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Unaccompanied asylum seekers and refugee minors: War trauma, psychopathology and social support

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Overview

The literature review presents a summary of the multiple risk factors experienced by unaccompanied asylum-seeking and refugee minors during pre-migration, flight and resettlement periods. The impact of such experiences is evaluated in relation to psychological well-being. Two models of social support, the stress buffering model and the main effect model are examined in relation to this population. The potential difficulties in accessing and utilising social support are discussed.

The empirical paper assesses exposure to war trauma and psychological well-being in a sample of 44 unaccompanied youngsters who have sought asylum in the UK. The benefits of received and perceived social support are also explored. Results of the study indicated that participants reported high incidents of exposure to war trauma, and symptoms of posttraumatic stress disorder (PTSD), depression and anxiety. There was a significant association between exposure to trauma and PTSD symptoms. High levels of perceived social support were associated with lower levels of depression and PTSD symptoms of intrusion. Findings are discussed in relation to future research and clinical implications

The critical review considers the potential benefits of conducting research with unaccompanied asylum-seekers and refugees. Methodological challenges and limitations of the current study are discussed.

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Paper 1 : Review paper

Unaccompanied minor asylum seekers and refugees:

Potential benefits of social support in a high risk population

Abstract

Unaccompanied minor asylum seekers and refugees are a unique population, who have experienced multiple traumas and loss. A summary of trauma and risk factors faced by these youngsters during pre-migration, flight and resettlement periods is presented. The potential impact of such experiences is evaluated in relation to psychological well-being.

Social support is widely accepted as playing a protective role in psychological well-being following stress and trauma (Joseph, 1997). The potential benefits of social support for unaccompanied youngsters seeking asylum in the UK are considered in relation to the stress buffering model and main effect model. Challenges to accessing and utilising social support, such as insecure attachment relationships are discussed in relation to this population. Implications for service providers and future research are also explored.

Introduction

Thousands of unaccompanied minors seek asylum in the UK. Home Office statistics indicate that in 2003 alone, more than 3,000 unaccompanied children applied for asylum in the UK (Heath, Jeffries & Purcell, 2004). Approximately 90% of these youngsters were adolescents aged between 14 and 17 years. Unaccompanied minor asylum seekers and refugees have experienced multiple losses. In addition to the death of or separation from parents, they have been extracted from all that is familiar to them including family, friends, home, possessions, language and culture (Thomas, Thomas, Nafees & Bhugra, 2003). Asylum is likely to be sought following multiple stressors or traumatic experiences, which do not usually stop when an unaccompanied minor reaches a host country and attempts to negotiate the asylum application process and a new life (Kidane, 2001; Stanley, 2001).

Traumatic, uncontrollable dislocation from one's customary world is likely to have a catastrophic impact on psychosocial well-being. Children and adolescents, whose identity and beliefs about the world around them are still being formed, may be particularly vulnerable. Young asylum seekers are faced with the complex task of trying to make sense of their original world disrupted by conflict and violence. In addition, they are required to comprehend and integrate into the culturally unfamiliar world of their host country. This challenge is summed up by one young unaccompanied asylum seeker who had sought refuge in the UK, who described feeling like he had "lost the steering wheel to his life" (Kohli, 2000, p. 6).

Multi-disciplinary research provides strong evidence for the protective role of social support, in relation to both physical and psychological well-being (Cohen, 2004; Cohen, Underwood & Gottlieb, 2000). In particular, social support is widely accepted as a protective factor against the development of psychopathology following traumatic or stressful events (Joseph, 1999). The benefits of social support have been noted in research on asylum-seeking and refugee populations (Almqvist & Broberg, 1999; Gorst-Unsworth & Goldenberg, 1998). However, current research has not attempted to apply theoretical models of social support to the unique population of unaccompanied minors. In addition, very few studies have evaluated the availability and impact of social support received by unaccompanied minors seeking asylum in the UK.

The first section of this paper summarises the relevant literature relating to the experiences and functioning of unaccompanied minor asylum seekers and refugees. The potential protection, usually offered by parents during times of war, conflict and forced migration that unaccompanied minors lack is discussed. Multiple risk factors faced during pre-migration, flight and resettlement periods are described, and the impact evaluated in relation to psychological well-being. Where research has not addressed the specific experiences of unaccompanied minor asylum seekers arriving in the UK, findings from international research conducted with the wider refugee population, including adults and accompanied children, will be drawn upon.

The second section commences with a brief overview of two main theoretical models of social support, the stress buffering model and the main effect model (Cohen, 2004). These social support models are considered in relation to unaccompanied minor asylum seekers, addressing both immediate needs on arrival in the UK and longer-term psychosocial development. The influence of early attachment relationships in the utilisation and effectiveness of social support is discussed. The limitations of applying predominantly Western theoretical models to ethnic and culturally diverse populations are acknowledged. The paper concludes by highlighting the role that services and society can play in the delivery of social support to unaccompanied minor asylum seekers, and areas requiring further research are identified. Abbreviations of terms are listed in Appendix 1.

1. Experiences and psychosocial well-being of unaccompanied minor asylum seekers and refugees

1.1 Definitions

The United Nations High Commissioner for Refugees (UNHCR) defines unaccompanied minors as children under 18 years of age who have been separated from both parents and are not being cared for by an adult who, by law or custom, is responsible to do so (UNHCR, 1994). The UNHCR has recently widened this definition to include 'separated' children in order to highlight the needs of youngsters who are not deemed 'unaccompanied' according to the 1994 UNHCR definition, but may not be receiving the same level of care and protection as previously experienced. These youngsters may be separated from their parents or legal guardian, but accompanied by traffickers, agents, siblings, extended family or family acquaintances (UNHCR, 2004).

The United Nations 1951 Convention relating to the Status of Refugees refers to a refugee as a person who, "owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable 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, 1996, p.16). In the UK, if a person has submitted an asylum claim with the Immigration and Nationality Directorate at the Home Office and is waiting for a decision on their

claim, they are called an 'asylum seeker'. A person becomes a 'refugee' when their application for asylum has been accepted by the Home Office, and they have been granted 'indefinite leave to remain' (ILR). Applicants may also be granted 'temporary leave to remain' (TLR) for a specified period, which recognises that the current situation in an individual's home country is too dangerous for them to return, or that deportation would contravene human rights, such as removing someone with a serious medical condition, or returning a child to a country where there was no one to care for them (Refugee Council, 2003).

It is extremely unusual for unaccompanied minors to be granted refugee status in the UK. Based on data for initial decisions prior to appeal, UK Home Office statistics for 2003 indicate that only 4% of unaccompanied minors were granted refugee status. A further 74% were granted temporary leave to remain in the UK and the remainder had their application refused (Heath, Jeffries & Purcell, 2004). In the case of unaccompanied minors, temporary leave to remain is usually granted until they reach 18 years of age, when they are required to re-apply for asylum (Refugee Council, 2003).

The current paper uses the term 'unaccompanied minor asylum seekers' to refer to all unaccompanied and separated children and young people who are under 18 years of age, and includes those with both ILR and TLR, and those still awaiting a decision from the Home Office, unless otherwise stated.

1.2 Parental support in asylum-seeking and refugee families

A wealth of evidence exists to demonstrate the protective role of parental and family support in the lives of children at times of conflict and disruption. Widely referenced research conducted during the Second World War found that evacuated children who were separated from their parents experienced a higher rate of psychological difficulties than those who remained with their parents in cities, despite being at an increased risk of bombing (Freud & Burlingham, 1943). More recent studies in the US offer further support for this finding. In a review of the relevant literature published between 1983 and 1992, Fox and colleagues (1994) consistently found that unaccompanied South-East Asian refugee children living in the US experienced greater emotional distress than youngsters who were accompanied by a family member.

However, the protective role that parents may play in their children's adjustment and well-being following traumatic events may be impaired if parents themselves are having difficulties functioning or coping (Kohli & Mather, 2003), a finding relevant to both general populations and asylum seekers. In a study of 339 war-exposed Bosnian children aged between 9 and 14 years, a significant correlation was found between poor maternal mental health and increased difficulties in children's post-war adjustment (Smith, Perrin, Yule & Rabe-Hesketh, 2001). This study utilised both self-report and maternal report measures of children's well-being, which helped control for potential bias in maternal ratings due to maternal mental health difficulties. However, one important limitation of this study was that it only evaluated children's exposure to

traumatic events. If both mother and child had been exposed to high levels of trauma this may also explain the association between poor maternal mental health and the child's adjustment difficulties. Further studies including measures of both child and maternal trauma exposure are required to clarify and further explore the findings of Smith et al. (2001).

Despite dangerous, chaotic and stressful situations faced by asylum seekers and refugees, most parents do continue to offer a degree of safety and stability to their children. Parents often provide essential resources such as food and water, as well as offering protection from physical harm. Through emotional support, parents may also help buffer the psychological impact of trauma and adversity by offering a sense of normality and consistency, despite changes and disruption following forced migration. By remaining with one's parents or primary carer, children also retain a critical sense of 'belonging', either to someone or something such as their culture. In addition, ongoing parental support enables youngsters to develop faith in adults' abilities to care and protect them, a pre-requisite for successful negotiation of the challenges faced during psychosocial development (Lustig et al., 2004).

Parents clearly play a multi-faceted protective role in the lives of their offspring during times of adversity. Without such support, unaccompanied minors are at increased risk of physical and psychological harm. However, the impact of separation from parents will be greatly influenced by the age of the child at time of separation, with the assumption

being that the longer a child remains with their parents, the more protection they are afforded (English, 2002). As stated previously, most unaccompanied minors arriving in the UK are adolescents (Heath, Jeffries & Purcell, 2004), which suggests that many of these youngsters may have benefited from parental protection for most of their early years, and possibly during times of war and conflict. As discussed in the next section, further research into unaccompanied minors' experiences of pre-migration parental protection is required.

1.3 Pre-migration experiences of unaccompanied minor asylum seekers

Extensive research documents the multiple stressors and traumas faced by asylum-seeking children prior to flight from their home country. Berman (2001) and Lustig et al. (2004) provide comprehensive reviews of pre-migration experiences during war and conflict that includes witnessing or direct experience of violence, loss and separation, and limited resources such as shelter, food and water. These stressors may have been endured for extended periods of time and may also have occurred in detention or refugee camps.

Few studies have specifically addressed the pre-migration experiences of unaccompanied minors, although those that have suggest unaccompanied minors are also at high risk of exposure to traumatic events. In a retrospective study carried out in the UK by Thomas and colleagues (2003), 86 out of 100 unaccompanied minors interviewed reported directly experiencing or witnessing violent acts towards others, with an average of

almost five incidents being cited by each child. Violence included beatings, execution of family members and public executions. Thirty-two of the young people had been raped, six of whom were male. For some of the youngsters, the sexual assaults had occurred on more than one occasion, had involved gang rape and had taken place in front of family members. Other traumatic experiences noted included imprisonment and living in hiding.

It is well known that some youngsters are forced to join militia groups as child soldiers. The United Nations Children's Fund (UNICEF) estimates that there are up to 300,000 child soldiers in the world at any one time (UNICEF, 2002). Child soldiers involved in armed combat are at high risk of injury, torture and rape. They may experience guilt and shame in relation to their actions, but are also at risk of becoming confused regarding moral judgements, perhaps adopting a belief system that justifies looting and killing for political purposes (de Silva, Hobbs & Hanks, 2001).

Current research has not addressed whether unaccompanied minors experience greater exposure to pre-migration traumas than youngsters accompanied by their parents. However, as noted in the previous section, unaccompanied minors lack parental protection, and may therefore be at higher risk of trauma exposure. Research into the length of time youngsters usually remain in their home country following separation from their parents or carers has not been carried out. Experiences are likely to be diverse, but many youngsters may not have fled their home country until becoming

separated from their parents and therefore may have been afforded some benefits of parental protection before this time. Further research assessing pre-migration experiences of unaccompanied minors is required in order to explore the hypothesis that they are at an increased risk of exposure to traumatic events compared to their accompanied asylum-seeking peers.

1.4 Separation and flight experiences of unaccompanied minor asylum seekers

A multitude of circumstances lead children to become separated from their parents or legal carers. Ayottee (2000) cites armed conflict and persecution as primary causes of separation. Parents may be dead, missing, imprisoned or unable to care for their child due to ill health (Mitchell, 2003). Other reasons include trafficking for sexual exploitation, deprivation and poverty, and the threat of forced recruitment into military, political or religious groups (Ayotte & Williamson, 2001; Williamson, 1998).

Research is sparse in relation to how children actually leave their home countries and arrive in the UK. In a minority of cases children may be accompanied by a parent who after arrival in the host country returns home. Older siblings, extended family, family friends, agents, traffickers, community groups or aid workers may also escort children and young people to the UK. For others, the journey is made completely alone (Ayotte, 2000; Bhabha, 2004; Kohli & Mather, 2003; Rutter, 2001; Williamson, 1998).

Journeys may be made under extremely difficult conditions, with some youngsters having to spend extended periods of time in refugee camps. Journeys may last for weeks and months, and may expose children to secondary stressors such as precarious transport and a lack or basic resources such as food, water and warmth. Children and young people are also vulnerable to further harm during the flight from their home country, such as sexual exploitation (Ayotte, 2000). A child may have little warning that they are being sent away, and may lack knowledge about where they are going or what should be done on arrival in a host country (Kidane, 2001).

1.5 Post-migration experiences of unaccompanied minor asylum seekers

Relevant literature widely accepts that elevated levels of stress and trauma are likely to continue when asylum seekers and refugees are resettled in a host country (Hodes, 2000). Asylum seekers frequently experience socio-economic adversity in new countries due to a lack of financial support, multiple and inadequate housing, and limited educational and employment opportunities. In addition, asylum seekers often have to understand and learn a new language, support services, legal system and culture, whilst still recovering from traumas experienced in their home countries. Asylum seekers often have to adapt to such challenges within the context of hostile communities that view asylum seekers and refugees as a threat to already limited resources such as housing, benefits and employment (Westermeyer, 1991).

The majority of unaccompanied minors, particularly those aged 16 and 17 years, must manage this difficult transition alone. Although there is a paucity of research evaluating the resettlement experiences of unaccompanied minors in the UK, recent qualitative studies indicate that these youngsters have difficulty coping with the demands and pressures of their new lives in the UK (Dennis, 2002; Kidane, 2001; Mitchell, 2003; Stanley, 2001). Particularly stressful experiences identified include initial arrival in the UK, the asylum application process, and accessing social services support and accommodation provisions, which are discussed in further detail below. Although these secondary stressors may not be as life threatening as events experienced in their home countries, such ongoing pressures are likely to be detrimental to the well-being of this already vulnerable group.

1.5.1 Arrival in the UK

When youngsters arrive in the UK they may be in shock following the sudden departure from their home country and difficult travel experiences. They may not be aware of what country they are in, understand the language or realise that they need to claim asylum. In a qualitative study for Save the Children, Stanley (2001) interviewed 125 unaccompanied minors about their experiences since arrival in the UK. This research highlighted the difficulties faced by these youngsters when they first arrived, with at least a quarter of them receiving little support or guidance at their port of entry. A typical example is that cited by a 15 year old boy who described being abandoned by an agent on arrival at an airport. After spending 2 nights waiting for the agent to return, the

youngster got a lift from local police into a city centre. He then spent a further week sleeping rough before he managed to find the local authority office due to the help of a stranger (Stanley, 2001, p. 27).

1.5.2 Claiming asylum

When an unaccompanied minor submits an asylum claim, the onus is placed on the young person to prove that they meet the criteria laid down under the 1951 United Nations Refugee Convention recognised by the UK, i.e. a well-founded fear of persecution due to their race, religion, nationality, membership of a particular group or political opinion (UNHCR, 1996). In order to assess for asylum, the Home Office will consider the basis of the claim, the asylum seeker's credibility, the current political situation, the human rights record of their home country, and, if applicable, medical evidence of torture and abuse (Refugee Council, 2004).

This process may be confusing and daunting for unaccompanied minors, especially as many of them may lack identification papers. Others may have been given false identity documents to allow them to leave their country of origin, and may also have been given false stories to tell about their new identity in order to protect themselves and their families (Staehr, Lindskov & Carey, 2000). Understandably, youngsters may find it very hard to share their difficult experiences with strangers. They may be scared, and may also have inhibitory feelings of shame and guilt concerning things that have happened in their home country, especially sexual assaults. The struggle to present a coherent

argument for asylum will also be affected by the detrimental effects of high emotional distress and symptoms of posttraumatic stress disorder (PTSD), which have been shown to lead to inconsistencies when repeating accounts of traumatic events in adult refugees (Herlihy, Scragg & Turner, 2002).

1.5.3 Accessing social services support

Unless youngsters are able to stay with extended family or friends, unaccompanied minors are completely dependent on the government or charities for essential provisions such as food and accommodation. Youngsters have to access support from social services with little guidance or independent advocacy, which understandably may be both confusing and challenging, especially if there is not a suitable interpreter available. For adolescents lacking identification papers, the process may be further complicated if their age is being disputed, as this dictates which agency provides support (e.g. social services being responsible for those under 18 years of age and the National Asylum Support Service providing services for those aged 18 and over). With no national guidelines available on how to embark on the precarious task of determining age, the onus of providing proof of age is usually left to the applicant. This is likely to result in further stress and anxiety for youngsters, who may feel interrogated and disbelieved. Age disputes are commonplace, with some suggestions that local authorities may dispute the ages of claimants in an attempt to avoid providing support (Ayotte & Williamson, 2001).

Social services support is provided under the Children Act (1989), which views unaccompanied minors as children 'in need', that is, "they are unlikely to reach or maintain a satisfactory level of health and development, or their health or development is likely to be significantly impaired, without the provision of services" (Children Act 1989, section 17 (10), as cited in Mitchell, 2003, p. 180). Recent government legislative guidance indicates that all unaccompanied minors should now be assessed under Section 20 of the Children Act (1989), which places a duty on local authorities to 'look after' a child in need (Department of Health, 2003). Assessment and support under Section 20 involves a general duty to safeguard the welfare of the child, consult directly with the child and, where necessary, develop care and education plans (German, 2004). Historically, unaccompanied minors have also been supported under Section 17 of the Children Act (1989), which is widely recognised as offering less support and protection than Section 20 (Mitchell, 2003). Under Section 17, local authorities can arrange for third parties to provide support, for example, external agencies who provide housing and a link worker (who does not necessarily need to be a qualified social worker) (German, 2004). Until recently the majority of unaccompanied minors aged 16 and 17 years were provided for under Section 17 (Dennis, 2002). It is hoped that the recent legislative changes will now result in all unaccompanied minors receiving the additional support and protection provided through Section 20, but it waits to be seen if this guidance follows through to practice in already over-stretched social services' departments.

1.5.4 Accommodation provisions

Type and location of housing accommodation plays a significant role in the well-being of unaccompanied minors. Research suggests that youngsters offered foster care and residential housing under Section 20 of the Children Act (1989) receive a higher standard of support and protection than unaccompanied minors who are housed in independent and semi-independent accommodation such as hostels, bed and breakfasts, or privately rented houses (Dennis, 2002; Stanley, 2001). For those housed independently, accommodation is often in poor physical condition (Mitchell, 2003). In addition, the vulnerability of unaccompanied minors living independently is increased due to the lack of assessment of adults who share the accommodation, raising child protection concerns (Dennis, 2002; Stanley, 2001).

If there are limited local resources, an unaccompanied minor may be placed in accommodation outside of their supporting local authority. Social workers can play an important advocacy role for youngsters, for example, by providing assistance with registering at education and health services. This support is difficult if the youngster is located a long distance from the social services office, and often results in increased isolation of the young person (Mitchell, 2003; Stanley, 2001).

Unaccompanied minor asylum seekers are clearly exposed to multiple stressors, losses and potential bereavements in both their home and host countries. Discussion now turns to evaluate the impact that such adversities potentially have upon on the psychosocial

well-being of these youngsters.

1.6 Psychosocial well-being of unaccompanied minor asylum seekers

Extensive research with asylum-seeking children accompanied by their families indicates elevated rates of psychological disturbance compared to indigenous peers (Fazel & Stein, 2003; Lustig et al., 2004; Yule, 2000). Symptoms noted in up to 40% of refugee children include PTSD, depression, grief reactions and other anxiety-related difficulties (Hodes, 2000). Sleep disturbances, concentration problems and memory difficulties are also common (Yule, 1998).

