Surviving, Striving, and Thriving: A Qualitative Study with former Refugees and their Service Providers in Australia

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Abstract

Over the years, the major focus of refugee mental health has been on trauma and psychopathology. Research has reported varying rates of psychiatric disorders among refugees including elevated rates of PTSD compared with the general population in resettlement countries (Beiser, 2014; Fazel, Wheeler, & Danesh, 2005; Steel et al., 2009).

More recently, there has also been growing research interest in the resilience, coping and successful adaptation of refugees mainly because the vast majority of refugees in resettlement countries successfully overcome past adversity, manage post-migration stressors, and adapt to their host environments (Simich, 2014).

Accordingly *Research Project I* explored the coping resources and strategies of refugees to overcome past and ongoing distress; and how they find meaning in their life experiences. *Research Project II* explored the experiences of service providers working with refugees and asylum seekers. In *Research Project I* (*empirical studies 1 and 2*), I used qualitative narrative methods (Riessman, 2008; Squire, 2008) to collect and analyse life narratives of 25 former refugees of two African communities (i.e. Sierra Leonean and Burundian) living in the Australian state of South Australia. *Research Project II* (*empirical studies 3 and 4*) was conducted with a cross section of 28 physical healthcare, mental health and resettlement workers; I systematically analyzed service providers’ interviews using a thematic qualitative method (Braun & Clarke, 2006, 2013).

In the first empirical study (*Chapter 3*) I identified ‘altruism and helping’ as a prominent and recurring pattern in refugee life narratives. ‘Altruism and helping’ was encapsulated in four subthemes: (1) surviving war and exile; (2) adapting to Australian society; (3) reaching back home; and (4) meaning-making through religious beliefs.
Past research has indicated that altruism and helping behaviours can be prompted by positive experiences preceding or following adverse life experiences together with psychological reactions such as empathy, identification with others’ suffering and a sense of social responsibility (ABS; Hernández-Wolfe, 2011; Staub & Vollhardt, 2008; Vollhardt & Staub, 2011). However no study had explored the significance of altruism and helping among refugee populations.

Study findings demonstrated how participants reached out to help others both individually and collectively, prompted by the help they themselves had received in times of need. Supportive family relationships, communal spirit within collective societies and ‘learning by doing’; together with empathy, identification, and a sense of responsibility for the welfare of family, community and friends also promoted altruism. Helping, cooperating and sharing were entwined with participants’ coping strategies and meaning-making of past and present experiences (e.g. via religious beliefs/ spirituality).

In the second empirical study (Chapter 4) I observed how refugees talked about past trauma and strove to make meaning of their past, present and future lives. Previous research has shown that people made sense of their life experiences—especially after disruptions to life—through the stories they told, including the ‘silences’ and incomplete narrative segments within those stories (Ghorashi, 2008; Riessman, 2008; Sorsoli, 2010; Squire, 2008).

Accordingly, I identified salient differences between the stories shared by the two refugee communities: whereas Sierra Leonean stories were evenly distributed along their life storyline and contained fully-formed narratives of all stages of their narrated lives from home to host country; Burundian narratives were largely silent about life in the home country. Five narrative types were also identified along a continuum from detailed
disclosure to near-complete silence about past trauma: (1) avoiding narratives; (2) struggling narratives; (3) prompted narratives; (4) narratives exceeding demarcated boundaries of disclosure; and (5) returning narratives. I analyzed the personal, interpersonal, sociocultural and historical influences together with the differences in narrative structure and content to offer several hypotheses as to how participants engaged in identity reconstruction and meaning-making through the stories they told.

In the third empirical study (Chapter 6) I identified vicarious resilience (VR) and vicarious traumatization (VT) together with work satisfaction and cultural flexibility as prominent and recurring themes of service provider interviews. VT is the negative psychological impact of trauma work (McCann & Pearlman, 1990a) whereas VR, a more recent concept, indicates the positive consequences to workers of identifying with the strength, growth and empowerment of traumatized clients (Engstrom, Hernández, & Gangsei, 2008; Hernández, Gangsei, & Engstrom, 2007). Few if any studies have inquired into VT and VR in a cross section of service providers working with refugees and asylum seekers.

The fourth analytic study (Chapter 7) was an exploration into how service providers ameliorated their clients’ psychological trauma and eased their ongoing distress. The identified themes were: (1) establishing safety, trust and connection; (2) talking about trauma (3) working with silences and (4) promoting coping and growth. Service providers described the importance of establishing a trusting relationship with clients and the innovative strategies they used to work with clients who were reluctant or unable to talk about traumatic experiences (e.g. drumming, art, theatre). The study also described how participants explored, promoted and enhanced the resilience, strengths and capacity of clients based on a strengths-based model of therapeutic intervention.
*Research Project I* findings with refugees were to a large extent triangulated by the findings of *Research Project II* with service providers. Together both Research Projects supported the meta-theme of this thesis: the importance of moving beyond the negative focus on refugee people, for service providers, policy makers, and others, to take advantage of their tremendous capacity: to heal from past trauma, to utilize their unique coping strategies, to reach out to others and make meaning, to experience growth and to inspire their service providers.
Declaration

I, Teresa Puvimanasinghe, certify that this work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will in the future, be used in a submission for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide.

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Teresa Puvimanasinghe: Date: 15/6/2014
List of Publications

Publications are listed in order of appearance in this dissertation.


Statement of Contributions on Jointly Authored Papers

**Title of Paper 1:** ‘Giving back to society what society gave us’: Altruism, coping and meaning-making by two refugee communities in South Australia.
Publication Status: Published.
Co-Authors: L. A. Denson, M. Augoustinos, D. Somasundaram

**Title of Paper 2:** Narrative and silence: How former refugees talk about loss and past trauma.
Publication Status: Published.
Co-Authors: L. A. Denson, M. Augoustinos, D. Somasundaram

**Title of Paper 3:** Vicarious resilience and vicarious traumatization: Experiences of working with refugees and asylum seekers in South Australia.
Publication Status: Accepted for Publication.
Co-Authors: L. A. Denson, M. Augoustinos, D. Somasundaram

**Title of Paper 4:** Talking therapies and therapeutic silences: Working with refugees and asylum seekers in South Australia.
Publication Status: Text in Preparation; to be submitted for publication.
Co-Authors: L. A. Denson, M. Augoustinos, D. Somasundaram
Contributions: I was responsible for initiating the aforementioned studies; after consultations with supervisors (the co-authors), as well as key informants from refugee communities and service providers at resettlement, mental health and healthcare agencies in South Australia. I was also responsible for the study design, literature searches, data collection, data analysis and interpretation; and manuscript preparation. All co-authors acted in a supervisory capacity during all stages of this research and manuscript preparation. Preparation of manuscripts was also assisted by the recommendations of the anonymous Reviewers of Journal manuscripts presented in Chapters 3, 4, and 6.

The undersigned agree that the aforementioned statements regarding author contributions are accurate and true:

L. A. Denson: Date: 12/6/2014

M. Augoustinos: Date: 12/6/2014

D. Somasundaram: Date: 12/6/2014
Permission to use Published Papers

Chapter 3

I give permission for the following publication to be included in Teresa Puvimanasinghe’s Thesis:


L. A. Denson: Date: 12/6/2014
M. Augoustinos: Date: 12/6/2014
D. Somasundaram: Date: 12/6/2014

Chapter 4

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L. A. Denson: Date: 12/6/2014
M. Augoustinos: Date: 12/6/2014
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Chapter 6

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M. Augoustinos: Date: 12/6/2014
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Chapter 7

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D. Somasundaram: Date: 12/6/2014
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Abbreviations and Acronyms

ABS – Altruism Born of Suffering

ACHR – Australian Commission of Human Rights

ACT – Acceptance and Commitment Therapy

AMHOCN – Australian Mental Health Outcomes and Classification Network

AMR – Applied Muscle Relaxation

BF – Biofeedback

BV – Bridging Visa

CA-CBT – Culturally Adapted Cognitive Behaviour Therapy

CBT – Cognitive Behaviour Therapy

CaLD – Culturally and Linguistically Diverse

DA – Discourse Analysis

DESNOS -- Disorders of Extreme Stress Not Otherwise Specified

DIAC – Department of Immigration and Citizenship

DIBP – Department of Immigration and Border Protection

EMDR – Eye Movement Desensitizing and Reprocessing

GAD – Generalized Anxiety Disorder

GP – General Practitioner
HRW – Human Rights Watch

HSS – Humanitarian Settlement Services

ICIB – International Commission of Inquiry for Burundi

IDP – Internal Displaced Person

IPA – Interpretative Phenomenological Analysis

IPT – Interpersonal Psychotherapy

IPV – Intimate Partner Violence

K-10 – Kessler-10

KIDNET – Narrative Exposure Therapy for children

MDD – Major Depressive Disorder

NET – Narrative Exposure Therapy

NGOs – Non Governmental Organizations

PPV – Permanent Protection Visa

PTG – Post Traumatic Growth

PTSD – Post Traumatic Stress Disorder

QMHS – Queensland Multicultural Health Services

RCOA – Refugee Council of Australia

SA – South Australia
SBS – Special Broadcasting Service

SGP – Settlement Grants Program

SLTRC – Sierra Leonean Truth and Reconciliation Commission

TAU – Treatment As Usual

TIS – Translating and Interpreting Service

TPV – Temporary Protection Visa

THCV – Temporary Humanitarian Concern Visa

TT – Testimony Therapy

UNDP – United Nations Development Program

UNHCR – United Nations High Commission for Refugees

V-PTG – Vicarious Post Traumatic Growth

VR – Vicarious Resilience

VT – Vicarious Trauma

WHOQOL – World Health Organization Quality of Life
Chapter 1. Background, Aims and Overview

Chapter contents

1.1 Introduction
1.2 Thesis overview
1.3 The global refugee crisis and Australia’s humanitarian response
1.4 The refugee experience
1.5 Resilience, adaptation and coping
1.6 Meaning-making to posttraumatic growth
1.7 Altruism born of suffering
1.8 Aims and objectives

1.1. Introduction

I begin this chapter with an overview of the eight chapters contained in this thesis; followed by an introduction to the prevailing global situation with regards to refugees and Australia’s response to its obligations under the Refugee Convention of 1951. I set out early refugee mental health research that focused on the psychiatric consequences of past traumatic experiences; gradually moving towards the recognition that refugees are negatively impacted by both past trauma and post-migration resettlement stressors. I discuss more recent research exploring refugees’ resilience, coping and meaning-making. Thereafter two potential areas of interest, investigated with other populations but rarely with refugees, are discussed; namely, posttraumatic growth and altruism born of suffering. I conclude the chapter by setting out the aims and objectives of my thesis.

