Understanding Behaviour and Mental Health for Children with Refugee Backgrounds

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Abstract

Despite there being an ample amount of evidence indicating the high prevalence of mental health disorders for people with refugee backgrounds, there remains scarce research addressing the relationship between mental health and behaviour for refugee children– resulting in a lack of culturally appropriate measurement tools for assessment and a coherent model to inform the development of interventions. This study aimed to address this paucity of research and gain insight, from the perspective of service providers, into understanding behaviour for children with refugee backgrounds, including the relationship with mental health, and barriers and facilitators for supporting refugee children. Semi-structured qualitative interviews were conducted with nine individuals who had experience working with refugee children. Thematic analysis of the qualitative interview data highlighted the impact of trauma, as well as environmental, social, and cultural factors on behaviour for children with refugee backgrounds. Furthermore, the importance of community involvement and cultural responsiveness, patience, and building trust can be seen as facilitators for supporting positive behaviour for children with refugee backgrounds. These findings could potentially inform the development of a coherent model of behaviour and mental health and contribute to the development of future interventions and services for children with refugee backgrounds.

Keywords: Mental health, behavioural issues, refugee children, culture, community

DECLARATION

This thesis contains no material which has been accepted for the award of any other degree of diploma in any University, and, to the best of my knowledge, this thesis contains no material previously published except where due reference is made.

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CHAPTER 1: Introduction

1.1 Background

In 2020, the number of people forcibly displaced worldwide reached a record high of 82 million, with 26 million of these being refugees, and refugee children comprising approximately half of this figure (United Nations High Commissioner for Refugees (UNHCR), 2020). Many of these children have experienced considerable emotional and social disruption (Blackmore et al. 2020), exposure to multiple potential traumatic experiences, challenging living conditions, separation or death of family members, and disrupted education (Bean et al., 2007). Unaccompanied refugee minors are exposed to even greater risks, including greater vulnerability to traffickers and mistreatment (Mitra & Hodes, 2019). Thus, a great international concern exists for the protection and welfare of refugee children, as they are often among the most gravely impacted by adverse conditions due to their minority status and lack of social power (Boyden & Mann, 2005).

Additionally, exposure to traumatic events at crucial points in a child's emotional and cognitive development can result in negative wellbeing and developmental outcomes (Eruyar et al., 2017; Reed et al., 2012). Although many young refugees display immense resilience, research indicates others are at increased risk of developing mental illness including post-traumatic stress disorder (PTSD), anxiety disorders and major depression (Turrini et al., 2017). Thus, the prevalence of mental disorders and psychological distress in refugee children is generally high, though approximations vary significantly (Turrini et al., 2017). Refugee children are also known to frequently experience challenges in relation to behaviour in resettlement countries (Ceri & Nasiroglu, 2018; Ziaian et al., 2013). However, there remains a paucity in research addressing the relationship between mental health and behaviour for refugee children. Therefore, this study explored the perspectives of service providers on determinants for behaviour for children with refugee backgrounds, including the

relationship with mental health, and barriers and facilitators for supporting refugee children in relation to behaviour and mental health.

1.2 Definitions

This study will focus on school-aged children from refugee backgrounds, from ages five to eighteen years. The term 'refugee' refers to those who meet the definition provided by UNHCR:

> *"Owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it."* (UNHCR, 2020).

Importantly, it is acknowledged in this thesis that being a refugee does not comprise a child's entire identity, but for the purpose of this paper, the terms "refugee children" and "children from refugee backgrounds" are used interchangeably.

1.3 Trauma Exposure and Refugee Children

In a systematic review, Fazel et al. (2012) outlined the adverse factors that affect refugee children's mental health outcomes in order of stage in the migration process. Risk factors occurring pre-migration include loss of family members and systemised violence. During migration risk factors include lack of safety, interruption of schooling and poverty. Post-migration risk factors encompass language barriers, low socio-economic status, stigmatization, repeated relocations, and uncertainty about visa status for those not on permanent visas. Research has shown that this trauma exposure typically leads to significant adverse outcomes for refugee children (Bronstein & Montgomery, 2011). For example, a recent meta-analysis on refugee children and adolescents under the age of 19 resettled in five

different countries (Germany, Malaysia, Norway, Sweden, and Turkey) indicated approximate prevalence rates as 23-35% for PTSD, with incidence being significantly increased for children displaced less than two years (Blackmore et al., 2020). Additionally, the impact of trauma can be dependent on the form of trauma experienced, with trauma associated family members as victims and witnessing violence/killing resulting in graver mental health outcomes than other traumatic experiences such as seeing bomb explosions (Nasiroglu et al., 2018; Gormez et al., 2018). The outcomes of exposure to trauma at these various stages of the migration journey are often dependent on the presence of risk and protective factors such as the presence (or loss of) family members, individual resilience, and sense of safety in resettlement countries (Lau & Thomas, 2008).

Importantly, exposure to traumatic events and resulting psychological trauma can have cyclical effects, whereby the psychological trauma children experience has itself grave impacts on children, often causing regression in developmental, cognitive, emotional, and behavioural domains (Enoch, 2011). Thus, Ceri and Nasiroglu (2018) found a cumulative adverse effect of traumatic events on behaviour for refugee children, where increased exposure was strongly associated with behavioural problems such as conduct issues and hyperactivity problems. Common trauma-related symptomology reported by refugee children include mood swings, irritability, problems concentrating, guilt, withdrawal, feeling disconnected, sleep disturbances, and hyperarousal (Montgomery & Foldspang, 2001; Chipalo, 2021; Ceri & Nasiroglu, 2018). Age can also mediate trauma effects on children, as early childhood trauma typically has more severe impacts compared to trauma suffered later in life; largely due to sensitive neurological and psychological periods of development (De Bellis et al., 2005).

It is also important to note that, as trauma assessment, diagnostic and research tools were typically developed for Western adult populations, researchers have argued that there

are issues concerning the measurement of mental illness in child refugee populations, including the cross-cultural applicability of trauma measures (Hollifield et al., 2002). This makes accurate assessment of both the extent of psychological trauma for refugee children and then relationships between trauma and behaviour difficult to explore.

1.4 Mental Health and Behaviour for Refugee Children

Many refugee children who are survivors of childhood trauma may suffer from co-occurring mental disorders– approximately 40% of refugee children experience other disorders such as depression, anxiety, and other trauma related disorders (Hodes, 2000), with unaccompanied minors facing an even higher risk of developing psychiatric disorders (Huemer et al., 2009). Mental illnesses that persist throughout the lifespan often originate in childhood, manifesting as two main domains of dysfunction: internalising and externalising problems (Cabaj et al., 2014; Achenbach et al., 2016). Externalising problems are characterised as conflicts with other people and with social norms such as defiance, hyperactivity, and aggression, whereas internalising problems principally reflect issues within the self, including anxiety, withdrawal, and depression (Achenbach et al., 2016).

In terms of mental health and behaviour, research with refugee children has to date primarily focused on mental health and emotional problems, and rarely addressed behaviour or behavioural issues. For example, a systematic review of 22 studies assessing psychological distress of refugee children resettled in Western countries indicated the prevalence of depression as 3-30%, PTSD as 19-54% and behavioural and emotional problems as varying significantly (Bronstein & Montgomery, 2011). Other limited studies addressing mental health and behaviour for refugee children include small sample sizes but have found behavioural problems can be dependent on age and whether issues are self, or parent reported (Ceri & Nasiroglu, 2018; Montgomery, 2008). Furthermore, as childhood behaviour exists on a continuum, children may not meet the criteria for clinical diagnoses but still suffer long-

term impacts in multiple domains such as health, academic success, social and economic achievement, and learning (Hertzman & Wiens, 1996; Beers & De Bellis, 2002).

While there is little research on the interactions between mental health and behaviour, it is notable that research has highlighted prominent issues with diagnoses between behavioural problems and mental health disorders due to similarities between the symptomology of disorders for children in non-refugee populations (e.g., Ford & Courtois, 2014; Due et al., 2019). Children who display behavioural symptoms of underlying psychological trauma including hypervigilance, aggression and hyperarousal are often instead assessed for behavioural disorders including Attention-deficit/Hyperactivity disorder (ADHD) and Oppositional Defiant Disorder (ODD), and not mental health disorders such as PTSD (Ford & Courtois, 2014). This focus on diagnosis of behavioural issues may be compounded by the fact that, although some refugee children exhibit significant mental health and behavioural problems, research suggests that families seldom focus on psychological considerations (Due et al., 2019).

1.5 Acculturation

Within resettlement countries, Berry's (1980) influential acculturation model suggests that refugee children will face a gradual process of sociocultural adaptation, and that refugee children integrate to varying extents within the host community, depending on a range of factors. Higher levels of integration i.e., adopting features of the new culture while upholding practices of their primary culture, has been associated with lower levels of mental health disorders for refugee children (Tozer et al., 2018). Additionally, integration, in the form of competence in the host country's language, has indicated lower levels of internalising behaviour for refugee children (Montgomery, 2008). Furthermore, research indicates that acculturation can occur at different rates for parents and children migrating to new countries,

forming an “acculturation gap” (Kwak, 2003). Variable acculturation rates in refugee families can exert strain on parent-child relationships (Eruyar et al., 2019).