Although to date there has been no quantitative research conducted in the UK to assess psychological well-being of unaccompanied minors, international studies suggest that this vulnerable group also experience an elevated level of psychopathology. A research study conducted with unaccompanied minors from Sudan living in a Kenyan refugee camp on behalf of the UNHCR, noted that high numbers of youngsters experienced PTSD symptoms of hyperarousal, avoidance and intrusive thoughts. Of the 168 youngsters assessed, 75% of them were rated as having moderate to severe PTSD. High levels of moderate to severe depression symptoms were also recorded (Duncan, 2000). In a study of 46 young unaccompanied minors in a Finnish asylum centre, approximately half of the youngsters fell within clinical or borderline range as assessed by the Child Behaviour Checklist, a 118 item questionnaire looking at problem behaviours such as social problems, attention problems and aggressivity (Sourander, 1998). Both of these

studies evaluated the well-being of youngsters living within communal camps and centres. Caution must therefore be noted when considering how these rates of psychopathology relate to unaccompanied minors living independently in the UK. Communal living may present additional stresses, such as cramped conditions, but it may also be beneficial due a reduction in social isolation and a sense of communal hope (Lustig et al., 2004).

As noted in previous sections, it is likely that unaccompanied minor asylum seekers may be at higher risk of exposure to trauma due to a lack of parental support, and may therefore be at greater risk of developing psychological difficulties. However, there is a lack of research comparing the psychological well-being of accompanied and unaccompanied minor asylum seekers, which is perhaps partly due to methodological challenges. Presence or absence of a parent may be the only common factor within these groups, with both sets of youngsters being vulnerable to diverse multiple losses and traumatic experiences which would make it almost impossible to provide matched case-controls. However, in one attempt of a direct comparative study, Wolff and Fesseha (1999) found that a group of Eritrean orphans between the ages of 4 and 7 years living in a group home demonstrated more behavioural problems than refugee children living in a nearby camp with one or both of their parents. In a further study, Cheng (1995) found that unaccompanied Chinese adolescent immigrants living in America experienced significantly higher rates of depression than those who were accompanied, providing preliminary support for the hypothesis that unaccompanied youngsters are at higher risk

of developing psychological difficulties such as depression. However, the youngsters in the study by Cheng (1995) were immigrants rather than asylum seekers, so may not have been exposed to the high levels of traumatic events endured by many asylum-seeking youngsters.

Exposure to traumatic events, such as witnessing or experiencing violence, is a known risk factor in the development of psychopathology, in particular PTSD (Fletcher, 2003). Research demonstrates a direct exposure-effect relationship between intensity and amount of traumatic stress and psychopathology, suggesting the greater the amount and extent of exposure, the poorer one's psychological outcome. For example, Macksoud and Aber (1996) evaluated the relationship between the number and type of war traumas and psychological well-being in 224 Lebanese children, aged between 10 and 16 years. Although these youngsters were not seeking asylum in a host country, they had lived in a conflict environment, and were displaced from their homes. Results supported the exposure-effect relationship, with youngsters experiencing multiple traumas such as direct exposure to violence and bereavement, demonstrating more symptoms of PTSD than those who had not witnessed or experienced such traumas. Interestingly, Lebanese youngsters who had been separated from their parents experienced higher rates of depression; a finding which supports the study by Cheng (1995) with Chinese immigrants noted earlier, suggesting that depression may be a particular risk for unaccompanied youngsters.

The long-term effects of exposure to traumatic events in refugee children has probably been studied in most depth by Kinzie, Sack and colleagues who conducted a longitudinal study over 12 years to evaluate the psychological well-being of forty Cambodian refugees living in the US (Kinzie, Sack, Angell, Clarke & Rath, 1989; Kinzie, Sack, Angell, Manson & Rath, 1986; Sack et al., 1993; Sack, Angell, Kinzie & Rath 1986; Sack, Him & Dickason, 1999). These youngsters were approximately 14 years of age when they sought asylum following years of massive trauma under the Pol Pot regime. At 12 year follow up, 35% of the 27 young adults still involved in the study had symptoms of PTSD which fell within the clinical range, and 14% experienced significant depression. Although this study demonstrated the persistence of PTSD and depression over time in this group of Cambodian refugees, it also highlighted the remarkable resilience of these youngsters, the majority of whom were functioning well with full-time employment despite these difficulties.

Unaccompanied minor asylum seekers will be vulnerable to grief and bereavement reactions, following their separation from, and possible death of, parents, siblings, extended family and friends. Many youngsters may be unaware of the fate of their families, and therefore will be in limbo, unable to grieve their loss properly. A study conducted with Bosnian adolescents found that 4 years after the war in Bosnia-Herzegovina, youngsters whose fathers were still missing had more symptoms of depression according to the Birleson Depression Scale than their peers who knew the fate of their fathers. However, the group whose father's had disappeared had also

experienced more war-related traumatic events, which may also have contributed to their low mood (Zvizdic & Butollo, 2001).

Research has attempted to identify individual risk and protective factors regarding the development of psychopathology following traumatic events; however findings have often been conflicting and have not been carried out with refugee populations. Research that has been conducted with youngsters following exposure to war traumas indicates that girls report greater distress than boys, a finding in line with general population research (e.g. Klingman, Sagi & Raviv, 1993). However, research has failed to clarify whether elevated distress rates in females are due to genuine greater levels of distress, or if it reflects gender differences in reporting distress. This may be influenced by gender roles in certain cultures which dissuade expression of emotion in males (Thomas & Lau, 2002). Potential gender differences have not been evaluated in unaccompanied minors in the UK.

Research findings in relation to age have been contradictory, and therefore inconclusive. The study by Sourander (1998) of unaccompanied minors in Finland suggested that younger children are at higher risk of developing psychiatric illness according to the Child Behaviour Checklist, as completed by adults from the asylum centre who knew the children well. In contrast, a study of accompanied war-exposed Croatian children indicated that older children experienced greater depression and anxiety symptoms when compared to younger children (Vizek-Vidovic, Kuterovac-Jagodic & Arambasic, 2000).

Research findings do suggest that children who are exposed to war-related events show their distress in different ways according to their age. Younger children are noted to become clingy and anxious, whereas adolescents are more likely to act aggressively towards themselves and others (Montgomery, 1998). Age is clearly a complex factor, closely associated with cognitive capacity, which also impacts on functioning. Older children may have greater insight into the threats posed by war, leading to feelings of fear, shame and guilt. However, cognitively mature children will also benefit from more developed coping mechanisms which may serve a protective role (National Children Traumatic Stress Network, Refugee Trauma Taskforce, 2003). Research is clearly required to explore and clarify the impact of age and cognitive functioning on psychological well-being following war trauma. Such research must take into account older children's increased capacity to report symptoms that may be in line with Western diagnostic criteria such as PTSD and depression. Younger children may display more behavioural difficulties that do not fit such diagnoses. In addition, research with younger children is often based on adult reports, involving little consultation with the child. Particular caution is also required when conducting research with unaccompanied minors based on an adult's report, as it is unlikely that an adult will have known the child for long, and may therefore not know the child or their culture well.

One individual factor noted to be critical to the psychological well-being of unaccompanied minors is the child's understanding of why they have been separated from their parents or legal guardians. Christiansen and Faighel (1990) reflect on the

difficulties that youngsters have in making sense of why they have become separated, even if the child is well informed and understands that they have been sent away for their own protection. Children may experience a paradoxical set of emotions, such as feeling loved and treasured as they were sent away to safety, but also discarded and lonely. A sense of relief at being in a safe place is likely to be accompanied by feelings of guilt and fear concerning family members who may have died or remain in their home country. Guilt, often termed 'survivor's guilt', relating to leaving loved ones behind, or concerning actions that the child may have been carried out to in order to keep themselves safe, is commonly noted in asylum seekers, and is often co-morbid with psychological difficulties (Yule, 1998). Unaccompanied minors may be affected by such feelings of guilt, especially if their entire family remains in their country of origin. The complexity of these contrasting feelings will leave such youngsters struggling to contain difficult and confusing emotions, which will be exacerbated by post-migration stressors faced during resettlement.

As highlighted throughout the previous section, children and young people exposed to the multiple traumas of war and forced migration are understandably at high risk of developing psychological difficulties. Research is required to assess the well-being of unaccompanied minors in the UK, with consideration being given to the influence of individual factors such as gender, age and cognitive functioning.

Despite the vulnerability of asylum-seeking children, many youngsters do not experience incapacitating psychological difficulties, and in fact do well in their new lives in the UK (Hodes, 2000). Adaptability and good adjustment has been noted in unaccompanied minors during resettlement in the UK. A comparison study of youngsters leaving social services' care in a central London borough found that those who were asylum seekers or refugees demonstrated better social adjustment than indigenous peers (Fraser, 2003, as cited in Hodes & Tolmac, 2005, p. 253). Quite how such youngsters overcome the multiple difficulties and challenges faced as war-exposed asylum seekers is often put down to their 'resilience'. According to Rutter (1999, p. 135), resilience, "does not constitute an individual trait or characteristic...resilience involves a range of processes that bring together quite diverse mechanisms operating before, during and after the encounter with the stress experience or adversity". As discussed above, individual factors such as gender and age are likely to play a role in how well asylum-seeking children adapt and cope. Other personal characteristics, including an easy temperament, high self-esteem and self-efficacy, and a sense of agency and autonomy have also been noted to contribute to a child's resiliency (Barwick, Beiser & Edwards, 2002; Loughry & Flouri, 2001; National Children Traumatic Stress Network, Refugee Trauma Taskforce, 2003).

However, as Rutter (1999) highlights, such individual characteristics develop and function as part of a diverse process which incorporates life-long experiences. For most individuals, this process will be inextricably linked with their early attachment

relationships and ongoing inter-personal experiences of support. Discussion now turns to address the potential role that supportive relationships, both past and present, may play in the well-being of unaccompanied minor asylum seekers at times of acute and chronic adversity. The models of social support presented are based on Western research, and therefore caution must be taken when applying them to different cultures. However, these models provide a useful framework from which to consider and hypothesise how social support may protect and promote the well-being of unaccompanied minor asylum seekers in the UK. Future research evaluating cross-cultural social support is required to provide further understanding of how these models may be applied to different cultures.

2. The role of social support for unaccompanied minor asylum seekers and refugees

2.1 Social support

Research evidence indicates that social support plays a protective role in physical and psychological well-being. Comprehensive reviews of research studies conducted with general population samples are widely available (Bloom, 1990; House, Landis & Umberson, 1988; Robinson & Garber, 1995)

Studies with asylum seekers and refugees also indicate that social support can play an important role in the psychosocial well-being of this population. Gorst-Unsworth and Goldenberg (1998) found depression in Iraqi asylum-seeking adults living in London to be more closely linked to a history of poor social support than a history of torture. Emotional support from friends rather than professionals was noted to be of particular importance to well-being in this study. In a similar study of Lebanese adolescents living with their families, Farhood and colleagues (1993) found depression to be more strongly correlated with a reduction in social networks than exposure to war traumas. A study by Almqvist and Broberg (1999) also demonstrated the benefits of social interactions in young, accompanied Iranian refugee children living in Sweden, with positive peer support being the main predictor of social adjustment and a sense of self-worth.

Few studies with asylum-seeking populations have attempted to identify how social support may function as a protective factor. Perhaps this is because social support is not

a simple unitary construct that is applicable across all cultures (Sarason, Sarason & Pierce, 1990). Extensive research and debate has long grappled with achieving agreement on a definition of social support, demonstrating the complexity of what initially may appear a simple concept.

General consensus amongst social support researchers has now identified three main aspects of social support. Firstly, structural aspects relate to an individual's social network, for example, number of social contacts, marital status and involvement in community activities. This aspect of social support focuses on the quantity, rather than quality, of social support (Hogan, Linden & Najarian, 2002). Secondly, the functional aspect of social support highlights experiences which lead an individual to believe that they are cared for, loved, esteemed, valued and part of a worthwhile mutually supportive network (Cobb, 1976). Thirdly, enacted aspects of support refer to the provision of specific supportive behaviours, such as giving advice at times of stress (Robinson & Garber, 1995).

Social support provision has also been classified into three subtypes; instrumental, informational and emotional (Cohen, 2004). Instrumental support involves the provision of material aids or practical assistance, for example, financial assistance or preparing a meal. Informational support refers to giving advice or information which helps an individual cope with a problem, such as advising an asylum seeker where to go to obtain financial benefits so that they can buy food. Emotional support may be provided through

listening, being empathic and caring, and providing a reassuring and trusting relationship. This diverse range of support can be provided by multiple individuals or organisations including family, friends, neighbours, religious groups, social, health and educational services. Cohen (2004) postulates that these types of support offer protection by helping individuals manage and cope successfully during times of stress. However, Cohen (2004) also highlights that integration within a social network provides an essential basis for physical and emotional well-being, irrelevant of the degree of stress. The views of Cohen (2004) are broadly encompassed in two widely accepted models of social support, the stress buffering model and the main effect model.

2.1.1 Stress buffering model of social support

The stress buffering model states that social support is only beneficial during times of stress and adversity (Milne, 1999). Social support is believed to reduce the impact of stressful life events upon health in two ways (Lakey & Cohen, 2000).

Firstly, supportive actions of others allow one to cope better with stressors. 'Received' instrumental, informational and emotional supports act in such a way. Supportive actions of others will be optimally effective in promoting coping if they match the demands of specific stressors. For example, emotional support, such as empathy and caring, does little to protect an individual from the risks of sleeping rough on the streets, unless they are also given informational advice regarding the nearest hostel.

Secondly, the perception that social support is available allows one to appraise potentially threatening situations as less stressful. According to Lazarus and Folkman (1984) an individual's interpretation of situations is critical in determining how stressful they experience an event to be. Cohen (2004) suggests that the belief that support is available if required enhances an individual's view that they will have the necessary resources to meet the demands of a specific stressor, which potentially results in a more positive cognitive appraisal of events. For example, moving to a new city may be perceived as being less threatening if a friend who may be able to assist if problems arise already lives there. This perception may be based on an individual's beliefs and past experiences, but does not necessarily rely on received support from others at the time of the stressful event. Perceived social support may also enable better coping with a stressor as the view that support is available may lead to reduced emotional and physiological stress responses, which can themselves lead to further anxiety (Cohen, 2004).

2.1.2 Main effect model of social support

The main effect model hypothesises that social support is critical to well-being, independent of stress and adversity (Cohen, 2004). Integration and connections within social networks provide individuals with potentially positive, stable, socially rewarding experiences which are essential for physical and psychological well-being. Individuals who engage in social networks are provided with information regarding social norms that may be beneficial to health, such as how to behave and keep safe. For example,

social networks that help highlight the risks of illegal drugs and deter their use can influence health behaviours in a beneficial way (obviously some social networks can act in a converse way by promoting negative health behaviours). Specific roles within social networks provide essential opportunities for the development of identity, sense of self and high self-esteem, all of which assist psychological well-being and resiliency (Bal, Crombez, Van Oost & Debourdeaudhuij, 2003; Cohen, 2004). Social interactions may also help enhance appropriate emotional regulation, by limiting the intensity and duration of negative affective states, such as anxiety and anger (Cohen, 1988). In addition, social integration can reduce isolation, which in itself has been recognised as a potential stressor due to an increase in negative feelings of alienation and loneliness that can be associated with a reduced sense of control and self-esteem (Cohen, 2004).

The stress buffering model and main effect model of social support provide potential insight and understanding of how social support may influence the well-being of unaccompanied minors, as discussed below. Although these models are presented separately, there is likely to be an overlap in explaining how unaccompanied minors benefit from social support according to the different models. The impact of early attachment relationships on the utilisation and effectiveness of social support is considered.

Unaccompanied minor asylum seekers in the UK are not a homogenous group in terms of their experiences, beliefs and culture. Western models of social support and

attachment are therefore applied with caution due to the inevitable ethnic and cultural diversity which will play an important role in how social support is experienced and functions for each individual.

2.2 The stress buffering model of social support and unaccompanied minor asylum seekers

As clearly demonstrated in the first section of this paper, unaccompanied minors experience multiple stressors, both pre- and post-migration, and as a consequence, are at high risk for developing psychopathology. On arrival in the UK, 'received' instrumental, informational and emotional support will be essential to assist unaccompanied minors to cope with the challenges of their current situation. As demonstrated in the qualitative study by Stanley (2001), many unaccompanied minors arriving in the UK have a stressful time, with difficulties accessing services and asylum procedures due to a lack of available support and advocacy. In some cases, this lack of support leads to immediate increased health risks, for example, the likelihood of hypothermia and exploitation incurred by sleeping rough on the streets. Provision of instrumental support, such as money, accommodation and health services, will be critical to the well-being of unaccompanied minors. Informational support such as English lessons and basic life skills, including self care, cookery classes and nutritional information on English food which may be very different to food from home countries, will also be needed to help youngsters function and cope within their new surroundings. Access to educational services is also important, both in terms of academic progress and

social integration (Stanley, 2001).

Emotional support will be invaluable for unaccompanied minors, allowing them to experience and benefit from a caring, trusting relationship in a strange country. Emotional support, in particular the opportunity to talk freely in a safe environment, is also essential in helping unaccompanied minors cope with and gain understanding of difficult feelings regarding loss and traumatic experiences. The opportunity to 'retell' one's trauma story is a central component in therapeutic approaches to PTSD (McKelvey & Webb, 1995). Talking about one's experiences with a trusted person (who does not necessarily need to be a therapist) may help address and process traumatic memories in a supported environment. In addition, it allows for joint evaluation of negative appraisals of events or symptoms, for example feelings of guilt and responsibility, or concern that one is going mad (Ehlers & Clark, 2000). For many unaccompanied minors, the only time they will have to 'retell' their story is during the intimidating asylum process, an environment which does not lend itself to being a therapeutic experience.

As highlighted in the stress buffering model of social support, it is essential that the support provided meets the demands of the current situation for individual unaccompanied minors. For example, the offer of long-term intense psychotherapy may not be optimally beneficial to a youngster at a time when they have nowhere to live. It is likely that on arrival in the UK the need for instrumental and informational support will be a priority in order for them to obtain the basic resources to survive.

Received social support clearly plays an important role in buffering the impact of previous traumatic experiences and the forced migration process. However, as discussed previously, an individual's perception of how much support is available to them is likely to affect how threatening they believe a situation to be and their ability to cope. In fact, research assessing the impact of received and perceived social support demonstrates that perceived support is more closely related to well-being than received support (Sarason, Sarason & Pierce, 1990; Thoits, 1995). However, such research is based predominantly on general population samples, in particular those with pre-existing health difficulties. In the case of asylum seekers and refugees, it may be hypothesised that received social support may play a more important role, at least on arrival in the UK. The theory proposed by Maslow (1954) relating to a hierarchy of needs highlights the importance of satisfying low-order needs such as hunger and safety, before addressing high-order esteem needs such as competence and approval. Initially, asylum seekers may not have had time to develop a perception of a support network in the UK. In addition, believing that support is available may not be helpful if basic needs, such as food and housing, are not being met.

The importance of received social support is highlighted in a study of adult refugees carried out by Emmelkamp and colleagues (2002). Received and perceived social support was assessed in relation to symptoms of anxiety and depression in Bhutanese torture victims living in refugee camps in Nepal, as well as Nepalese survivors of torture.

In both groups, received social support, which included measures of instrumental, informational and emotional support, was found to be more strongly related to psychological symptoms than perceived social support. This research, conducted with two different groups, provides preliminary support for the enhanced protective role of received social support for victims of torture. However, this study needs to be replicated before the conclusion that received social support may initially be more closely related to well-being in asylum seekers than perceived social support can be accepted. In addition, studies assessing the roles of received and perceived support with accompanied and unaccompanied minors will be required before further understanding of the role of social support is gained in relation to asylum-seeking children.

2.3 The main effect model of social support and unaccompanied minor asylum seekers

Although stress is likely to be ongoing for many unaccompanied minor asylum seekers, even when they have been in the UK for a long time, the main effect model of social support highlights a number of issues which will be important to their well-being, both at times of stress and when they are in a safe and stable situation. The main effect model identifies engagement in positive social networks as being beneficial by providing an opportunity to learn and understand social norms and rules of a new culture, and by reducing social isolation. Unaccompanied minors lack parental role models and may therefore be reliant on other support resources to help them understand acceptable behaviours and rituals of their host culture. In addition, these youngsters are at high risk of isolation especially if their accommodation is outside the borough of their supporting

social services. As isolation is a well-known risk factor for psychopathology in adolescence (Thomas & Lau, 2002), social integration, even when the acute stressors of forced migration have been dealt with, will clearly play an important role in the general well-being of unaccompanied minors by allowing them to share a sense of belonging and feel connected to a social network.