Taking Mum’s hand, I whispered ‘Are we really safe, here?’

1.2. Thesis overview

In Chapter 1, I introduce the global refugee crisis and Australia’s treatment of refugees and asylum seekers. Thereafter I offer an overview of the literature and theory relating to refugee trauma including research findings indicating that a considerable proportion of refugees are not diagnosed with psychopathology such as PTSD and depression (e.g. Fazel et al., 2005; Steel et al., 2009). Also included in the chapter is a comprehensive literature review on resources and strategies utilized by diverse refugee groups to reduce, manage or alleviate their trauma and distress (i.e. coping). There is also an introduction to several related theoretical concepts such as posttraumatic growth and altruism born of suffering followed by the aims and objectives of the thesis.

In Chapter 2, I afford a brief overview of the advantages and disadvantages of the methodologies used in refugee research including the importance of ensuring cultural appropriateness in research. The narrative method (cf. Riessman, 2008; Squire, 2008), utilized in the two empirical studies presented in Chapters 3 and 4, and the thematic analysis method (Braun & Clarke, 2006, 2013) utilized in the two empirical studies detailed in Chapters 6 and 7, are elaborated. Next, participants’ characteristics as well as the method and procedure adopted when conducting research are described followed by an introduction to the context of participant communities namely, the Sierra Leonean and Burundian communities living in South Australia. I conclude the chapter with some personal reflections about my sociocultural and historical background that could have influenced data collection and research findings.

Chapters 3 and 4 contain empirical studies. Chapter 3 includes an exploratory study utilizing experience-centred narrative methodology to explore how refugees from the Sierra Leonean and Burundian communities in South Australia cope with their past and
present distress. Altruism born of suffering was an unexpected finding of this study. Accordingly I have analyzed how altruism and helping were encompassed within participants’ experiences of surviving war and exile; adapting to Australian society; reaching back home; and meaning-making through religious beliefs. I have also discussed how altruism and coping were entwined with participants’ efforts to make meaning of their past and present experiences.

Chapter 4 contains a second study also using narrative methodology to explore how people from the Sierra Leonian and Burundian communities used different types of narratives including silences and fragmented narrative segments to talk about their loss and past trauma. I highlight a salient group difference between the narratives of the two communities, with regard to narrative content and structure; as well as individual differences between participants’ narratives that could be ordered on a continuum from near-complete silence to complete narration of trauma related experiences.

Chapter 5 begins with an overview of the literature regarding working with refugee populations including the experiences of diverse groups of service providers – doctors, psychologists, counsellors, social workers, and case workers. I also describe vicarious resilience (Hernandez, Gangsei, & Engstrom, 2008) and vicarious traumatization (Pearlman & McCann, 1990) and review the literature regarding these concepts. I then present a summary of some of the salient therapeutic interventions found to be effective with refugees or indicating future potential. I conclude the chapter with the aims and objectives of the empirical studies present in Chapters 6 and 7.

Chapters 6 and 7 report two empirical studies conducted with service providers to refugees and asylum seekers in South Australia. Chapter 6 contains the findings of a qualitative study exploring the experiences of vicarious resilience and vicarious
traumatization—which emerged as major themes—of the interviews with 26 healthcare, mental health and resettlement workers assisting refugees and asylum seekers in South Australia. Included is an exploration of the reciprocal relationship experienced by service provider participants in the context of empowering and being empowered by clients; learning from clients’ stories of perseverance, strength and growth; reconnecting and bonding. I also explore two additional emergent themes—service providers’ work satisfaction and the cultural flexibility required to work in this field. Study findings thus supported the empirical studies in Chapters 3 and 4 regarding the enormous potential of refugee people to adapt, grow, and furthermore to inspire their service providers.

**Chapter 7** contains a second study conducted with service providers to refugees and asylum seekers. In this fourth empirical study, I explore the different interventions and other devices utilized by service providers to reduce, manage, or alleviate the trauma and distress of their refugee clientele. Specifically emphasized are the benefits and limitations of traditional talk therapies and the alternatives to verbalization used by service provider participants when talk therapies are less effective. Additionally I explore how workers utilize and promote the coping resources and strategies of their refugee clientele, thereby triangulating the findings of Chapters 3 and 4 as well as past literature regarding a range of coping devices utilized by refugees from diverse communities.

In **Chapter 8**, I include a summary of the results of the empirical studies presented in Chapters 3, 4, 6, and 7; including how **Research Project I** (Chapters 3 and 4) with the refugee communities complements and triangulates many findings from **Research Project II** (Chapter 6 and 7) with service providers. Methodological limitations of the empirical studies are discussed followed by the many implications of study findings for policy, service provision and future research. I conclude the chapter by emphasizing the overall theme running through the entirety of this thesis: the importance of moving beyond the
negative focus on refugee people, for policy makers, service providers and others, and
taking advantage of their tremendous capacity: to heal from past trauma, to benefit from
their unique coping devices, to reach out to others and make meaning, to experience
growth and to inspire their service providers.

1.3. The global refugee crisis and Australia’s humanitarian response

1.3.1 Global refugee crisis

At the end of 2012, 45.2 million people worldwide had been displaced including 15.4
million refugees and almost one million asylum seekers according to the United Nations
High Commission for Refugees (UNHCR, 2013). The vast majority of people forced from
their homes and their communities (i.e. 28.8 million) continued to be displaced within their
countries of origin. Referred to as internally displaced persons (IDPs), their plight in most
situations was as dire as or worse than those who had crossed State boundaries (UNHCR,
2013). Some lived as stateless people, or were refugees who had voluntarily returned to
their home countries but continued to be displaced.

According to Article 1 of the Convention relating to the Status of Refugees (1951;
Refugee Convention), ‘a refugee’ is defined as:

Any person who has 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.

State signatories to the Refugee Convention\(^1\) have agreed not to penalize refugees for entering their territories without the requisite entry permits if they present themselves to the authorities and show that there is a serious threat to their life (Article 31(1)). State parties to the Convention have also agreed not to expel or return anyone having a reasonable fear of persecution on grounds of race, religion, political opinion and so forth, to their countries of origin where their lives could be in jeopardy (Article 33(1)). This is in keeping with the international law principle of non-refoulment. Australia voluntarily signed the Refugee Convention on 22 January 1954, and its 1967 Protocol, thereby agreeing to abide by all the stipulations in the Convention.

The UNHCR advocates one of three solutions to the global refugee crisis: voluntary repatriation of refugees back to their countries of origin, integration into the communities and countries where they first sought asylum, or resettlement in a third country. Resettlement is considered the most durable but also the most costly; hence only a small proportion of the total number of people seeking refuge is offered resettlement. During 2012, approximately 88,600 of the 15.4 million refugees worldwide had been resettled into 22 countries including the United States that accepted 66,300 refugees, followed by Canada (9,600), Australia (5,900) and Sweden (1,900). Meanwhile, more than 80 percent of refugees remained in refugee camps or other temporary accommodation in developing

\(^1\) Currently 145 countries have signed the Refugee Convention (UNHCR, 2013).
countries such as Pakistan, the country hosting the largest number of refugees in the world (UNHCR, 2013).

1.3.2 Australia’s humanitarian program

**Refugee intake.** Australia has a humanitarian program comprising offshore and onshore components. The offshore component offers resettlement to people who are overseas, who apply, and are selected to be resettled in Australia (Department of Immigration and Citizenship (DIAC), 2013a). The onshore component affords the opportunity for people to seek asylum after arriving in Australia. According to Refugee Convention provisions Australian authorities are required to assess asylum seekers’ claims and offer resettlement to anyone found to be a refugee. Since July 1996, the offshore and onshore components have been integrated, reducing the number of people resettled from overseas because for every extra place offered under the onshore program, one less place has been made available under the offshore program (Refugee Council of Australia (RCOA), 2013). In 2012-13, subsequent to the recommendations made by the Expert Panel on Asylum Seekers, Australia’s integrated humanitarian program increased its intake from 13,750 to 20,000 places (DIAC, 2013). Accordingly, 20,019 people (offshore, 12,515; onshore, 7,504) were resettled in Australia under three visa categories: Humanitarian Entrants (visa sub-class 200); Women at Risk (visa sub-class 204) and people sponsored by an Australian citizen or organization (visa sub-class 202). However in September 2013, the refugee intake (offshore and onshore combined) was reduced back to 13,750 places.

**Refugee services.** People accepted under Australia’s humanitarian program are offered three types of services to assist in their resettlement. Before arrival, a cultural orientation program provided on Australia’s behalf by the International Organization for Migration (IOM) gives prospective newcomers an introduction to Australian lifestyle and
culture. After arriving in Australia, they are offered a range of services under two main programs, the Humanitarian Settlement Services (HSS) during the first 6 to 12 months and the Settlement Grants Program (SGP) from 6 months to 5 years (DIAC, 2013).

Under the HSS newly arrived refugees are given accommodation, an initial food package, household goods, case management, and assistance to register with social security (Centrelink), free government-provided health insurance (Medicare), health services, banks, and schools. Less intensive support is offered to eligible persons under the SGP by way of settlement-related information, advice, advocacy or referral services pertaining to education, housing, immigration issues, and so forth. Each person is offered 510 hours of free English language classes and has access to 24-hour telephone translating and interpreting services. People identified by service providers as having ‘complex needs’ are offered more intense support. Service providers to refugees include medical doctors, nurses, psychologists, psychological counsellors, case workers, coordinators, interpreters and administrative staff. Trauma counselling and specialized healthcare services are also provided under separate federal and state level funding arrangements but eligibility is assessed on stringent criteria because of limited resources.

