents (Anstiss et al. 2019). The result obtained in this study also shows that host country main language used is associated with reducing the PTSD score and the use of both host country language and the mother tongue is correlated with happiness. However, language use is not significantly associated with PTSD when PTSD is measured as a binary variable. This could be because the extent of PTSD is not captured in the binary variable and a good majority of refugee adolescents did not meet the criteria for PTSD in the binary variable.

The second important result from this study is the detailed age by gender focus in the analysis of factors associated with well-being measures of adolescent refugees. Empirical evidence shows that results obtained using aggregated samples and controlling for age and gender by a single dummy variable mask differences in the underlying associations of factors with well-being measures. This may provide misleading intervention strategies using a one-size-fits-all approach for all adolescents due to varying results for girls and boys as well as young and old. Thus a targeted focus on older and younger adolescents further differentiated by gender is likely to be more effective. Perhaps this distinction may also enable the refugee participants to feel at ease or be comfortable with the peers in their targeted groups who are of the same gender and age cohort when discussing their challenges or sharing experiences in the environment of a support group being assisted.

For example, discrimination related to religion and culture is associated with PTSD and happiness using the entire sample of adolescent refugees. But on close examination, it is associated with increased PTSD levels of younger boys, while with happiness, it is correlated with both younger and older boys. The mixed results on these measures need to be further scrutinised to understand the mechanisms underlying these associations in each of these groups. One limitation of the yes/no response to the discrimination variable in this study is that it does not consider the severity of racism experienced to differentiate the association. Benner et al. (2018) however observed some evidence that racial/ethnic discrimination had higher stakes for younger (versus older) adolescents' distress. This lends some credence to the hypothesis that

as they age, adolescents have a larger array of socio-cognitive resources from which to protect older adolescents against some of the challenges when they face discriminatory treatment. Ours is the first study to show that this is also the case for refugee children but only in the case of boys.

Discrimination related to colour or language on the other hand has no correlation with the happiness of refugee youth and this has no bearing on gender or age. This could reflect the high levels of support for cultural diversity in Australia where long-standing multiculturalism has enabled a more tolerant society over time. This comes under the umbrella of the multiculturalism policy which was first introduced in Australia in the 1970s and has seen changes over time. This policy reaffirms the government's support for a culturally diverse and socially cohesive nation and addresses the need to balance the rights and obligations of all who live in Australia.[5] However, one limitation is in the survey question posed as adolescents were asked to reflect on discrimination experiences in a time-limited way (last 6 months) but cumulative risk theories of child development (Benner et al. 2018, Sameroff et al. 1987) note that risks accumulate and compound over time for adolescents in their effect. Thus this could have underestimated the association in our results.

Another key result in this study is the empirical evidence of the importance of mother's education and mental state for the refugee children. Although on average, father's mental state was significantly better than the mother's, it was not correlated with the PTSD or happiness levels of their children. While some refugee studies (Ajdukovic and Ajdukovic 1993, Quota et al. 2005) have highlighted the importance of mother's mental health for their children's mental health, these studies however did not examine the association separately for daughters and sons or based on the age cohorts of the children. Neither did these or other studies compare fathers' and mothers' mental health state separately on their children as was done in this study.

Our results showed a positive correlation of mother's PTSD with older girls' PTSD scores and a negative correlation with older boys' happiness. This intergenerational association of the mental state of mothers with daughters could reflect a stronger bond between the two generations and potential spending of more time together due to the gendered nature of roles.

[5] Retrieved from https://www.runnymedetrust.org/uploads/events/people-of-australia-multicultural-policy-booklet.pdf

For instance, if girls are expected to undertake domestic chores unlike the boys, they would be supervised by their mothers and thus be exposed to the adverse association of maternal PTSD. In fact, mothers' influence (via their mental state) on the mental state of daughters but not on sons has been widely evidenced in the broader psychological literature for the non-refugee population (Fergusson et al. 1995, Goodman 2007, Piche et al. 2011). Science too (Yamagata et al. 2016) shows that the mother-daughter association in depression is more powerful than we thought.