1.6 Applying an Ecological Model

Research has highlighted the significance of considering multiple determinants for children including social situations in resettlement countries, their age at resettlement, culture, health status, educational organisations, culture, language, period in resettlement country and relationships between family (Scharpf., 2021). For this reason, adaptation to the migration experience should be viewed from an ecological perspective in which the individual child, community and family are considered as distinct, yet interacting systems (Lau et al., 2018).

Accordingly, the ecological model (Bronfenbrenner, 1979) can be applied to this area of research due to its emphasis on the impact of environment on the child (Betancourt & Khan, 2008). This ecological approach divides the refugee child’s environment into four interrelated systems known as the microsystem, mesosystem, macrosystem and ecosystem.

1.6.1 The Microsystem

The microsystem is the child’s proximate environment which includes immediate relationships or interactions with organisations including family (Bronfenbrenner, 1979).

Research highlights the importance of immediate relationships to family as protective for refugee children; however, refugee experiences often alter family unit dynamics (Forrest-Bank et al., 2019). For example, traumatic experiences may negatively affect refugee parents’ emotional availability, just as their children’s exposure to stressors such as displacement and time in refugee camps can negatively affect their attachment representation (Van Ee et al., 2016; Punamaki, 2002). Dalgaard et al., (2015) recognised a significant association between insecure attachment styles and both behavioural and emotional problems. Furthermore, risk of behavioural and emotional issues is increased for refugee children whose parents suffer

from mental illness (Eruyar et al., 2019). Contrarily, familial connectedness including understanding, respect, and care is associated with decreased levels of internalising issues, particularly for refugee boys (Betancourt et al., 2012). Several studies examining a possible mechanism underlying these links proposed that parents' own exposure to traumatic instances including war trauma was related to increased mental health problems which in turn were associated with increased negative parenting, thus impacting children's mental health (Bryant et al., 2018; Sim et al., 2018).

1.6.2 The Mesosystem

The mesosystem entails the relationships between diverse microsystems such as the education system in a resettlement country (Bronfenbrenner, 1979). Schools play a critical role for the adjustment of refugee children during resettlement, as they foster socialisation and acculturation (Scharpf et al., 2021). Thus, refugee children who reported feelings of acceptance and support from teachers and peers display decreased levels of aggressive behaviour (Beiser & Hou, 2016), psychological distress (Tozer et al., 2018) and emotional dysregulation (Khamis, 2019), and exhibited increased levels of wellbeing (Tozer et al., 2018). Contrarily, perceived discrimination has been associated with higher levels of emotional and behavioural issues (Beiser & Hou, 2016). Furthermore, research has shown increased self-reported, and parent perceived school performance being associated with higher psychological wellbeing, and less emotional and behavioural problems for refugee children (Correa-Velez et al., 2010; Lau et al., 2018).

1.6.3 The Exosystem

The exosystem is the system in which the child is not actively involved and has an indirect effect on their developmental outcome (Bronfenbrenner, 1979). Experiencing time in mandatory detention centres post migration tends to negatively affect children's wellbeing (Scharpf, 2021). Zwi et al. (2018) indicated children who were held in a detention centre on

their journey to Australia had significantly higher emotional and behavioural problems (as reported by parents) in comparison to children living in community settings in Australia. Social determinants upon settlement can also affect refugee children, as Correa-Velez et al. (2010) indicated that secure housing is fundamental to their wellbeing. In contrast, parental concern regarding finances being associated with increased depressive symptoms and low self-esteem for Bosnian refugee children (Sujoldzic et al., 2006) and increased limitations in living arrangements being associated with higher levels of internalising issues and depression scores for unaccompanied minors (Reijneveld et al., 2005; Hollins et al., 2007).

1.6.4 The Macrosystem

The macrosystem is the final level of the ecological model, involving the society, culture, and economic conditions where the child lives (Bronfenbrenner, 1976).

Children facing difficulties are often reliant on adults to access support services on their behalf, meaning that parents and other family members become informal 'gateway providers' (Stiffman, 2004; Flisher et al., 1997). However, refugee parents may be slow to access services, for a range of reasons including stigma surrounding mental illness (Segal & Mayadas, 2005). Additionally, numerous further barriers to accessing help for refugee children and families are well documented in literature such as: lack of culturally appropriate care and resources (Ziaian et al., 2011), cultural stigma, preferred consultation practices including seeking help from spiritual or faith healers (Lustig, 2010), and reduced trust in health providers (Davidson et al., 2004).

1.7 Aims of the Present Study

As can be seen in the previous sections, there exists a paucity of research exploring the associations between mental health and behaviour for children with refugee backgrounds. Thus, this study aimed to address the gap in the literature by examining: 1) behaviour for children with refugee backgrounds, including the complex relationship with mental health,

and: 2) barriers and facilitators for supporting refugee children in relation to behaviour and mental health, from the perspective of service providers.

CHAPTER 2: Method

2.1 Participants

Participants were individuals who have current or previous experience working with children with refugee backgrounds. Inclusion criteria were that participants must have proficient English communication skills, be over the age of 18, and have worked with refugee children in some capacity (e.g., social worker, case worker, program facilitator) in the past five years.

In total there were nine participants; two social workers, one behavioural support specialist, three individuals who worked in the education department, one program facilitator for refugee children, one support/case worker and a team leader for refugee youth services (see Table 1 for more information).

Table 1

Participant Demographics

Participant (pseudonym)	Gender	Role	Experience	Cultural Background
Matthew	M	Refugee Liaison officer, Education Department	8 years	Middle Eastern
Chelsea	F	Former Social Worker	19 years	Hispanic
Zeke	M	Education Department	3 years	Middle Eastern
Karla	F	Social Worker	4 years	Hispanic
Stephen	M	Behaviour Support Specialist	5 years	European
Shaban	M	Program Facilitator for refugee children	3 years	Bhutanese
Ana	F	Teacher, New Arrivals Program (NAP)	9 years	Caucasian

Participant (pseudonym)	Gender	Role	Experience	Cultural Background
Joey	M	Team Leader for refugee youth services	9 years	African
Josh	M	Support worker/Case worker	5 years	Asian

Participants' ages ranged from 27- 58 years (M^{age} = 37.7, *SD* =10.41). Participants were categorised according to their current workplace, but several participants had experience working with children with refugee backgrounds in a variety of settings. The average experience working with refugee children was 7.2 years (*SD* =5.01).

2.2 Procedure

This project was approved by the University of Adelaide School of Psychology Human Research Ethics Sub-committee on the 6th of April 2021 (approval number 21/16). Participants were recruited through a convenience method of sampling, including reaching out to organisations working with refugee children, and snowball sampling. The recruitment process involved a flyer (Appendix A) being emailed to the heads of services and individuals who met the inclusion criteria and asking interested people to contact the researcher. Five interviews were conducted in person, and four over the phone. Utilising a mixed mode of data collection is unlikely to have affected the data, as research indicates data collected with phone and in person interviews are equally effective for research studies (Sturges & Hanrahan, 2004).

Interviews were carried out by the researcher over a four-month period from April to August 2021. Interview times ranged from 22 minutes to 95 minutes (*M* = 50.61, *SD* = 27.06). Informed written consent was obtained from participants at the time of the interview for face-to-face interviews, and verbal consent for over the phone interviews (see Appendix B and C for the Information Sheet and Consent Form).

Initially, the project aimed to interview service providers *and* community leaders who have experience with refugee children to allow for triangulation. However, due to time constraints and difficulty in recruitment, the researcher decided to use service providers as the principal participants.

Semi-structured interviews were conducted with service providers, with questions and prompts used are required (see Appendix D). The interview schedule was formulated to address the scarcity of research addressing behavioural issues for refugee children, including any associations with mental illnesses, diagnoses of childhood disorders and effective ways to support refugee children experiencing mental health or behavioural issues, building on the research outlined in the previous chapter (e.g., Blackmore et al., 2020; Nasiroglu et al., 2018; Bronstein & Montgomery, 2011; Montgomery, 2008). An iterative approach was employed, where interesting topics identified in one interview aided the adaptation of subsequent interview questions for participants – allowing further exploration of these ideas (DiCicco-Bloom & Crabtree, 2006).

Demographic details, including age, gender, cultural background, role, and years of experience working with refugee children were collected. An audit trail was kept throughout the course of research to document thoughts on revising questions, participant feedback, and other annotations for subsequent interviews and analysis (Tracey, 2010). The audit trail cultivated reflexive practice for the researcher by providing an opportunity to continuously examine their individual biases or subjectivity throughout the progression of data collection and analyses (Tracey, 2010).

All interviews were recorded and transcribed verbatim. Member reflections – a key component of achieving excellent qualitative research (Tracey, 2010) - was fulfilled by emailing transcripts to participants who had requested to read them (three participants in total). One participant made changes for clarification, one participant made no changes in

their review and one participant did not respond. Participant names were substituted with pseudonyms and any information specific to a participant were removed to ensure privacy and protection of identity.