The main effect model also highlights the essential role that social relationships play in the development of a positive sense of identity, which is often associated with characteristics seen in resilient youngsters, such as high self-esteem, self-efficacy and self-worth. This will be relevant to all asylum seekers, as they are faced with the task of integrating new roles and circumstances into their pre-existing sense of self. The study on Iranian refugee children by Almqvist and Broberg (1999) demonstrated that social support plays an important role in psychosocial adjustment by promoting positive features of identity, such as a sense of self-worth.

Western developmental theorists, such as Erikson (1959), suggest that adolescence is a critical time for identity formation. Although this view may not be applicable to all cultures, it provides a useful framework with which to consider the challenges faced by unaccompanied minors arriving in the UK, many of whom are adolescents that will still be struggling with developing a stable sense of who they are and how they fit into their immediate world. The formation of identity will be further challenged for these youngsters by the need to assimilate potentially conflicting cultures of home and host

countries. The tasks of identity formation and acculturation are explored in further detail below.

2.3.1 Identity formation and social support

Erikson (1959), who advocated a staged approach to development, stated that identity formation is a major task of psychosocial development. According to Erikson, identity refers to, "an unconscious striving for a continuity of personal character...maintenance of an inner solidarity with a group's ideal and identity" (1959, p. 102). Although Erikson believed identity formation was an evolving process, he highlighted the period of adolescence as a key stage in the establishment of a coherent identity. Due to rapid biological and social change, adolescence presents youngsters with the challenge of incorporating multiple childhood identities into a core identity that provides a basis for fulfilling the varied goals and roles presented in adolescence and later life. Erikson believed that if an individual fails to integrate different identities and roles they are left with a sense of a fragmented personality, termed 'identity diffusion' (Miller, 2002).

Although the staged approach to psychosocial developmental proposed by Erikson (1959) has received criticism, for example by failing to clarify how children actually progress between stages and lacking cross-cultural validation, it is useful in highlighting the process of identity formation which can be influenced by social support. Ongoing supportive social interactions help individuals experiment in new roles and achieve developmental goals, such as autonomy and independence. In Western cultures, it is

typical for adolescent youngsters to begin to distance themselves from their parents in their role as a child, and increasingly depend on friends, peers and wider social groups to provide opportunities for new roles and an understanding of acceptable social behaviour and social norms (Coleman & Hendry, 1999). Some cultures may not associate adolescence with growing independence. However, for unaccompanied minor asylum seekers in the UK, they will by definition be distanced from their parents and therefore have to depend on other social supports, such as friends and peers, for experiences that will contribute to their sense of self.

Identity formation is a challenge for any young person, but for unaccompanied minor asylum seekers the task will be particularly difficult. Previous stages of development that according to Erikson (1959) are pre-requisites for identity formation, such as basic trust, autonomy, learning to take initiative and a sense of industry, may have been disrupted by earlier experiences of stress, trauma and loss (Miller, 2002). In addition, identity formation, which for many will be inextricably linked with ethnic identity, will depend on social integration within a new culture that may be extremely different from their previous culture, in terms of rituals, beliefs and values.

2.3.2. Acculturation and social support

An important factor in resettlement experiences of asylum seekers and refugees is acculturation, the successful assimilation of old and new cultures. Maintaining links with one's ethnic culture has been shown to assist transition to a new country, as it

reduces the impact of cultural bereavement often experienced by refugees who are forced to leave their country of origin (Eisenbruch, 1991a). Cultural bereavement reactions mirror those seen in bereavement following the loss of a person, such as guilt, anger and ambivalence. This may result in refugees clinging to and idealizing their old culture or having difficulties making attachments in their new culture (Eisenbruch, 1991b). Social support from members of one's own cultural background may be essential in reducing the impact of cultural bereavement, by allowing the validation of beliefs through culturally appropriate rituals and behaviours (German, 2004).

Asylum-seeking children accompanied by their parents and family may be protected from the effects of sudden cultural loss as their parents offer an opportunity to continue cultural habits and rituals, and allow them to maintain a sense of cultural belonging. However, unaccompanied minors lack this major potential cultural link due to parental separation and may therefore be at greater risk of grief reactions and psychological difficulties related to cultural detachment and bereavement. Research demonstrates that unaccompanied minors who are able to maintain cultural links are likely to fair better than more culturally isolated youngsters. Cambodian unaccompanied adolescents fostered in group residential homes with other Cambodians in America demonstrated greater psychological functioning than their peers who were placed with adolescents indigenous to the US (Eisenbruch, 1991b). In addition, research in the US with Vietnamese and Haitian refugees conducted by Adler (1985) and Indochinese youngsters by Porte and Torney-Purta (1987) noted that support from an adult of similar ethnicity

mitigates against the stress experienced by unaccompanied minors adapting to a new country.

However, in order to acculturate successfully asylum seekers and refugees must also acknowledge and integrate, at least to some degree, into the culture of their host country. For this process to be successful, individuals will be reliant on social support resources available in the host country which will enable them to understand social norms and rituals, as well as to integrate such behaviours into their sense of identity.

It has been noted that children and adolescents acculturate more readily than adults in their host country. Both emotional and practical factors may underlie this apparent flexibility in youngsters. Firstly, adults may feel greater loyalty for their ethnic background that may make them reluctant to interact readily in their host country (Barwick, Beiser & Edwards, 2002; Hodes, 2000; Westermeyer, 1991). Adults may also have greater insight into the vulnerability of their current situation, which may result in a reluctance to establish new relationships as they may fear this will lead to further losses if they are deported (Howard & Hodes, 2000). On both a practical and developmental level, rapid language acquisition is more typical in children, allowing them to communicate in their host country with greater ease than adults (Lustig et al., 2004). Children may also have greater exposure to the new culture and environment through their attendance at school or college. Adults who are unable to seek employment due to their asylum status will lack such a fundamental connection with their new society.

The main effect model of social support is clearly relevant to unaccompanied minor asylum seekers in terms of understanding social norms and reducing social isolation. However, it also highlights the important challenge of integrating past and present experiences and cultures into a developing sense of identity. Although adolescence has been highlighted as a psychologically vulnerable time in identity formation, it has also been noted to be an adaptive time, when normal, "adolescent reassemblage of psychic comments" allows for greater flexibility in the integration of diverse experiences and cultures (Blos, 1962, cited in Weine et al., 1995, p. 1158). This suggests that some adolescents may adapt better to their new circumstances than adults who are likely to have a more rigid sense of self. Longitudinal research assessing levels of social integration and sense of identity of different age groups of asylum seekers living in the UK would help explore this possibility further.

So far, this paper has made the implicit assumption that if social support is available, it will be utilised and benefited from by recipients. However, this is not necessarily the case as social support involves interactive, interpersonal processes that can be challenging for some individuals. Asylum seekers and refugees who have experienced trauma and adversity may have had their assumptions of the world as a safe place shattered, and may therefore find it hard to trust people, particularly those who are strangers. In addition, evidence now exists to suggest that individuals who have had difficult early attachment experiences may also have problems developing supportive, trusting relationships (Collins & Feeney, 2004).

During previous sections, the critical protective role that parents play has been highlighted based on the assumption that unaccompanied minors have benefited from positive early parental relationships, which may not necessarily be the case. The importance of early attachment relationships is now considered and implications for their influence on social support for unaccompanied minor asylum seekers discussed.

2.4 Attachment theory and social support

The protective role that parents may play assumes that parent-child relationships are positive experiences, based upon secure early attachments. Bowlby (1969) proposed that young infants become emotionally attached to their care-givers, usually mothers, and become distressed when separated due to an innate behavioural system designed to promote safety and survival. When a child is faced with a stressor, such as an unfamiliar or feared environment, they seek out the safe, secure base of their attachment figure. In addition to the immediate protection from harm as a child, secure attachments impact on psychosocial development throughout the life span by strengthening sense of identity and self-esteem, promoting good interpersonal skills and developing a functional sense of autonomy. When early attachment relationships fail to offer a safe, reliable base, youngsters are at risk of developing anxious and avoidant attachment relationships, which are believed to increase vulnerability to psychological difficulties (Carr, 1999).

Attachment systems continue to be activated in older children, adolescents and adults, with the safe base and support of a significant other continuing to be sought at times of stress or threat (Collins & Feeney, 2000). Attachment styles are therefore likely to influence social support perceptions and interactions throughout development. Research indicates, that in contrast to insecurely attached individuals, securely attached adults who have benefited from reliable, early supportive relationships are more likely to have an optimistic view of available support and feel satisfied with the support that they receive (Wallace & Vaux, 1993). Self-report and observational research also indicates that secure individuals are most likely to seek out support, and provide appropriate care towards others, perhaps due to early positive modelling experiences of rewarding social relationships (Collins, 2004). Such research evidence therefore suggests that attachment styles may play a role in both objective and subjective experiences of social support.

Based on data from normative populations, it would be predicted that not all unaccompanied minor asylum seekers will have benefited from secure, early attachment relationships, and may therefore be challenged by the interpersonal process of obtaining and utilising social support (Carr, 1999). Research has not attempted to evaluate early attachment relationships in this population, perhaps because of the methodological challenges posed due to the reliance on self-report retrospective accounts that are likely to be influenced by bereavement and separation experiences. In addition, cultural factors are likely to affect attachment relationships. For example, children raised within communal groups, such as Kibbutz or nomadic tribes, may have different early

attachment experiences than youngsters raised in a traditional western family. Despite such difficulties in comparing and understanding culturally diverse attachment relationships, cross-cultural studies demonstrate the universal importance of early, stable supportive relationships as protection against the development of psychopathology (German, 2004). It is therefore feasible to hypothesise that securely attached unaccompanied minors are more likely to seek out and benefit from social support, in both their home and host country, and therefore may be offered and benefit from more protection in the face of adversity.

Research studies that investigate attachment relationships, and the potential impact of bereavement and trauma on retrospective self-report accounts of early attachment experiences in this population, would help provide further understanding of unaccompanied minors attachment styles and social support utilisation in the UK. If, as has been suggested throughout this paper, social support plays a critical protective role, it will be essential to identify and engage youngsters who, perhaps because of insecure attachment styles, are having difficulty accessing and benefiting from social support. As now discussed in the concluding section of this paper, organisations, such as social services, mental health teams and educational establishments, will play a critical role in engaging such youngsters, and in monitoring the impact of culturally appropriate support.

Conclusion: Clinical and research implications

Unaccompanied minor asylum seekers are a highly vulnerable group who have experienced multiple losses and traumatic experiences that do not usually end when they reach the UK. The negative experiences of many unaccompanied minors on arrival to this country, such as a lack of practical help and advocacy, does little to protect or enhance the well-being of these youngsters.

Despite multiple adverse experiences and losses, some unaccompanied minors seeking asylum in the UK adapt well to their new environment and do not appear to suffer from psychological difficulties. This paper has noted some of the potential factors which may play an interactional role in this resilience, such as gender, age, cognitive functioning and identity formation incorporating high self-esteem, self-efficacy and a sense of autonomy.

Appropriate social support can also play a role in reducing the potentially negative impact of stress and trauma. Unaccompanied minor asylum seekers lack the essential source of parental support. The stress buffering model of social support outlines the important role that instrumental, informational and emotional support may play in offering some compensatory physical and psychological protection to these youngsters at times of adversity. As highlighted in the main effect model, social integration within a welcoming, positive social environment allows opportunities to learn cultural and social norms and reduce social isolation. In addition, social integration enhances opportunities

for positive identity formation which accommodates past and present experiences and cultures. Practical factors may impact on an individual's ability to access and utilise social support, such as language difficulties and being accommodated a long distance away from support services. However, the potential benefits of social support are also likely to be moderated by an individual's previous experience of support and their attachment style.

The process of successful adaptation to a new culture, and for those that need it, assistance with coping with past and present difficult experiences, will depend on a diverse range of support services. Organisations, such as social services, health services, the education system and voluntary groups, already provide support which helps moderate the impact of adversity on unaccompanied minors' well-being. However, more support based on direct consultation with unaccompanied minor asylum seekers in the UK is required. Current research indicates that unaccompanied minors would benefit from an independent advocate who can guide young people through the asylum process, starting at their point of entry into the UK (Stanley, 2001). In particular, youngsters need help in understanding and making sense of their own experiences so that they can present a coherent statement when applying for asylum. Social workers already play a major role in this work, but the opportunity for an advocate or befriender who can offer independent, long-term support would also provide the chance for youngsters to re-experience reliable, secure relationships.

Changes in government legislation (Department of Health, 2003) reflect a consensus that unaccompanied minors need more support than just the provision of accommodation and food. The increased level of support and protection in relation to care and education afforded by Section 20 of the Children Act (1989) should lead to a reduction in physical and psychological difficulties. Monitoring of the implementation of this legislation is essential to guarantee that such guidance is followed.

Health services have the potential to provide a critical role in supporting unaccompanied minor asylum seekers. All unaccompanied minors should be offered a physical health screening as many of them may have injuries or illnesses following exposure to war traumas and adverse environments, such as overcrowded camps or flight conditions. Mental health services are also essential in offering a trusting therapeutic relationship through which young people can 'retell' their story, and try to manage difficult feelings relating to trauma, anxiety, grief and depression. Services must be aware of potential stigma in certain cultures towards mental health difficulties, and practioners must be sensitive in how they explore youngsters' experiences. Therapeutic approaches must respect different cultures methods for dealing with trauma. For example, in African countries, such as Ethiopia and Mozambique, active forgetting is the usual means of dealing with bad memories (Burnett & Peel, 2001). Therefore for many unaccompanied minors, Western psychological therapies may be an alien concept that feels more like further interrogation, rather than a cathartic experience. As highlighted in the stress buffering model, support must meet the current demands of each individual, emphasising

a need for multi-disciplinary teams and interagency assessments, consultations and support.

In addition, government policies and service providers must prioritise support that promotes acculturation by providing opportunities for integration into ethnically similar and indigenous social networks. Educational services may play a particularly important role in this integration by at the very least, ensuring every unaccompanied minor asylum seeker in the UK is offered a place at school or college and given careers advice.

Unfortunately, social integration within the wider British culture and society will depend on more than just the work and dedication of a minority of individuals or organisations. Undoubtedly, acceptance and integration of unaccompanied minors within British society relies heavily on the British public's perception of asylum seekers and refugees in general, which at present is not a predominantly positive one. Both the government, and perhaps more importantly the media, can play an important role in creating a more balanced, accepting view of asylum seekers and refugees in the UK, which may make this integration more feasible and beneficial in the future.

It has been made clear throughout this paper that there is a paucity of research assessing the experiences, well-being and needs of unaccompanied minor asylum seekers in the UK. Priorities for future research should focus on gaining greater insight into the experiences of these youngsters, and possible psychological consequences, in order to

inform appropriate support services. Although experiences are likely to be diverse, research is required to assess specific risk factors for unaccompanied youngsters, such as elevated levels of traumatic events and the length of time since parental separation. Assessment of psychological difficulties experienced by unaccompanied minors, such as PTSD, depression and grief reactions, is also essential to inform appropriate mental health service providers. Assumptions have been made that unaccompanied minors will experience similar difficulties to their accompanied asylum-seeking peers, but this may not be the case.

The potential protective role of social support also needs to be explored in relation to unaccompanied minors seeking asylum in the UK. The impact of received and perceived social support should be assessed in relation to psychological and psychosocial functioning outcomes, both at times of acute stress on arrival in the UK and when youngsters have been in the country for some time. Such research needs to involve qualitative investigations incorporating direct consultation with unaccompanied minors from a range of cultural backgrounds in order to identify beneficial and culturally appropriate types of social support. Studies assessing potential barriers to accessing and utilising available support should also be conducted, addressing both practical barriers, such as language and location, as well as individual characteristics, such as attachment styles. This social support research will be critical in highlighting optimal types of support, whilst also helping to identify particularly vulnerable youngsters who may benefit from different types of support, such as outreach services. Longitudinal studies

assessing psychological well-being, sense of self and cultural integration of unaccompanied minors seeking asylum in the UK is also needed to provide understanding of the long-term impact of multiple adverse effects, such as trauma, loss and forced migration. Such research must be carried out with care and sensitivity, with special consideration being given to ethical issues, such as obtaining appropriate consent and risk of causing further distress by asking youngsters to talk about their experiences (Thomas & Byford, 2003).

Unaccompanied minor asylum seekers are undoubtedly resilient youngsters who have already survived excessive trauma, adversity and loss. Research that helps to inform and further develop culturally appropriate support services is essential to limit the impact of these difficult experiences, both in the short and long term, for those youngsters arriving in the UK. The political climate of the world suggests that unaccompanied minors will continue to seek asylum in the UK. Therefore, as professionals and as a wider society, we need to take responsibility and consult directly with unaccompanied minors and representatives from their cultures in order to support and protect these youngsters from further unnecessary harm.

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Paper 2: Empirical paper

Young unaccompanied asylum seekers and refugees in the UK:

War trauma, psychopathology and social support

Abstract

Standardized self-report questionnaires were utilised in the current study to evaluate exposure to war trauma and symptoms of posttraumatic stress disorder (PTSD), depression and anxiety in a sample of 44 unaccompanied youngsters, aged between 15 and 19 years who had sought asylum in the UK. The role of received and perceived social support was also explored.

The current sample had experienced a high number of war traumas, such as death of parents and physical assault. A large proportion of the sample reported experiencing symptoms of PTSD (75%), depression (66%) and anxiety (32%). There was a significant association between exposure to war trauma and overall PTSD symptoms, as well as PTSD symptoms of intrusion and arousal. Having indefinite leave to remain asylum status was associated with lower self-reported symptoms of PTSD.

High levels of perceived social support were associated with lower levels of depression and PTSD symptoms of arousal. Findings are discussed in relation to future research and clinical implications.

1. Introduction

The desperate plight of child and adolescent asylum seekers and refugees[1] has slowly been creeping into public awareness. Media coverage and psychosocial research has helped to highlight the experiences and needs of displaced children throughout the world, of which there are thought to be over 10 million (UNHCR, 2003). Many of these youngsters have become separated from their parents or legal guardians. According to the UNHCR (2004, p. 2), unaccompanied and separated minors are defined as, "children under 18 years of age who are separated from both parents or from their previous legal or customary primary caregiver".

Home Office statistics indicate that in the UK alone, more than 3,000 unaccompanied[2] children applied for asylum in 2003. Approximately 90% of these youngsters were adolescents aged between 14 and 17 years (Heath, Jeffries & Purcell, 2004). On initial application, only 4 % of these minors were granted indefinite leave to remain (ILR), which allows them the right to stay in the UK permanently. The remainder were given

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[1] The United Nations Convention on the Status of Refugees (1951) refers to a refugee as a person, who, owing to a well-founded fear of persecution due to race, religion, nationality, membership of a particular political group or political opinion is unable, or owing to fear, unwilling to return to their home country (UNHCR, 1996, p. 16). In the UK, a person who is awaiting a decision on an asylum application is legally defined as an 'asylum seeker'. A person becomes a 'refugee' when their application for asylum has been accepted by the Home Office, and they have been granted 'indefinite leave to remain' (ILR). Applicants may also be granted 'temporary leave to remain' (TLR) for a specified period, which recognises that the current situation in an individual's home country is too dangerous for them to return, or that deportation would contravene human rights.

[2] The term 'unaccompanied' will be used in the current paper to refer to unaccompanied and separated asylum seekers and refugees according to the UNHCR (2004) definition unless otherwise stated.

temporary leave to remain (TLR), often only until their 18th birthday, or had their claim refused (Refugee Council, 2003).

Research has explored and documented the experiences and psychosocial adjustment of asylum-seeking and refugee children. Literature reviews indicate that, despite many accounts of resilience, these youngsters are at high risk of exposure to traumatic events, multiple losses and psychological difficulties, including posttraumatic stress disorder (PTSD), depression and other anxiety disorders (e.g. Hodes, 2000; Loughry & Eyber, 2003; Lustig et al., 2004; Thomas & Lau, 2002).

The hypothesis that unaccompanied asylum-seeking and refugee youngsters may be at an increased risk of exposure to trauma and psychopathology due to a lack of parental support and protection has strong face validity. Yet very little research has explicitly aimed to evaluate the specific experiences and needs of this unique population.