Asylum seekers. As aforementioned asylum seekers are people who enter Australia without a valid visa or other legal documentation and seek refugee status afterwards. They travel to Australia either by plane or by boat; and depending mainly on the mode of transport utilized they are subjected to differential treatments as well as political and media scrutiny (RCOA, 2013). It is the people who arrive by boat who are commonly referred to as ‘asylum seekers’ or ‘boatpeople’; and more recently as ‘illegal arrivals’ thus denoting the escalating vilification of these people (Hall, 2013).
People seeking asylum are increasingly being detained around the world. Most countries temporarily detain asylum seekers arriving on their shores for preliminary inquiry, medical check-ups and so forth, and then release the asylum seekers into the community pending a decision on their application (e.g. the UK). However since 1992 (with a brief respite in 2007-2008), Australia has maintained a policy of mandatory detention and all people arriving by boat are incarcerated at specially constructed detention centres often of substandard quality, situated in remote and inhospitable areas and run in prison-like style (Zion, Briskman, & Loff, 2010). Two of the most notorious detention centres, at Baxter and Woomera in South Australia, were closed after a public outcry regarding the inhumane treatment of inmates. Under the ‘Pacific Solution’ of the former Liberal-National Coalition government (2001-2007) asylum seekers were removed to detention centres on Papua New Guinea and Nauru. The Pacific Solution was abolished in 2008 by the Labor government of Rudd but reintroduced in 2012 by the succeeding Gillard Labor government.

In July 2013, Rudd returned as Prime Minister and hastily signed the ‘Regional Resettlement Arrangement’ enabling all boat arrivals to be sent to Papua New Guinea and Nauru to be detained, have their refugee status determined and to be permanently settled in these countries if found to be in need of protection (Power, 2014). However these measures were not tough enough for the newly-elected Prime Minister and his Liberal-National Coalition, elected in September 2013. They set up a military style operation (Operation Sovereign Borders) to turn boats back to Indonesia ‘when it was safe to do so’. People who arrived before July 2013 lost access to government-funded legal aid, and those who were found to be refugees were deprived of family reunion rights (Power, 2014). This increasing vilification and victimization of people seeking asylum in Australia can...
reasonably hypothesized to have a negative psychological impact on people working with these people [see Chapter 6].

Also, between 1999 and 2007, asylum seekers who applied for and were recognized as refugees were issued with Temporary Protection Visas (TPVs). From October 2013, the new Abbot government resumed issuing all asylum seekers with another temporary alternative, Temporary Humanitarian Concern Visas (THCVs) which, in effect, are similar to the earlier TPVs. TPV (or THCV) holders are entitled to remain in Australia for a limited period of time, to be determined on an individual basis but not extending beyond three years. At the end of that time period they could be forcibly returned to their home country if the Australian government decided it was safe for them to go back (RCOA, 2013). Hence they lived in perpetual fear and uncertainty that exacerbated their vulnerability, insecurity and mental health. The absurdity of TPVs has been noted by the fact that after its introduction in 1999 until 2008 about 11,000 refugees were issued TPVs of which about 90 percent were eventually granted permanent protection (RCOA, 2013). Although between 2008 and 2013 no TPVs were issued, people transferred from detention into the community were still issued a Bridging Visa (BV) until their immigration status was determined.

Asylum seeker status (including life on a TPV, THCV or BV) implies a number of consequences including limited access to essential services (e.g. affordable accommodation, food, household goods, finances, language training, employment and

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2 THCVs were issued because the Bill tabled in Federal Parliament to legalise TPVs was later rejected on 29.11.2013 by the Australian Senate after the Australian Greens and Labour Parties refused to support the Bill (Liberal Party of Australia, 2013). Subsequently an amended version of the Bill introducing TPVs was passed by both Houses of the Australian Federal Parliament on 5.12.2014.
healthcare), thus preventing people from integrating into Australian society. Moreover the temporary status leads to uncertainty and insecurity; amidst the constant threat of their refugee status being revoked and the fear of being returned to the home country. Moreover, the politically constructed class division between ‘onshore’ and ‘offshore’ refugees creates tensions between ethnic communities and unduly burdens their communities within Australia by the high support needs of TPV holders while negative political and media discourse on ‘boatpeople’ impedes successful resettlement (RCOA, 2013). When they eventually received permanent status, they were most likely to be dependent on the public healthcare and mental healthcare services for a long time. Most importantly these visas prohibited the reunification of families thus encouraging many women and children to take the dangerous boat journey to Australia as the only way to unite with loved ones—counteracting the initial rationale for harsh asylum seeker policies (RCOA, 2013).

Both international and local organizations such as the UN Refugee Agency and the Australian Commission of Human Rights (ACHR, 2012), have been very critical of the mandatory detention policies of successive Australian governments and have considered these as a violation of international law. The most difficult for people already vulnerable is the prolonged detention and its uncertainty, elevating the risk of self-harm and mental health damage (Power, 2014). The deleterious psychological impact of Australia’s inhumane policies towards asylum seekers is highlighted in the next section.

1.4. The refugee experience

Numerous empirical studies have indicated that there are serious negative psychological consequences of the refugee experience which usually involves forced migration, exposure to multiple traumatic events and the distress of resettlement. A meta-
analysis of 56 studies and 67,294 participants indicated that refugees (including asylum seekers) had significantly poorer mental health outcomes than non-refugees. (Porter & Haslam, 2005). Another meta-analysis reported that around 30 percent of refugees and other conflict-affected persons developed PTSD and/or depression, despite wide variability in the rates of psychiatric illnesses reported by selected surveys (Steel et al., 2009).

**Transitions and trajectories of the refugee journey.** Although numerous research studies have investigated the risks and adverse mental health outcomes of the refugee journey, a discussion involving such a vast array of literature appears to go beyond the scope of this thesis. Instead, I will endeavour to capture some of the salient research findings by discussing a literature review conducted for the Canadian Collaboration for Immigrant and Refugee Health (CCIRH) to identify risk factors for mental health problems among new immigrants and refugees (Kirmayer et al., 2011). In consultation with experts in immigrant and refugee mental health, the researchers reviewed the literature from January 1998 to December 2009 in databases such as MEDLINE, EMBASE, PsycINFO, CINAHL, and the Cochrane Database of Systematic Reviews. They identified 845 relevant records including quantitative and qualitative studies; as well as large-scale public surveys (Kirmayer et al., 2011). These and other related research findings discussed below, provide important background information for the empirical studies presented in Chapters 3, 4, 6 and 7. That is, the discussion affords important general background information on refugee participants, the workers with refugee experiences, as well as about the clientele of the service providers.

Kirmayer and colleagues (2011) found that unlike immigrants who—at least initially—indicated better mental health outcomes than that of the general population in both the sending and receiving countries (“healthy immigrant effect”) refugees and asylum
seekers were at a considerably higher risk than the general population for psychiatric disorders such as PTSD, depression, chronic pain and other somatic complaints. Refugees’ adverse mental health status was attributed to their experiences of war, violence, torture, forced migration, prolonged exile in refugee camps and/or uncertain immigration status when seeking asylum (Kirmayer et al., 2011).

According to Kirmayer et al. (2011) migration involved three types of transitions (changes in personal ties and social networks; socio-economic systems; and cultural systems) whereas the migration trajectory was divided into three phases (pre-migration, migration and post-migration resettlement) with each stage associated with particular risks. For example, for refugees and asylum seekers, the pre-migration phase included experiences of war or extreme violence that resulted in injury or the threat to life; destruction of homes and villages; and the separation from families and communities. Refugees could also spend extended periods in refugee camps with poor resources and endemic violence; and asylum seekers could be held in detention centres for long periods fostering a sense of powerlessness, hopelessness and frustration. Because migration usually stressed family ties and fragmented families; forcing people to leave behind close family members sometimes in dangerous situations, the researchers emphasized that service providers working with immigrants and refugees needed to attend not only to the individuals they worked with, but also to family systems and social networks in other countries (Kirmayer et al., 2011).

Resettlement usually positively impacted on refugees’ mental health because it brought optimism and hope for a brighter future. However when people suffered losses associated with migration, when their hopes and expectations were not realized, or they faced structural barriers, inequalities, discrimination or racism in host societies, demoralization and depression set in. For example refugees may face difficulty in having

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their educational and professional qualifications recognized, not find work commensurate with their previous education levels or indeed struggle to find any kind of employment. According to Kirmayer et al.’s (2011) literature review, the main areas of resettlement stress included social and economic strain, social alienation, discrimination and status loss as well as the experience of violence. Events and experiences that were reminiscent of past loss and trauma contributed to the re-emergence of psychiatric problems. Cultural change from home to host country posed challenges for individual identity and family relationships (detailed later in this section). The reception and support received in the host country or the lack thereof, also impacted on people’s mental health.

Steel, Silove, Bird, McGorry, and Mohan (1999), demonstrated that although pre-migration trauma accounted for 20 percent of the variance in posttraumatic symptoms among a group of asylum seekers in Australia, post-migration stress contributed 14 percent of the variance. Post-migration stressors identified in studies included generally experienced stress in adapting to a new environment (communication difficulties, racial discrimination, unemployment); loss of cultural and social support (limited access to traditional foods and social group); and fear for family members left behind in the home country (Steel et al., 2009). Other resettlement stressors impacting mental health were: living in institutional or temporary accommodation; limited economic opportunity; and restricted access to employment (Porter & Haslam, 2005).

Experiencing loss has been a powerful predictor of psychological difficulties in resettlement. For instance, the loss of socioeconomic status and the non-recognition of previous educational qualifications (Porter and Haslam, 2005) as well as the loss of meaningful social roles, life project and levels of daily activity have been identified as exacerbating distress (Miller et al., 2002). The ‘culture gap’ between refugees’ traditional societies and that of the host country; and acculturation were also distressing.
Acculturation could entail learning a new language; accepting new cultural values, traditions and worldviews; and navigating new systems of governance, health and trade.

Berry (1997) proposed four categories of acculturation strategies utilized by refugees and immigrants in the host society namely assimilation, integration, separation and marginalization. Assimilation involves adopting most aspects of the host country culture whereas integration means adapting to the host culture while maintaining some aspects of the home culture. Separation is the rejection of the host society culture whereas marginalization is the rejection of both host and home country cultures. Although assimilation and separation did not appear to impact on mental health, marginalization negatively impacted mental well-being during resettlement. Integration or adapting to both home and host cultures actually facilitated psychological well-being of refugees and immigrants (Berry 1997). Acculturation can also lead to identity confusion and a loss of identity until people are able to reconstruct their individual and collective identities incorporating aspects of both home and host country cultures to find their unique position vis-à-vis the bicultural continuum. Meanwhile inter-generational conflict and family disharmony due to different rates of acculturation within families and changing roles of family members can also add to post-migration distress (Renzaho, Green, Mellor, & Swinburn, 2011; Renzaho, McCabe, & Sainsbury, 2011).