Ely et al. (1997) highlights the importance of reflexivity by stating "*if themes 'reside' anywhere, they reside in our heads from our thinking about our data and creating links as we understand them"* (p.205). Self-reflexivity encourages the authors' consciousness of their limitations and strengths, facilitating reflection of the influence on subjective biases and values on the research (Tracey, 2010). It is a fundamental component in achieving credibility in qualitative research in the form of sincerity (Tracey, 2010). As such, it is noted that the researcher is of a culturally and linguistically diverse background and knows people with refugee backgrounds in her Hispanic community and friends. The researcher also volunteers for the Australian Refugee Association as a tutor for students. It is her relationships with refugees in her personal life which motivated this research. Moreover, she has studied psychology and midwifery in Australia and thus her views have been shaped predominately by Western psychological models of health and illness. These experiences may have shaped the ways in which interviews were conducted and the data was analysed.

2.3 Data Analysis

Thematic analysis was employed for the analysis of the data due to its theoretical autonomy and explorative nature, ideal for providing a comprehensive yet multifaceted analysis of qualitative data (Braun & Clarke, 2006). The study adopted a realist ontological viewpoint, as the researcher assumed participants' language reflects meaning and experiences (Braun & Clarke, 2006). The guide to thematic analysis proposed by Braun and Clarke (2006) was adopted for the analysis method. Firstly, familiarisation with the data was achieved by transcribing and reading and re-reading the data and recording initial ideas after each interview. Then, initial codes were generated using an inductive (data-driven) approach

by organising data into meaningful groups, predominately focusing on behaviour and mental health. Next, codes relating to behaviour and mental health were identified and organised into potential themes. Themes were then reviewed by the researcher and supervisor, and some themes were combined whilst other more complex themes were separated into sub-themes. Themes were then refined, and distinct definitions and names were established. To help generation of themes, themes were considered by themselves but also in relation to the other themes identified – identifying the 'story' each theme tells within the broader picture of the data. The most fitting and interesting extracts relating to themes and overall research aims were chosen for each theme. Lastly, exemplar extracts were chosen.

The analytical approach was both collaborative and reflexive, as the author and supervisor discussed, reviewed, and finalised themes together. This collaborative process facilitates rigour in thematic analysis (Braun & Clarke, 2006). Furthermore, the analysis and final report comprised of multiple and varying viewpoints of participants. This process, known as multivocality is important to ensure credibility (Tracey, 2010).

CHAPTER 3: Results

3.1 Overview

Analysis of the data generated five themes and appropriate subthemes. The first themes addressed understanding behaviour: 'Looking beyond the Behaviour', 'Trauma has a Pervasive Impact on Behaviour for Children with Refugee Backgrounds', 'Environmental, Social and Cultural Factors Impact Behaviour for Children with Refugee Backgrounds', with subthemes relating to: 'Schooling' and 'Language and Culture'. The second cluster of themes focused on 'Barriers and Facilitators for Supporting Positive Mental Health Outcomes and Behaviour in Children from Refugee Backgrounds'. Subthemes were named: 'Relationships are Crucial to Support Positive Mental Health Outcomes and Behaviours for Children with

Refugee Backgrounds', 'Cultural Responsiveness, Building Trust and Safety' and 'Community Involvement'.

3.2 Looking Beyond the Behaviour

The first theme – "Looking beyond the behaviour" – captures participants' understandings and perceptions of behavioural issues for children with refugee backgrounds, particularly the concept of considering underlying issues or causes. Drawing from examples focused on refugee children they had supported, participants discussed behavioural issues as on a continuum including internalised symptoms such as withdrawal, to externalised displays such as violence. Behaviours of concern were often described as physical outbursts toward themselves "physically hurting themselves" (Stephen, a behaviour support specialist) and others "he used his pen to stab like teachers' hand or something" (Shaban, a program facilitator for refugee children). Behavioural issues were often depicted as unpredictable, subject to complex social and environmental influences. For example, Josh, who previously worked as a support worker and case manager for five years, discussed his experiences of working with unaccompanied minors:

> "They were quite withdrawn initially, and some of them gradually opened up better. But there were behavioural issues as such, depending on their trauma and how the outcome of the visa goes some of them would become aggressive. I do remember some instances of self-harm and attempted suicide and things like that so, behavioural, all the behavioural problems were related to trauma. And also it was ongoing from because, as I said they were unaccompanied so their parents, their siblings and relatives were back in the country, origin. And so, every day would be different so if there's any problem happening there we could see the behavioural changes so one day they might be very friendly with us the next day they may not be friendly at all or in fact, totally withdrawn."

(Josh, case/support worker, lines 21-30)

Here, Josh discusses "behavioural problems" in a specific group of children (unaccompanied minors) as particularly related to trauma, as well as various external circumstances such as visa outcomes and family separation. Indeed, across the interview participants, behavioural issues were often seen as a response to multiple stressors where "they've hit their limit at that moment" which "triggered it" (Ana, NAP teacher). Thus, participants highlighted that behaviour should be interpreted within context and events which may have instigated the behaviour need to be considered. Ana describes, "he [a refugee child] could have had a shit night, a shit morning, and could have had things go on in the classroom that he didn't know how to react to that then they were being teased or whatever". Ana highlighted that consideration of context was also important in cases where behavioural challenges were triggered by a singular stimulus, such as loud noises:

> "…the things they've witnessed the stuff that you couldn't even dream of, especially if you've come from a war-torn country, and you've just seen death, devastation, um, bombing, but we have a lot that will be triggered by noises, or they'll just panic and something will go off. So say hears like a bang in a in the yard, their reaction, can be exceptionally extreme. But then so someone who knows, you think well that's that's showing you that wasn't just a bang when you know how some kids like if a balloon pops, it's just like yea this is a whole other level, their behaviour will show it, their physical appearance, their temperature, their facial expressions, their body even shaking and things like that."

(Ana, NAP teacher, lines, 160-167)

Thus, participants indicated that behaviours should not be viewed as superficial, and emphasis should be given to understanding the causes of behaviour rather than focusing on the behaviour itself: "you kind of look at the bigger picture" (Stephen). Zeke, who is from a

refugee background himself, highlighted that: “we should try understand that it’s not a matter of behaviour”, but that “we have to actually look at what caused the behaviour, what trauma is linked to it, rather than straight away saying yes, there is a behaviour problem”. Ana agreed, explaining that, “there's a lot more to it normally, than what you're just seeing on the surface” and that behaviour, “doesn’t tend to be random, it doesn’t tend to be without reason”. Importantly, participants accentuated that behaviour should not define the child, and instead prompt further investigation into incidents which may have instigated changes in behaviour:

> “People usually are labelled. It's like, in the old days, oh, there's the liver. There's the heart. There's the right, you labelled them that this one is the autistic one this one is… So I think that kids and people go through difficult situations. And those difficult situations, make them act in a different way. So you have to find out what the difficult situation is, before you apply anything else a treatment or and even interviewing them You have to find out you have to do with your research, you have to go into the country where they came from, find out what it is, what was it? What, why, why are they why they're the people from Myanmar coming to Australia or what, why, why? Why are they being killed? Why, why was you have to ask why. So you need as a professional, you need to educate yourself, then you find that this the situation that they find themselves in right, and it's a situation that has made the children behave in a different way.” (Chelsea, former social worker, lines 239-248)

Overall, participants highlighted that understanding behavioural issues in children with refugee backgrounds was exceptionally complex and that professionals should consider underlying causes of behaviour rather than interpreting the behaviour in isolation. Often, ‘causes’ of behaviour were seen to be related to trauma, as discussed in Theme 2.

3.3 Trauma Has a Pervasive Impact on Behaviour for Children with Refugee Backgrounds

Participants highlighted the pervasive impact of exposure to traumatic events and any resulting psychological trauma, on the lives of many refugee children: "trauma impacts everything" (Ana). This included behaviour – for example, when asked what causes of behavioural issues for refugee children may be, Josh explained that trauma was the greatest contributor:

> "I think trauma is the biggest, the trauma of being a refugee being labelled a refugee. There's different level levels to this, and different, it's very individual, there's an individual context to this. For example, how does it feel for us not to be called by a name but by by some number, say, instead of Adrianna I call you CX412 or something like that… and then the trauma of being a small kid all by yourself having to make the journey. Some of these kids like, for example, kids from Sri Lanka, they tell stories of being in the boat, small boat for 15 days in the sea to cross the ocean, no food just half glass of water and couple of biscuits, so about their experience of starting to hallucinate for food and really struggling a lot starving, and, yeah, I mean, they also say about people they know who couldn't, who have not survived the journey so there's a lot of this lot of this trauma of loss and the war and how it's impacted their families so it's more to do with loss, grieving, the trauma and then the ongoing trauma, it's not ending."
>
> (Josh, support/case worker, lines, 308-322)

Here, Josh highlighted exposure to traumatic events at all stages of the refugee journey as potentially culminating in behavioural issues for refugee children. Importantly, participants noted that trauma was an especially important consideration in the case of

refugee children because of its potential effects on development, and therefore both direct and indirect effects on behaviour. As Stephen said:

> "…trauma obviously has, like a huge implication on a child's development, it literally changes their brain and changes their entire ways of thinking, ways of functioning."
>
> (Stephen, behaviour support specialist, lines 233-234)

As such, participants saw a bidirectional relationship between trauma and behaviour, such that, as underlying psychological trauma influenced behaviour, behaviour was in turn perceived as affecting mental health which then went on to further impact behaviour. For example, Josh said:

> "Because there is an underlying mental health problem or issue, that's why they have that behaviour so yeah it's both ways. Yeah, behaviour would impact and it's just the tip of the iceberg this because of our trauma-based care which we trauma informed care we always look at the underlying trauma or mental health issues that that leads to those behaviours."
>
> (Josh, support/case worker, lines 297-300)

In terms of pathways to effecting behaviour, participants noted that trauma often manifested as behaviours which suggested hypervigilance, including disassociation, increased emotional expression, and paranoia, as well as difficulties sleeping. In relation to behaviour, Ana noted that this hypervigilance was observable in extreme responses to perceived threats in the environment, including at school:

> "And same with cowering when you hear if the big bangs go off, or if there's fire and explosions, often if we've got things that involve um loud noises, or people coming into the school to do shows, whether it be music or performances often when you're in assembly, for example, you're in a gym and the acoustics are quite loud. So if you've got a child who's been in an experience where the bomb went off and the noise and

> pretty much deafened them or they've seen an explosion where the light was just that bright, when they're seeing strobes, or when they're seeing the fireworks, their reactions have changed, like with the cowering whether trying to hide whether running away, whether reacting and if they feeling threatened, acting violently." (Ana, NAP teacher, lines 316-324)

Overall, trauma was seen as a key driver of behaviour for children with refugee backgrounds. The prevalence of trauma was noted by all participants, and interacted with a range of other environmental, social, and cultural factors as seen in the following theme.