It must be noted that there are several other factors which have been found to have significant association on some cohorts and not others. But a detailed discussion on the implications of these results require a deeper understanding of complex issues that the empirical models fail to capture. Hence the results from this study are suggestive at best in part due to a lack of longitudinal data to uncover trends over time or have causative influences.

Conclusions

This study highlighted the difference in factors associated with PTSD and happiness levels of refugees aged 11-17 years and further differentiated the analysis by considering four different cohorts among the refugee youth – younger and older adolescents by gender. This has implications for a targeted focus on intervention for effectively improving the well-being of refugee youth. But the 2016 data on refugee children of this survey undertaken by the Australian government is a one-off attempt. Given the findings of this study, it is imperative that a nation-wide longitudinal panel of refugee children and adolescents be undertaken to better understand inter-temporal changes over time and if possible to track the same cohort.

This study is not free from limitations. The analysis of this study is based on responses provided by children in the BNLA child module. As such, it was not possible to consider differences in ethnicity, religion and country of origin as data on these variables are not available in the child module of the BNLA dataset. Although such data are available for parents, no data is recorded for children. In fact, only 58 responses out of 356 in the sample had data for these three variables.

Second, data on the location in which the refugees reside in Australia – urban or regional was unavailable and this is an important factor as experiences can be varied based on how refugees are treated in their environment and if there are differences in support facilities. Third, the

nature of the secondary data in the BNLA survey did not allow for mechanisms underlying the associations to be examined, leaving only correlations to be observed. For instance, given the importance of academic achievement, it would be useful to examine if school performance has a mediating role on some of the factors such as bullying or discrimination at school, or for the build-up of social capital related to the well-being measure.

Fourth, an important caveat to be noted is that the children in the study already have permanent humanitarian visa which can positively bias their PTSD and happiness. The children whose status is still undecided and currently being processed are more likely to have adverse outcomes for PTSD and happiness. Lastly, it is unclear if reducing PTSD and/or raising happiness level is indeed the path for refugees towards resettling well and enjoying a sense of belonging in the new environment. The concept of resettlement and belonging is known to be complex. While several qualitative studies (Chen and Schweitzer 2019, Moensted 2020) have explored various forms of these concepts, there is a lack of quantitative evidence on these paths and linkages.

Table 1 Summary statistics

Variable	Percentage	Variable	Percentage
Age (years)		Both parents in Australia	
11-14	56.28	No	32.61
15-17	43.72	Yes	67.39
Gender		Community involvement	
Girls	48.07	No	32.37
Boys	51.93	Yes	67.63
Use English		Community award	
Strongly disagree	3.73	No	50.97
Disagree	5.72	Yes	49.03
Neither disagree nor agree	12.19	Unfair treatment: language/accent	
Agree	43.78	No	85.05
Strongly agree	34.58	Yes	14.95
Use mother tongue		Unfair treatment: skin colour	
Strongly disagree	3.77	No	94.38
Disagree	10.05	Yes	5.62
Neither disagree nor agree	28.64	Unfair treatment: religion/culture	
Agree	36.18	No	90.46
Strongly agree	21.36	Yes	9.54
PTSD		Safety threatened	
Unlikely to have PTSD	85.35	No	82.29
May have PTSD	14.65	Yes	17.71
Happiness		Exposure to trauma	
Strongly disagree	2.49	No	78.27
Disagree	2.49	Yes	21.73
Neither disagree nor agree	8.73		
Agree	32.42		
Strongly agree	53.87		

Variable	Mean (standard deviation)		
Average no. days of physical activity	2.94 (1.88)	Father's education decile (1 to 10)	2.62 (5.84)
Days skipped school	0.98 (2.69)	Mother's education decile (1 to 10)	3.80 (4.45)
Overall school achievement * (lowest= 1, highest =5)	3.73 (0.92)	Father's Kessler score (6 to 30)	9.03 (8.29)
Caregiver warmth* (minimum 1, maximum 5)	3.36 (1.65)	Mother's Kessler score (6 to 30)	10.91 (10.97)
Caregiver hostility* (minimum 1, maximum 5)	0.43 (0.91)	PTSD score generated (0 to 2.19)	0.61 (0.40)

Note: * reported by primary caregiver/parent.