In their literature review, Kirmayer et al. (2011) presented several factors that impeded the mental health of refugee adults and children. Table 1.1 is an adaptation of the factors postulated by these researchers.
Table 1.1 *Factors that impact on mental health status of refugees*

<table>
<thead>
<tr>
<th></th>
<th>Pre-migration</th>
<th>Migration</th>
<th>Post-migration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult</strong></td>
<td>▪ Economic, educational and occupational status in country of origin</td>
<td>▪ Trajectory (route, duration)</td>
<td>▪ Uncertainty about immigration or refugee status</td>
</tr>
<tr>
<td></td>
<td>▪ Disruption of social support, roles and network</td>
<td>▪ Exposure to harsh living conditions (e.g. in refugee camps)</td>
<td>▪ Unemployment or under employment</td>
</tr>
<tr>
<td></td>
<td>▪ Trauma (type, severity, perceived level of threat, number of episodes)</td>
<td>▪ Exposure to violence</td>
<td>▪ Loss of social status</td>
</tr>
<tr>
<td></td>
<td>▪ Political involvement (commitment to a cause)</td>
<td>▪ Disruption of family and community networks</td>
<td>▪ Loss of family and community social support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Uncertainty about outcome of migration</td>
<td>▪ Concern about family members left behind and possibility for reunification</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Difficulties in language learning, acculturation and adaptation (e.g.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>change in gender roles)</td>
</tr>
<tr>
<td><strong>Child</strong></td>
<td>▪ Age and developmental state at migration</td>
<td>▪ Separation from caregiver</td>
<td>▪ Stresses related to family’s adaptation</td>
</tr>
<tr>
<td></td>
<td>▪ Disruption of education</td>
<td>▪ Exposure to violence</td>
<td>▪ Difficulties with education in new language</td>
</tr>
<tr>
<td></td>
<td>▪ Separation from extended family and peer networks</td>
<td>▪ Exposure to harsh living conditions (e.g. refugee camps)</td>
<td>▪ Acculturation (e.g. ethnic and religious identity; gender role conflicts)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Poor nutrition</td>
<td>▪ Intergenerational conflict within family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Uncertainty about future</td>
<td>▪ Discrimination and social exclusion (at school or with peers)</td>
</tr>
</tbody>
</table>

Adapted from Kirmayer et al., 2011
Children and adolescents. In their meta-analysis inquiring into risk and protective factors for refugee children, Fazel et al. (2012) utilized the ecological model of human development (Bronfenbrenner & Ceci, 1994) to identify four categories of risk (and protective) factors impacting the mental health of children and adolescents. These categories were individual, familial, communal and societal factors, several of which resonate with the abovementioned.

An individual factor predicting psychological ill-health and social maladjustment was a history of physical, psychological or developmental problems. However there was much diversity in research findings regarding the impact of age and sex on mental health because the relationship was likely to be confounded by factors such as whether children were accompanied by their parents or not. For example, unaccompanied minors seeking asylum indicated increasing symptoms of PTSD as they grew older but children accompanied by parents did not (Fazel, Reed, Panter-Brick, & Stein, 2012). The authors hypothesized that unaccompanied children worried about deportation and change in immigration status once they turned 18. Porter and Haslam (2005) found that children and adolescents had better mental health outcomes after migration than adults, with people over 65 years faring particularly badly. Additionally higher educational achievements and socioeconomic status in the home country negatively impacted refugee well-being after migration whereas an urban (as opposed to rural) background and knowledge of English prior to migration were conducive to better mental health (Colic-Peisker & Tilbury, 2003; K. E. Murray, Davidson, & Schweitzer, 2008).

Regarding family factors, children whose parents had been tortured, were missing, or in detention indicated more deleterious consequences to their psychological functioning (Fazel et al., 2012). Lack of family cohesion and parental support, together with mental illness in parents were other family factors negatively impacting refugee children’s mental
health. Additional risk factors included discrimination and bullying that interfered with children’s developing a sense of belonging (a community factor important for adults also), and experiencing immigration detention where children witnessed rioting, violence and self-harm by adults (a societal factor) (Fazel et al., 2012).

*Asylum seekers.* Australia’s policy of mandatory detention of asylum seekers has also been found to be a negative socialization experience aggravating past trauma; and associated with significantly higher rates of suicidal behaviour, psychiatric disorders (e.g. MDD, PTSD, anxiety), and psychological distress compared to the general population of adults and children (Murray et al., 2008). Results of a comparison study between people on TPVs and those who had been issued permanent protection (i.e. PPVs) showed that TPV holders had higher psychiatric symptomatology with TPV status being the strongest predictor of anxiety, depression and posttraumatic symptoms. Both groups had been matched for levels of past traumatic experiences (Momartin et al., 2006). The negative psychological impact of Australia’s harsh asylum seeker policies over the years has been documented by several prominent refugee scholars in Australia (Newman, Dudley, & Steel, 2008; Newman & Steel, 2008; Steel et al., 2006).

*Barriers to mental healthcare access.* Another objective of Kirmayer et al.’s literature review was to determine the use of healthcare by migrants and refugees and the barriers to accessing healthcare. The researchers found that in general, immigrants and refugees were less likely to access mental health services compared with their mainstream counterparts. Failure to use interpreters has been identified as one of the most important barriers to accessing services—not ad hoc translators like family members but professional interpreters who translate not only language but cultural concepts and frameworks. Conversely the presence of members of their cultural community sometimes gave rise to confidentiality concerns. Kirmayer et al. (2011) also emphasized that a person’s needs and
requirements had to be assessed in each situation to determine the language he or she is most comfortable and fluent communicating in. It is also important to identify which community he or she feels part of and not to assume that the person necessarily will feel comfortable with a group that shares aspects of national, religious or ethnic identity.

Finally the literature review revealed the importance of the culture dimension of the illness experience. Culture influenced every aspect of illness and adaptation, including interpretations of and reactions to symptoms; explanations of illness; patterns of coping, of seeking help and response; adherence to treatment; styles of emotional expression and communication; and relationships between clients, their families and health care providers. A good example is when refugees suffering from depression or anxiety sometimes focus on physical symptoms or use culture-specific bodily idioms to express distress.

Mental health disorders among refugees: brief overview. Traditionally refugee mental health research has focused on the psychopathological effects of experiencing trauma before migration. Research over the past 25 years has reported varying rates and types of psychiatric disorders among refugee people including posttraumatic stress disorder (PTSD), major depression (MDD), psychotic disorders and general anxiety. Hence, in the following paragraphs I will present a brief discussion on research findings regarding mental health disorders among refugees.

A meta-analysis conducted with 20 studies and 6793 adult refugees resettled in seven developed countries including the US, Australia, and New Zealand, depicted the proportion of refugees diagnosed with PTSD symptoms as ranging from 3 percent to 86 percent; while the prevalent rate for major depression varied from 3 to 80 percent (Fazel et al., 2005). The authors also found that original studies with more than 200 participants reported lower rates of illness (9% for PTSD, 5% for depression) than studies with smaller samples. A more recent systematic review and meta-analysis of 181 surveys (81,000 participants
residing in 40 developed and developing countries) also reported a wide ranging illness prevalence rate of: 0 - 99 percent for PTSD and 3 - 85.5 percent for depression (Steel et al., 2009). Again, studies with larger samples produced more conservative estimates for mental illness than smaller studies.

There are several plausible reasons for the wide disparity of reported rates of psychopathology among refugees. Porter and Haslam (2005) found that part of the variance was explained by participant characteristics including ethnic group (lower rates had been reported with Southeast Asians), age (children appeared to fare worse than adults), and the duration of displacement; together with the heterogeneity of study design. Besides sample size, other design issues that impacted on study findings included diagnostic instruments being used (self-report versus clinical interviews), sampling method (random versus non-random sampling), and the language of the interviewer (whether he/she was a native speaker or not) (Fazel et al., 2005; Steel et al., 2009). Non-random sampling, using self-report questionnaires, and interviewers not being native speakers of participants’ language were associated with higher incidence rates being recorded for PTSD and depressive disorders.

When methodological variability was adjusted for, being tortured or experiencing other potentially traumatizing events (PTEs) such as serious threat to life, witnessing murders and destruction of property were positively associated with high rates of psychological problems. Time elapsed since experiencing conflict was negatively associated with mental illness (Steel et al., 2009). However, a study with former Vietnamese refugees in Australia revealed improvement with the passing of time—except for people experiencing more than three traumatic events; indicating greater risk of mental illness even after 10 years compared with others who had not experienced such adversity (Steel, Silove, Phan, & Bauman, 2002). Physical and psychological torture, especially
when combined were the main predictors of PTSD (Punamäki, Qouta, & Sarraj, 2010) possibly because torture and other gross human rights abuses challenged the five core adaptive systems of safety, attachment, justice, identity-role, and existential meaning (Herman, 2001; Silove, 1999) more than other traumatic experiences.

Several studies have indicated that depressive symptoms decreased over time whereas PTSD was resistant to such change. Other studies have found a curvilinear relationship between mental illness and time with mental distress increasing during the initial stages of resettlement but reducing after people became more settled and familiarized with their new environment (K. E. Murray et al., 2008). The timeframes proposed by studies for the reduction of distress varied, indicating the absence of a straightforward relationship between symptomatology and time. Nonetheless, the general trend appeared to be one of improvement over time since first experiencing trauma (see also Fazel et al., 2012).

Earlier refugee research also identified a positive relationship between traumatic experiences—as assessed by for example, the Harvard Trauma Questionnaire (HTQ)—and severity of mental health problems. This positive relationship was referred to as the ‘dose-effect relationship’ and symptoms identified included including comorbid disorders (e.g. combination of PTSD and depression) (Mollica, McInnes, Pham, et al., 1998; Mollica, McInnes, Poole, & Tor, 1998). In their meta-analysis inquiring into risk and protective factors for refugee children, Fazel et al. (2012) also suggested that children’s direct experiences of violence increased their risk of psychological problems including sleep disturbance, anxiety and PTSD. However the authors cautioned that possibly it was the number of adverse events experienced by refugees throughout their lifetime (before and after migration) that impacted on psychological well-being rather than pre-migration trauma events alone (Fazel et al., 2012). The authors utilized the ecological model of
human development (Bronfenbrenner & Ceci, 1994) to identify four categories of risk (and protective) factors impacting the mental health of children and adolescents. These categories were individual, familial, communal and societal factors and are described below.