3.4 Environmental, Social, and Cultural Factors Impact Behaviour for Children with Refugee Backgrounds

In addition to trauma, participants discussed the impact of a range of environmental factors including schooling, language, and cultural differences on mental health and resulting behaviour for children with refugee backgrounds.

3.4.1 Schooling

The school setting was seen by participants as a principal source of identifying behavioural issues in school-aged refugee children. Four of the participants (Ana, Zeke, Matthew and Shaban) had worked closely with students from refugee backgrounds in schools, three of whom had come from refugee backgrounds themselves. Overall, schooling was perceived as having both positive and negative influences on behavioural change for children with refugee backgrounds, dependent on the individual's experiences and the support or lack thereof provided by teachers. In particular, participants noted that behavioural challenges at school were often related to children being unsure about the content or feeling like they were falling behind. As Joey said: "behaviour is just a form of communication", while Ana indicated that:

> "Because they don't know how to tell you they're struggling, they don't know how to tell you, they don't understand, their physical behaviour is showing that they're naughty. But it could be because they don't get it, they don't understand they're way behind in what you're even sort of teaching and communicating."
>
> (Ana, NAP teacher, lines 605-609)

Furthermore, participants highlighted how underperforming at school or not understanding the curriculum often led to issues with self-esteem, which in turn affected behaviour; again, highlighting the bi-directional relationship between mental health and behaviour for this group of children. Shaban reflected on his own experience as a refugee adolescent:

> "And then I had to like I couldn't make a sentence even though [he had attended English school] yeah…And that will affect a lot of obviously, that will affect their like, self-confidence, their mental health, and I'm sure they will they struggle a lot in like schools as well."
>
> (Shaban, program facilitator, lines 188-191)

Overall, schooling was understood to influence behaviour, particularly if refugee students were struggling with understanding the content, which led to issues with self-esteem and behavioural concerns as children often did not know how to communicate that they were having difficulties understanding the curriculum.

3.4.2 Language and Culture

Language and culture were also seen as impacting mental health and behaviour, although participants indicated that there were differences here based on the age at which children arrived in Australia, with those arriving as teenagers: "probably need[ing] more attention" (Chelsea, former social worker), as younger refugee children "have got more time

to adapt in the culture of Australia" (Zeke, Education Department). Chelsea, a former social worker, and current community leader noted:

> "But kids past 11,12 years old and that's where I come in, that's where I've seen it with other kids children as well. I think that's that we need to do a lot more work with them. Particularly in two of their journeys, one of them either because they get here when they were about their teenagers, or they've come from a background still where they feel that they're not part of society, and they're growing up and they get to that adolescent year, years that they still think that there's something's not quite right with them…"
>
> (Chelsea, former social worker, lines 26-31)

Here Chelsea links language with social isolation, highlighting that this is especially hard when children are simultaneously working through aspects of development associated with adolescence. Shaban (program facilitator) agreed that language was one of the primary causes of behavioural issues for children with refugee backgrounds as a result of the social isolation that followed from poor language skills in the primary language of a resettlement country: "because they can't be part of other social groups because of those [language] barriers". Additionally, language barriers were also perceived as obstructing communication with others in relation to thoughts and feelings, therefore affecting communication and influencing behaviour. As Stephen explained:

> "If you were a child who came from another culture, and it was your second language, it would still be similar to someone who didn't have, you know, effective communication in some ways because they not they may not be able to communicate, you know, what the problem is… they may not have the tools in the English language to say what they're feeling. So, yeah, you could I could definitely imagine how that would be frustrating and could contribute to their behaviours."

(Stephen, behaviour support specialist, lines 428-433)

Relatedly, issues in communication due to language barriers were seen as an obstacle to diagnosing disorders for children – particularly as a result of making it hard to distinguish between where behavioural issues could be potentially emblematic of a potential disorder. For example, Zeke explained how teachers might attribute symptoms of ADHD to a lack of assimilation and language barriers:

> "Then what I saw was that a teacher would look at it and say, you know what, the kids are not speaking this language. But I would see that the child was writing one word, and then leave it and then it's time to go play. And certain other things that I said, look, I know that the child doesn't speak the language very well, all of those things, but the behaviour is very simple, that the child is really struggling to stick to one task at a time, and has a very, very small attention span. So those sorts of things about these can be treated the language and these things will come to him within a couple of years but this has to be addressed from the word get go…"
>
> (Zeke, education department, lines 235-241)

Similarly, Matthew recounted an incident where a refugee child's behaviours were attributed to behavioural issues initially, when in fact that child had a hearing issue that was missed as a result of language barriers:

> "I actually was involved in a primary reception kid, where he had a hearing problem, but nobody knew about it. He was not diagnosed at all and when I first met, I went there to see the to see this kid, this kid was very bright and everything and but he just didn't do any work, he didn't listen to anyone, he didn't do anything… And that's when I realized… he wasn't understanding some of the stuff even I was saying [in the same language], and that's when I think, we referred him to another to our

> psychologist, to our psychology in the school. And that's when she organized for her for him to get tested."
>
> (Matthew, refugee liaison officer, lines 348-360)

In this instance, it took someone who spoke the same language as the child to eventually work out that there was an additional health issue. On the other hand, some participants also discussed instances where children from refugee backgrounds were incorrectly diagnosed when in fact the issues stemmed from their language issues in relation to learning English and catching up to the school content after backgrounds of disrupted education:

> "I remember a girl that was referred to us [refugee youth services], they said she is disruptive in class, but I found out that the young person was struggling with the content because they were not getting it."
>
> (Joey, team leader for refugee youth, lines 123-124)

In addition to language challenges and the various impacts this had on behaviour for refugee children, participants also noted that cultural differences also influenced behaviour both directly (e.g., through different behavioural norms or customs relating to appearance) and indirectly as a result of bullying from other children. For example, Shaban talked about norms concerning wearing rings for children from Nepal: "They do face lots of challenges... It could be their like, like dressing like sense. Like worrying, for example, like having an earring…It's very common back in country… but they would be bullied or things like that that.". While Zeke similarly shared:

> "Let's say something which be very, very common back home would be so weird in Australia. Like, let's say you meet in Afghanistan guys meet and they, when they say hello, they kiss each other on the cheeks once or twice, and that's a very common thing and then you come in here and you do that you get laughed at people saying, 'oh, what's your problem?'. Are these little shocks that they come to see experience

> every day, that becomes a very big problem for them, which is a major shock. And that takes them time to realize, and that actually affects their behaviour because they are saying, 'okay, should I do this? should I not do this?' even if it is something is very right in their mind, they are hesitant to do it. Or sometimes they try to do something right, which is totally wrong. And they just want to do it because they think it's right to do it here. Yeah. And those are the main factors that affect their behaviours."
>
> (Zeke, education department, lines 61-70)

Participants noted that gender norms were a key area that affected the behaviour of some children with refugee backgrounds. For example, cultural beliefs in terms to gender roles, and expectations of the child to behave one way at home, according to their families' cultural beliefs and then a different way at school were seen to lead to confusion, which in turn influenced behaviour. This was particularly relevant for some boys in relation to relationships with female teachers:

> "And especially with females and males, the roles in their home. Like, respect is a big thing. And a lot, there's certain cultures that they'll come here and you're female teacher so it doesn't matter what you say, how you say it, like if there's a male teacher, they they'll behave differently, like boys are the authority. So if they're going home to a family as well, where there is no dad, it's often the older brother, well, it's often the eldest boy or whatever, who controls what's going on how it's going on when it's going on, and all these sort of things. And when they come to school, they're being asked to do it differently. And suddenly, you're a woman, you're this. So yeah, a lot of it's just through their own experiences and how things operate. How things function it's, you can't really say it's wrong because it's all they know."
>
> (Ana, NAP teacher, lines 190-198)

Overall, the relationship between language, culture and behaviour was seen as complex for refugee children. Participants highlighted that the effect of culture and language depended on the age the child arrived, with older children facing greater difficulties because of less time to integrate and also due to attempting to integrate into a new society while facing the standard developmental challenges that come with adolescence. A lack of proficient English skills was perceived as a barrier to communicating with others, often leading to social isolation, and an inability to express thoughts/feelings which in turn led to behavioural issues.