Table 2 PTSD Measures by Age and Gender

	Sample size 356	Percentage suffering from PTSD	PTSD Level (std. dev)	ANOVA Difference in PTSD (t-stat)		
				Full sample	Aged 11-14	Aged 15-17
All boys	185	14.77	4.319 (0.887)	-0.393	-0.995	0.629
All girls	171	14.51	4.345 (0.955)			
Boys 11-14	93	17.14	4.413 (0.807)	-1.782*	Not applicable	
Boys 15-17	92	12.24	4.194 (0.960)			
Girls 11-14	90	15.32	4.513 (0.702)	-3.077**	Not applicable	
Girls 15-17	81	13.33	4.091 (1.205)			

Notes: The ANOVA difference for full sample is between the two groups seen within each row.
The ANOVA difference for the two age groups is between the genders in each age group.
* and ** refers to significance at 10% and 5% level respectively.

Table 3 Estimation results for PTSD and happiness models (full sample)

Variable	PTSD (binary model) (1)	PTSD score (OLS model) (2)	Happiness (3)
Constant	-0.788 (0.423)	0.253 (0.358)	-1.535 (0.004)
Demographic factors			
Age	-0.028 (0.538)	-0.002 (0.923)	-0.109 (0.001)
Gender (0=girl, 1=boy)	0.231 (0.212)	0.118 (0.053)	0.025 (0.845)
Parental factors			
Both parents in Australia	-0.046 (0.820)	-0.013 (0.835)	-0.045 (0.756)
Any parent in paid work	-0.221 (0.288)	-0.121 (0.135)	0.138 (0.154)
Caregiver warmth	0.043 (0.396)	0.003 (0.851)	0.039 (0.328)
Caregiver hostility	-0.012 (0.900)	0.030 (0.390)	-0.218 (0.002)
Mother's Kessler score	-0.002 (0.973)	0.002 (0.598)	-0.002 (0.771)
Mother's education	-0.053 (0.203)	0.022 (0.164)	-0.007 (0.780)
Community factors			
Community Involvement	-0.360 (0.850)	-0.126 (0.039)	-0.084 (0.572)
Community award	0.016 (0.934)	0.012 (0.857)	-0.106 (0.429)
Days of physical activity	0.017 (0.546)	-0.007 (0.519)	-0.002 (0.920)
Use English	-0.086 (0.363)	-0.033 (0.049)	0.357 (0.000)
Use mother tongue	0.197 (0.152)	-0.001 (0.988)	0.269 (0.000)
Unfair treatment: language/accent	0.201 (0.469)	0.185 (0.084)	-0.108 (0.635)
Unfair treatment: skin colour	0.597 (0.136)	0.245 (0.163)	-0.109 (0.751)
Unfair treatment: religion/culture	0.708 (0.048)	0.318 (0.025)	-0.778 (0.002)
Pre-migration factors			
Safety threatened	0.349 (0.097)	0.276 (0.004)	0.108 (0.590)
Exposure to trauma	0.618 (0.004)	0.180 (0.041)	-0.145 (0.427)
School factors			
Days skipped school	0.016 (0.552)	-0.009 (0.388)	0.002 (0.934)
School achievements	-0.246 (0.014)	-0.086 (0.019)	0.050 (0.482)
Sample size	356	356	356
Prob > χ^2 (Prob>F)	0.000	(0.000)	0.000
(Pseudo) R^2	(0.190)	0.1906	(0.120)

Note: p values in parenthesis.