The death of, or enforced separation from, a parent has a potentially catastrophic effect on the psychological well-being of any child or adolescent (Carr, 1999). However, this impact may be even greater when it occurs at a time of high stress. Research has demonstrated the protective role that parents and family can play in the well-being of children at times of war and conflict. Children separated from their parents through evacuation programmes during the Second World War developed more psychological difficulties than children who had remained with their parents in inner city areas, despite

a greater risk of bombing (Freud & Burlingham, 1943). The important role played by family members during times of war and conflict has also been replicated in more recent studies. Fox, Muennich-Cowell and Montgomery (1994) reviewed the literature relating to South-East Asian refugee children living in the US and consistently found that unaccompanied youngsters experienced greater distress than those accompanied by a family member. Young Vietnamese refugees in the Philippines who were accompanied by family were also found to be less distressed than youngsters who had arrived alone (Felsman, Leong, Johnson & Felsman, 1990).

Although it has been noted that the presence of mental health difficulties in parents can have a negative impact on their off-springs' well-being (Smith, Perrin, Yule & Rabe-Hesketh, 2001), it is probable that the majority of parents are able to offer some protection to their children during times of war and adversity. On a practical level, parents are likely to maintain some responsibility for providing essential resources such as food and water to meet their child's basic needs, as well as endeavouring to protect their child from exposure to physical harm and exploitation. At an emotional level, the continued presence of a parent enables children and adolescents to have a stable relationship at a time of stress. This relationship will offer the child a continued sense of 'belonging', as well as assisting in the development of their faith in an adult's abilities to protect and care for them (Lustig et al., 2004).

Unaccompanied youngsters lack such protection, and therefore may be at high risk of adversity through deprivation of resources, increased risk of exposure to trauma and a lack of emotional support and stability. Qualitative research conducted with unaccompanied asylum-seeking minors living in the UK has highlighted high rates of traumatic events experienced by these youngsters, such as multiple experiences of witnessing or directly experiencing violence including public executions and sexual assaults (Thomas, Thomas, Nafees & Bhugra, 2003).

Exposure to traumatic events is a known risk factor in the development of psychopathology in both adults and children, in particular PTSD (Salmon & Bryant, 2002). According to the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV, 1994), PTSD may follow the direct experience or witnessing of an event involving actual or threat of death or injury to self or other. For a diagnosis of PTSD to be considered the event must be associated with subjective appraisals of fear, helplessness or horror, or in the case of young children, disorganisation or agitated behaviour. Symptoms of PTSD have been categorised into three main clusters; firstly, re-experiencing or intrusions such as memories, nightmares or a sense of re-living the trauma; secondly, avoidance behaviours including avoidance of thoughts, feelings and reminders of the traumatic event and withdrawal from normal activities; thirdly, arousal symptoms which include insomnia, difficulty concentrating, hypervigilance, irritability and exaggerated startle response (Fletcher, 2003). These symptoms have now been confirmed to occur in similar forms in both adults and children (Meiser-Stedman, 2002;

Salmon & Bryant, 2002).

PTSD is often comorbid with other psychological problems such as depression and anxiety (Shaw, 2003). Symptoms of PTSD in children exposed to war traumas can also have a long-term effect, with young adults exposed to war atrocities in childhood still demonstrating symptoms up to 12 years later (Sack, Him & Dickason, 1999). Girls report greater distress than boys following war trauma, although it is unclear whether this reflects true levels of distress, or if it reflects a gender difference in reporting distress (Klingman, Sagi & Raviv, 1993; Thomas & Lau, 2002). Although evidence exists to demonstrate the effect of war trauma on all children, no consistent pattern has been identified in terms of age as a risk factor (National Child Traumatic Stress Network, 2003).

Research has demonstrated a direct exposure-effect relationship between trauma and psychopathology, indicating that in most instances, the greater the intensity and amount of trauma, the poorer the psychological outcome (Pfefferbaum, 1997). This finding has been supported by studies with British children and adolescents who have experienced single traumatic incidents, such a shipping accident (Yule, 1992). The exposure-effect relationship has also been found in war-exposed youngsters who have faced multiple traumas and losses. For example, Macksoud and Aber (1996) noted that Lebanese children who had experienced direct exposure to violence and bereavement during times of conflict demonstrated more symptoms of PTSD than Lebanese youngsters who had

not directly experienced such traumas, but had been in the same geographical area. If the prediction that unaccompanied youngsters who lack parental protection are more vulnerable to exposure to war trauma events is true, it would follow that they are at greater risk of developing psychological difficulties, which would no doubt be exacerbated through grief and bereavement issues following the death of, or separation from their parents, siblings, extended family and friends. Many youngsters may be unaware of the fate of their families, and therefore will feel in limbo, unable to grieve their loss properly. Studies involving war-exposed adolescents have indicated that not knowing what has happened to parents can be more detrimental to psychological well-being than knowing for certain that parents are deceased (e.g. Zvizdic & Butollo, 2001).

Social support is widely accepted as a protective factor against the development of psychopathology following traumatic events or at times of stress in general populations (Brown & Harris, 1978; Cohen, 2004; Cohen, Gottlieb & Underwood, 2000; Joseph, 1999). Preliminary studies indicate that social support can also play a protective role in the psychosocial well-being of asylum-seeking and refugee populations. Gorst-Unsworth and Goldenberg (1998) found depression in Iraqi asylum-seeking adults living in London to be more closely linked to poor emotional support than a history of torture. Support, such as the provision of resources, advice and practical assistance, has also been associated with improved psychological well-being in a similar study of adult torture victims in Nepal (Emmelkamp, Komproe, Van Ommeren & Schagen, 2002). In addition, the benefits of social support have been demonstrated in refugee children. For

example, Almqvist and Broberg (1999) studied a group of young, accompanied Iranian refugee children living in Sweden, and identified positive peer support as the main predictor of social adjustment and self-worth.

The stress buffering model of social support indicates that support reduces the impact of stressors in two ways (Lakey & Cohen, 2000). Firstly 'received' support helps individuals directly cope with stressful events. Secondly, social support reduces the impact of stress though 'perceived' support. If an individual believes support is available should they need it, they are more likely to make a more positive cognitive appraisal of a potentially stressful event. This will enhance their ability to cope with the event, and reduce emotional and physiological stress responses (Cohen, 2004). Social support is also believed to be critical to well-being, independent of stress and adversity. The main effect model of social support highlights the importance of integration within social networks in order to provide understanding of social norms and promote the development of identity, self-esteem, self-efficacy and a sense of belonging, factors that are acknowledged to influence psychological well-being irrelevant of stress (Bal, Crombez, Van Oost & Debourdeaudhuji, 2003; Cohen & Wills, 1985).

Both received and perceived social support may be critical to the well-being of unaccompanied youngsters who are seeking asylum in the UK without their parents. Received support, such as the provision of resources including accommodation, food, clothing, health care and education, may help buffer against the adversity of trauma and

forced migration, particularly in the early stages of resettlement when youngsters may be dependent on support from others for their basic needs. In addition, perceived support will help youngsters cope with resettlement stress by empowering them to appraise new situations and challenges in a positive way. In the longer-term, social support will also play an important role in allowing youngsters to socially integrate within their host country and culture, and by promoting a sense of identity that incorporates past and current experiences.

The present study aims to test the following hypotheses:

Hypothesis One: Given their lack of parental protection, unaccompanied asylum-seeking and refugee youngsters will report exposure to a high number of war traumas.

Hypothesis Two: Unaccompanied asylum-seeking and refugee youngsters will report high rates of PTSD, depression and anxiety symptoms. The effects of age, gender and asylum status on psychological well-being will be explored.

Hypothesis Three: Unaccompanied asylum-seeking and refugee youngsters who report more exposure to war trauma will also report more symptoms of PTSD, depression and anxiety.

Hypothesis Four: Unaccompanied asylum-seeking and refugee youngsters with high levels of received and perceived social support will report fewer symptoms of PTSD, depression and anxiety. The extent to which exposure to war trauma and social support independently predict symptoms of PTSD, depression and anxiety will be explored.

2. Method

2.1 Participants

Nineteen male and 25 female asylum seekers and refugees, aged between 15 and 19 years of age, living in the London area took part in the study. The participants had all entered the UK as minors (i.e. under 18 years of age), and had been classified as unaccompanied or separated youngsters according to the UNHCR (2004) definition. They originated from 18 countries. Thirty three (76%) came from African countries, predominantly Ethiopia and Eritrea. Participants spoke 17 different languages. Full details of the participants' home countries and main languages are available in Appendix 2. Ninety percent of the participants spoke English competently, and did not require an interpreter. Participants had been in the UK for an average of 23 months and most had been granted temporary leave to remain (TLR). Demographic characteristics of participants are presented in Table 1.

Table 1: Demographic characteristics of participants ($n = 44$)

Characteristics	Mean	Standard Deviation	*n*	%	Min	Max
Age: (Years)	17.5	0.99	-	-	15.3	19.7
Length of time in UK: (Months)	23.2	20.5	-	-	3.48	108.29
Gender:						
Male	-	-	19	43	-	-
Female	-	-	25	57	-	-
Current asylum status:						
Indefinite leave to remain (ILR)	-	-	8	18	-	-
Awaiting initial decision	-	-	3	7	-	-
Negative initial decision and awaiting appeal	-	-	2	5	-	-
Temporary leave to remain (TLR)	-	-	31	70	-	-
Continent of origin:						
Africa	-	-	33	76	-	-
Eastern Europe	-	-	5	11	-	-
Asia	-	-	4	9	-	-
South America	-	-	1	2	-	-
India	-	-	1	2	-	-

2.2 Procedures

Five participants (11%) were recruited through social services departments, 9 (20%) through mental health services and the remaining 30 (68%) through schools and colleges. Study information sheets were presented to unaccompanied youngsters by their allocated social worker, psychological therapist or school/college tutor. Youngsters interested in participating met with a researcher to discuss the study before written consent was obtained. (See Appendix 3 for study information sheets and consent forms). Participants were each given £5 as reimbursement for their time and travel expenses.

Participants aged 16 years and older provided consent to take part in the study. In the case of participants below 16 years of age, consent was obtained from the young person and their social worker or legal guardian.

Two researchers, one a trainee clinical psychologist and the other a qualified clinical psychologist working with refugee youngsters in a child and adolescent mental health service, collected the data, comprising of 37 interviews (84 %) and 7 interviews (16 %) respectively. Data collection took place where the participant had been recruited, e.g. social services offices, mental health service buildings or school/colleges. Interviews were conducted in a private room, and took approximately 1 hour, although additional time was always made available after each interview for debriefing. The researchers presented the standardised questionnaires verbally to the participants. For those participants who were not competent in English, an interpreter was used to translate the

questionnaires and the participant's responses (back-translated versions of measures evaluating PTSD and depression were also made available to the participants in their first language).

If participants scored above the clinical cut-off range on questionnaires assessing symptoms of PTSD, depression and anxiety, or became distressed while answering the questionnaires, referral to a support agency was discussed directly with the young person. The researcher also asked the participant for permission to share their concerns with the young person's social worker or tutor. Where necessary, referrals were made to appropriate support services, including college counsellors and mental health services. Participants were supported in making a self-referral or, where appropriate, the referral was made by the researcher, social worker or tutor.

2.3 Ethical approval

For participants recruited through mental health services and social services, ethical approval was obtained through the Ethical Committee of the South London and Maudsley NHS Trust. For participants recruited through schools and colleges, ethical approval was obtained through the University College London Committee for the Ethics of Non-NHS Human Research (see Appendix 4 for copies of ethical approval). Individual schools and colleges also obtained approval for the study from the head teacher and governing body.

2.4 Materials

Participants completed self-report questionnaires to assess exposure to trauma, symptoms of PTSD, depression and anxiety, and levels of received and perceived social support (see Appendix 5). Measures originally designed for use with children and adolescents were utilised with all participants, including those aged 18 and 19 years, because of their potentially basic skills in English, and in order to provide consistency in scores between participants.

Exposure to trauma and psychological well-being

Exposure to trauma and symptoms of PTSD, depression and anxiety were assessed by a standardised battery of measures that have been used widely in research with refugee children and adolescents (Yule, 2002). This battery includes the War Trauma Questionnaire, the Revised Impact of Event Scale, the Birleson Depression Self-Rating Scale and the Revised Children's Manifest Anxiety Scale. These measures have been translated into many languages, and have been demonstrated to have good cross-cultural validity (e.g. Papageorgiou et al, 2000; Smith, Perrin, Yule & Rabe-Hesketh, 2001). Questionnaires designed to assess symptoms of psychopathology indicate degree of difficulty, but do not provide a clinical diagnosis when used in isolation without clinical assessment.

War Trauma Questionnaire (WTQ: Macksoud, 1992). The WTQ was originally designed to assess war-related traumatic events experienced by Lebanese children (Macksoud, 1992). An adapted version of the original WTQ, which prompted participants to answer 30 yes/no questions relating to their exposure to war and conflict-related traumas, including knowledge of parental well-being and whereabouts, was used in the current study. A higher score indicates that a greater number of traumatic events have been experienced.

Revised Impact of Event Scale - 13-item version (RIES: Dyregrov & Yule, 1995). The impact of event scale was originally developed by Horowitz, Wilner and Alvarez (1979) to assess re-experiencing and avoidant stress reactions in children following traumatic events. The scale was later revised by Dyregrov and Yule (1995) to include assessment of hyperarousal, providing a comprehensive evaluation tool of major symptoms associated with PTSD. Participants were asked to rate how frequently they had experienced symptoms in the last week on a scale of never (0), rarely (1), sometimes (3) or often (5). A score of 17 or above on combined intrusion and avoidance items have been consistently shown to suggest a likely diagnosis of PTSD, with high specificity and sensitivity rates of 90% (Dyregrov & Yule, 1995; Yule, 1998). Intrusion and avoidance subscales have good internal consistency, with Cronbach's Alpha of .82 and .74 respectively (Hollifield et al., 2002).

Depression Self-Rating Scale (DSRS: Birleson, 1981). This 18-item scale was developed by Birleson to assess common symptoms of depression in children and adolescents. Participants were asked to judge how much they felt a particular item was true for them in the last week, based on a 3-point scale of most, sometimes and never. The scale has been validated for use with children between the ages of 7 and 18 (Firth & Chaplin, 1987). It has good internal consistency, and is moderately efficient in discriminating between depressed and non-depressed children in different samples. Specificity rates of between 77% and 88%, and sensitivity rates of between 64% and 67% have been noted when assessing British children (Asarnow & Carlson, 1985; Birleson, Hudson, Buchanan & Wolff, 1987). According to Birleson's (1981) original study, 'normal' children who were not low in mood did not get a total score higher than 11. Children who had been diagnosed with clinical depression obtained scores of 17 or above. However, larger studies based on participants from both normative populations and populations exposed to disasters have demonstrated a wider spread of scores (Yule, 1992; Yule, Udwin & Murdoch, 1990). A cut-off score of 17 has been adopted in the current study to indicate that an individual would be likely to meet the criteria for a diagnosis of clinical depression, although scores between 11 and 16 may also suggest low mood.

Revised Children's Manifest Anxiety Scale (RCMAS: Reynolds & Richmond, 1978). The RCMAS is a standardised self-report questionnaire designed to measure generalised non-specific symptoms of anxiety in children and adolescents between the ages of 6 and 19

years. Participants are asked to rate the presence or absence of 28 anxiety-related symptoms (9 lie items included in the original study by Reynolds and Richmond, 1978, were omitted from the current study). Scores of 19 or above have been associated with a diagnosis of anxiety disorder (Stallard, Velleman, Langsford & Baldwin, 2001). The scale has good internal consistency with Cronbach's Alpha = .82 (Reynolds, Bradley & Steele, 1980), test-retest reliability (Wisniewski, Jacks, Mulik, Genshaft & Coury, 1987), content and face validity (James, Reynolds & Dunbar, 1994; Reynolds & Richmond, 1978) and construct validity (Reynolds & Paget, 1981).

Social support

Two measures were utilised in the current study to provide an indication of a participant's received and perceived social support.

Received Social Support Measure (RSS). An objective self-report measure of received social support was designed for the current study based on findings from a qualitative study that identified social support resources that were thought to benefit unaccompanied minor asylum seekers in the UK (Stanley, 2001). Participants were presented with yes/no questions relating to a range of social support networks including family, foster care, social services, legal support, health services, educational placements, friends, charities, refugee support organisations and religious groups. The number of different supports was totalled, with higher scores indicating a greater number of types of received social support. The RSS provides a measure of available social supports, but does not

assess the quality of such support.

Multi-dimensional Scale of Perceived Social Support (MSPSS: Zimet, Dahlem, Zimet & Farley, 1988). The MSPSS is a 12-item scale which assesses perceptions of support from family, friends and significant others. The questionnaire uses a 7-point Likert scale ranging from very strongly disagree (1) to very strongly agree (7), which provides total average and subscale average scores. Although this scale has not been used with refugee populations, it has proven reliability, validity and factor structure with diverse populations including university populations (Dahlem, Zimet & Walker, 1991), urban adolescents in the US (Canty-Mitchell & Zimet, 2000), adolescents living abroad (Zimet, Powell, Farley, Werkham & Berkoff, 1990) and adolescents on an inpatient psychiatry unit (Kazarian & McCabe, 1991). The scale has good internal consistency with an overall Cronbach's Alpha = .82 for the 12 items. Family, friends and significant other subscales demonstrate Cronbach's Alpha of .91, .89 and .91 respectively (Canty-Mitchell & Zimet, 2000). The MSPSS was adapted in the current study to replace 'family' with foster carer or social worker if participants had no contact with any family members.

2.5 Power analysis

Due to a lack of previous research conducted with unaccompanied and separated youngsters living in the UK, it is difficult to specify the predicted effect size needed for adequate statistical power in the current study. However, past literature assessing the

relationship between intensity and quantity of trauma and psychopathology in accompanied war-exposed children found a correlation of $r = .37$ (Smith et al., 2001). A similar correlation ($r = .39$) was found when assessing the relationship between social support and psychological well-being of adult torture victims (Emmelkamp et al., 2002). Based on these studies, a power analysis calculation found that a sample size of $n = 55$ would be required for 80% power in detecting a significant correlation, with Alpha = .05. However, as highlighted in the Introduction, unaccompanied adolescent asylum seekers and refugees may be a more psychologically vulnerable group than accompanied minor and adult asylum seekers, hence a larger effect size may be found with a lower number of participants. Therefore, it was felt that a smaller sample size of 44, in part dictated by the reality of recruiting this vulnerable population, would be sufficient to achieve statistical and clinical significance in this exploratory study.

2.6 Data Analysis

Data analysis was conducted using the Statistical Package for Social Sciences 11.5 (SPSS, 2002). Descriptive data is presented to outline participant's self-reported exposure to war trauma, rates of psychopathology and levels of social support. Correlations and regression analysis are used to assess associations between exposure to trauma and psychopathology, and psychopathology and social support.

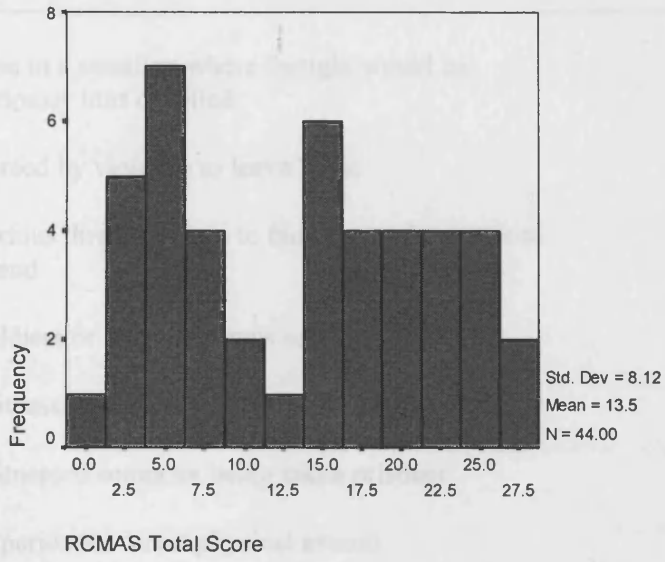
3. Results

3.1 Distribution of variables

Distribution of key variables was assessed for normality using the Kolmogorov-Smirnov test (see Appendix 6). Three of the variables were not normally distributed. Square root transformations were conducted in the case of the Depression Self-Rating Scale (DSRS), and the Received Social Support Measure (RSS) to enable parametric statistical analyses to be carried out.

As Figure 1 indicates, the distribution for the Revised Children's Manifest Anxiety Scale (RCMAS) was bimodal. As the median score of 13.5 fell just below the halfway score on the scale (14), the sample was split into two subgroups: RCMAS lower anxiety (scores of 14 and below) and RCMAS higher anxiety (scores of 15 or above). However, it is acknowledged that if a participant falls into the higher anxiety group this does not necessarily mean they experience clinically high rates of anxiety symptoms. According to the RCMAS cut-off scores, only participants who score 19 or above are likely to receive a clinical diagnosis of an anxiety disorder based on follow-up clinical assessment.