Language was also seen as an obstacle to diagnosing behavioural issues, as potential disorders were often attributed to language barriers. Contrarily, disruptive behaviour which stemmed from a lack of understanding (due to language barriers) was interpreted as behavioural instead of considering language barriers. Moreover, culture was seen as to influence behaviour directly, through different behavioural norms relating to appearance, and indirectly because of other children bullying refugee children due to their appearance. Gender norms specific to culture were perceived as influencing behaviour too, as children were expected to behave one way at home, according to their cultures gender norms and another way at school, where gender norms were less apparent. This led to confusion, resulting in changes in behaviour at times.

3.5 Barriers and Facilitators for Supporting Positive Mental Health Outcomes and Behaviour in Children from Refugee Backgrounds

The relationship between refugee children and their parents was viewed as being highly influential, particularly regarding paths to support for mental health and behavioural issues. Furthermore, the importance of community, culturally safe support, and building therapeutic relationships built on trust and safety were seen as imperative when facilitating positive behaviour and mental health outcomes for refugee children. According to

participants, service providers from the same cultural background as the refugee child would be ideal, however, a lack of culturally diverse individuals in the sector was conveyed. Participants highlighted connecting with community, including community elders would help alleviate some of the barriers surrounding cultural differences between service providers and refugee children.

3.5.1 Relationships are Crucial to Support Positive Mental Health Outcomes and Behaviours for Children with Refugee Backgrounds

Participants highlighted the importance of relationships between children from refugee backgrounds and a range of adults and other children in relation to behaviour and mental health. This included parents, teachers, and peers. In relation to parents, participants viewed parents as highly influential in the lives of children, but potentially not able to recognise mental health or behavioural issues in their children. This could lead to misdiagnosis or delayed diagnosis for childhood disorders:

> "If a parent is unable to identify, you know, children's behaviours and stuff like that, children go undiagnosed…[they] might not realize that their child's actually going through, you know, like a, like a emotional dysregulation, like mental health issues." (Karla, social worker, lines 154-155, 166-167)

Other participants noted that refugee parents were often focused on meeting the basic needs of their children, including securing housing and obtaining employment – meaning that there was insufficient time to consider whether children needed additional psychological or behavioural support. For example, Zeke recounted a particular incident in which parents from a refugee background unintentionally overlooked symptoms of their child's ADHD as they were preoccupied with meeting his physiological needs:

> "Now, keep in mind that people who will come from, the child, this particular child was from Afghanistan. The parents there did not have a lot of time to focus on these

> kind of issues, because it's very difficult to put a meal on a dinner plate. So their focus is more on basically providing 2 or 3 meals for the kids. So they've got a bigger problems to deal with than looking at, not that this is not a big problem, it is a big problem. But for them, feeding them is a more challenge than doing anything else."
>
> (Zeke, education department, lines 257-262)

In part, participants indicated that these relationships were cemented in experiences that many refugees have, including life in a refugee camp:

> "…and then in refugee camp, like, obviously, the parent have to work, like seven days a week to like, run the family. And then they wouldn't spend much time with the kids… and then, yeah, I feel like they don't spend like quality time with each other. And there's always a gap, like the children they wouldn't be able to share their concerns with the parents."
>
> (Shaban, program facilitator, lines 191-196)

Importantly, Shaban here notes that children might not "be able to share their concerns" with their parents. Other participants also noted that there were issues with listening to the voices of refugee children- not only from parents but also on the part of professionals. For example, Chelsea explains that when refugee families seek help from service providers, the focus is often on the parents:

> "And so they, the child also is in the background, I think the child is in the background, more emphasis is put on the on the ones who can articulate better which is the parents. The children don't know what to articulate they don't know what's normal or what's abnormal…"
>
> (Chelsea, former social worker, lines 358-360)

Additionally, parents were perceived as facing their own challenges with conveying issues which may arise in themselves or their children. Participants highlighted that families

from refugee backgrounds often lack “knowledge that these services are there to be help” and often do not realise “it's okay to seek help” (Shaban), except potentially in “extreme cases”:

> “Depending on the culture again, some of these cultures, mental health, counselling, or even support for mental health it's rarely seen only in extreme cases when the person's got say schizophrenia or if they think that person is insane, that's when he's gone, he or she is gone for mental health support so they, they look at it in that way so the mental health support part of it is not seen that when trauma is seen as a way of life in some of them, it's not something that they want to address or to get some support for addressing this trauma so they think that's how life is. And the effects the ill-effects of the trauma, the think that's also part of their life.”
>
> (Josh, team leader for refugee youth, lines 334-340)

As such, Zeke suggested that stigma, due to cultural beliefs, could obstruct children from refugee backgrounds from expressing their mental health struggles with parents or others for fear of being labelled as ‘weak’ – particularly for boys. He discussed the importance of removing social stigma to help refugee children seek help when they needed to, saying:

> “… a lot of the times our solution is provided to a child, which is going to be amazing for a child, but the child is not, the child is hesitant to take that solution to their parents. Because of let's say, the, the child is an Afghan male, and he's 15-year-old. And we have got a social problem that a man cannot have. If a man is saying that ‘I've got anxiety or depression’, that man is basically labelled as weak. Because Afghan man should not be depressed or should not have anxiety. Because if you do have these things, you're a weak person. But now, let's say a kid is facing this problem. And the person working with the kid is finding the problem that the or the child, the child is facing the problems of anxiety and depression and all of those things. But then the

> child is carrying the social stigma of saying that, 'yes, I have this'. And now to educate that child that saying that, 'yes, I understand you have the things but now let's go and talk to your parents at the same time and educating them that this is a reality in life, the strongest men can have this problem' and we need to basically take that stigma away from it."
>
> (Zeke, education department, lines 149-160)

Overall, refugee parents were perceived as being highly influential as avenues of support for mental health and behavioural issues for their children. Their relationship was seen as intricate, with many experiences including periods at refugee camps affecting the formation of attachment and view on mental health. Additionally, refugee children were perceived by participants as facing difficulty expressing their needs, often as a result of stigma surrounding mental health.

3.5.2 Cultural Responsiveness, Building Trust, and Safety

There was broad agreement amongst the participants that anyone working with children from refugee backgrounds "should know about cultural differences, the background information of the culture" (Shaban). Thus, anyone working with children in relation to their behaviour needed to consider "culturally sensitive type ways" (Ana) of providing services. Chelsea further explained:

> "Always connecting the person with a culture where they come from there has to be a sense of meaning you can't just put a person in, in isolation and treat them in a white society. Because there's no meaning for that person. It has to be he has to be treated according to the culture of that person that's the most important thing that we need to remember here. A treatment for a white person is may not be the same than for a Latin American person from Peru or from Colombia you know you, may not be the same."
>
> (Chelsea, former social worker, lines 505-510)

Moreover, participants emphasised that having a service provider from the same background as the refugee child would be ideal, as they were more likely to share similar cultural beliefs, shared life experiences (including understanding trauma) and speak a child's primary language. As Zeke expressed:

> "A lot of people it's a lot easier to have someone who speaks your language, who understands your trauma, who understands your problem to open-up with that person, and trust that person."
>
> (Zeke, education department, lines 189-191)

Here, the link between trauma and behaviour, as previously examined, became apparent once more when supporting children from refugee backgrounds; with one possible response being ensuring that refugee children are supported by someone from their own cultural background, with whom they could build trust and rapport. Similarly, Karla, a social worker, in the child protection field, explained how she would generally ask a worker from the same cultural background as the family to accompany her when making home visits. However, she noted that this was not always possible, in which case she asked the workers whether there were any cultural nuances that she should take into consideration before the visit:

> "We've got our cultural services team so I've linked in with them kind of have like a pre planning meeting, see if there's any one available to come from the team and also like not always available, but if it is seeing if I have a culturally specific worker to come out to do that, that co-visit with me, if, if not just kind of asking them, like you know 'so and so is from this background, do you have any tips or anything that I should like you know be mindful of? Should I be like you know, be considerate of you know, eye contact, language, use an interpreter?' like you know, I'd kind of yea, give them a rundown of what we know, see if they know the family at all. Or yea like,

> what should I consider, should I be bringing out an elder should I be you know taking my shoes off, that kind of stuff."
>
> (Karla, social worker, lines 245-252)

Other participants explained that service providers do not always need to come from the same culture as the client. Josh described how his migrant background assisted him in having increased cultural awareness when working with unaccompanied minors and how using a "cultural lens" helped him build trust with his clients:

> "I think my experience as a migrant there are a lot of overlapping experiences in terms of coming to a new country, cultural differences the way that I have had to adapt. And I can empathize better and probably understand their perspective, and sometimes even the language, cultural similarities, have helped me understand the situation from the lens of culturally from a cultural lens that's helped me as well. And that's also helped me build the trust with someone."
>
> (Josh, support/case worker, lines 272-277)

Generally, however, building trust with refugee children was seen as of utmost importance, as it was this relationship that helped children open-up and respond to assistance for any mental health or behavioural issues. Participants acknowledged that refugee children are often hesitant to trust people in authority due to past experiences, "a survival mode was still on so they still, it took them some time to start trusting you fully" (Zeke) and the importance of building relationships became apparent:

> "And I mean, in terms of dealing with, I think, more than any kind of skills that are required in working with children, the ability to, to connect with them relationally and also, making sure that that relational connection embraces emotional connection with other people. I think it's significant, because what happens most of the time, whatever the problem is, with a young person, that affects their mental health, it's the breaking

> of a relationship that leads to that chaotic situation for the young person. And it's important for the therapists to think about the relational aspect, before thinking about all the other modalities and stuff like that, helping that child to feel connected, and feel accepted and feel acknowledged and trusted. I think that is a key. And I think that's where the healing starts. It doesn't start with using all the modalities that we can come up with."
>
> (Joey, team leader for refugee youth, lines 521-529)

Here Joey highlighted the significance of not only building a relationship with refugee children but also helping them build relationships with others. He explained that many mental health (and therefore likely behavioural) issues stem from the breakdown of a relationship, and that facilitating connection for refugee children, and feelings of acceptance and trust is where healing will begin. However, building trust and a therapeutic relationship was perceived by participants as requiring patience, due to past traumas, as Joey said, "most of these clients it takes months to even get to know them and get them to trust you as well, because kids go through that trauma, the journey…".