Table 4 Estimation results by gender and age for PTSD score

Variable	**Boys**			**Girls**		
	PTSD Full sample (1)	PTSD 11-14 (2)	PTSD 15-17 (3)	PTSD Full sample (4)	PTSD 11-14 (5)	PTSD 15-17 (6)
Constant	-0.395 (0.276)	-0.702 (0.106)	0.170 (0.751)	1.563 (0.000)	0.827 (0.007)	1.323 (0.993)
Age	0.008 (0.716)	-	-	-0.034 (0.122)	-	-
Both parents in Australia	0.022 (0.802)	0.040 (0.715)	-0.006 (0.960)	0.004 (0.969)	0.110 (0.343)	-0.342 (0.047)
Any parent in paid work	0.071 (0.856)	0.056 (0.551)	-0.084 (0.218)	0.088 (0.287)	-0.067 (0.462)	0.121 (0.675)
Caregiver warmth	-0.019 (0.456)	-0.067 (0.023)	-0.057 (0.305)	-0.019 (0.524)	-0.035 (0.277)	0.020 (0.680)
Caregiver hostility	0.061 (0.276)	0.057 (0.465)	-0.052 (0.574)	-0.003 (0.905)	0.014 (0.809)	-0.061 (0.396)
Mother's Kessler score	0.004 (0.427)	0.002 (0.565)	0.010 (0.214)	0.002 (0.191)	0.004 (0.459)	0.054 (0.048)
Mother's education	0.017 (0.228)	0.042 (0.132)	-0.013 (0.052)	0.045 (0.113)	0.039 (0.167)	-0.066 (0.125)
Community involvement	-0.077 (0.416)	-0.118 (0.042)	0.032 (0.875)	-0.190 (0.018)	-0.124 (0.243)	-0.148 (0.304)
Community award	0.042 (0.685)	0.065 (0.629)	-0.081 (0.663)	-0.073 (0.409)	0.044 (0.670)	-0.275 (0.096)
Days of physical activity	-0.027 (0.124)	-0.015 (0.078)	-0.047 (0.158)	0.019 (0.147)	0.007 (0.692)	-0.051 (0.054)
Use English	0.025 (0.620)	-0.042 (0.593)	0.057 (0.602)	-0.084 (0.065)	-0.124 (0.037)	-0.017 (0.089)
Use mother tongue	0.292 (0.471)	0.034 (0.518)	0.002 (0.978)	-0.041 (0.323)	-0.021 (0.663)	-0.106 (0.169)
Unfair treatment: language/accent	0.214 (0.204)	0.208 (0.045)	0.045 (0.856)	0.160 (0.270)	0.001 (0.046)	0.327 (0.137)
Unfair treatment: skin colour	0.145 (0.188)	0.326 (0.182)	-0.298 (0.405)	0.361 (0.274)	0.215 (0.000)	0.480 (0.296)
Unfair treatment: religion/culture	0.448 (0.013)	0.781 (0.000)	0.203 (0.526)	0.050 (0.814)	0.217 (0.395)	-0.829 (0.109)
Safety threatened	0.319 (0.013)	0.184 (0.260)	0.503 (0.005)	0.257 (0.178)	0.393 (0.155)	-0.115 (0.565)
Exposure to trauma	0.260 (0.039)	0.076 (0.672)	0.397 (0.026)	0.067 (0.617)	0.022 (0.909)	0.299 (0.179)
Days skipped school	-0.021 (0.493)	-0.002 (0.907)	-0.034 (0.616)	0.003 (0.780)	-0.004 (0.879)	0.001 (0.959)
School achievements	-0.044 (0.388)	-0.014 (0.788)	-0.079 (0.046)	-0.133 (0.012)	-0.072 (0.267)	-0.204 (0.037)
Sample size	185	93	92	171	90	81
Prob > F	0.000	0.000	0.011	0.002	0.001	0.009
R^2	0.287	0.340	0.341	0.251	0.408	0.352

Note: p values in parenthesis.