Figure 1: Revised Children's Manifest Anxiety Scale (RCMAS): Distribution of outcome scores



3.2 Hypothesis One: Unaccompanied asylum-seeking and refugee youngsters will report exposure to a high number of war traumas.

Hypothesis One was supported in the current study. Self-report scores on the War Trauma Questionnaire (WTQ) indicate that participants have experienced high levels of exposure to trauma (WTQ, M = 19.09, SD = 6.14). Details of the most frequently reported traumas during war and conflict experienced by participants in the current study are presented in Table 2.

Table 2: Rates of most frequently experienced war trauma (WTQ)

War and conflict traumatic experiences	*n*	%
Was in a situation where thought would be seriously hurt or killed	41	93
Forced by violence to leave home	41	93
Serious threat of harm to family member or close friend	40	91
Soldiers or men with guns entered home	38	86
Witnessed someone with a severe injury	36	82
Witnessed someone being taken prisoner	33	75
Experienced direct physical assault (e.g. hit or kicked)	32	73
Personally threatened with serious harm or killed	32	73
Witnessed a family member taken away to prison or camp	31	70
Witnessed murder or serious assault	30	68
Father killed or missing	30	68
Mother killed or missing	30	68
Witnessed looting, burglary or serious vandalism	29	67
Experienced serious physical injury	28	64
Witnessed dead bodies	27	61
Witnessed shooting at a close distance	26	60
Witnessed the mass destruction of buildings	25	57
Sibling (s) killed or missing	22	50

Thirty five participants (80%) reported that both of their parents were dead, or that they did not know of their well-being or whereabouts. Seventeen participants (30%) reported that they knew for certain that their father was dead, although 4 of the fathers had died from illness or accident prior to war. Fourteen participants (32%) reported that their mother had died, of which 6 had been due to illness or accident. Further details of parental mortality and knowledge of whereabouts are presented in Table 3.

Table 3: Participants knowledge regarding parental well-being

Knowledge of parental well-being	*n*	%
Both parents deceased	8	18
One parent deceased / no knowledge of other parent's well-being or whereabouts	11	25
No knowledge of either parent's well-being or whereabouts	16	36
One parent reported deceased / One parent reported alive and whereabouts known	4	9
One parent reported alive and whereabouts known / no knowledge of other parent's well-being or whereabouts	1	3
Both parents reported alive and knowledge of whereabouts	4	9

3.3 Hypothesis Two: Unaccompanied asylum-seeking and refugee youngsters will report high rates of PTSD, depression and anxiety symptoms.

Hypothesis Two was supported in the current study. Participants' self-reported levels of PTSD (RIES), depression (DSRS) and anxiety (RCMAS) symptoms are presented in Table 4.

Table 4: Self-reported symptoms of PTSD (RIES), depression (DSRS) and anxiety (RCMAS)

Measure	*n*	M	Median	SD	Minimum	Maximum
PTSD: RIES (Total)	44	33.06	-	13.64	4.00	59.00
RIES Subscales:						
Intrusion	44	12.00	-	5.87	0.00	20.00
Avoidance	44	10.75	-	5.28	0.00	20.00
Arousal	44	10.11	-	6.49	0.00	25.00
Depression: DSRS (Total)	44	12.01	-	6.16	4.00	29.00
Anxiety: RCMAS (Total)	44	13.50	14.5	8.11	1.00	27.00

PTSD

Based on self-report responses to the RIES, participants reported high rates of PTSD symptoms (RIES, M = 33.06, SD = 13.64), with 33 participants (75%) exceeding the cut-off for likely diagnosis of PTSD according to the 8 items relating to intrusion and avoidance symptoms (RIES Intrusion and Avoidance, M = 22.75, SD=8.82).

In the current study, PTSD symptoms of intrusion and arousal were positively correlated, but neither was correlated with avoidance (see Table 5). Statistical analysis was therefore conducted separately for PTSD total scores and subscales of intrusion, arousal and avoidance.

Table 5: Correlations between PTSD severity subscales and total score, as measured by the Revised Impact of Event Scale

Severity		PTSD total	Intrusions	Avoidance	Arousal
PTSD total	*r*	1.00			
	p	-			
Intrusions	*r*	.825	1		
	p	<.001	-		
Avoidance	*r*	.608	.250	1	
	p	<.001	.102	-	
Arousal	*r*	.861	.640	.269	1
	p	<.001	<.001	.077	-

Depression

Participants reported high rates of symptoms of depression (DSRS, M = 12.02, SD=6.16). Seven of the participants (16%) in the current study obtained scores of 17 or above, providing a strong indication of a diagnosis of clinical depression. A further 22 participants (50%) obtained scores between 11 and 16, indicating low mood.

Anxiety

The total number of participants that fell above the clinical cut-off for likely diagnosis of an anxiety disorder was 14 (32%). As discussed previously the bimodal distribution of scores suggests two distinct groups of participants in relation to anxiety symptoms. Half of the participants obtained scores of 14 or below (M = 6.40, SD=3.82) and were classified as RCMAS lower anxiety. The remainder scored 15 or above (M = 21.15, SD=3.58) and were classified as RCMAS higher anxiety.

There was a significant positive correlation between self-reported symptoms of PTSD (RIES), depression (DSRS) and anxiety (RCMAS) (RIES and DSRS, $r = .64$, $n = 44$, $p<.01$, two tailed; RIES and RCMAS, $rbi = .723$, $n = 44$, $p<.01$, two tailed; DSRS and RCMAS, $rbi = .697$, $n = 44$, $p<.01$, two tailed). Participants whose self-reported anxiety scores fell into the RCMAS lower anxiety group had significantly lower PTSD symptoms (RIES, M = 23.31, SD = 10.28) than those classified as RCMAS higher anxiety (RIES, M = 42.81, SD = 8.74; t (42) = 6.77, $p<.001$, two tailed). Participants classified as RCMAS lower anxiety also had significantly lower levels of self-report

symptoms of depression (DSRS, M = 7.95, SD = 2.88) than participants classified as RCMAS higher anxiety (M = 16.09, SD = 5.90; t (42) = 6.29, p<.001, two tailed).

Association between gender, age, asylum status and psychological distress

As demonstrated in Table 6, independent variables of gender and age were not associated with psychological distress. However, participants who had been granted indefinite leave to remain (ILR) asylum status had significantly fewer total symptoms of PTSD (RIES total, M = 24.62, SD = 14.98) than those who had not been granted ILR (RIES total, M = 34.94, SD = 12.80). However, it appeared to be PTSD symptoms of an intrusive nature that were most significantly associated with not having ILR asylum status.

Table 6: Associations between gender, age and asylum status and self-reported symptoms of PTSD (RIES), depression (DSRS) and anxiety (RCMAS)

	PTSD Total	PTSD Avoidance	PTSD Arousal	PTSD Intrusion	Depression	Anxiety (High/Low)
Gender (19 male/ 25 female)	t = .03 (42)	t = -1.41 (42)	t = .45 (42)	t = .56 (42)	t = .35 (42)	X_2 = .83 (1)
Age M=17.5years (SD=0.99)	r = -.04	r = .15	r = .08	r = -.16	r = -.04	t = .66 (42)
ILR 8 yes / 36 no	t = 2.00* (42)	t = -.81 (42)	t = -1.20 (42)	t = -2.46** (42)	t = .13 (42)	X_2 = .61 (1)

**. Correlation is significant at the .01 level (two tailed)
*. Correlation is significant at the .05 level (two tailed)

3.4 Hypothesis Three: Unaccompanied asylum-seeking and refugee youngsters who report more exposure to war trauma events will also report more symptoms of PTSD, depression and anxiety.

Hypothesis Three was supported in relation to symptoms of PTSD, but not depression and anxiety symptoms.

Exposure to war trauma and PTSD

Participants' symptoms of PTSD were significantly related to the number of traumatic events experienced during war and conflict. Exposure to traumatic events recorded on the WTQ correlated with RIES total scores ($r = .421, p<.01$, two tailed). Exposure to trauma was related to RIES subscale scores for intrusion ($r = .581, p< .01$, two tailed) and arousal ($r = .413, p< .01$, two tailed), but not for avoidance ($r = .063, p = .684$, two tailed).

Exposure to war trauma and depression

Self-reported level of exposure to war and conflict-related trauma was not associated with symptoms of depression, as measured by the DSRS ($r = .126, p = .415$, two tailed).

Exposure to war trauma and anxiety

There was a trend for participants classified with lower anxiety on the RCMAS to experience fewer war traumas (M = 17.68, SD = 6.44) than those classified with higher anxiety (M = 20.50, SD = 5.62), however this difference was not significant (t (42) = 1.54, p = .130, two tailed).

3.5 Hypothesis Four: Unaccompanied asylum-seeking and refugee youngsters with high levels of received and perceived social support will report fewer symptoms of PTSD, depression and anxiety.

Hypothesis four was not supported in terms of received support, but was partially support in terms of perceived support.

Received Social Support

Total scores on the Received social Support (RSS) measure indicate that participants reported receiving support from an average of 11 different sources, with individual scores ranging from 6 to 17 sources of social supports (M = 11.27, SD = 2.71). Table 7 presents details of the different types of social support resources.

Table 7: Received social support (RSS)

Type of received social support	*n*	%
Solicitor	43	98
School / college placement	43	98
GP	42	96
English lessons	40	91
A teacher to talk to about their problems	38	86
A friend who also originated from their home country	37	84
A friend to talk to about their problems	36	82
Attends a place to practice faith e.g. mosque, church	35	80
Social worker	31	71
Communication with family member e.g. speaks on telephone, e-mail	15	34
Mental health professional	15	34
Sports club e.g. football, gym	15	34
Family member living in the UK	13	30
Connexions advisor	13	30
Attends a youth group e.g. drama	12	27
An adult living or working in home as a key worker or carer (excludes foster carers)	12	27
Assistance from family tracing service e.g. Red Cross	11	25
Attends the Refugee Council	7	16
Foster care	7	16

Perceived social support

Participants self-reported levels of perceived social support based on the Multi-dimensional Scale of Perceived Social Support (MSPSS) are presented in Table 8. Participants felt that they received most support from a 'significant other'.

Table 8: Perceived social support (MSPSS total and subscale scores means)

Perceived support	Mean	SD	Minimum	Maximum
Total	4.94	1.15	1.33	6.75
Significant other	5.02	1.44	1.50	7.00
Friend	4.92	1.44	1.50	7.00
Family / foster carer / social worker	4.88	2.16	1.00	7.00

As demonstrated in Table 9, subscales measuring perceived support from a 'significant other' and 'friend' were highly correlated, indicating that they may be measuring the same construct. Therefore they were collapsed together under the heading of 'significant person' for statistical analysis.

Table 9: Correlations between MSPSS total and subscales

Perceived Social Support		MSPSS Total	Significant Other	Friend	Family / foster carer / social worker
MSPSS Total	*r*	1.00			
	p	-			
Significant Other	*r*	.698	1		
	p	<.001	-		
Friend	*r*	.621	.407	1	
	p	<.001	<.001	-	
Family / Foster carer/ Social worker	*r*	.722	.178	.056	1
	p	<.001	.248	.719	-

No relationship was found between outcomes for self-report measures of received social support (RSS) and perceived social support (MSPSS) in the current study ($r = .15$, n = 44, $p = .585$, two-tailed).

Association between self-reported social support and psychological distress

The association between social support and psychological distress is presented in Table 10. Received social support was not associated with self-reported symptoms of PTSD, depression or anxiety.

Total perceived social support was significantly negatively correlated with PTSD symptoms of arousal (r = -.38, p < .01, two tailed), but not associated with overall self-report rates of PTSD symptoms, or symptoms of avoidance or intrusions.

Total perceived social support was significantly negatively correlated with depression (r = -.37, p < .05, two tailed). There was a trend for participants classified as low anxiety to report more total perceived social support (M = 5.20, SD = .88) than those in the high anxiety group (M = 4.68, SD = 1.34), although this difference was not significant (t (42) = 1.51, p = .137, two tailed).

Perceived social support from a significant person was negatively correlated with both overall PTSD symptoms (r = -.37, p < .05, two tailed), arousal symptoms (r = -.45, p < .01, two tailed) and intrusion symptoms (r = -.41, p < .01, two tailed). Participants classified as lower anxiety reported more perceived support from a significant person (M = 10.69, SD = 1.69) than those in the higher anxiety group (M = 9.21, SD = 2.83; t (42) = 2.09, p = .042, two tailed).

Perceived social support from family / foster carer / social worker was not associated with symptoms of PTSD, depression or anxiety.

Table 10: Association between social support and symptoms of PTSD (RIES), depression (DSRS) and anxiety (RCMAS)

	PTSD Total	PTSD Avoidance	PTSD Arousal	PTSD Intrusion	Depression	Anxiety low / high
	r	*r*	*r*	*r*	*r*	*t*
Received social support	.130	-.087	.160	.171	.061	.248(42)
Perceived social support Total	-.246	.111	-.387**	-.196	-.377*	1.516(42)
Perceived social support Significant Person	-.376*	.061	-.452**	-.417*	-.279	2.097*(42)
Perceived social support Family / Foster carer / Social worker	.026	.109	-.114	.153	-.292	.138(42)

**. Correlation is significant at the .01 level (two tailed)
*. Correlation is significant at the .05 level (two tailed)

Predicting psychological distress

Depression (DSRS) and anxiety (RCMAS lower / higher) were only found to be significantly correlated with one independent variable each, total perceived support and perceived support from a significant person respectively. Therefore regression analysis was not conducted for these variables.

PTSD symptoms (RIES total, RIES arousal and RIES intrusions) were correlated with both exposure to trauma and perceived social support from a significant person. Asylum status was also correlated with PTSD symptoms of intrusion. In order to evaluate the extent to which these variables independently predict symptoms of PTSD in the current sample, regression analysis was conducted.

All means were converted to *z* scores, in order to assist interpretation of coefficients (Bohrnstedt & Knoke, 1994). Due to the small number of participants, the Enter method of regression analysis was utilised (Brace, Kemp & Snelgar, 2003).

Predicting Overall PTSD Symptoms (RIES Total)

Correlations indicated that PTSD symptoms were associated with exposure to war trauma, perceived social support from a significant person and ILR asylum status. As indicated in Table 11, these variables combined to explain 23% of variance of overall PTSD symptoms, as measured by the RIES (Total). However, the only independent significant predictor in this model was exposure to war trauma, predicting 12% of the variance.

Table 11: Multiple regression analysis - Overall PTSD symptoms (RIES Total). Predictor variables: exposure to war trauma (WTQ), perceived social support from significant person (MSPSS significant person) and asylum status (ILR)

Predictor Variable	Beta	*t*-statistic	*F*-statistic	*p*-value	R^2	Adjusted R^2	SR^2
Model	-	-	$F(3,43) = 5.30$	.004	.28	.23	-
War trauma (WTQ)	.347	2.50	-	.016	-	-	.12
Perceived support significant person (MSPSS)	-.220	-1.49	-	.142	-	-	.05
ILR	.191	1.34	-	.188	-	-	.04

Predicting PTSD arousal symptoms (RIES arousal)

Correlation analysis indicated that exposure to war trauma and perceived social support from a significant person were associated with PTSD arousal symptoms. These combined variables account for 26 % of the variance in PTSD arousal symptoms, as indicated in Table 12. Both of these variables independently predict arousal symptoms; exposure to war trauma 10%, and perceived social support from a significant person 13%.

Table 12: Multiple regression analysis - PTSD arousal symptoms (RIES arousal). Predictor variables: exposure to war trauma (WTQ) and perceived social support from significant person (MSPSS significant person)

Predictor Variable	Beta	*t*-statistic	*F*-statistic	*p*-value	R^2	Adjusted R^2	SR^2
Model	-	-	$F(2,43) = 8.707$	.001	.29	.26	-
War trauma (WTQ)	.317	2.33	-	.024	-	-	.10
Perceived Support Significant Person (MSPSS)	-.370	-2.72	-	.009	-	-	.13

Predicting PTSD intrusion symptoms (RIES intrusion)

Correlations indicated that exposure to war trauma, perceived social support from a significant person and having ILR asylum status were associated with PTSD intrusions symptoms. These variables combined to account for 42 % of the variance in PTSD intrusion symptoms, as indicated in Table 13. The only variable to be an independent significant predictor was exposure to war trauma (25%), although asylum status (ILR / TLR) did account for 6% of variance independently.

Table 13: Multiple regression analysis - PTSD intrusion symptoms (RIES intrusion). Predictor variables: exposure to war trauma (WTQ), perceived social support from significant person (MSPSS significant person) and asylum status (ILR)

Predictor Variable	Beta	*t*-statistic	*F*-statistic	*p*-value	R^2	Adjusted R^2	SR^2
Model	-	-	$F(3,43) = 11.639$	<.001	.45	.42	-
War trauma (WTQ)	.508	4.24	-	<.001	-	-	.25
Perceived social support Significant Person (MSPSS)	-.201	-1.58	-	.121	-	-	.04
ILR	.244	1.98	-	.054	-	-	.06

4. Discussion

The current study hypothesised that unaccompanied asylum-seeking and refugee youngsters would report high levels of exposure to war trauma, and high rates of PTSD, depression and anxiety symptoms. It was predicted that war exposure to trauma would be associated with psychological symptoms. In addition, it was hypothesised that participants with high levels of received and perceived social support will have less symptoms of PTSD, depression and anxiety.

Conclusions are drawn in relation to these hypotheses individually, but caution is noted due to a number of methodological issues highlighted below. Despite possible limitations, the current study provides a number of interesting and clinically useful preliminary findings worthy of further exploration.

As predicted in hypothesis one, unaccompanied refugees and asylum seekers reported high levels of exposure to traumatic events, with an average of 19 adverse incidents per participant. Reported rates of war trauma exposure in the current study were higher than rates of trauma exposure noted in other studies with war-exposed children living with their families that also used the War Trauma Questionnaire[3] (Macksoud, 1992: M = 5.74, SD not reported; Smith, Perrin, Yule, & Rabe-Hesketh, 2001: M = 13.03, SD = 4.16).

[3] Comparisons made with other studies throughout the Discussion section are all significant unless otherwise reported. However, as studies were not equivalent in factors such as age, gender and country of origin, comparisons are tentative and were therefore not reported in the Results section.

This suggests that young unaccompanied asylum seekers and refugees may be at increased risk of exposure to traumatic events.

There are a variety of possible explanations as to why the current sample may be at increased risk of exposure to trauma. As the War Trauma Questionnaire classifies loss of, or separation from, a parent as a trauma, by the definition of being unaccompanied, youngsters in the current study would have experienced these additional traumatic events when compared to their accompanied peers. Unaccompanied youngsters may also experience more traumatic events because they lack direct parental protection. However, other factors such as age may also play a role in degree of trauma exposure. War-exposed youngsters in the studies by Macksoud (1992) and Smith et al. (2001) were younger than the current sample. Human instinct predisposes us to protect young children from harm, even if they are not a blood relation. Therefore, it is possible that unaccompanied minors who are younger than the current sample may have been shielded by adults, and hence not experienced such elevated levels of trauma. Adolescents who have some capacity to survive independently may be left to fend for themselves, especially when resources are short. This is likely to be the case in war-torn countries where, by the time adolescence is reached, many youngsters are viewed as adults, and may even be expected to fight as soldiers. In addition, the current study did not establish the length of time youngsters had been separated from their parents before they fled from their home country. Many may have remained with their parents until they left their home country, which would therefore indicate that the higher incidence of trauma

experienced was not due to a lack of parental protection. The fact that the majority of participants' parents had been killed or were missing may also indicate that these youngsters had come from particularly volatile areas, which may also account for elevated exposure to trauma.

Future studies directly comparing accompanied and unaccompanied youngsters matched for factors such as age and country of origin would help clarify whether unaccompanied minors are actually at higher risk of exposure to traumatic events and, if so, provide insight into whether this increased vulnerability is due to separation from parents or other factors.

Hypothesis two which stated that young unaccompanied asylum seekers and refugees would experience high rates of PTSD, depression and anxiety symptoms was supported in the current study. Symptoms of PTSD, depression and anxiety were also highly correlated. However, the interpretation of levels of psychological distress can only be made tentatively as the measures used in the current study have not been standardized with refugee populations. Clinical interview-based assessments that take account of cultural factors would be required to confirm likely diagnoses based on questionnaire findings.