Importantly, Stephen discussed how a standard clinical practice setting can be an "alien experience" for refugee children, and how he chooses to conduct sessions in environments which are familiar and comfortable for children:

> "You know, for example, like, clinical practice can be strange and intimidating for some kids like, especially if it's like an office setting. And if the kids from different cultural backgrounds I got, especially for Aboriginal kids, it can just be such an overwhelming and alien experience sitting in an office and a white guy in a, you know, dressed up, you know, talking to him making eye contact is just an extremely strange setting. So,yeah, I guess, um, I never really worked by I never really liked to

> deliver sessions in the office, I preferred to go to the home where they comfortable or to the school but yea I think making them comfortable you know…"
>
> (Stephen, behaviour support specialist, lines 323-329)

Chelsea agreed, explaining issues with the power dynamic of sitting behind a desk and instead proposing that service providers respond to refugee children more flexibly – such as sitting side by side – to build trust:

> "Having people also, I hate having people across, I'd rather have people next to me but yeah, it's sort of like this. I don't mind the across, but we are the same level. But things are not we're talking. Be inclusive, we try to be inclusive, and you have to mind that people are literally their desks and chairs are higher, people in banks and people like that actually bit like this. So, they say they're making a point that they are higher than you, even if they get out and they're shorter but their chair up here you know, so this is all psychological as well and it is to tell you, you, your place is down there and my place is up here. So, we try to avoid those things and that's how you gain trust."
>
> (Chelsea, former social worker, lines 818-824)

In summary, participants highlighted the significance of being culturally responsive when working with refugee children regarding behaviour and mental health. Although cultural workers from similar backgrounds as refugee children were seen as ideal, participants highlighted the lack of diverse individuals in the mental health sector. Incorporating cultural mentors or liaising with individuals from the same cultural background as the refugee child were proposed as ways to overcome this barrier, as the next theme will address. Lastly, participants indicated that refugee children are often hesitant to trust others due to past experiences, therefore, building a therapeutic relationship which encourages trust and promotes safety was seen as imperative. Participants also accentuated the need to

consider environmental settings and culturally responsive care for refugee children, to foster a sense of safety.

3.5.3 Community Involvement

All participants highlighted that connecting children and families from refugee backgrounds to community support and working alongside community leaders would be the best way to support positive behaviour. As Stephen explained: “therapy isn't enough they need cultural connection, as well”. In relation to this issue, participants suggested that there should be a bridge between schools and parents in the form of a ‘community educator’ who worked both ways: to help educate parents on any issues their children may be facing and to also assist in promoting awareness of culture and the refugee experience to schools. As Shaban said:

> “I feel like there is a need for, like community leaders are coming to educated to be part of, you know, kind of like bridge between the school and families so that should be community educators they should have access to those things. And then the school should know about like cultural differences. The background information of the culture.”
>
> (Shaban, program facilitator, lines, 484-487)

Karla built on this by highlighting the role of elders in the community, who “are quite passionate of being involved in those big decision making, especially when you're coming back from a child protection background, like they want to obviously protect their community”. Chelsea agreed, explaining: “you should involve more people like us, leaders, you should involve more us” when it comes to providing services for families with refugee backgrounds. Working with community leaders was suggested to fill knowledge gaps that service providers may have when working cross culturally with children with refugee backgrounds. Stephen explains not only the significance of working with the community, but

also the importance of an evidence-based approach and weaving these together when working with refugee children:

> “So experts need to actually work more with the community to say like, 'I don't know, like, I don't know why this is happening. I don't understand how your community works, I don't understand how your traditions work, I need your help. I need you to help me understand this person and help me understand the culture and the values'. And, yes, so we need to not like, I definitely agree, we need to have the evidence-based approach but at the same time, we need to take a step back and say, well, I don't actually know some of the stuff and if I'm going to work best with this young person from this community, I need to actually ask for help from that community. I think working more with the community.”
>
> (Stephen, behaviour support specialist, lines 575-583)

Matthew also proposed working with leaders, saying: “people in those communities, they follow their leaders.” However, importantly, participants explained that not all families will want to have affiliations with their community, due to personal reasons or past negative experiences:

> “Yeah, some kids. They appreciate being connected with their community leaders, other kids don't appreciate that. So it has to be, that's why I'm saying it has to be kind of include the child in the process. So if a child is happy with that, that's what we're gonna do, if the child is not happy with that. We'll do what, I mean an alternative to that.”
>
> (Joey, team leader for refugee youth, lines 308-311)

Therefore, encouraging community connection and involving community elders should be discussed with the family and child first. Joey explained that connecting children to

their community should be a decision which involves the child and service providers should be guided by the child's voice.

Hence, the importance of involving the family in decision making when it comes to these matters is reiterated. Zeke encapsulated the multiple benefits of connecting families to community, for education purposes and to form relationships with teachers and discuss issues children may be facing to open the conversation to accessing help. Specifically, he discussed using the medium of language classes to engage parents and children:

> "So in our Afghan community, we've got multiple Sunday schools. So we teach every Sunday morning we called classes, we teach our own language. That's basically a free of cost. Some is voluntary classes, anybody who wish to join, they can bring their kids so not only that, they learn the language and help with the homework and homework, clubs, everything else. But also, if the parents wish, then the local community teachers who are volunteers, they can work with the teachers of schools and tried to present the issue in a better way to the parent and say, Look, this is the issue let's get the psychologists or psychiatrists or whatever level it is that we can get this fixed."
>
> (Zeke, education department, lines 285-291)

Overall, incorporating community leaders into the provision of services and helping connect families to communities was perceived as imperative when supporting children and families from refugee backgrounds in terms of behaviour and mental health. Benefits to this meshed approach of working alongside community leaders included education for parents and service providers and promoting friendships and connections. However, participants did indicate that the involvement of community leaders should be at the discretion of the individual child and family.

CHAPTER 4: Discussion

4.1 Overview

This study provides valuable insight into understanding behaviour, including its intricate relationship with mental health, and risk and protective factors for behavioural and mental health issues for refugee children. Behavioural issues were seen as stemming from trauma; thus, participants understood a bi-directional relationship between mental health and behaviour, with trauma a key component of this relationship. Consistent with an ecological model, language barriers, culture, interpersonal relationships, and schooling were seen as key interrelated determinants for behavioural and mental health issues, sitting at various levels of the ecological model (Bronfenbrenner, 1979). Whilst these factors were perceived as influential on the lives of all refugee children, refugees who migrated during adolescent years were seen as being at increased risk due to their critical stage of development and reduced amount of time for acculturation, in comparison to young children. The importance of developing trust, nurturing safety, cultural awareness and fostering connections to community was perceived as imperative when working with refugee children and their families.

4.2 Understanding Behaviour: Context and Trauma

Generally, behaviour was interpreted as fluid and contextual. Behavioural problems were seen as responses to stressors present at any level of the ecological system, and often involved complex interactions between these. These stressors were seen to overshadow the refugee child's ability to cope, and thus instigate behavioural change. Therefore, to understand behaviour, participants suggested maintaining a comprehensive view of individual, contextual and environmental determinants.

In particular, participants highlighted the impact of trauma on behaviour and mental health for refugee background children. The incidence of trauma exposure and psychological

trauma unique to the refugee experience was well-recognised by participants, reflecting existing research (Fazel et al., 2005). Trauma was perceived as one of the primary causes of behavioural issues, sitting outside of, and influencing, a bi-directional relationship between mental health and behaviour. Trauma was seen as manifesting in diverse forms such as mental, emotional, and behavioural disorders for refugee children (Bronstein & Montgomery, 2011; Ceri & Nasiroglu, 2018). However, research specifically addressing a bi-directional relationship for mental health, particularly trauma, and behaviour for refugee children's behaviour is limited and thus a good focus for future research.