One of the few longitudinal studies with refugees, conducted with Cambodian adolescents and young people living in the US, indicated that depression was related more to post-migration stress whereas PTSD was related more to past traumatic experiences (Sack et al., 1993). Another longitudinal study with 131 refugee children, 8-9 years after their arrival in Denmark, revealed that ongoing stressful experiences including the mother’s education (indicating adaptation) and discrimination were stronger predictions of predicted children’s mental health status than their experiences before migration (Montgomery, 2008).

I conclude this section by presenting the model developed by Nickerson, Bryant, Silove, and Steel (2011) to portray the complexity of the refugee experiences and potential psychological responses to the multiple traumas and distress encountered along the refugee journey. The model depicts how pre-migration traumas (e.g. mass violence) interact with refugee camp stressors (detention, starvation), together with distress after migration including being separated from family, discrimination and insecure asylum status to impact memory, cognition and emotion; eventually resulting in psychopathology or other psychological reactions such as anger, grief or guilt. An adapted version of the model is depicted in Figure 1.1 below.
Figure 1.1 Model depicting the complexity of the refugee experience developed by Nickerson et al. (2011).

* DESNOS: Disorders of extreme stress not otherwise specified
1.5. Resilience, adaptation and coping

There has been growing research interest in the resilience, coping and successful adaptation of refugee populations. Coping is a person’s attempt to alleviate, reduce, manage or protect against psychological reactions to trauma and distress (cf. Lazarus & Folkman, 1984). The renewed interest in refugee coping can probably be attributed to research findings indicating that the majority of refugees are free from debilitating mental illness despite past traumas and ongoing stressors; or that their condition improves with time (Fazel et al., 2005). In Steel et al.’s (2009) meta-analytic study the unadjusted weighted prevalence rate for PTSD and/or depression (both approximately 30%) was quite high compared to the general population (cf. Beiser, 2014), but at the same time indicated that almost 70 percent of refugees did not meet criteria for these diagnoses. Adverse refugee-like experiences also do not necessarily lead to social maladjustment and withdrawal, or violent behaviour (Staub & Vollhardt, 2008). Furthermore, coping resources and strategies are aspects of people’s lives and their surroundings that can be modified to enhance overall well-being and successful resettlement—unlike experiences and events of the past. Hence, I believe it is vital to investigate how the majority of people with refugee experiences overcome past adversity, manage post-migration stressors, and successfully adapt to their host environments. Resilience is a similar concept to coping, and is broadly defined as the ability of a person to successfully adapt to or recover from stressful or traumatic experiences (Luthar, Cicchetti, & Becker, 2000; Masten & Wright, 2009). Although initially focusing on personal attributes such as self-esteem, self-efficacy, and hardiness, resilience theory has progressed to depict a multidimensional construct encompassing personal characteristics and skills (e.g. active problem-solving) as well as external protective factors such as a supportive family, community networks and social environment. Likewise, adaptation depicts the process of change that individuals and
groups of persons go through in response to environmental demands. According to Berry (1997), adaptation to a new culture (also referred to as acculturation) can take place in the short- or long-term. However short-term change is usually disruptive with positive adaptation to a new cultural context likely to take place only over an extended period of time. In the present thesis, I refer to the concepts of ‘resilience’, ‘coping’ and ‘adaptation’ interchangeably vis-à-vis refugees’ efforts to overcome adverse reactions to past traumas, manage current distress, and adjust to their host society. Exploring how refugees utilize their coping resources and strategies to make meaning of their experiences was the initial objective of the empirical studies in Chapters 3 and 4 with refugee participants; hence reviewing past literature regarding refugee resilience, coping and adaptation forms a vital backdrop for these empirical studies.

Although to date I have not been able to locate any published systematic review of the overall literature on refugee coping resources and strategies, as aforementioned one meta-analysis/ literature review has discussed the protective (and risk) factors influencing the psychological well-being of child refugees (Fazel et al., 2012). The study authors utilized the ecological model (Bronfenbrenner & Ceci, 1994) to differentiate between individual, family, community and societal aspects of risk and protective factors of child refugees. The ecological model emphasizes the importance of a person’s immediate setting (individual, family, community) as well as the larger social context in which immediate settings are embedded, to influence that person’s biopsychosocial development. Another literature review focusing on the psychological well-being of refugees included the coping resources and strategies utilized by child and adult refugees of the Sudanese ethnic/ national community (Tempany, 2009). The coping resources and strategies identified in this study could be broadly categorized into cognitive or emotional coping (individual) familial and communal (immediate context); and cultural and religious beliefs (social
context). Henceforth in this chapter, I have utilized an adapted version of the ecological model to categorize the coping devices of refugee populations contained in the literature.

**Individual factors.** According to Fazel et al. (2012), individual factors such as being free from physical, psychological and developmental impediments are conducive to refugee children’s mental health. In Tempany (2009), Sudanese refugees reportedly utilized what were described as cognitive coping strategies such as: downward comparison (i.e. deriving comfort by comparing their present situation with past war and refugee camp experiences), negative normalizing (everyone goes through the difficulties they encountered in resettlement), accepting difficulties such as perceived discrimination in the host society and reframing their problems to appear in a more positive light. Refugees also described how they preoccupied themselves with thinking about reuniting with family members currently overseas instead of focusing on distressing thoughts of the past and present (Tempany, 2009). Unaccompanied youth from Sudan reported using culture-based coping methods such as suppressing distressing thoughts and distracting themselves by reading books, engaging in school work or playing games (Goodman, 2004).

Lazarus and Folkman (1984) in their acclaimed work, ‘Stress, Appraisal and Coping’ distinguished between problem focused and emotion focused coping by individuals. Problem focused or active coping involved managing and solving problems, whereas emotion focused coping was concerned with managing the negative emotions that arose when the person encountered a problem, but without the accompanying action.

Accordingly, in their research with a mixed group of refugees in the Netherlands, Kramer and Bala (2004) identified four kinds of participants based on the coping styles they utilized to manage uncertainties arising during resettlement. The four participant categories were: ‘drifters’, ‘hibernators’, ‘fighters’ and ‘explorers’. The coping style of the ‘drifters’ indicated that they lacked control over external events, felt powerless and desperate, and
sometimes even spoke of taking their lives. The ‘hibernators’, although attempting to live in the present and address present difficulties, continued to hang on to the past—similar to the former Bosnians in Miller’s (2002) study who reportedly took comfort by nostalgically reliving their harmonious lives in the home country before the war. Conversely participants described as ‘fighters’ actively searched for ways to change their situation whereas ‘explorers’ were also opened to new options and opportunities. The authors concluded that the active and exploratory coping strategies of ‘fighters’ and ‘explorers’ were more conducive to psychological well-being and adaptation in the new society, than those of ‘drifters’ and ‘hibernators’.

Notwithstanding the findings of Kramer and Bala (2004), emotion focused coping can be beneficial when dealing with previous traumatic experiences, or current stressors that one has limited ability or opportunity to change. Bosnian participants in Oakes (2003) study described how they engaged in emotional coping (i.e. intense emotional reactions) that acted as a precursor to the cognitive coping mechanism of meaning-making. They also engaged in cognitive coping when active coping was not possible, as in ongoing conflict and war, and employed a combination of cognitive and active coping strategies to achieve a sense of control, however minor, after migration. A combination of active and emotional/cognitive coping strategies was also reported by a group of Afghani women who described how they took action to increase their family’s security; took on new family roles when their spouses were lost or killed; and made the difficult decision to leave the country of origin when their lives became unbearable. During resettlement the women had continued to cope with their situation by focusing on the future, maintaining hope and trying to make sense of both their past and present experiences through their religious beliefs (Ross-Sheriff, 2006; Welsh & Brodsky, 2010).
Numerous studies have also found the utility value of cognitive coping methods for refugee people from a range of cultural backgrounds. For example, Goodman (2004) and (Luster, Qin, Bates, Johnson, and Rana (2009)) described the emotional, cognitive and active coping strategies utilized by Sudanese youth. Using a narrative methodology, Anderson et al. (2010) noted how Chinese and Somali immigrants including refugees utilized ‘repositioning’ to ‘fit in’ to Canadian society in order to overcome dissonance between their expectations of Canadian society and their perceived social reality. Colic-Peisker (2009) described how a combined sample of ex-Yugoslavian, African and Middle Eastern refugees compared their current position to their immediate and distant past; and accepted their perceived low status and discrimination based on ‘otherness’ inferred from racial visibility and cultural distance in Australia. As aforementioned, former Yugoslavian refugees also utilized their cherished memories of an era of community harmony before the war, as a source of comfort as well as a reference point to evaluate life in the US (Miller et al., 2002). However it is noteworthy in several of these instances cognitive coping was resorted to in response to broader societal factors such as discrimination and the expectation of the host society requiring refugees to ‘fit in’ to an existing social order.

Other studies have described the conscious attempts made by some refugee groups to forget the past, focus on the present and maintain hope including envisioning an optimistic future. For instance, focusing on their children’s education and safety; aspiring for a successful future for children; and maintaining general optimism have been adaptive for young and older refugees from Africa, the Middle East and Asia (cf. Brough, Gorman, Ramirez, & Westoby, 2003; Este & Tachble, 2009; Khawaja, White, Schweitzer, & Greenslade, 2008; Reiboldt & Goldstein, 2000). (Yohani and Larsen (2009)) also described the importance of hope for a group of refugee and immigrant children in Canada, in motivating them to cope with difficulties, and enabling them to engage in empowering
activities such as building relationships with others and with the natural world around them.

**Family and community factors.** According to Fazel et al. (2012), family factors that protect children from adverse mental health effects in resettlement include: migrating with parents, siblings and extended family members as opposed to arriving in the host country alone; high family cohesion instead of disharmony, violence, separation and divorce in the family; the perception of being supported by family; and maintaining open communication channels with parents. Children with parents—especially mothers—of sound mental health, and children whose families avoided discussing conflict related incidents at home also fared better than other children.