Despite these limitations, findings indicate preliminary support for extremely high rates of PTSD symptoms in the current sample, with 75% of participants obtaining scores that

fall above the cut-off for a likely diagnosis of PTSD. PTSD scores for intrusion and avoidance symptoms in the current study were higher than those recorded in a sample of 3000 9 to14-year-old war-exposed Bosnian children (Smith, Perrin, Schwartz & Yule, 1996; M = 17.24, SD = 9.62). This suggests that the current sample may experience more symptoms of PTSD than youngsters who remain with family members. This makes theoretical sense if the youngsters in the current study have been exposed to more traumatic events. However, further matched case control studies of accompanied and unaccompanied youngsters would be required to support this finding.

PTSD subscale scores on the Revised Impact of Event Scale (RIES) for intrusions and arousal were positively correlated; however, neither of these subscale scores were associated with avoidance symptoms. This may be because war-exposed youngsters who experience high intrusions and arousal do not demonstrate equivalent levels of avoidance behaviours, or vice versa. It is also possible that youngsters who are extremely avoidant would be less likely to participate in research which involved talking about difficult experiences. This may be the case for youngsters who have experienced sexual assaults, which are likely to evoke inhibitory feelings of shame in many cultures (Moszynski, 2004).

Alternatively, avoidance may not be correlated with other symptoms of PTSD, because the RIES used to measure PTSD symptoms in the current sample does not reveal subtle symptoms of avoidance that may be experienced by some youngsters. Many participants

in the current study seemed perplexed by the questions relating to avoidance symptoms. For example, when asked if they stayed away from reminders of a traumatic event, such as a place or situation, participants usually said 'no', explaining that because they were living in a new country, which differed greatly to their home country, there were few reminders of bad things that had happened to them. In addition, when asked if they tried to remove thoughts of the trauma from their memory, some stated that, according to their culture, removing painful memories was known to be the best way to deal with difficult experiences.

Seven (16%) participants reported symptoms of depression that fell within the clinical range and a further 22 (50%) participants reported symptoms of low mood. Participants reported more symptoms of depression than a normative sample of British 15-year-old youngsters (M = 8.66, SD = 4.35; Yule, Ollendick & Blagg, 1992, cited in Sclare, 1998). Self-reported depression symptom rates were also higher than studies using the Depression Self-Rating Scale (DSRS) with war-exposed Bosnian children, aged between 9 and 14, years who had remained in their home country (Smith et al., 2001: M = 9.4, SD = 5.03). However, scores in the current study were lower than those reported on the DSRS by younger Bosnian children aged between 9 and 13 years living in Greece, many of who were missing a significant adult carer (Papageorgiou et al., 2000: M = 15.3, SD = 5.9). This could suggest lower levels of depression in the current sample of older unaccompanied asylum-seekers. However, it may also reflect a lack of sensitivity of the scale used in the current study with older populations. This measure was originally

designed for use in younger children, and may therefore not be an appropriate measure of depression symptoms of older participants.

Fourteen (32%) participants reported symptoms of anxiety that would be classified as indicating a diagnosis of an anxiety disorder according to a normative data study in the US (Reynolds & Richmond, 1978). The distribution of anxiety scores was bimodal, suggesting two groups of participants in the current study. This may reflect a true split in lower and higher anxiety levels. However, it may also be influenced by the dichotomised response style of the Revised Children's Manifest Anxiety Scale (RCMAS). Participants were asked to state 'yes' or 'no' in response to questions relating to anxiety symptoms such as, 'I worry a lot of the time', 'I worry when I go to bed at night' and 'I am nervous'. Many respondents struggled to choose a response as they felt they experienced these symptoms some of the time but not continually. Participants who felt more positive may therefore have consistently minimised their anxiety symptoms by opting for a 'no' response, whereas respondents who were low in mood may have been more likely to maximise their anxiety symptoms by responding 'yes' more frequently. Therefore a measure which provides an opportunity to rate frequency of anxiety symptoms may be a more appropriate scale for understanding rates of anxiety in this population.

As predicted in hypothesis three, exposure to traumatic events was associated with high rates of overall PTSD symptoms, and symptoms of intrusion and arousal. This

association was significant even when other factors such as social support had been controlled for. However, exposure to trauma was not associated with PTSD symptoms of avoidance, or symptoms of depression and anxiety.

The positive correlation between high rates of exposure to trauma and elevated levels of PTSD symptom of intrusions and arousal supports previous studies that have demonstrated an exposure-effect relationship between traumatic events and PTSD (Pfefferbaum, 1997). In addition, most of the youngsters (93%) reported that they had been in a situation where they thought that they would be seriously hurt or killed. The subjective appraisal of stressors as a perceived threat to life or physical integrity has also been noted to predict PTSD severity in both children and adults (Ehlers, Mayou & Bryant, 2003).

Exposure to trauma was not associated with PTSD avoidance symptoms in the current study, a finding that replicates previous studies also using the RIES (Hollifield et al., 2002). As discussed previously, this may be because highly avoidant youngsters may not participate in the study, avoidance symptoms may not be applicable to the current sample, or because the measure may not reveal subtle symptoms of avoidant behaviours. Further research which assesses avoidance symptoms more thoroughly, such as through a full clinical assessment interview, is required to understand avoidant behaviours in unaccompanied asylum-seeking and refugee populations. Such research should also explore the role of developmental factors on avoidant behaviours, for example, younger

children may be more avoidant due to immature coping mechanisms.

Although participants in the current study reported high rates of symptoms of depression, this was not associated with exposure to trauma. Other studies with refugee populations have attributed high rates of depression to current stressors. For example, in a study of 170 young Cambodian adults living in the US current life stress and poor spoken English, but not exposure to war trauma, were the only significant predictors of depression, (Sack, Clarke & Seeley, 1996). This finding has also been supported in other refugee populations (Mghir, Freed, Raskin, & Katon, 1995; Westermeyer, Vang & Neider, 1983). Therefore the high rates of depression in the current sample may reflect multiple adverse life events and experiences during resettlement, rather than exposure to war trauma. In addition, elevated rates of depression may be associated with low perceived social support, as discussed below.

Although it was not assessed in the current study, it is likely that many of the participants would be experiencing extreme grief and bereavement reactions following the death of, or enforced separation from their parents, which is also likely to impact greatly on mood and symptoms of depression. Out of the 44 youngsters interviewed, only four (9%) knew that both of their parents were alive and well, although none of these youngsters said that they were able to make contact with their parents. Many of the youngsters reported that they did not know whether their parents were still alive. Although it was not possible to evaluate the psychological impact of having a missing parent compared

to a deceased parent in the current study because so many of the youngsters had both experiences, it is likely that not knowing whether one's family is alive or dead is also likely to contribute greatly to psychological difficulties (Zvizdic & Butollo, 2001).

Although self-reported symptoms of anxiety were not related to exposure to trauma in the current study, the non-significant trend for participants classified as experiencing high levels of anxiety symptoms to report more trauma suggests this finding may be worthy of further investigation with a larger sample size, and as discussed previously, with a rating scale of anxiety which evaluates the frequency of anxiety symptoms.

Participants who had been granted indefinite leave to remain (ILR) in the UK for as long as they wished had significantly fewer PTSD intrusion symptoms than participants who were still awaiting a decision, or had only been given temporary leave to remain (TLR) asylum status. This supports previous studies with adults that highlight elevated rates of psychological difficulties experienced by asylum seekers who are awaiting the outcome of their asylum claim (Thomas & Lau, 2002; Silove, Sinnerbrink, Field, Manicavasagar, Steel, 1997). One may speculate that PTSD intrusion symptoms are high, because the continued fear of being returned to one's home country maintains memories of what may be experienced on their return, resulting in the re-experiencing of previous traumas through intrusive thoughts, flashbacks and nightmares. Research is required to replicate and further explore this result, but initial findings suggest that living in fear of repatriation may maintain PTSD symptoms of intrusion in some asylum-seeking

youngsters.

Many participants reported receiving support from multiple sources, in particular solicitors, schools / colleges and GPs. However, in contrast to the prediction in hypothesis four, the number of received sources of support was not associated with fewer symptoms of PTSD, depression and anxiety. The Received Social Support measure (RSS) used to assess the number of social supports in the current sample may not have captured the diverse range of support that may be available to this population. For example, the measure did not assess whether support was received from a girlfriend or boyfriend, which may be an important source of support for many adolescents. In addition, this measure does not assess the quality of support received, such as sensitivity and stability. Inappropriate received social support may play a detrimental rather than beneficial role in well-being, for example, having an unsupportive foster carer or attending a school where the youngster is bullied.

Received social support may have a greater impact on well-being for unaccompanied asylum seekers who have recently arrived in the UK, as they will depend on this type of support for all of their basic needs such as food, money and accommodation. In the current study all participants had been in the country for 3 months or longer, and therefore received social support may have had less of an impact on their well-being at the time of the interview. In addition, professionals who view youngsters as being less distressed may provide them with fewer support resources. Relevant information from

social workers in future studies would be useful to clarify if this happens in practice. Further research is also required to assess the quality, as well as quantity of received social support in order to explore unaccompanied youngsters experiences of received support. In addition, studies that assess the impact of particular types of support, such as foster care, are required to evaluate the impact that such support may have for this unique population.

Perceived social support scores suggest that participants in the current sample believed that they had less support than participants in studies of non-refugee populations such as American adolescents living in urban areas, which also used the Multi-dimensional Scale of Perceived Social Support (Canty-Mitchell & Zimet, 2000: M = 5.55, SD = 1.20). However, in agreement with this study on a population of American adolescents, participants rated significant other / friends as more important than family or legal guardians (Canty-Mitchell & Zimet, 2000; significant other, M = 5.90, SD = 1.30; friend, M = 5.42, SD = 1.42; family, M = 5.33, SD = 1.48). It is most likely that this will be related to separation from families in the current sample, but it may also reflect the typical trend of adolescents to rely on peers for support rather than adult carers (Robinson & Garber, 1995)

In support of hypothesis four, total perceived social support was associated with fewer symptoms of psychopathology, in particular, depression. This supports the finding of previous studies that highlight the importance of perceived social support to

psychological well-being (Brown and Harris, 1978; Joseph, 1999).

According to the stress buffering model of social support, believing that one has support suggests that individuals are more likely to make positive cognitive appraisals about potentially stressful events, which will enhance their ability to cope with stressors. In the current sample, it might be that perceiving that there are available people to offer advice and support in a new environment is likely to enhance an individual's confidence to deal with potentially challenging situations. Further studies incorporating matched control groups of youngsters who were not experiencing stress are needed to clarify exactly how social support functions at times of stress. However, due to the experiences related to becoming an unaccompanied youngster seeking asylum in the UK, such as trauma and loss, it would be challenging, if not impossible, to find appropriate matched controls who were not experiencing stress and adversity.

Participants in the current study also stated that the emotional support offered by having someone to talk to, even if they could not provide any practical help, was invaluable as it allowed them to share difficult emotions and to feel less isolated. This is likely to buffer against the emotional impact of their current stress. However, it may also be indicative of processes that are postulated by the main effect model of social support in the well-being of participants in the current study. According to this model, integration within new social networks is thought to have an impact upon well-being by reducing isolation and providing a sense of belonging in a new environment, which are likely to have a

positive impact on an individual's sense of identity (Cohen & Wills, 1985). The design of the current study does not allow the predictions of the stress buffering and main effect models of social support to be differentiated from one another.

High perceived social support from a significant person was also associated with lower symptoms of PTSD, in particular arousal symptoms. In fact, having perceived social support from a significant person significantly predicted lower arousal symptoms, independent of other factors such as exposure to trauma. In addition, having high perceived social support from a significant person was associated with lower anxiety. This may be because perceived social support that allows individuals to feel that they are able to cope with a difficult situation effectively is likely to result in lower levels of physiological stress and anxiety responses (Cohen, 2004).

However, the association between perceived social support and PTSD arousal symptoms may be due to the methodological confound of the young person self-reporting on both measures, which may artificially inflate the relationship between two variables. This potential confound will also apply to other self-report measures of trauma and psychological distress. In particular, youngsters who are experiencing psychological distress may appraise social support negatively due to depressive cognitions. Future studies which obtain observer ratings of psychological well-being may help eliminate this possible methodological flaw. However, care would be required in choosing appropriate observers, as there may not be adults who know unaccompanied youngsters

well enough to report on their psychological symptoms.

As with all cross-sectional research exploring the role of social support, this study has not established the causative relationship between psychological well-being and social support. Participants with severe psychological difficulties may attract social support resources, and therefore receive more benefits. Alternatively, participants who are less disabled by psychological problems may be more able to access, utilise and perceive social support. Longitudinal studies that monitor social support utilisation and benefits will help inform understanding of the causal relationship between social support and psychological well-being in unaccompanied asylum seekers and refugees. In addition, it may highlight barriers to accessing social support in this unique population, such as language and cultural difficulties, mistrust of adults due to traumatic experiences (Lustig et al., 2004) and insecure attachment styles (Collins & Feeney, 2004). Gender has also been noted to influence social support, although no consistent pattern has been identified as to whether males or females benefit more (Cohen, 2004). The impact that gender may play in social support utilisation, which may differ across cultures, also requires exploration in young unaccompanied and separated asylum seekers and refugees.

In summary, this study suggests that the current sample of unaccompanied youngsters have experienced significant exposure to war trauma and associated high levels of PTSD. Participants also demonstrated elevated levels of depression and anxiety symptoms, but these were not found to be related to exposure to war trauma. High levels

of perceived social support, but not received social support, were associated with lower psychological distress such as depression, anxiety and some PTSD symptoms.

As stated previously, these conclusions are drawn with caution due to methodological limitations, some of which have been highlighted already. Replication of this study with a larger sample will be required to confirm and further explore the current findings. Young unaccompanied refugees and asylum seekers are a difficult group to engage in research. Barriers to recruitment in the current study included the reliance on over-stretched social workers, mental health professionals and teachers to contact young people, as well as language difficulties and fear of talking to an unknown professional about past traumatic experiences and feelings. Obtaining 44 participants was therefore considered a success in the current study when such difficulties with recruitment and engagement are taken into account. However, for statistical purposes a sample size of 44 is relatively small, increasing the chance of Type 2 errors.

Participants were a self-selected sample, hence there may be a bias within the results of the current study, such as the young people being less distressed. In addition, a high proportion of participants were recruited through educational establishments. Such youngsters may be functioning at a higher level than unaccompanied peers who are not attending school or college. Attendance at school may reduce social isolation, increase peer relationships and provide the opportunity to improve their English, which has been noted to improve well-being in other studies (e.g. Sack, Clarke, & Seeley, 1996).

Finally, this study involved unaccompanied refugees and asylum seekers from 18 different countries. It was clear from participants' responses that, although all youngsters had been exposed to trauma and loss, experiences differed greatly. For example, participants from African countries, such as Ethiopia and Eritrea, appeared to have endured extended periods of poverty, war and violence prior to leaving their home country. This was in contrast to the reports of two participants from China who described affluent, well-educated backgrounds which had continued until the time of their parents' imprisonment due to their religious beliefs. Larger studies with sufficient representative participants from different countries would provide greater understanding of the diverse experiences and psychological well-being of youngsters from around the world. Such research should be guided by knowledge of specific cultures in relation to expression of psychological distress and social support, in order to avoid over-testing samples and the increased risk of Type 1 errors.

Despite possible limitations, this study has highlighted a number of important areas for future research, in particular, the need to develop culturally specific questionnaires which can be used with young asylum seekers. In addition, replication of the current study with a larger sample may allow an opportunity to further assess the impact of gender and age on this vulnerable population, which was not found to be associated with distress in the current sample.

Clinically, this study suggests that many unaccompanied youngsters arriving in the UK as asylum seekers will have sustained high levels of trauma, loss and adversity. As a consequence, they are likely to be experiencing psychological difficulties, such as symptoms of PTSD, depression and anxiety, which may also be influenced by ongoing stressors experienced on arrival in the UK. Although it is impossible for us to erase traumatic experiences that have been shown in the current study to negatively influence the well-being of these youngsters, we do have effective ways to treat resulting PTSD symptoms. In addition, we often have some capacity to prevent further trauma during resettlement experiences in this country and provide support services which can help to buffer the impact of current stressors and promote successful integration into a new culture.

Mental health services can play an important role in helping individuals manage psychological difficulties, although this support must be sensitive and respectful of different cultural views of mental health issues and treatment approaches. Therapists must take care to consider other factors that may predispose youngsters to psychological difficulties, such as negative early childhood experiences, insecure attachment styles, personality difficulties and possible learning difficulties, rather than just focusing on experiences of war-related trauma.

Not all cultures view talking therapies as a panacea (Burnett & Peel, 2001). Therefore other forms of support may be more beneficial to some youngsters. The promotion of

support networks from a wide variety of sources, such as social services, schools, refugee support groups, youth groups and religious groups, may offer isolated and vulnerable young unaccompanied asylum seekers and refugees essential support. However, it should not be assumed that youngsters will utilise such services, and where necessary outreach approaches may be required. As with mental health services, support is likely to be most useful if it incorporates cultural norms and beliefs. The most effective method of obtaining such understanding is to consult directly with unaccompanied asylum-seeking youngsters, and people from their country of origin.

Although this study has highlighted the difficulties experienced by young unaccompanied asylum seekers and refugees in the current study, consideration of their strengths and resilience must not be overlooked. Despite symptoms of PTSD, depression and anxiety, most of the youngsters in this study function well in society, for example making friends, attending school / college and achieving high standards academically. This demonstrates a phenomenal achievement and resilience when past and present challenges faced by these individual youngsters are taken into account.

As with many quantitative studies of this kind, the reality of these young people's experiences is in danger of being lost amongst numbers and statistics. Many of the youngsters in the current study were keen to share their experiences during interviews, wanting to expand their answers to more than a simple yes/no, or rating scale responses. A selection of participants' stories have been made anonymous and included in

Appendix 7. These biographical accounts help remind researchers and clinicians that although these youngsters do experience psychological difficulties, this is likely to result from their experiences in a dysfunctional and disrupted world, rather than pathological difficulties within the young people.

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Paper 3 : Critical appraisal paper

Research with young unaccompanied asylum seekers and refugees:

The benefits and challenges

Research involving asylum-seeking and refugee populations is essential to gain an increased understanding of the immediate and longer-term physical, psychological and social implications of their adverse experiences, which is required to inform appropriate policies, support services and models of intervention. However, research with this vulnerable population presents many challenges, especially when it involves unaccompanied minors.

Inviting refugees and asylum seekers to talk about past experiences risks painful revisiting of traumatic events and possible re-traumatisation (Thomas & Byford, 2003). Full informed consent for individual participants is therefore critical, but this is often not a straightforward procedure.

Language difficulties may result in participants not fully understanding what the research involves, and implications for participating or not participating. The use of translated information sheets, consent forms, and interpreters is beneficial in helping participants understand the purpose and procedures of a research project. Ideally, written and verbal information and consent forms should be provided in a participant's first language, even when they appear to be able to speak English competently. Participants must be invited to ask questions about the research, as many may be reluctant to seek clarification as they feel shy or anxious. Unfortunately, due to financial limitations, language-specific

written information and consent forms were not available for use in the current study[4], although interpreters were used to translate information and consent forms verbally if participants did not have a good grasp of the English language. However, any future research should endeavour to adopt good practice of providing information and consent forms which have been translated and back-translated into all participants' first languages.

Commonly, asylum seekers and refugees experience a disparity of power between themselves and professionals in a host country. An asylum seekers' fate in terms of legal status and service provisions is dependent on authority figures such as Home Office representatives and social workers. Many asylum seekers may have no experience or understanding of research paradigms, and may view researchers as another figure of authority. Therefore, individuals may feel pressured into participating because they fear negative repercussions if they refuse, such as having their asylum claim turned down, or because they hope the researcher may be able to help them with their claim or service provisions. As adhered to in the current study, researchers have a duty to reinforce verbally and in written format the message that participation or refusal to participate does not affect asylum applications and access to services. This must be done even if it increases the likelihood that an individual will refuse to take part.

[4] Please see Part Two for details of the current study

Researchers working with refugee populations may be required to make 'judgement calls' on an individual's capacity to provide voluntary consent. If researchers have doubts regarding an individual's understanding and motives for participation in research, they have an ethical duty to discuss the research further with the individual, and where necessary not include them. When conducting research which may cause harm and distress, results of power calculations must not override individual well-being.