Trauma was perceived as instigating changes in behaviour through hypervigilant states in response to perceived threats, impacting development (particularly learning) and affecting seek-helping behaviour, as distrust with authorities and service providers often stemmed from trauma (Davidson et al., 2004). Though under-researched for refugee children, research for non-refugee populations indicates trauma can have significant effects on brain development, affecting information processing and the capacity to regulate behavioural and cognitive responses (Briere & Scott, 2006; Nemeroff, 2004). However, outcomes of trauma exposure (and thus impact on behaviour) can be mediated by risk or protective factors including resilience and resettlement experiences (Lau & Thomas, 2008), which can sit at various levels within an ecological approach, as seen in the following sections.

4.3 An Ecological Model for Mental Health and Behaviour for Refugee Children

4.3.1 The Microsystem

At the microsystem, friends and community was seen as imperative to nurturing adaptive behaviour and mental health for refugee children. Mental health and behavioural issues were perceived as often stemming from the breakdown of relationships, and as such, participants indicated that it was primarily through supporting refugee children to form emotional connection with others that healing from psychological issues could take place. As

Herman (1992) states, "*recovery can take place only within the context of relationships; it cannot occur in isolation*." (p. 113).

The relationship between refugee children and their parents was seen by participants as of particular importance. However, participants noted that refugee parents' own trauma could impact their ability to care for their children in some cases, reflecting previous research (Thommesen et al., 2018). Additionally, insecure attachment styles can adversely influence behavioural and emotional problems for refugee children (Dalgaard et al., 2016). On the other hand, parental support can be a protective factor for children developing mental health issues (Drury & Williams, 2012). Furthermore, parents were viewed as highly influential to accessing help for refugee children, again mirroring previous research where parents have been identified as 'gatekeepers' (Stiffman, 2004; Flisher et al., 1997). However, Segal and Mayadas (2005) suggests that refugee parents seldom actively access help for their children unless issues become so substantial that individuals outside of the family unit convey concern for the child and some participants in this study also indicated that this was the case. Overall, then, ecological models of behaviour and mental health for refugee children thus need to consider the complex relationships for parents with refugee backgrounds and the ways that they can support their children while coping with their own trauma.

Additionally, participants stressed that refugees who migrate as adolescents are at increased risk of mental health and behavioural issues, as they are in a transitional period of development and have less time for acculturation, in comparison to younger children. Other research has suggested youth of over 16 years reported higher levels of internalising problems than younger children (Braun-Lewensohn & Al-Sayed, 2018). Adolescence in general is an important phase of development, where various physical, cognitive, and psychosocial changes take place, and many psychological problems first appear (Filler et al., 2021). While stress can have adverse effects at all ages, research suggests due to the unique

stage of development, stress occurring in adolescence can have a more profound effect compared to younger children (Romeo, 2014), which can be exacerbated by the resettlement process for refugee adolescents (Fazel et al., 2012). Participants indicated that refugee children, including adolescents, are at risk of social isolation, discrimination, cultural and language barriers, trauma, and issues at school, and this finding supports previous research (Beiser & Hou, 2016; Montgomery, 2008; Correa-Velez et al., 2010; Ellis et al., 2011; Fazel et al., 2005) Therefore, special consideration should be given to this age group.

4.3.2 The Mesosystem

At the mesosystem, schooling was perceived as having a pivotal role in the diagnosis of disorders and a key determinant of behavioural change and mental health. Schooling is the most widely available protective community factor for children, and the impact it can have on mental health and behaviour for refugee children is renowned in literature (Betancourt & Khan, 2008; Yule., 2000; Howard & Hodes., 2000) as well as being recognised as a primary resource for early detection and intervention for mental health concerns (Fazel et al., 2016; Baak et al., 2019). Moreover, Baak et al. (2019) highlighted the pivotal role of behaviour when identifying mental health issues for refugee adolescents in school settings.

In this study, unsupportive teachers were viewed as influencing behaviour and mental health, in concurrence with previous findings for refugee children (Beiser & Hou, 2016). Relationships with peers and teachers are extremely important for children with families who are unable to provide effective parenting and emotional support, as these relationships may moderate adverse effects of early attachment experiences for children (Luthar, 2015). However, language barriers were viewed as impairing refugee children's ability to communicate and connect with teachers and peers, often resulting in social isolation, further influencing mental health and behaviour. Language acquisition and social isolation has a

significant impact on mental health and behaviour, as indicated in previous research (Montgomery, 2008; Beiser & Hou, 2016; Correa-Velez et al., 2010).

Furthermore, language barriers were perceived as extending to numerous further difficulties for refugee children. Poor academic performance, due to language barriers was perceived as adversely affecting self-esteem. This often led to further changes in classroom behaviour – accentuating the importance of considering the bi-directional relationship between mental health and behaviour. Other research has indicated an association between school performance and behavioural and emotional problems for refugee children (Lau et al., 2018; Correa-Velez et al., 2010), and thus the central role of school in ecological models must be considered.

According to participants in this study, the diagnoses of potential developmental and behavioural disorders became confounded by language barriers. Disruptive behaviour was often attributed to a behavioural disorder, when in fact the child's behaviour was a form of communicating that they did not understand school content. On the other hand, developmental disorders were sometimes mistakenly perceived as issues with adjusting to the new culture. Challenges in discerning learning difficulties from difficulties acquiring English have been found in previous research with culturally and linguistically diverse populations (Clifford et al., 2013). Other research indicates teachers expressing difficulties recognising mental illness symptoms due to lack of training, a fear of labelling students, lack of explicit screening tools and difficulties discerning between typical adolescent behaviours and mental health problems (Murray et al., 2010; Vieira et al., 2014; Dwyer et al., 2006).

4.3.3 The Exosystem

At the exosystem, in line with previous research, refugee parents were perceived as often prioritising primary needs (i.e., financial needs, food, safety) over psychological or

behavioural needs (Palmer, 2006), resulting in potentially missing signs that their child may need help – and thus, delaying, or missing diagnoses of potential disorders.

Furthermore, the importance of connecting refugee children and to their families to community was perceived as a key method to facilitate positive behaviour, as building friendships and connections could decrease social isolation and promote a sense of belonging. The role of a 'community educator' was proposed to help educate refugee families and to help endorse awareness of culture and refugee experiences to schools also. Weine et al (2003) found connecting refugee families to their cultural community improved access to mental health services, improved communication within the family and decreased depression symptoms. The increased social support and access to services this connection provided helped provide structure in the often-chaotic environment of refugee families (Lustig, 2010).

4.3.4 The Macrosystem

Influences existent in the macrosystem, had noteworthy effects on many of the other levels of the ecological system and on behaviour and mental health. Participants highlighted that differences in cultural norms such as those around gender or dress codes could influence behaviour and mental health for a range of reasons, including discrimination. Adverse effects of discrimination on behaviour are evident in previous research for refugee children (Ellis et al., 2008), however interactive effects between cultural beliefs, behaviour and mental health require more attention.

Culture also played a pivotal role on engagement with behavioural and mental health services for refugee children. Cultural beliefs, such as stigma surrounding mental health, often instigated hesitancy within refugee children to communicate their psychological (and thus likely behavioural) difficulties with their parents, and in turn for parents to initiate help-seeking as previously discussed. These findings mirror previous research concerning service

engagement for refugee populations (May et al., 2013; Pacione et al., 2013; Lustig et al., 2004).

4.4 Overcoming Barriers

As can be seen in the review above, barriers and facilitators to supporting good behaviour and mental health are evident at every level of the socio-ecological system. At the microsystem level, the importance of involving family, particularly parents, when addressing behavioural or mental health concerns was discussed. Participants suggested providing education for the child and parents to help overcome prominent cultural stigma associated with mental health, in line with other literature (Ellis et al., 2011). Filler et al. (2019) found adolescent youth were more receptive to discussing mental health when alternative descriptors for mental health issues such as "*stress"* and "*pressure*" were used (p. 777). Moreover, Dybdahl (2001) provided psychoeducation on trauma and guidance on facilitating parent-child interactions for mothers of traumatized refugee children. This resulted in decreased psychological distress for children *and* mothers.

At the mesosystem level, developing trust and nurturing safety should be one of the primary goals of service providers when working with refugee children. Engaging with families when providing services to refugees has shown success in moderating power differentials and building trust (Ellis et al., 2011). Furthermore, understanding that this therapeutic relationship will require time, and patience is needed, as supported by previous research (Ehntholt & Yule, 2006; Nadeau & Measham, 2005). Moreover, fostering safety by considering environmental settings such as sitting side by side to children and avoiding formal office settings (which could harbour power differentials) when working with refugee children was suggested by participants.

At the macrosystem, the significance of cultural awareness and responsiveness when working with refugee children and their families was noted of great significance,

corresponding with research from Ehntholt & Yule (2006). Individuals from the same cultural background were perceived as ideal for working with refugee children, as they may share cultural beliefs, language, and understand past traumas from their country of origin. However, a lack of culturally diverse workers in the field was noted. Therefore, participants suggested collaboration with community leaders and cultural advisors to overcome this barrier. Involving a community voice and cultural experts for the development and delivery of services has been suggested by previous research also (Ellis et al., 2011).