Immediate and extended family members, community and social support services perform a vital function of helping refugees adjust to resettlement in a strange environment (Lewis, 2008, 2010; Lim, 2009; Sossou, Craig, Ogren, & Schnak, 2008). Family members are a source of comfort as well as material support in times of difficulties, highlighting the importance of family reunion and explaining how focusing on family reunion could became a coping strategy. Contrastingly Wilmsen (2013) described the numerous negative consequences of being separated from family for refugees resettling in Australia.

Other studies have similarly highlighted the importance of maintaining family ties and the ability to rely on close family and community members. Lewis (2005, 2008, 2010) for example, described the vital importance of the ‘Khmer family’ concept for Cambodian former refugees in order to reconstruct intergenerational ties and how the newly constructed family unit provided individual members the security and reliance required to overcome the ‘culture gap’ between home and host cultures. Weine et al. (2006; see also Weine et al., 2004) utilized interventions focusing on the family such as ‘families
rebuilding lives’ to assist Bosnian refugees to manage the adverse consequences of war experiences and adapt to their new life in the US.

Simich, Beiser and Mawani (2003) described the informational, instrumental and emotional benefits of sharing experiences and receiving social support from family and community; justifying refugees’ decision to move from initial settlement sites in Canada to other places in search of family, friends and community. The adaptive value of interacting with members of one’s community, conversing with friends, as well as service providers such as counsellors and doctors, was highlighted in Brough et al.’s (2003) study with refugee youth from Africa, former Yugoslavia, Southeast Asia and South America. Conducting an ethnographic study, Guribye, Sandal, and Oppedal (2011) described several proactive coping activities engaged in by Tamil refugees in Norway including how participants predicted future stressors and took collective action to reduce or manage anticipated distress. The researchers also observed how participants reverted to reactive coping when they received news about the deteriorating situation and the intensification of the conflict in their homeland. The phenomenon of collective traumatization of entire societies facing targeted oppression over long periods of time has been highlighted by several authors (Somasundaram, 2007, 2014; Weine, Kulenovic, Pawkovic, & Gibbons, 1998). Expanding on this theme, Guribye et al., (2011) also observed participants engaging in collective healing in response to the traumatization of the Tamil community in Norway.

Collective activities with friends and community members have been identified as a coping strategy that assisted refugee populations to overcome past and present distress. For example Warin and Dennis (2008) described how unspeakable past traumatic experiences of Iranian women in Australia were enclosed and transformed into mundane and creative daily activities such as sewing, preparing food and sweets, painting and interacting with others while engaging in collective activities. The multiple benefits of sewing for
immigrant and refugee women in South Australia (e.g. a means of expression, maintaining culture, providing employment, coping with transition) as well as participating in weddings and parties, enjoying traditional music and wearing traditional dress has also been noted (Boerema, Russell, & Aguilar, 2010; Guerin, Elmi, & Guerin, 2006). Participating in social and cultural forms of recreation with one’s ethnic community and host society friends, learning English and attending English classes, engaging in sports and music also facilitated efforts to overcome social isolation, address cultural bereavement and feel ‘a little bit of home’ (Brough et al., 2003; Stack & Iwasaki, 2009; Yates, 2011).

Research in developing countries like Pakistan, where there is large scale displacement of Afghani refugees in often substandard living conditions, has revealed how religious rituals and family, sports and occupational activities (e.g. cooking, factory work) help people cope with their past and present difficulties (Kassam & Nanji, 2006). Engaging in multiple forms of wage-earning to cope with economic deprivation was resorted to by Rohingya refugees in Bangladesh (Crabtree, 2010); whereas receiving financial and emotional support from children and a mutual understanding of filial piety added to the life satisfaction of older Tibetans exiled in Dharmasala, India (Wangmo, 2010; Wangmo & Teaster, 2010).

Researchers have also explored the coping and adaptive strategies used by particular groups within refugee communities. For example, a study with women from South Sudan who had experienced sexual violence suggested that maintaining silence about their traumatizing experiences was a culturally accepted coping strategy for the women together with focusing on resettlement matters, because disclosing sexual violence was not acceptable within the Sudanese community and culture (Tankink & Richters, 2007). Ting (2010) described the multiple coping strategies used by female African survivors of intimate partner violence (IPV) such as believing in spirituality and divine retribution,
orientating to the future, maintaining a sense of self-efficacy, accepting and enduring the abuse, normalizing abuse, resorting to avoidant behaviour and thoughts, as well as being empowered by the knowledge of informal and formal services from which they could seek help.

However the contradictory or ‘double-edged’ nature of family and community was highlighted in Boulden’s (2009) study with gay Hmong men who said that although their sense of belonging was enhanced by family cohesion and social support from extended family and community, they also faced stigmatization and isolation for their sexual orientation. Pre-migratory trauma compounded by exile-related stressors sometimes led to family violence when for instance male family members suffering from conflict-related trauma also became frustrated at losing their social role as the dominant figure in the family, and engaged in domestic violence. In these circumstances, although the women who experienced Intimate Partner Violence (IPV) received much needed support from their extended families and communities, they were often discouraged from leaving a violent partner because it was culturally unacceptable (Bui & Morash, 2007). Hence although the presence of and interaction with family and community provided vital emotional, social and material support, these potential coping resources could also become sources of enormous distress. Similarly, although former Bosnian participants in Miller et al.’s (2002) study yearned for the rich social life they had enjoyed with family members and friends in the home country before the war, in the US participants sometimes avoided contact with compatriots to protect themselves against painful memories brought up in conversations.

Societal factors. The perception of being accepted by the host society, inculcating a sense of belonging, in which the school environment and support from peers played a major part, were societal factors that enhanced refugee children’s psychological
functioning (Fazel et al., 2012). Integrating into host society by for example mastering the host society’s language and adopting some aspects of the host culture while simultaneously maintaining one’s home country traditions and values were beneficial for refugee children. This finding is supported by Berry (1997) (see p.17 above).

Research provides rich descriptions of the cultural negotiation, positioning and repositioning refugees and migrants engage in, during the process of adapting to the new culture. For example, an ethnographic study of a community-based photography project conducted with refugee youth in the US revealed how participants negotiated their identities and constructed their discourses around displacement. They were also actively involved in reconstructing the meanings of their experiences through language and social interactions thus facilitating integration into US society (Guerrero & Tinkler, 2010). Two focus group studies with several ethnic communities revealed how refugees in Melbourne, Australia coped with acculturation and changing family roles (Renzaho, Green, et al., 2011; Renzaho, McCabe, et al., 2011). Parents for instance, did not hit their children as may have been customary, due to fear of Australian law, but used positive and negative reinforcement to discipline their children. Other individual and collective adaptive practices engaged in included getting a job, striving to learn the host country language perfectly, valuing equal rights and independence, objecting to being referred as an ‘immigrant’ and using the local idiom of ‘stress’ to cope with ill-health (Colic-Peisker & Walker, 2003; Keyes & Kane, 2004; Obrist & Büchi, 2008). As aforementioned under ‘cognitive coping’ researchers have explored how refugees and immigrants repositioned their attitudes, values and cultural practices to ‘fit in’ to the host society and their attempts to minimize the differences between their previous and current socioeconomic situation (Anderson et al., 2010; Colic-Peisker, 2009). Nonetheless refugees also engaged in cultural continuity as a coping device through the preparation and sharing of traditional foods,
home décor, dress, as well as the concept and meaning of ‘home’ to help preserve social identity, socialization and connection to the past (Rosbrook & Schweitzer, 2010; Vue, Wolff, & Goto, 2011).

Ethnicity or region of origin can also be associated with mental health outcomes because refugee adults and children from different parts of the world may have encountered different types of traumatic events, of varying durations, and also have different coping strategies and culture-based reactions to trauma (Fazel et al., 2012). A series of studies comparing refugee children and adolescents (together with reports of their parents) living in South Australia and formerly from Africa (Sudan, Liberia), the Middle East/ South Asia (Iran, Iraq, Afghanistan) and the former Yugoslavia (Bosnia, Serbia) indicated that African youth had fewer depressive symptoms and behaviour problems, and greater resilience than their Middle Eastern/South Asian and European peers (Ziaian, de Anstiss, Antoniou, Baghurst, & Sawyer, 2011, 2012; Ziaian, de Anstiss, Antoniou, Sawyer, & Baghurst, 2011). African children and adolescents also reported better health-related quality of life (HRQOL) despite more African youth indicating experiencing trauma than the others (Ziaian et al., under review); thus somewhat confounding the previously identified ‘dose-effect relationship’ between traumatic experiences and mental health (e.g. Mollica et al., 1998).

Religious or spiritual coping. Because religion and culture are closely entwined and thus established an overall framework guiding thoughts and feelings, personality and identity as well as behaviour, I have included religious beliefs within the societal component of the ecological model. Moreover, although making meaning via cultural or religious beliefs may be considered an individual coping strategy and has been explained via cognitive coping models (Park & Ai, 2006; Park & Folkman, 1997) (discussed later in this chapter), meaning-making can also be situated in the social and cultural milieu of a
person. In the case of refugees and immigrants, they not only strive to make meaning of past experiences, but also of present confusions within an alien society; including their positioning and repositioning between home and host cultures and the reconstruction of identities incorporating aspects of both cultures in a new environment.

Somewhat mixed results have been reported for the adaptive function of religious beliefs among child refugees (Fazel et al., 2012). Maintaining religious beliefs and participating in religious activities was associated with better psychological well-being for some child refugees whereas for others who had witnessed religious persecution and/or had abandoned their faith, religion was not a coping resource. Religious and spiritual coping also emerged as a major theme in several studies focusing on refugee coping (Goodman, 2004; Khawaja et al., 2008; Raghallaigh, 2011; Schweitzer, Greenslade, & Kagee, 2007; Tempany, 2009); Sudanese adult refugees resident in Queensland, Australia for instance, described how they prayed to God for strength and for the situation in the home country to improve and how they placed their fate in God and believed that eventually, things will improve. During transit in the refugee camp, they continued to pray for things to get better and also benefited from material and social support provided by church groups. Although prayer continued to be used after migration, belief in future improvement had become a theme that emerged less often (Khawaja et al., 2008). Strong religious or ideological belief systems as in a political struggle, were a protective factor against PTSD (Brune et al., 2002), and cultural relaxation methods such as ‘dhikir’ improved psychiatric symptoms of 75 Muslim torture and trauma survivors attending a mental health clinic in Adelaide, South Australia (Somasundaram, 2010).