The challenge of obtaining informed consent is further complicated in the case of asylum seekers and refugees under 16 years of age, particularly those who are unaccompanied. Ethical guidelines in the UK indicate that a child who has 'sufficient intelligence' to understand what is involved in a research study can legally provide consent, rather than a parent or guardian (Royal College of Paediatrics and Health Care, 1992). The term 'sufficient intelligence' is an arbitrary construct that is difficult to evaluate, particularly when a child is not known to the researcher. This task will be further complicated with asylum-seeking and refugee youngsters due to language and cultural differences. Therefore, in line with The Declaration of Helsinki guidelines (1964, 2000), the current study obtained consent from individuals under 16, *and* their 'legal' guardian.

In the UK, local authorities have a legal responsibility to care for unaccompanied minor asylum seekers and refugees (Refugee Council, 2003). However, this does not equate to 'parental responsibility', which is only obtained by the local authority if they undertake care proceedings under Section 31 of the Children Act 1989 (Children's Legal Centre,

2005). In the current study, four 15-year-olds wished to take part in the study, but their allocated social workers would not consent to their participation. The social workers would not provide reasons why they felt it was not appropriate for the youngsters to participate, but it may have been because they had concerns about the research being upsetting for the child. However, it may also reflect an understandable reluctance of social workers to take on what may be seen as 'parental responsibility' for the well-being of individual youngsters. According to one college, many social workers would not provide consent for unaccompanied minor asylum seekers and refugees to partake in school activities such as day trips and course field trips. This suggests that unaccompanied minors seeking asylum in the UK may be missing out on opportunities for pleasurable experiences due to a lack of guidance on legal responsibility in some London boroughs.

For youngsters to miss out on participating in a research project is unfortunate. However, as discussed in the current study, social integration is likely to play an important role in the well-being of unaccompanied minors in the UK, yet it appears that opportunities for such integration through school trips etc. may be being lost. Clearer guidance on guardianship of unaccompanied asylum seekers and refugees is needed to enable an appropriate adult representative to provide consent for these vulnerable youngsters.

Obtaining informed consent is only one challenge for researchers working with unaccompanied youngsters. It is inevitable that whilst talking about past trauma and losses, some young people will become distressed. In accordance with guidelines from the Royal College of Paediatrics and Health Care (1992), research involving asylum-seeking and refugee youngsters must include provisions for continuing care. In the current study, local support resources such as college counsellors, Child and Adolescent Mental Health Services (CAMHS) and refugee support groups were notified of the study in advance, and referral routes established. Following participation in the current study, 2 youngsters were referred to their local CAMHS, and a further 6 were referred to their college counsellor. This indicates that 8 youngsters (18%) who took part in the study wanted psychological support, but had not been aware that such support was available or how to access it. This highlights the direct beneficial role that the current study played in the lives of some youngsters, as well as providing useful information for future research and longer term policy and service development.

It is also inevitable that most professionals who support unaccompanied asylum-seeking youngsters will, at times, find the work emotionally challenging. As a clinician, working with unaccompanied young people can be extremely distressing. However, clinicians are able to work with individuals over time to improve the young person's well-being and monitor their progress. During research such as the current study, researchers usually meet with asylum-seeking and refugee youngsters on only one occasion, during which time they often hear of traumatic stories and see very distressed youngsters.

Understandably, this can leave researchers themselves feeling very distressed and helpless, with a sense of not knowing what will become of the youngster. As with clinical work, good supervision was imperative in the current study to assist the researcher manage these difficult feelings, and consider issues regarding risk and referral to support services. However, the potentially distressing nature of this research also highlights the importance of conducting studies with vulnerable individuals in a supportive environment, where if necessary, other professionals can be made aware of a youngster's distress and assist them in obtaining appropriate support.

Many of the participants in the current study were recruited through their school or college. Thanks to the dedication and care of teachers, this proved to be an excellent place to carry out research with unaccompanied asylum-seeking youngsters. The teachers who assisted in the current study had clearly worked hard to develop a trusting and respectful relationship with their pupils, and were keen to support them in whatever way they could. All of the participants who scored above clinical cut-off ranges on posttraumatic stress disorder (PTSD), depression and anxiety measures, or who were very distressed gave their permission for the researcher to discuss their concerns about the youngster with their teacher. This was the case for youngsters who wished to be referred on to other services, but also for youngsters who did not wish to receive support from mental health services. Teachers are often the only adults who have frequent contact with unaccompanied youngsters. As a researcher, being able to advise someone who sees the young person daily of their concerns was reassuring, as the teachers were

keen to support self-referrals, or make referrals in the future if necessary. However, this emphasises the importance of providing appropriate support for teachers, such as training on the mental health needs of asylum-seeking youngsters and local support services. In the current study, the teachers at one of the colleges had not been aware of a local specialist refugee support service. Through participating in the study, links were made between the college and the specialist service, and as a result, staff training and ongoing network meetings have now been set up.

Although schools and colleges may provide a supportive environment to recruit unaccompanied asylum seekers and refugees for research studies, as already discussed in the current study, researchers must acknowledge that this may lead to biased findings. Youngsters who are recruited through schools and colleges may be functioning at a higher level than those who are too traumatised, depressed or anxious to attend classes. In addition, some young refugees and asylum seekers do not gain a school or college place due to limited resources (Stanley, 2001). Education plays an essential role in any young person's life, both academically and socially. For unaccompanied youngsters, attendance at school or college may play a particularly critical role in their well-being by providing an opportunity to learn English, gain qualifications, make friends, integrate socially and receive social support. Unaccompanied youngsters are already at high risk of isolation, which will only be exacerbated if they are unable to attend school or college.

Forty two participants (95%) in the current sample were attending school or college regularly. Of the 2 youngsters that were not in education, one had been offered a place but was too depressed and anxious to attend, whilst the other had been unable to obtain a place. Statistics are not available on how many unaccompanied asylum-seeking and refugee youngsters are in education in the UK. However, as many of the participants in the current study were recruited through schools and colleges, they may be an unrepresentative sample of the general unaccompanied population, with the current sample functioning at a higher level and receiving more supported than youngsters who are not in education. Future research with youngsters, who for whatever reason, are unable to attend school or college is required to explore their well-being and functioning.

Inevitably, the current sample will also be biased because it includes a self-selected group of unaccompanied asylum-seeking youngsters. Individuals who have experienced greater trauma and loss, or are suffering from more severe psychological difficulties may be less likely to participate. This may be particularly the case for youngsters who are affected by avoidance symptoms of PTSD, who actively try not to talk or think about difficult past experiences. Despite being based on a self-selected sample that may be functioning at a higher level, the current study still found high rates of PTSD, depression and anxiety symptoms, which suggests that those who did not participate may also be experiencing similar or more extreme difficulties.

One important but intentional limitation of the current study was that it did not evaluate the occurrence and impact of sexual assault and rape. Sexual assault, of both male and females, is recognised to have a potentially catastrophic impact upon psychological well-being (e.g. Ellis, Atkeson & Calhoun, 1981; Stekette & Foa, 1987). Children who have been the victims of rape have been found to experience long term psychological difficulties that may continue to affect them in adulthood (e.g. Saunders, Kilpatrick, Hanson, Resnick & Walker, 1999). Unfortunately, sexual assault and rape are common occurrences during times of war and conflict. Studies have reported mass rape and sexual assault in up to 60% of female refugee populations from countries such as Azerbaijan and the Democratic Republic of Congo (e.g. Amnesty International, 2004a; Kerimova et al., 2003). Human rights organisations such as Amnesty International (2004b) state that girls as young as eight are frequently being raped and involved in sexual slavery in countries such as Sudan. Sexual violence against men and boys is also common (Amnesty International, 2004a).

As well as psychological risks, sexual assault and rape also incur many risks to physical well-being such as injuries sustained during the attack, unplanned pregnancies and the high risk of sexually transmitted diseases, including AIDS. Physical injuries are often exacerbated by a lack of appropriate medical care. In addition, the stigma that rape carries in many cultures results in few victims seeking necessary medical support even when it is available (Moszynski, 2004). Rape is so stigmatising in some countries that it equates to social and economic death. Women who have been raped are often viewed as

'spoiled', and will be disowned by their husbands or unable to marry (Amnesty International, 2004b).

Although sexual assault and rape are known risk factors for the development of psychological difficulties, extensive consultation with professionals who work within the field of refugee mental health (e.g. psychologists from the Young Mental Health Refugee Project, Maudsley Hospital and the Traumatic Stress Clinic, London) led to the decision that it would not be appropriate to specifically ask youngsters if they had been raped or sexually assaulted in the current research project. Psychologists who work with this vulnerable group stated that they spent a lot of time with clients in order to build up trust and rapport before making enquiries about sexual assaults. This is because, in their experience, if the client was asked about sexual assault or rape early on in clinical sessions, there was a significant risk of pronounced distress and shame for some individuals which are likely to be detrimental to their mental well-being. It was also suggested that some young people may deny that an assault such as rape occurred if they do not feel they can trust the psychologist, or were ashamed of what had happened to them. As the current study involved a single interview with a researcher who was unknown to participants, it was felt that asking young people if they had been raped or sexually assaulted presented substantive risk of causing excessive distress for some participants and therefore should be avoided.

Although the current study did not ask about assaults of a sexual nature, four of the participants did talk openly about their own experiences of being the victims of rape. It is possible that many more of the youngsters may have experienced similar assaults, although it is also likely that youngsters who had been sexually assaulted may be less likely to participate in the research for fear of being asked about such incidents. If youngsters had been sexually assaulted this could be an important predictive factor in the development of psychological difficulties that was not explored within the current study. Future research, which may be conducted as part of clinical work during which young asylum seekers have already reached the stage of being able to talk about experiences of sexual assaults, may provide insight into the occurrence and impact of this particular type of trauma in different cultures. However, all support services need to be aware that many asylum-seeking and refugee youngsters will be at risk of having experienced sexual assault.

The current study utilised questionnaires to assess exposure to trauma, psychopathology and social support. Although questionnaires offer the advantage of providing a cost-effective method of obtaining preliminary information, they also have a number of limitations, particularly when being used with asylum-seeking and refugee populations. For example, Richman (1996) noted that questionnaires using rating scales rely on subjective interpretation of concepts such as 'a little' and 'sometimes', which can differ greatly between individuals, but do have a direct impact on whether a respondent is classified as being above a clinical cut-off. Richman also noted that even when

questionnaires are translated into different languages, the meaning of terms and phrases may be lost. In addition, questionnaire results relating to symptoms do not indicate an individual's level of functioning. This was noted in the current study, where participants received high scores for PTSD, depression and anxiety, yet were still managing to function well, for example attending school / college regularly.

Many questionnaires used with asylum-seeking and refugee populations have been developed using Western models of psychopathology, and are standardized with Western populations. In a review of 183 English-language published articles relating to refugee trauma and health status, only 12 measures were identified that had been specifically designed for refugee population, and none of these fulfilled all criteria in relation to purpose, construct definition, design, developmental process, reliability and validity (Hollifield et al., 2002).

An underlying difficulty with developing appropriate measures for refugee populations is that there is little agreement behind 'theory-based construct definitions' of impairment and diagnoses in culturally diverse refugee populations (Hollifield et al., 2002). Summerfield (1999) argues that psychological distress in asylum seekers and refugees is misinterpreted and distorted to fit Western psychiatric classifications such as ICD-10 and DSM-IV. Summerfield (1999) also noted that labelling psychological distress experienced by asylum seekers and refugees risks categorising understandable responses to abnormal and adverse events as pathological. Unfortunately this extensive debate is

too complex to address in the current paper, but reviews of the relevant issues are available elsewhere (Barenbaum, Ruchkin & Schwab-Stone, 2004; Hodes, 2000; Summerfield, 1999; Summerfield 2000). However, the debate is helpful in highlighting the need to consider cultural and social issues when interpreting results of psychopathology based on measures from Western cultures. For example, trying to 'actively forget' about bad memories is viewed in some cultures as a healthy way of dealing with bad experiences and memories (Burnett & Peel, 2001), yet according to Western models such behaviour may indicate symptoms that would be classified as PTSD symptoms of avoidance.

Research and consultation with community representatives will help clarify specific cultural reactions to war and conflict. However, estimates suggest that there have been at least 160 wars and armed conflicts in developing countries over the past 60 years (German, 2004). Therefore it is unlikely that researchers and therapists will be able to fully comprehend all of the culturally relevant reactions in asylum-seeking and refugee populations, coming from so many diverse countries. In such cases, questionnaires based on Western diagnostic systems can provide practioners with a useful place to begin in trying to understand a person's difficulties. However, professionals should remain open-minded and curious about exploring how such difficulties fit into the context of an individuals experiences, and where relevant and available, their cultural beliefs and norms.

The current study has emphasised the potentially important role that social support can play in psychological well-being of young unaccompanied asylum seekers and refugees. However, social support relies largely on interpersonal processes. As noted in the current study, cross-sectional research does not provide clarification that social support directly improves well-being. Highly functioning unaccompanied individuals may be able to access support more easily. In addition, youngsters who are perceived by others as being in greater need may actually attract more support resources. Prospective longitudinal studies are needed to help clarify the interaction between social support and well-being in this population.

Theoretically, it is possible to suggest that social support may benefit unaccompanied youngsters at both times of stress and stability, as they face the challenges of coming to terms with trauma, loss and bereavement and resettlements in a new country and culture. However, future research is required to further clarify the function of social support in this vulnerable group. Exploration of how unaccompanied youngsters access social support, the types of social support they find most helpful, and cultural and gender differences in utilising social support will be particularly valuable in informing service providers. Such research is also essential in order to identify and engage youngsters who find it difficult to benefit from social support, who perhaps due to early insecure attachment relationships, or because their trust in those around them has been shattered by war and conflict experiences, find it impossible to develop new relationships.

Despite many potential challenges, researchers should not be put off or shy away from conducting studies with unaccompanied asylum seekers and refugees. Such research is essential for guiding culturally sensitive support services which will be critical for the ongoing well-being of these youngsters. For some young people, taking part in the current study provided the first opportunity to talk about their past experiences without the pressure of it being part of their asylum claim. In fact, many of the participants were keen to share their experiences, and enjoyed the opportunity to talk about their home country and culture. As a researcher, it is an honour to share such stories, which although at times may be distressing, also serve to remind us of human strength, resilience and courage. Research studies can also play an important role in identifying and referring youngsters to appropriate services who may be in need of support but have been unable to access it. Finally, research is an excellent way of connecting various networks and services that are involved in the care of unaccompanied asylum seekers and refugees, in order to provide consistent, multi-disciplinary support to both youngsters and professionals alike.

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Appendices

APPENDIX 1: Abbreviations list

CAMHS	Child and Adolescent Mental Health Service (UK)
DOH	Department of Health (UK)
DSRS	Depression Self Rating Scale (Birleson, 1981)
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders - 4th Edition
ILR	Indefinite leave to remain
ICD-10	International Classification of Diseases - 10th Edition
M	Mean
MSPSS	Multi-dimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)
PTSD	Posttraumatic stress disorder
RSS	Received Social Support measure
RCMAS	Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978)
RIES	Revised Impact of Event Scale (Dyregrov & Yule, 1995)
SPSS	Statistical Package for Social Sciences
SD	Standard Deviation
TLR	Temporary leave to remain (includes exceptional leave to remain, discretionary leave to remain and humanitarian protection)
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
WTQ	War Trauma Questionnaire (Macksoud, 1992)

APPENDIX 2: Countries of origin / Languages of participants

Table 1: Home countries of participants

Country	*n*	%
Ethiopia	9	20
Eritrea	7	17
Congo	4	9
Somalia	4	9
Liberia	3	7
Uganda	2	5
China	2	5
Vietnam	2	5
Kosovo	2	5
Serbia	1	2
Angola	1	2
Mali	1	2
Nigeria	1	2
Sudan	1	2
Turkey	1	2
Albania	1	2
Colombia	1	2
Sri Lanka	1	2

Table 2: First language of participants

Language	*n*	%
Amharic	12	28
French	5	12
Albanian	4	9
Somali	4	9
Fullah	3	7
Tigrana	3	7
Mandarin	2	5
Vietnamese	2	5
Swahili	1	2
Lugana	1	2
Portuguese	1	2
Youbria	1	2
Arabic	1	2
Turkish	1	2
Spanish	1	2
Oromo	1	2
Tamil	1	2

APPENDIX 3: Information and consent forms

Information and consent form for children and young people

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

Information sheet for children and young people

Project to explore the well being and support of young people who have come to the UK as asylum seekers, without their parents or carer.

We would like to ask you to take part in this project.

What is the project about?
We would like to understand more about the experiences and well being of young people who have arrived in the UK as asylum seekers, without their parents or carer. We would also like to know what support is available to you, and how helpful this support is.

If I took part in this project, what would I have to do?
You would be asked some questions by a psychologist. This may take place at your school, college or home. It will take about an hour and a half to answer the questions. An interpreter who speaks your own language can help if you have problems understanding and speaking English. The questions will be about things that may have happened to you in your home country, or since you have been in the UK. You will also be asked how you are feeling, and what support you are receiving at the moment. You may find some of the questions upsetting. You can spend time talking to the psychologist about these things if you find it helpful. The information that you provide is anonymous and confidential, and will only be seen by the researchers working on the project. Participants will be given a small amount of money in recognition of their travel costs and time.

Do I have to take part in this project?
No, taking part in this project is entirely voluntary. You can decide not to take part at any time. You do not have to a give a reason why and it will not affect any help you may receive in the future, or any application for asylum.

What if I want to ask more questions about this project?
Please ask if you have any more questions. You can talk to Claire Arnold on 07968 847062 or Dr Stephen Butler on .

Many thanks for your help with this projec

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

Consent form for children and young people

Project to explore the well being and support of young people who have come to the UK as asylum seekers, without their parents or carer.

Please tick the following:

☐ I have read and understand the information sheet provided.

☐ I have had the opportunity to ask questions and discuss this project, and have received satisfactory answers to all my questions.

☐ I understand that I will be asked to fill in questionnaires during an interview with a psychologist that will last approximately one and a half hours.

☐ I understand that participation is voluntary, and that I can withdraw at any time without giving a reason and this will not affect my access to present or future services or treatment.

☐ I understand that the information I give is confidential and will only be seen by the research team, and that all responses I provide will be recorded anonymously.

☐ I understand that involvement in this study does not affect my asylum application in any way.

☐ I agree with the publication of the results of this study in an appropriate outlet / s.

Comment or concern during the study
If you have any comments or concerns you should discuss these with the Principal Researcher, Dr Stephen Butler. If you wish to go further and complain about any aspect of the way you have been approached or treated during the course of the study please write to The Graduate School, North Cloisters, Wilkins Building, UCL, Gower Street, London, WC1E 6BY, who will take the complaint forward as necessary.

Signature .....

Name printed .....

Date .....

Many thanks for your help with this project

Information and consent form for legal guardians

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

Information sheet for legal guardian

Project to explore the well being and support of young people who have come to the UK as asylum seekers, without their parents or carer.

We would like to ask your permission to invite a child for whom you / your organisation have legal responsibility, to participate in this project.

The aim of the study
The aim of this project is to investigate the experiences and psychological well-being of children and young people who have arrived in the UK as asylum seekers, without their parents or carer. The project will also investigate what social support is available to these young people, and how helpful they find this support.

How will the study be carried out?
Participants will be asked to complete some questionnaires in an interview with a trainee clinical psychologist, which will last for about an hour and a half. The questionnaires will ask about the young person's experiences in their home country and since arrival in the UK. Participants will also be asked about how they are feeling at present. Finally, the questionnaires will ask about what support is available from family, friends, professionals and support organisations, and how helpful this is perceived to be.
The interview can be arranged to take place at the young person's school, college or home. An interpreter will be available upon request. A small reimbursement in recognition of participants travel costs and time will be available.

What are the risks and discomfort?
Some people might find it difficult to talk about these issues. The interview timing can be flexible if extra time is needed to talk about upsetting experiences. If the psychologist thinks it may be helpful for a participant to receive extra support from a mental health professional, they will contact the GP or social worker to recommend a referral. The psychologist will not do this without discussing it with the participant first.
The psychologist who is interviewing the young person has undergone a satisfactory criminal records check, and the study has been approved by University College London's Committee on the Ethics of Non-NHS Human Research.

What are the potential benefits?
This study may enable the participant to talk confidentially about their experiences with a health professional in a way that they have not done before. It is hoped that it will be interesting and helpful for participants to think and talk about these issues in this way.
Participation in this project will also provide a better understanding of the experiences and difficulties of young asylum seekers who arrive in the UK without a parent or carer. This will help us plan psychological input and social support to meet the needs of other children and young people in similar situations.