Table 5 Estimation results by gender and age for Happiness

Variable	Boys			Girls		
	Happiness Full sample (1)	Happiness 11-14 (2)	Happiness 15-17 (3)	Happiness Full sample (4)	Happiness 11-14 (5)	Happiness 15-17 (6)
Constant	0.857 (0.065)	1.286 (0.736)	1.862 (0.052)	2.651 (0.000)	1.268 (0.002)	1.229 (0.432)
Age	-0.082 (0.179)	-	-	-0.166 (0.004)	-	-
Both parents in Australia	-0.193 (0.359)	-0.461 (0.124)	-0.054 (0.861)	0.088 (0.687)	-0.065 (0.837)	-0.156 (0.694)
Any parent in paid work	0.012 (0.187)	0.002 (0.562)	0.065 (0.657)	0.051 (0.342)	0.113 (0.452)	0.011 (0.176)
Caregiver warmth	0.061 (0.241)	0.070 (0.325)	0.080 (0.352)	0.003 (0.967)	-0.102 (0.313)	0.186 (0.090)
Caregiver hostility	-0.223 (0.054)	0.014 (0.940)	-0.282 (0.128)	-0.259 (0.007)	-0.162 (0.226)	-0.462 (0.009)
Mother's Kessler score	0.004 (0.658)	-0.006 (0.593)	-0.006 (0.069)	-0.009 (0.353)	-0.017 (0.231)	-0.013 (0.430)
Mother's education	0.053 (0.102)	0.001 (0.988)	0.102 (0.024)	0.088 (0.025)	0.145 (0.003)	0.057 (0.524)
Community Involvement	0.378 (0.096)	0.560 (0.069)	0.088 (0.849)	-0.009 (0.964)	-0.227 (0.460)	0.532 (0.153)
Community award	-0.115 (0.535)	0.490 (0.074)	0.072 (0.822)	-0.060 (0.775)	0.036 (0.906)	-0.287 (0.504)
Days of physical activity	0.005 (0.842)	-0.028 (0.475)	0.028 (0.495)	-0.020 (0.542)	-0.027 (0.578)	0.006 (0.940)
Use English	0.401 (0.000)	0.434 (0.000)	0.483 (0.006)	0.327 (0.001)	0.386 (0.007)	0.451 (0.034)
Use mother tongue	0.278 (0.007)	0.150 (0.239)	0.482 (0.005)	0.332 (0.001)	0.216 (0.073)	0.447 (0.011)
Unfair treatment: language/ accent	0.119 (0.782)	0.137 (0.848)	0.702 (0.192)	-0.406 (0.159)	-0.731 (0.136)	-0.104 (0.799)
Unfair treatment: skin colour	0.218 (0.634)	0.548 (0.357)	0.256 (0.708)	-0.314 (0.623)	0.755 (0.496)	-0.799 (0.313)
Unfair treatment: religion/ culture	-1.210 (0.001)	-0.848 (0.047)	-1.921 (0.001)	-0.314 (0.443)	-0.519 (0.450)	-0.252 (0.759)
Safety threatened	0.508 (0.190)	0.284 (0.487)	0.487 (0.270)	-0.430 (0.093)	-0.279 (0.454)	-0.892 (0.037)
Exposure to trauma	-0.390 (0.130)	-0.147 (0.694)	-0.741 (0.092)	0.354 (0.174)	0.423 (0.284)	0.194 (0.694)
Days skipped school	0.046 (0.314)	0.060 (0.484)	0.001 (0.993)	-0.008 (0.823)	0.027 (0.661)	-0.005 (0.918)
School achievements	0.071 (0.456)	0.055 (0.691)	-0.032 (0.835)	0.121 (0.301)	0.183 (0.297)	0.127 (0.456)
Sample size	185	93	92	171	90	81
Prob > χ^2	0.000	0.000	0.000	0.000	0.003	0.001
Pseudo R^2	0.124	0.175	0.185	0.183	0.176	0.233

Note: p values in parenthesis.

References

AJDUKOVIC, M. and AJDUKOVIC, D. (1993) 'Psychological well-being of refugee children,' *Child Abuse and Neglect* 17: 843–54.

ALLEN, P. and BENNETT, K., (2010) 'PASW Statistics by SPSS: A practical guide', version 18.0, Cengage Learning Australia Pty Limited, Melbourne.

ALLSOPP, J., SIGONA, N., and PHILLIMORE, J., (2014) *Poverty among refugees and asylum seekers in the UK: Evidence and policy review.* University of Birmingham, Institute for Research into Superdiversity.