Refugees’ attempts to make meaning of their life experiences through religious beliefs and rituals have been identified in a wide range of research. Tibetan refugees in India for instance, made sense of both past and present lives through the intense faith in the
Dalai Lama, Buddhist faith and practice; the advice and healing power of Buddhist monks; and in the acceptance of the law of karma (Hussain & Bhushan, 2013). In pursuance of their beliefs, these refugees practiced traditional healing rituals and divinations (pujas), used traditional medicines, and were also observed to integrate eastern and western treatment. The Buddhist concept of ‘karma’, a kind of determinism based on the belief in reincarnation and the impact of previous life deeds on one’s present life circumstances, played a dual role of either preventing or precipitating mental distress (Mercer, Ager, & Ruwanpura, 2005; Ruwanpura, Mercer, Ager, & Duveen, 2006). Omeri, Lennings, and Raymond (2006) suggested that although Afghan refugees engaged in both transformative and regressive coping, their religious beliefs appeared to be more transformative than regressive. The sense of continuity afforded by religious beliefs that remained constant in a changing environment and fluctuating life circumstances, were also coping strategies used utilized by a mixed group of unaccompanied youth resident in Ireland (Raghallaigh, 2011; Raghallaigh & Gilligan, 2010). The ability to make meaning of extremely traumatizing past experiences by attributing them to ‘God’s will’ also had a healing effect as reported by a group of ‘lost boys’ from Sudan (Goodman, 2004).

I conclude this section on refugees’ resilience, adaptation and coping, by highlighting Jeppsson & Hjern’s (2005) research with Sudanese unaccompanied minors. The researchers found that although participants had experienced many traumatic events and indicated high rates of posttraumatic symptoms, their individual and collective coping strategies enabled them to function reasonably adequately. These findings demonstrate that in certain situations at least, PTSD symptoms per se were not necessarily debilitating and trauma survivors may learn to live and cope with such symptoms successfully.
1.6. Meaning-making to posttraumatic growth (PTG)

There is a close relationship between coping and posttraumatic growth (PTG) because in certain instances, efforts to reduce, manage, or alleviate trauma and distress can go beyond coping; to produce positive psychological outcomes or PTG (Tedeschi & Calhoun, 2004). PTG includes five domains of positive outcome that have been measured (i.e. via the Post-Traumatic Growth Inventory). These are: (1) appreciation of life and changes in life’s priorities; (2) more intimate interpersonal relationships; (3) personal strength; (4) new possibilities in life and (5) spiritual development.

PTG has been found in survivors of a wide variety of adverse experiences, for example, cancer, heart attacks, HIV infections; transportation accidents, bereavement, childhood sexual abuse and sexual assault, natural disasters and combat. PTG also appears to be prevalent in diverse cultural settings, in Eurocentric societies, as well as in Japan, China, South Africa, Bosnia and Herzegovina and Turkey (Splevins, Cohen, Bowley, & Joseph, 2010). However, only a few studies have investigated PTG in immigrants or survivors of mass violence (Kroo & Nagy, 2011; Powell, Rosner, Butollo, Tedeschi, & Calhoun, 2003; Weiss & Berger, 2008).

The meaning-making framework of trauma and coping (e.g. Park & Folkman, 1997) has been used to explain PTG. According to this model, ‘meaning’ encompasses both global meaning and situational meaning. Global meanings are the relatively stable and abstract assumptions, beliefs, expectations and goals that people have about themselves, about the world and about the relationship between themselves and the world. A good exemplar of a global belief is religious or ideological belief, possibly explaining why such beliefs have been among the most salient coping strategies identified by refugee survivors of mass trauma (e.g. Brune et al., 2002; Khawaja et al., 2008; Tempany, 2009). Other global meanings include believing in a just and fair world (i.e. just world theory; Lerner,
belief in the benevolence, controllability and predictability of the world; as well as in one’s identity, safety and future security (Tedeschi & Calhoun, 2004). Conversely, situational meaning refers to the meanings people assign to various occurrences in their lives, asking questions such as ‘why did this happen to me’ (Park & Folkman, 1997)?

Park & Folkman (1997) proposed that when people encountered overwhelming crises, a discrepancy arose between their appraisal of the situation as dangerous, hostile and uncontrollable, and their global beliefs in the benevolence, justice and predictability of the world. The dissonance between appraised and global meanings resulted in psychological distress that the person then attempted to alleviate, reduce, manage or protect against (i.e. coping). Resolution was most often reached by changing the meaning given to the situation, so that it became more compatible with the person’s relatively stable global beliefs. However if the crisis was overwhelming and shattered existing worldviews, global meanings were also revised, for instance when survivors of trauma perceived the world as inherently unjust and unfair (Lench & Chang, 2007). Alternatively, both global and appraised meanings could be modified to reduce inconsistency and thereby psychological distress (Park & Ai, 2006; Park & Folkman, 1997). More recently, Park and Gutierrez (2013) found that both global and situational meanings were independently related to well-being outcomes such as depression, anxiety, stress, and life satisfaction; hence the importance of both types of meanings when adapting to distressing life events.

According to the meaning-making and coping model, a person facing adversity repeatedly attempts to make sense by appraising and reappraising the situation and making comparisons with their global meanings, until acceptance or resolution is reached. It is when there is no resolution or acceptance that traumatic experiences result in rumination, and psychopathology such as PTSD and depression (Park & Ai, 2006; Park & Folkman, 1997). Similarly the struggle for compatibility between appraised and global meanings, or
meaning-making, could also lead to successful coping; or in certain circumstances, go beyond coping, to positive outcomes over and above that of a trauma survivor’s pre-trauma psychological status (Tedeschi & Calhoun, 2004).

Consequently people have reported profound changes in their self-perceptions, interpersonal relationships and philosophy of life, following traumatic experience. Studies have reported survivors of a tornado, a mass shooting, or a plane crash experiencing growth in the aftermath of their adverse experiences (McMillen, Smith, & Fisher, 1997). The literature review by Linley and Joseph (2004) suggested a positive relationship between subjective perceptions of threat and adversarial growth (defined similarly to PTG). However, a curvilinear relationship has also been reported with psychological benefits being greater at intermediate levels of traumatic experiences than at low or high levels (Fontana & Rosenheck, 1998). Tedeschi and Calhoun (2004), used the metaphor of an earthquake and its aftermath to describe PTG: although extreme adversity can shake, threaten or severely damage cognitive schemas or patterns of thinking underlying meaning-making, the reorganization and restructuring of cognitive schemas in the aftermath of the psychological upheaval can lead to psychological benefits similar to the sturdier, more durable structures designed and built in the aftermath of earthquakes. However, PTG does not lead to the alleviation of all distress; and the paradox of growth is that it is found to be independent of distress and well-being. Hence, whereas some research indicated a reduction of distress with experiences of PTG, others acknowledge that residual distress may remain alongside growth (Linley & Joseph, 2004).

Conversely, Splevins et al. (2010) argue that because hypothesized models of meaning-making and growth have been developed in Eurocentric and individualistic contexts, applying them to non-western groups such as refugee people from Asia, the Middle East, or Africa, could result in cultural bias. According to the authors, cultural bias
can arise with regards to (1) global meanings, (2) the need for consistency, and (3) the notion of self-actualization implicit in meaning-making and growth theory (Splevins, Cohen, Bowley, & Joseph, 2010).

First, people from all cultures may indeed have core assumptions, beliefs and expectations about the world and themselves but there may be cultural variations in these worldviews. Global beliefs in the goodness, justice and predictability of the world, as well as self-worth and self-control, may essentially be based on western, individualist cultural values and thus less relevant to people from other cultures. Compared to self-autonomy, self-sacrifice for the sake of the family or community may be the epitome of self-actualization in collectivist cultures. Similarly, the impact of traumatic experiences on global meanings may also be culture dependent. A person living within a more fatalistic or deterministic framework may respond to trauma with a sense of acceptance and contemplation, rather than trying to find meaning. For instance, belief in the Buddhist precept of ‘karma’ (principle of causality where one’s past and present intentions and actions are believed to influence one’s present and future) was psychologically beneficial to Buddhist refugees (cf. Ruwanpura et al., 2006) and the attribution to ‘God’s will’ of both positive and negative life events and experiences were healing to refugees of Christian and Islamic faiths (cf. Goodman, 2004).

Second, the meaning-making and PTG framework postulated that distress following trauma stemmed from cognitive dissonance, and that the inherent need for cognitive consistency motivated attempts to reduce dissonance and distress. Again, this hypothesized process may be a characteristic of individualistic cultures, whereas the need to reduce cognitive inconsistency between appraised and global meanings could be less relevant to persons from collectivist cultures. Instead, change and contradiction could be part of the complex collective self that also facilitates interpersonal relationships in non-western
collectivist societies. Distress arising from adversity may be the result not of cognitive
dissonance, but of the inability to maintain social roles (cf. Renzaho et al., 2011) or the loss
of social networks (cf. Miller et al., 2002).

Third, although psychological growth is often conceptualized as self-actualization or
a drive for personal completion, the characteristics of a self-actualized person may depend
on a person’s cultural orientation (individualistic vs. collectivistic); or the position he or
she occupies along the individualist-collectivist continuum. In predominantly
individualistic cultures, there is an emphasis on autonomy and agency, whereas in
collectivist societies maintaining social harmony could be more important. Moreover, PTG
is assumed to depend not on the nature of the events themselves, but on how people
appraise or interpret events (Linley & Joseph, 2004) including how they utilize their
cultural filters to do so. However authors such as Hobfoll et al. (2007) have found that
genuine growth was possible only if cognitive changes were transformed into action—at
least for their Palestinian study sample.