Who will have access to the information that is provided?
Only the researchers working on the study will have access to the information that is provided. Any data collected from the young person will be collected and stored anonymously in accordance with the Data Protections Act 1998.

Does the child / young person have to take part in this study?
Participation in this project is entirely voluntary. If you or the participant decide, now or at a later stage, that you no longer wish to be involved in the project, that is your right and will not in any way prejudice any present or future access to a service or treatment. In addition, participation in the study or refusal to be involved, or withdrawal at a later stage will have no influence on any application for asylum.

Who can I talk to if I want more information about this study?
Please ask if you have any questions. You can talk to Claire Arnold on or Dr Stephen Butler on

Many thanks for your help with this project

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

Consent Form for legal guardian

Project to explore the well being and support of young people who have come to the UK as asylum seekers, without their parents or carer.

Please tick the following:

☐ I have read and understand the information sheet provided.

☐ I have had the opportunity to ask questions and discuss this project, and have received satisfactory answers to all my questions.

☐ I understand that the participant will be asked to fill in questionnaires during an interview with a psychologist that will last approximately one and a half hours.

☐ I understand that participation is voluntary, and that the participant can withdraw at any time without giving a reason and this will not affect their access to present or future services or treatment.

☐ I understand that the information given by the participant is confidential and will only be seen by the research team, and that all responses provided will be recorded anonymously.

☐ I understand that participation in this study does not affect asylum applications in any way.

☐ I agree with the publication of the results of this study in an appropriate outlet / s.

Comment or concern during the study
If you have any comments or concerns you should discuss these with the Principal Researcher, Dr Stephen Butler. If you wish to go further and complain about any aspect of the way you have been approached or treated during the course of the study please write to The Graduate School, North Cloisters, Wilkins Building, UCL, Gower Street, London, WC1E 6BY, who will take the complaint forward as necessary.

I give permission for ..... to take part in this project which explores the psychological well-being of unaccompanied minor asylum seekers and refugees, and the social support available to them.

Legal Guardian's Signature .....

Name printed .....

Relationship to participant .....

Date .....

Many thanks for your help with this project

APPENDIX 4: Letters of ethical approval

Institute of Psychiatry

Ethical Committee
(Research)
Research Ethics Co-ordinator
Margaret M Chambers Msc

P006, Room W109
De Crespigny Park
Denmark Hill
London SE5 8AF

at The Maudsley

KING'S College LONDON

ETHICAL COMMITTEE (RESEARCH)

2 June 2004

Dr I Sclare
Child and Adolescent Psychiatry
Michael Rutter Centre
Maudsley

04 JUN 2004

Dear Dr Sclare

Re: Exposure to traumatic events and social support: the impact on psychological well-being of unaccompanied minor asylum seekers and refugees

At its meeting on 21 May 2004, the Ethical Committee (Research) considered and confirmed Chair's action to approve Study from an ethical point of view.

Yours sincerely

Margaret M Chambers
Research Ethics Co-ordinator

The Graduate School
University College London
Gower Street London WC1E 6BT

***Professor* Leslie C Aiello**
Head of the Graduate School

15 October 2004

Dear Ms Arnold

Re: Notification of Ethical Approval

Exposure to traumatic events and social support: The impact on psychological well being of unaccompanied minor asylum seekers and refugees

Thank you for satisfactorily addressing the remarks made by the UCL Committee for the Ethics of non-NHS Human Research. The research has now been given ethical approval for the duration of the project (October 2004 – October 2005) subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: http://zzz.grad.ucl.ac.uk/ethics/ and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

   Reporting Non-Serious Adverse Events.
   For non-serious adverse events you will need to inform Ms Helen Dougal, Ethics Committee Administrator (h.dougal@ucl.ac.uk), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events
The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

3. On completion of the research you MUST submit a brief report (maximum of two sides of A4) of your findings to the Committee. Please comment in particular on any ethical issues you might wish to draw to the attention of the Committee. We are particularly interested in comments that may help to inform the ethics of future similar research.

Yours sincerely

Sir John Birch
Chair of the UCL Committee for the Ethics of Non-NHS Human Research

Cc: Dr Stephen Butler, Sub-Department of Clinical Health Psychology, UCL

APPENDIX 5: Questionnaire booklet

Unaccompanied asylum-seeking and refugee youngsters
D.Clin.Psych Research Project

1. Your sex **Boy** **Girl**

2. Your age **.....years old** **.....DOB**

3. What country do you come from?

4. What languages do you speak?

5. When did you come to England (Date/Month/Year)?

6. What is your current asylum status?

   Awaiting decision ☐ Negative decision and appeal ☐

   TLR until 18 years ☐ ILR ☐ Humanitarian / DL ☐

   Other _____

7. Where do you live at the moment?

   With a Foster Carer ☐ Hostel ☐ B&B ☐

   Shared house with other young people ☐

   Other _____

8. Date of interview _____

RSSQ

1.	I have a foster carer	**YES**	**NO**	**N/A**
2.	There is an adult who lives with me or works in my home, who helps to take care of me Please specify	**YES**	**NO**	**N/A**
3.	A member of my family lives in the UK	**YES**	**NO**	**N/A**
4.	I am in contact with a family member E.g. by telephone, post, e-mail	**YES**	**NO**	**N/A**
5.	I have a social worker	**YES**	**NO**	**N/A**
6.	I have a solicitor	**YES**	**NO**	**N/A**
7.	I have been offered help from a family tracing service e.g. Red Cross	**YES**	**NO**	**N/A**
8.	I am registered with a GP	**YES**	**NO**	**N/A**
9.	I have seen a mental health professional E.g. Psychiatrist, psychologist, mental health nurse	**YES**	**NO**	**N/A**
10.	I have been offered a school / college place	**YES**	**NO**	**N/A**
11.	I have been offered lessons to learn English	**YES**	**NO**	**N/A**
12.	I have a Connexions Advisor	**YES**	**NO**	**N/A**
13.	I have at least one friend that I can talk to if I am feeling troubled	**YES**	**NO**	**N/A**
14.	I have at least one friend from my home country	**YES**	**NO**	**N/A**
15.	I go to the Refugee Council	**YES**	**NO**	**N/A**
16.	I go to other refugee support groups in my local area e.g. Albanian Youth Action	**YES**	**NO**	**N/A**
17.	I attend a youth group (E.g. drama, art)	**YES**	**NO**	**N/A**
18.	I attend a sports club	**YES**	**NO**	**N/A**
19.	I go to a place to practice my faith (E.g. Mosque, Church)	**YES**	**NO**	**N/A**
20.	I attend a religious group e.g. Bible Study Group, Church / Mosque Youth Group?	**YES**	**NO**	**N/A**

MSPSS

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the '1' if you **Very Strongly Disagree**
Circle the '2' if you **Strongly Disagree**
Circle the '3' if you **Mildly Disagree**
Circle the '4' if you are **Neutral**
Circle the '5' if you **Mildly Agree**
Circle the '6' if you **Strongly Agree**
Circle the '7' if you **Very Strongly Agree**

1. There is a special person who is around when I am in need	1	2	3	4	5	6	7
2. There is a special person with whom I can share my joys and sorrows	1	2	3	4	5	6	7
3. My family / foster carer / social worker really tries to help me	1	2	3	4	5	6	7
4. I get the emotional help and support I need from my family / foster carer / social worker	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me	1	2	3	4	5	6	7
6. My friends really try to help me	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong	1	2	3	4	5	6	7
8 . I can talk about my problems with my family / foster carer social worker	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings	1	2	3	4	5	6	7
11. My family / foster carer / social worker is willing to help me make decisions	1	2	3	4	5	6	7
12. I can talk about my problems to my friends	1	2	3	4	5	6	7

WTQ

About Things That Might Have Happened During The War*

* For the purpose of the current project the term 'War' may be used to refer to any period of violence or unrest which led the child or young person to flee their native country

Home and possessions

1. Was your home seriously damaged during the war?	YES	NO
2. Were you forced by violence or threat of violence, to leave your home?	YES	NO
3. Were things stolen from you or your family?	YES	NO

Threat or harm to loved ones

4. During or after your travel out of *(native country)*, was a family member or close friend missing or unaccounted for?	YES	NO
5. During the war, did someone threaten to seriously hurt or kill a family member or very close friend?	YES	NO
6. During the war, was anyone in your family or close friends hurt?	YES	NO
7. Was anyone in your family taken away to a camp or prison during the war?	YES	NO

Direct physical contact with danger

8. During the war, were you ever so hungry that you thought you would die?	YES	NO
9. Were you ever so cold during the war that you thought you would die?	YES	NO
10. Were you physically assaulted during the war? (someone hit or kicked you, or hit you with an object)	YES	NO
11. Were you ever arrested, taken prisoner, or confined in a Detention camp or Rebel camp during the war?	YES	NO
12. Were you ever seriously injured during the war?	YES	NO

Witnessing violence

13. Did you see the massive destruction of property, such as seeing bridges or buildings being burned or shelled?	YES	NO
14. Did you see shooting from a very close distance?	YES	NO
15. Did you see looting, burglary, or serious vandalism of property?	YES	NO

16. Did you someone who was severely injured? YES NO

17. Did you see any dead bodies? YES NO

18. Did you see anyone being killed or severely injured? YES NO

19. Did you see many people being killed at once (a massacre)? YES NO

20. Did you witness someone being taken prisoner by soldiers? YES NO

Physical threat

21. Were you ever shot at or seriously hurt? YES NO

22. Did a grenade or bomb ever land so close to you that you could have been seriously hurt or killed? YES NO

23. Did soldiers or men with guns come to your home? YES NO

24. Did anyone personally threaten to kill or seriously hurt you? YES NO

25. Was there ever a time during the war when you strongly believed that you would be seriously hurt or killed? YES NO

Losses

26. Was your father killed in the war? YES NO DK

If you know that your father is alive, do you know where he is now? YES NO

27. Was your mother killed in the war? YES NO DK

If you know that your mother is alive, do you know where she is now? YES NO

28. Was a brother or sister killed during the war? YES NO DK

If you know that your brother(s) or sister(s) are alive, do you know where they are now? YES NO

29. Was a close member of your extended family (grandparent, aunt, uncle or cousin) killed during the war? YES NO

30. Was a close personal friend killed during the war? YES NO

Revised Impact of Event Scale (13-item version)

Below is a list of comments made by people after stressful life events. Please check each item indicating how frequently these comments were true for you DURING THE PAST SEVEN DAYS. If they did not occur during that time, please mark the 'not at all' column.

During the last 7 days	Not at all	Rarely	Sometimes	Often
1.Do you think about it even when you don't mean to? (Int)				
2. Do you try to remove it from your memory? (Av)				
3. Do you have difficulties paying attention or concentrating? (Ar)				
4. Do you have waves of strong feelings about it? (Int)				
5. Do you startle more easily or feel more nervous than you did before it happened? (Ar)				
6. Do you stay away from reminders of it (e.g. places or situations)? (Av)				
7. Do you try not to talk about it? (Av)				
8. Do pictures about it pop into your mind? (Int)				
9. Do other things keep making you think about it? (Av)				
10. Do you try not to think about it? (Av)				
11. Do you get easily irritable? (Ar)				
12. Are you alert and watchful even when there is not obvious need to be? (Ar)				
13. Do you have sleep problems? (Ar)				

DSRS - 18 items

The statements below refer to how you have felt over the past week. There are not right answers but it is important to say how you have felt. Please answer as honestly as you can. Put a tick in the appropriate box.

During the last week	Most	Sometimes	Never
1. I look forward to things as much as I used to			
2. I sleep very well			
3. I feel like crying			
4. I like to go out to play / socialise			
5. I feel like running away			
6. I get stomach aches			
7. I have lots of energy			
8. I enjoy my food			
9. I can stick up for myself			
10. I think like isn't worth living			
11. I am good at things I do			
12. I enjoy the things I do as mush as I used to			
13. I like talking with my family / foster carer / social worker			
14. I have horrible dreams			
15. I feel very lonely			
16. I am easily cheered up			
17. I feel so sad I can hardly stand it			
18. I feel very bored			

RCMAS - 28 items

1. I have trouble making up my mind	YES / NO
2. I get nervous when things do not go the right way for me	YES / NO
3. Others seem to do things easier than I can	YES / NO
4. Often I have trouble getting my breath	YES / NO
5. I worry a lot of the time	YES / NO
6. I am afraid of a lot of things	YES / NO
7. I get upset and angry easily	YES / NO
8. I worry about what my social worker / foster carer will say to me	YES / NO
9. I feel that others do not like the way I do things	YES / NO
10. It is hard for me to get to sleep at night	YES / NO
11. I worry about that other people think about me	YES / NO
12. I feel alone even when there are people with me	YES / NO
13. Often I feel sick in my stomach	YES / NO
14. My feelings get hurt easily	YES / NO
15. My hands feel sweaty	YES / NO
16. I am tired a lot	YES / NO
17. I worry about what is going to happen	YES / NO
18. Other people are happier than I am	YES / NO
19. I have bad dreams	YES / NO
20. My feelings get hurt easily when I am fussed at	YES / NO
21. I feel someone will tell me that I do things the wrong way	YES / NO
22. I wake up scared some of the time	YES / NO
23. I worry when I go to bed at night	YES / NO
24. It is hard for me to keep my mind on my school / college work	YES / NO

25. I wiggle in my seat a lot	YES / NO
26. I am nervous	YES / NO
27. A lot of people are against me	YES / NO
28. I often worry about something bad happening	YES / NO

APPENDIX 6: Normality of key variables

Table 1: Normality of key variables

	Prior to transformation		After transformation (if applicable)	
Variable	Kolmogorov Smirnov	*P*-Value	Kolmogorov Smirnov	*P*-Value
RIES	.062	.200	-	-
RCMAS	.148	.017	-	-
DSRS	.134	.046	.094	.200
WTQ	.102	.200	-	-
ASS	.147	.018	.101	.200
MSPSS	.119	.126	-	-

- Did not need transforming

APPENDIX 7: Case studies

Vignette 1

S is a 16-year-old boy from Liberia who arrived in the UK in March 2004. During the war in his home country, S witnessed extreme violence, including a massacre of 'many people', and the destruction of homes and buildings. S also experienced direct violence, sustaining a head injury. S's father and younger brother were killed during the war. S fled his home for fear that militia fighters would try and force him to join them and fight against his own people. S left behind his mother, and has had no contact with her since. He fears that she may have been killed after his departure. S described himself as being 'lucky', as he met a British journalist who had helped him flee Liberia by paying for his flight and escorting him to the UK. On arrival in the UK, the journalist took S to a social services office in South London, who provided legal support and emergency accommodation in a hostel. S has now been granted temporary leave to remain in the UK until his 18th birthday. S has a social worker who he describes as being very supportive and like a 'friend'. He is now housed in independent accommodation with other unaccompanied minor asylum seekers. S stated that he was glad he could speak English before he arrived in the UK, as he feels it would have been very difficult to know what was going on otherwise. S attends college 5 days a week, which he finds enjoyable. However, S's greatest love is football. His social worker had provided S with details of a local team who had been impressed with his ability, and had asked him to attend trials for a professional team. S was extremely excited about this, but was worried about what would happen to his football career if he was returned to Liberia.

Vignette 2

B is a 17-year-old female from Mali. She had come to the UK in January 2004 with a family friend whom she was no longer in touch with. B explained that she had been forced to leave Mali following the death of her boyfriend. B is a Muslim, and her boyfriend had been a Christian, which had caused them great difficulty such as the disownment by her father. B had been with her boyfriend when he was beaten to death by people who did not approve of relationships between individuals from different religious groups. B had also been badly beaten at this time. B has claimed asylum in the UK on the basis of religious persecution, and has been grated temporary leave to remain until she is 18. She is living in a hostel and attends a local college. B explained that her 14-year-old sister had recently arrived in the UK as an asylum seeker, and was now living a few miles away in foster care. B said that it was wonderful to see her younger sister again. However, her younger sister who had also fled due to religious persecution told her that their mother had been murdered. Understandably, B was extremely distressed about her mother's death, which was exacerbated by feelings of guilt as she felt that her relationship with a Christian may have contributed to her killing. B was struggling to come to terms with the deaths of both her boyfriend and mother. She had not received any bereavement counselling, but was keen to receive support from a mental health professional to help her manage her difficult feelings.

Vignette 3

K is an 18-year-old female from Ethiopia, who arrived in the UK in October 2003. K described being at home with her family when men with guns came to her house. K was badly beaten and sexually assaulted by the soldiers, and her younger sister was taken away. K's parents paid for her to be escorted out of Ethiopia by an 'agent', as they found out that their youngest daughter had been killed, and feared for K's safety. K has had no contact with her parents since her departure from Ethiopia, and does not know whether they are safe. On arrival in the UK, the agent took K to a café in North London. The agent informed her that he was 'popping out' to make a phone call, but did not return. Whilst in the café, K overheard two women speaking Amharic, her native language, and approached them to ask for help. As it was late in the evening, one of the women took her to her home and allowed her to stay overnight. The following day, the woman took her to a local refugee support organisation, which helped her obtain support from social services and claim asylum. K was granted temporary leave to remain in the UK until her 18th birthday. When she turned 18 K reapplied for asylum, but was refused leave to remain. She is currently in the process of appealing against this decision. K does not want to return to Ethiopia. She said that she is scared of what may happen to her, and of finding out that her parents have been killed. K said that she has now started to make a life for herself in the UK, with friends and attending college.

K had been living in a shared flat with other young asylum seekers which was provided through social services. However, when she turned 18 her support was transferred to the National Asylum Support Service which meant she had to move to new accommodation.

K was upset that she had had to move away from her friends, but was also concerned that she was finding it very difficult to walk up the four flights of stairs to the new flat due to a back injury that she sustained during the assault in Ethiopia. In addition to back pain, K explained that she often had difficulty going to the toilet and had not had a period since the time of the attack. Although K had been in the UK for about 18 months, she was only just having medical investigations. K stated that it had been hard to explain to her GP what was wrong, and that she had been ashamed about how the injuries had occurred. K suffered extreme symptoms of PTSD, depression and anxiety, and was on a waiting list to be seen by a mental health professional.

Vignette 4

V is a 17-year-old Vietnamese female, who has been living in South London since June 2003. V's parents had been killed in a motor traffic accident in Vietnam in 2002. V, who is an only child, had gone to live with her uncle and his family. After 1 year, V's uncle told her that he was arranging for her to move to the UK so that she could obtain a good education. V's uncle escorted her to the UK, where she was left in the care of another 'uncle'. V said that this second 'uncle' had forced her to have sex with strange men, which she had not liked. V did not explain how she managed to leave the second uncle's house, but stated that someone she met took her to a social services department. V had applied for asylum, and had been giving temporary leave to remain until her 18th birthday. V said that she lived in a hostel with other asylum seekers, which was ok but very noisy. V said that she did not mind looking after herself, but wished that someone would help her with the cooking as she was not familiar with British cuisine. V attended college, where she was studying English, maths and information technology. V said that she had made some good friends at school, who she enjoyed going shopping with as she loved looking at clothes and jewellery. V said that she did not want to return to Vietnam, at least not for many years, as she had no trustable family to return too. She said that she still felt very sad about the death of her parents, and wished that they were around to look after her. V said that she now felt foolish to have agreed to leave Vietnam with her uncle, especially as she had initially been very excited about the prospect of coming to the UK.

Vignette 5

C is a 17-year-old male from China, who had arrived in the UK in July 2003. C, who is a Christian, said that he had to leave China following the imprisonment of his parents due to their religious beliefs. C, an only child, described in detail the day that he came home from school to find that his parents had been arrested. He explained that many people in China were imprisoned for their religious beliefs, and he had been advised in advance by his parents, that he should come to the UK should this happen to them. C travelled to the UK alone, and informed a staff member at Heathrow airport that he needed to claim asylum. He was interviewed by staff and then taken to a social services office, where he obtained legal support and emergency accommodation in a hostel. C has been granted temporary leave to remain in the UK until he is 18. Since arrival in the UK, C has lived in 4 different hostels. He now lives in a house with other young asylum seekers, including 2 other youngsters from China. C, who attends a local college, stated that he spends a lot of time studying as he is keen to get the most from his education. He said that he was very pleased to have progressed to the top class for English, and was hoping to go on and attend university. C also said that he spent a lot of time praying at his local Church. He said that he had met many kind people at the Church, and that God had been his greatest source of comfort since his arrival in the UK. He had not been in contact with his parents since he left China. However, he believed that they were likely to still be in prison, and had contacted the Red Cross for assistance in tracing them.