ANSTISS, H., SAVELSBERG, H., and ZIAIAN, T., (2019) 'Relationships in a new country: A qualitative study of the social connections of refugee youth resettled in South Australia,' *Journal of Youth Studies* 22(3): 346-362.

BANG, H. (2017) 'Iraqi refugee high school students' academic adjustment,' *Diaspora, Indigenous, and Minority Education* 11(1): 45–59.

BEIBERT, H., GONULTAS, S., and MULVEY, K., (2019) 'Social inclusion of refugee and native peers among adolescents: It is language that matters!' *Journal of Research on Adolescence* 30: 219-233.

BEISER, M., and HOU, F., (2016) 'Mental health effect of premigration trauma and postmigration discrimination on refugee youth in Canada,' *Journal of Nervous and Mental Disease* 204: 464-470.

BENNER, A., WANG, Y., SHEN, Y., and BOYLE, A., POLK, R., AND CHENG, P., (2018) 'Racial/Ethnic Discrimination and Well-Being During Adolescence: A Meta-Analytic Review,' *American Psychologist* 73: 855-883.

BHUI, K., LENGUERRAND, E., MAYNARD, M., STANFELD, S., and HARDING, S., (2012) 'Does cultural integration explain a mental health advantage for adolescents?' *International Journal of Epidemiology* 41: 791-802.

BROWN, R. WITT, A., FEGERT, J. KELLER, F., RASSENHOFER, M., and PLENER, P. (2017) Psychosocial interventions for children and adolescents after man-made and natural disasters: A meta-analysis and systematic review. *Psychological Medicine* 47(11): 1893- 1905.

BRYANT, R., EDWARDS, B., CREAMER, M., O'DONNELL, M., FORBES, D., … HADZI-PAVLOVIC, D., (2018) 'The effect of post-traumatic stress disorder on refugees' parenting and their children's mental health: a cohort study,' *Lancet Public Health* 3: 249-258.

CHEN, S., and SCHWEITZER, R., (2019) 'The experience of belonging in youth from refugee backgrounds: A Narrative Perspective,' *Journal of Child and Family Studies* 28: 1977-1990.

CORREA-VELEZ, I., GIFFORD, S., and BARNETT, A.G., (2010) 'Longing to belong: social inclusion and wellbeing among youth with refugee backgrounds in the first three years in Melbourne, Australia', *Social Science and Medicine* 71: 1399-1408.

CORREA-VELEZ, I., GIFFORD, S., and MCMICHAEL, C., (2015) 'The persistence of predictors of wellbeing among refugee youth eight years after resettlement in Melbourne, Australia,' *Social Science and Medicine* 142:163–168.

DHANJI, S. (2009) 'Welcome or Unwelcome? Integration issues and the resettlement of former refugees from Horn of Africa and Sudan in Metropolitan Melbourne,' *Australasian Review of African Studies* 30(2): 152-178.

DU PLOOY, D.R., LYONS, A., and KASHIMA, E.S., (2019) 'Predictors of flourishing and psychological distress among migrants to Australia: A dual continuum approach', *Journal of Happiness Studies* 20: 561–578.

EDWARDS. B., SMART, D., DE MAIO, J., SILBERT, M., and JENKINSON, R., (2018) 'Cohort Profile: Building a New Life in Australia (BNLA): the longitudinal study of humanitarian migrants,' *International Journal of Epidemiology* 47: 20–28.

ERUYAR. S., MALTBY, J., and VOSTANIS, P., (2018) 'Mental health problems of Syrian refugee children: the role of parental factors', *European Child and Adolescent Psychiatry* 27: 401-409.

EVERUSS, L (2020) Mobile sovereignty: The case of 'boat people' in Australia. *Political Geography* 79. https://www.sciencedirect.com/science/article/pii/S096262981930232X

FAZEL M, REED R., PANTER-BRICK, C., and STEIN A. (2012) 'Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors,' *Lancet* 379 (9812): 266–82.

FAZEL, M., and STEIN, A., (2002) 'The mental health of refugee children', *Archives of Disease in Childhood* 87: 366-370.