4.5 Strengths

The qualitative methodology was a strength of the study, allowing free responses from participants to generate a deeper understanding of behaviour and mental health, and barriers and facilitators for supporting good behaviour and positive mental health. Additionally, the study involved participants with experience working with refugee in diverse settings and roles. Furthermore, participants were from diverse cultural backgrounds, including from refugee backgrounds – helping cultivate a broader understanding of behaviour and mental health for refugee children due to the diversity of culture, life, and professional experiences within the sample. Overall, the study met standards for rigorous qualitative research and addressed a current significant issue, as demonstrated by the eagerness of participants to share their experiences to assist in the enrichment of support systems for refugee children (Braun & Clarke, 2013; Tracy, 2010).

4.6 Limitations and Future Research

Though care was taken to recruit participants who worked with refugee children in a variety of settings, one key area which may be helpful to include in further research would be individuals who work with refugee children in other primary or tertiary healthcare settings (i.e., doctors, nurses). Due to evident impacts of trauma on behaviour, mental health, and development, applying a biopsychosocial view (Engel, 1977) could assist in viewing

behaviour and mental health for refugee children from a broader perspective which includes physiology.

Furthermore, refugees are a heterogenous group regarding language, culture, and individual experiences. However, participants described experiences working with refugee children from numerous cultural backgrounds and ages and generally no distinction was made between countries of origin with regards to mental health and behaviour. Nevertheless, further research should focus on refugees from specific cultures sharing language and potentially more cultural nuances.

Additionally, as adolescents were identified as an at-risk group for behavioural and mental health issues, further research should be conducted on this age group. This could include exploring whether the potential extended exposure to trauma, due to spending more time in countries of origin, affects brain development more in comparison to younger children with less exposure.

4.7 Implications

This study highlights factors evident at multiple levels of the ecological system, which facilitate or impede good behaviour and positive mental health for refugee children. Therefore, supporting refugee children should entail practical efforts across each level, as has been suggested previously (Scharpf et al., 2021). Firstly, as trauma sat across all levels, using a trauma-informed approach of interventions, adapted specifically for the culture of the refugee child should be considered.

On the microsystem level, interventions should focus on supporting parent-child relationships, and providing culturally sensitive education regarding mental health and behaviour. School curriculums should be tailored for refugee children, bearing in mind the influence of language and trauma on learning at the mesosystem. School-based interventions for behaviour and mental health should also be implemented, as has been highly successful in

engaging refugee children in services (Ellis et al., 2011). At the exosystem level, helping refugee families connect to community and using integrative approaches assisting them in meet primary needs could be considered. Finally, at the macrosystem level, resources, training, and research regarding cultural awareness and responsiveness should continue – to guide the development of future interventions and services for children with refugee backgrounds.

4.8 Conclusions

Multiple central, often interrelating determinants, influencing behaviour and mental health for refugee children were identified in this study, including interpersonal relationships, exposure to trauma, language, culture, mental health, and schooling. Disruptions occurring at any level of the ecological system often resulted in maladaptive behaviour, which affected mental health, development, self-esteem, and socialisation. Adolescent refugees were considered a particularly at-risk group, due to the critical stage of development encompassing this age and decreased time for acculturation, compared to younger children. Barriers to refugee children and their families engaging in services for behaviour or mental health included stigma and distrust of service providers. Holistic approaches including cultural responsiveness, building trust, nurturing safety, community, and parental involvement were perceived as imperative for supporting behaviour and mental health for children with refugee backgrounds.

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Appendix A

Participant Flyer

Researchers from the University of Adelaide are conducting a study called:

Understanding refugee children's behaviour

We would like to interview you if you:

- Are a healthcare professional (e.g., psychologist, social worker, counsellor, paediatrician, GP) or service provider (e.g., case workers)
- Are over the age of 18
- Can speak enough English to do the interview in English
- Have worked with refugee children in the past five years

We will ask you about your understandings of refugee children's behaviour, diagnosis of behavioural difficulties in refugee children, and ways to support refugee children who may be experiencing challenges.

Interviews will take approximately 1 hour.
Interviews will be conducted at a time and place convenient for you.

If you would like further information or would like to take part in the project, please contact:

Dr Clemence Due
University of Adelaide School of Psychology
E-mail: clemence.due@adelaide.edu.au

Appendix B

Information Sheet

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Understanding behaviour in children with refugee backgrounds
HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER:
PRINCIPAL INVESTIGATOR: Dr Clemence Due
STUDENT RESEARCHER: Adrianna Munayco Wynman
STUDENT'S DEGREE: Psychology Honours

You are invited to participate in the research project explained below.

What is the project about?

This project focuses on behaviour in children with refugee backgrounds. We are interested in asking you about your understandings of child behaviour, the causes of any child behavioral problems, the diagnosis of childhood developmental disorders in this cohort of children, and the best ways to support good behaviour in children with refugee backgrounds.

Who is undertaking the project?
A team of researchers including Dr Clemence Due and Adrianna Munayco Wynman are undertaking this project and will be conducting the interviews. For Adrianna, this project composes a large component of the research area for the degree of Psychology of Honours at the University of Adelaide.

Who is being invited to participate?
You are being invited to participate if you:

- Are a healthcare professional (e.g., psychologist, social worker, counsellor, paediatrician, GP) or service provider (e.g., case workers)
- Are over the age of 18
- Can speak enough English to do the interview in English
- Have worked with refugee children in the past five years

What will I be asked to do?
You will be asked to take part in an interview lasting about one hour. The interview can be done face to face, over the phone or via zoom – it is up to you. If you decide on a face to face interview, we can organize a convenient location for you, or we could do the interview in an office at the University of Adelaide.

Participation is voluntary and you do not have to answer questions if you chose not to.

Are there any risks associated with participating in this project?
The project is unlikely to present any risks to you apart from the time to do an interview.

What are the benefits of the research project?
We hope that the project will improve understandings of behaviour in children with refugee backgrounds, and assist service provides to develop appropriate and evidence-based supports.

Can I withdraw from the project?
It is completely up to you if you would like to be a part of this project. If you would like to participate, you can still withdraw from the project at any time. We can remove your data if you choose up until the due date of Adrianna's thesis (September 2021).

What will happen to my information?

Your interview will be audio recorded and we will transcribe this into a written interview. You will have an opportunity to review this transcript.
We will make sure we do not disclose your name or any other identifying information in the written interview or any publications. Only the researchers will be able to access the data from this project. This data will be kept for 7 years on a password protected computer then erased. We can send you a copy of the results of the project if you would like. The final results might be included in a journal.

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2021-xxx). If you have any questions or concerns in regard to your participation in the project or would like to voice a concern or complaint, please contact the Principal Investigator. Contact the Human Research Ethics Committee's Secretariat on phone +61 8 8313 6028 or email to hrec@adelaide.edu.au if you would like discuss any concerns or complaints, enquire about the University's policy on research with human participants or your rights as a participant. Any concern or complaint will be confidential and investigated completely. You will be informed of the result.

If I have questions or want to participate, what do I do?
If you are interested in participating, please contact Adrianna (a1809547@student.adelaide.edu.au or 8313 6096) or Clemence (clemence.due@adelaide.edu.au or 8313 6096) to ask questions or arrange a time for an interview.

Yours sincerely,
Dr Clemence Due

Adrianna Munayco Wynman

Mtho Ngcanga

Amanda Taylor

Diana Dorstyn

Allyssa Sawyer

Appendix C

Consent Form

CONSENT FORM

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	Understanding Behaviour for Children with Refugee Backgrounds
Ethics Approval Number:	Approval number 21/16

2. I have had the project fully explained to my satisfaction by the research worker. My consent is given freely.

3. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.

4. Although I understand the purpose of the research project, it has also been explained that involvement may not be of any benefit to me.

5. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged, unless I specifically request otherwise. I understand I have the opportunity to read over the transcript of my interview and delete any text which may identify me, and this will not be used in any publications.

6. I understand that I am free to withdraw from the project at any time.

7. I agree to the interview being audio recorded:

   Yes ☐ No ☐

8. I would like a summary of the study's results emailed to me upon its completion:

   Yes ☐ No ☐

9. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

Participant to complete:

Name: _____ Signature: _____ Date: _____

Researcher/Witness to complete:

I have described the nature of the research to

_____

(print name of participant)

and in my opinion she/he understood the explanation.

Signature: ..... Position: ----------

Date: .....

Appendix D

Interview Questions

1. Could you tell us about your experience working as [insert title].
    a. Prompts: how long, what capacity
2. Could you tell us about your experience working with children with refugee backgrounds in your role?
    a. Prompts for differences for demographic characteristics (age, gender, etc.)
3. How would you define the term 'behavioural problems' in relation to children?
    a. Prompt refugee children
4. What are some of the causes of behavioural problems in children with refugee backgrounds?
    a. Prompts: impact of trauma, language, differences for demographic differences (age, gender, cultural background etc.)
5. Do you think being a refugee has an impact on behaviour for children? If so, how?
6. What do you think are the best ways to assist children with refugee backgrounds who have behavioural problems?
7. Have you been involved in diagnosing childhood disorders?
    a. If so, what has this experience been like? What are some of the difficulties or challenges for refugee children in relation to diagnosis?
8. What are the best ways to support children with refugee backgrounds in relation to behaviour?
9. Do you think that behaviour has an impact on mental health?
    a. Prompts: impact of trauma, language, differences for demographic differences (age, gender, cultural background etc.)
10. What other things would you like to tell us?