FERGET, J., SUKALE, T., and BROWN, R., (2018) 'Mental Health Service Provision for Child and Adolescent Refugees: European Perspectives' in Hodes, M., Gau, S., and De Vries, P., (eds. 2018) *Understanding Uniqueness and Diversity in Child and Adolescent Mental Health*. Academic Press: Elsevier, London.

FERGUSSON, D., HORWOOD, L., and LYNSKEY, M., (1995) 'Maternal depressive symptoms and depressive symptoms in adolescents,' *Journal of Child Psychology and Psychiatry* 36:1161–1178

GOODMAN, S., (2007) 'Depression in mothers,' *Annual Review of Clinical Psychology* 3:107–135.

HANSEN, M., ANDERSON, T., ARMOUR, C., ELKLIT, A., PALIC, S., and MACKRILL, T., (2011) 'PTSD-8: A Short PTSD Inventory,' *Clinical Practice and Epidemiology in Mental Health* 6: 101-108.

HEDRICK, K., ARMSTRONG, G., COFFEY, G., and BORSCHMANN, R., (2019) Self-harm in the Australian asylum seeker population: A national records-based study, S*SM Population Health* 8, https://www.sciencedirect.com/science/article/pii/S2352827319300850?via%3Dihub

HIRANI, K., PAYNE, D., MUTCH, R., and CHERIAN, S., (2019) Medical needs of adolescent refugees resettling in Western Australia,' *Archives of Disease in Childhood* 104: 880-883.

HODES, M., GAU, S., and DE VRIES, P., (eds. 2018) *Understanding Uniqueness and Diversity in Child and Adolescent Mental Health*. Academic Press: Elsevier, London.

HODES, M., (2019) 'New developments in the mental health of refugee children and adolescents,' *Evidence Based Mental Health* 22: 72-76.

HORSWOOD, D., BAKER J., FAZEL, M., REES, S., HESLOP, L., and SILOVE, D., (2019) 'School factors related to the emotional wellbeing and resettlement outcomes of students from refugee backgrounds: protocol for a systematic review,' *Systematic Reviews* 8 Article number 107. Retrieved from https://doi.org/10.1186/s13643-019-1016-6

KALDOR, A., and KALDOR, R. (2020) *Factsheet: Australia's Refugee Policy: An Overview*, Centre for International Refugee Law, University of New South Wales, Retrieved from https://www.kaldorcentre.unsw.edu.au/sites/default/files/Factsheet_Australian%20Refugee%20Policy_Apr2019.pdf

KAM, J., and LAZAREVIC, V., (2014) 'The stressful (and not so stressful) nature of language brokering: Identifying when brokering functions as a cultural stressor for Latino immigrant children in early adolescents,' *Journal of Youth Adolescence* 43: 1994-2011.

KEYES C. (2002) The mental health continuum: from languishing to flourishing in life. *Journal of Health and Social Behaviour* 43: 207–22.

LAU, W., SILOVE, D., EDWARDS, B., FORBES, D., BRYANT, R., … M., O'DONNELL (2018) 'Adjustment of refugee children and adolescents in Australia: outcomes from wave three of the Building a New Life in Australia study,' *BMC Medicine* 16: 157.

MAEHLER, D., POTZSCHKE, S., RAMOS, H, PRITCHARD, P., FLECKENSTEIN, J., (2020) 'Studies on the Acculturation of Young Refugees in the Educational Domain: A Scoping Review of Research and Methods,' *Adolescent Research Review*

MARES, S. (2016) 'Fifteen years of detaining children who seek asylum in Australia- Evidence and Consequences,' *Australian Psychiatry* 24: 11-14.

MELS, C., DERLUYN, I., BROEKAERT, E., and ROSSEEL, Y., (2010) 'The psychological impact of forced displacement and related risk factors on Eastern Congolese adolescents affected by war' *Journal of Child Psychology and Psychiatry* 51: 1096-1104.

MOENSTED, M., (2020) 'Nearness and distance: the double-sided nature of belonging for young refugees in Australia,' *Social Identities* 26: 270-285.

MONTGOMERY, E., (2011) 'Trauma, exile and mental health in young refugees,' *Acta Psychiatrica Scandinavica Supplementum* 124: 1-46.

PICHE, G, BERGERON, L, CYR, M, and BERTHIAUME, C (2011) Maternal lifetime depressive/anxiety disorders and children's internalizing symptoms: the importance of family context. *Journal of the Canadian Academy of Child and Adolescent Psychiatry 20:176–185*

PRITCHARD, P., MAEHLER, D., POTZSCHKE, S., and RAMOS, H., (2019) 'Integrating Refugee Children and Youth: A Scoping review of English and German Literature,' *Journal of Refugee Studies* 32: 194-208.

PUNAMAKI, R., (1989) 'Factors affecting mental health of Palestinian children exposed to political violence,' *International Journal of Mental Health* 18: 63-79.

QOUTA, S. PUNAMAKI, R., EL SARRAJ, E., (2005) 'Mother-child expression of psychological distress in war trauma,' *Clinical Child Psychology and Psychiatry* 10:135-156.

SAMARA, M., ASAM, A., KHADAROO, A., and HAMMUDA, S., (2020). Examining the psychological well-being of refugee children and the role of friendship and bullying. *British Journal of Educational Psychology* 90: 301-329.

SAMEROFF, A., SEIFER, R., ZAX, M., and BAROCAS, R. (1987). Early indicators of developmental risk: Rochester Longitudinal Study. *Schizophrenia Bulletin, 13,* 383–394.

SANDELL, A., BAKER, R., MACCARONE, J., and BAKER, S., (2017) 'Health status and anthropometric changes in resettled refugee children,' *Journal of Pediatric Gastroenterology and Nutrition* 65: 569-573.

SANGGARAN J, and ZION D (2016) Is Australia engaged in torturing asylum seekers? A cautionary tale for Europe *Journal of Medical Ethics* 42:420-423.

SUJOLDZIC, A., PETERNEL, L., KULENOVIĆ, T., and TERZIĆ, R. (2006) 'Social determinants of health: A comparative study of Bosnian adolescents in different cultural contexts', *Collegium Antropologicum,*30: 703–711.

UNHCR (United Nations High Commission for Refugees) (2019) *Global Trends: Forced Displacements in 2019*, http://www.unhcr.org/5ee200e37.pdf

WESTERHOF, G., and KEYES, C., (2010) 'Mental illness and mental health: The two continua model across the lifespan,' *Journal of Adult Development* 17:110–119.

WILKINSON, J., SANTORO, N., and MAJOR, J., (2017) 'Sudanese Refugee Youth and Educational Success: The Role of Church and Youth Group in Supporting Cultural and Academic Adjustment and Schooling Achievement,' *International Journal of Intercultural Relations* 60:210–219.

YAMAGATA, B., MURAYAMA, K., BLACK, J., HANCOCK, R., MIMURA, M., … HOEFT, F., (2016) 'Female-Specific Intergenerational Transmission Patterns of the Human Corticolimbic Circuitry,' *Journal of Neuroscience* 36(4): 1254-1260.

YOON, E., CHANG, C., KIM S., … GOMES, A., (2013) A Meta-Analysis of Acculturation/Enculturation and Mental Health. *Journal of Counseling Psychology* 60: 15-30.

ZWI K., RUNGAN S., WOOLFENDEN S., WILLIAMS K., and WOODLAND L, (2016) 'Methods for a longitudinal cohort of refugee children in a regional community in Australia,' *BMJ Open* 6: e011387.

ZWI K, WOODLAND L, WILLIAMS K, PALASANTHIRAN P, RUNGAN S, JAFFE A, and WOOLFENDEN S. (2018) 'Protective factors for social-emotional well-being of refugee children in the first three years of settlement in Australia,' *Archives of Disease in Childhood* 103(3): 261–8.

ZWI K, SEALY L, SAMIR N, et al. (2020) Asylum seeking children and adolescents in Australian immigration detention on Nauru: a longitudinal cohort study. *BMJ Paediatrics Open* 2020;4:e000615. doi:10.1136/ bmjpo-2019-000615