Hence, although the trauma, coping, meaning-making and PTG models are useful in
understanding the development of corresponding concepts, caution is required when
extending these concepts to Culturally and Linguistically Diverse (CaLD) communities.
Cultural bias or the ‘category fallacy’—application of western-oriented illness and other
categories to non-western populations to whom such categories are less relevant—may be
implicated (Kleinman, 1987). Moreover, the multilevel and multivoiced nature of identity
(which will be described in Chapter 2 of this thesis) indicates that creating meaning of the
past and present is a far more complex activity involving narrators’ historical, political,
sociocultural and interpersonal contexts.
1.7. Altruism born of suffering

Empathy, altruism and helping behaviour are by-products of PTG and meaning-making according to Tedeschi, Park and Calhoun (1998). Helping has also been identified as an effective coping device in the aftermath of traumatic experience and has been reported by refugee populations (Welsh & Brodsky, 2010). Altruism is defined as the motivation to engage in prosocial behaviour such as helping, sharing and cooperating that enhances others’ welfare (Batson & Powell, 2003). However, altruism and helping behaviour are not synonymous concepts because altruistic motives do not always lead to helping and prosocial behaviours are not always motivated by altruism. Hence, altruism can be broadly conceptualized as applicable to behaviours that are primarily motivated to benefit others despite sometimes being beneficial to the helper (Vollhardt, 2009).

Although the bulk of literature on altruism in the past four decades has focused on the positive antecedents of altruism and helping behaviour, such as secure attachments and supportive environments, there has been some suggestion that extreme adversity can also motivate people to reach out and help others, precisely because of their experiences of suffering. For instance, holocaust survivors in Europe reported a deep commitment towards preventing future violence (Kahana, Kahana, Harel, & Segal, 1986; Oliner & Oliner, 1988). Accordingly, Altruism Born of Suffering (ABS; Staub & Vollhardt, 2008) is a theory or model proposing that traumatic or extremely adverse life experiences can motivate people to be altruistic and engage in prosocial behaviour when they have encountered other experiences and psychological reactions as described below.

Staub and Vollhardt (2008) proposed several conditions and experiences that promoted ABS. The facilitating conditions included: healing from trauma, receiving help from others during or in the aftermath of suffering, being required to help, and deriving meaning from one’s own suffering. The cognitive and emotional reactions associated with
ABS promoting experiences comprised of perspective-taking, empathy and sympathy, greater awareness of other people’s suffering, perceived similarity and identification with others’ suffering, as well as a sense of personal responsibility to prevent the suffering of others (Staub & Vollhardt, 2008). Figure 1.2 depicts an adapted version of the ABS model proposed by Staub and Vollhardt (2008).

Figure 1.2 An adapted version of the Altruism Born of Suffering (ABS) model proposed by Staub and Vollhardt (2008)
According to the ABS model, psychological healing is essential for trauma survivors to fulfill their basic psychological needs such as a sense of security, self-worth and social connectedness. Processing traumatic memories through writing about painful experiences (Pennebaker, 2000), sharing one’s trauma story with empathetic others (Agger & Jensen, 1990), learning about the causes and consequences of violence (Staub, 2004), and creating meaning of adverse experiences have been recognized by therapists (Herman, 2001) and researchers (Janoff-Bulman, 1992; Staub & Vollhardt, 2008) as important to psychological healing.

As aforementioned, when people process their traumatic experiences they appraise and reappraise these experiences attempting to create meaning for themselves. The meaning they make in turn could motivate them to take action to prevent future victimization of others, including by reaching out and helping those who have suffered or are continuing to suffer (Herman, 2001). Receiving help from others who have risked their lives to help such as reported by holocaust survivors in Oliner and Oliner (1988) study, and experiencing caring and supportive relationships (from parents, siblings, significant others) prior to, during or in the aftermath of experiencing adversity, could also promotes altruism and helping by exposing people to helping role models and enabling them to learn from observing and identifying with helpers. In a study of Vietnam veterans who were suffering from PTSD, support received after the war was reported to be positively related to their helping activities (Kishon-Barash, Midlarsky, & Johnson, 1999).

Receiving help or support at the time of one’s suffering may reduce feelings of insecurity and vulnerability; and help sustain faith in humankind and in the world. According to Janoff-Bulman (1992), an effective way of finding meaning in one’s suffering is to help others because altruism and helping can restore shattered assumptions about the world as well as self-esteem and self-worth, resulting in future helping. People
may also help others because of norms of reciprocity (Gouldner, 1960), because they were inspired by altruistic role models, or through identification with both victims and helpers. Trauma survivors who had been required to help others because of situational contingencies or were called upon to help (e.g. employment, volunteering) and were able to take effective action to save themselves and others may feel empowered to act on behalf of others in the future. Helping others could lead to a perception of oneself as helpful resulting in a need to act on that perception, to maintain conformity between perception and action. Survivors could also help because they felt socially responsible for others or because of personal principles of justice and care; leading to greater awareness of and identification with other people’s suffering, to perspective-taking, and to empathy, thus motivating future helping activity (Staub & Vollhardt, 2008).

The value of incorporating altruism and helping behaviours into psychological interventions has been recognized for traumatized people such as torture victims and survivors of genocide (Mollica, Cui, McInnes, & Massagli, 2002), combat veterans (Kishon-Barash et al., 1999), children exposed to community violence (Errante, 1997), and at-risk youth (Canale & Beckley, 1999). Mutual helping, support and cooperation can become important tools of survival and meaning-making especially in non-western, collectivist societies. Helping can also contribute to breaking the cycles of violence between victims and perpetrators; because helping behaviour can lead to collective action and mass movements (Bloom, 1998; Eisenberg, Fabes, & Spinrad, 2006). Such collective action and mass movements may in turn assist in the dismantling of unequal and oppressive social structures that instigate or exacerbate violence and conflict.

In support of the above assertion, Hernández-Wolfe (2011) explored ABS among Colombian human rights activists who had also experienced massive political violence. Utilizing qualitative methods, the author described how the activists created meaning from
their experiences by working with other political survivors of violence to promote justice, peace and equity. Their helping actions in turn, facilitated their connection to community; helped rebuild personal identity; and healed trauma. According to this author, the salient themes identified in the study (e.g. affirmation of self despite fear, a search for meaning, leaving a legacy of peace and agency for the next generation) eventually led to the betterment of community life. In addition the concept of ABS also challenges the prevailing master narrative of psychological damage following extreme adversity (Frazier et al., 2013).

Although the literature available to date has directly or indirectly supported the concept of ABS together with its facilitating conditions and psychological processes (Staub & Vollhardt, 2008; Vollhardt & Staub, 2011), to date, I have not identified any study specifically reporting or investigating ABS with people from refugee backgrounds. Accordingly, the empirical study in Chapter 3 explores the relationship between altruism, coping and meaning-making of two groups of refugees living in Australia.

1.8. Aims and objectives

Traditionally refugee mental health research has focused on the psychopathological sequelae of the refugee experience using symptom checklists or structured clinical interviews to determine the prevalence of psychological disorders such as PTSD (Miller et al., 2002). These studies have been useful in documenting and identifying patterns of distress among refugees and in attracting vital public resources to address mental health problems of refugee populations in resettling countries. However, reducing the refugee experience to western-oriented psychiatric symptomatology has effectively ignored the complexity of that experience. The traditional methods have not been able to adequately
capture resettlement-related distress; nor the historical and sociocultural context influencing not only experiences and expressions of distress but also the unique coping strategies enabling the majority of refugees to cope with the adverse effects of trauma exposure. The shortcomings of the traditional approach to refugee research are more fully explained in Chapter 2.

More recently, refugee mental health research has gradually moved beyond symptom focused approaches to also explore the resilience, coping and successful adaptation of refugee populations. Arguably, if at least according to meta-analytic research, fewer than half of refugees meet criteria for psychological illnesses such as depression and PTSD (cf. Fazel et al., 2005; Steel et al., 2009), and others function quite well despite the prevalence of symptoms (Jeppsson & Hjern, 2005), it is of greater importance to investigate possible explanations for refugees’ resilience and coping notwithstanding their negative past experiences. Conducting exploratory studies using qualitative methods enables researchers to better understand the nuances of the unique coping and meaning-making devices of diverse refugee groups. Such research can assist service providers and professionals to design and implement culturally more appropriate and effective programs to assist those who have long term problems in coming to terms with their past traumatic experiences.

More importantly this type of research enhances the understanding of how refugee communities utilize their coping resources and strategies to create their own meaning of past and present experiences, simultaneously navigating through a new culture and society, and negotiating their individual positions between home and host cultures. In contrast to the emphasis of individual cognitive models described earlier in this chapter, meaning-making is not an individual effort alone, but involves sociocultural and historical considerations as well as the uncertainty of acculturation. Studying how people create their own meaning is important because if and when a person’s meaning-making process is
disrupted, findings from such exploratory studies can assist in the reconstruction of meaning not only for refugees but also for immigrants in general who encounter at least some of the distress involved in the refugee experience.

In Chapter 2 I have described a qualitative narrative method especially suitable for exploring how people make sense of their lived experiences through the stories they tell. Another benefit of exploratory qualitative methods is that they allow room for prominent and recurring patterns in the data to be observed; for unexpected findings that are sometimes outside the initial investigative aims of the researcher. The two empirical studies presented in Chapters 3 and 4 discuss such unexpected findings in my narrative research with two refugee communities.

I was also interested in conducting research with one or more under-researched refugee groups as per the refugee mental health literature; inter alia, to ascertain whether the coping resources and strategies reported by larger more researched ethnic or communal groups (as mentioned in section 4.0) would be similarly evident in these less researched groups. However I was also interested in the coping strategies and meaning-making of the selected communities—influenced by their unique cultural, social, political and historical contexts (set out in Chapter 2). The exploratory nature of my research allowed for new hitherto under-investigated phenomena of significance, to be identified as emerging from the analyses. Two such findings—each to be reported in a journal article—were: (1) how altruism, coping and meaning-making were entwined in participants’ narrative journey from home to host country; and (2) how refugee participants used different types of narratives including silences to make meaning of past and present experiences (see Chapters 3 and 4). To my knowledge these phenomena have not been previously explored with refugee communities.
To triangulate findings from my research with refugees, I conducted a second research project exploring the experiences of people providing services to refugees and asylum seekers from a wide array of countries. This project resulted in two further journal articles (one is currently under review). My service provider participants worked at organizations providing physical healthcare, mental health and resettlement services. They included case workers, counsellors, nurses, psychologists and medical doctors. A review of the relevant literature, details of this study and analyses of service provider interviews comprise Chapters 5 to 7. Among other things I was interested in (a) whether service providers observed their clients’ strengths and capacity to cope with adversity; and if so (b) how they utilized these strengths and coping strategies to assist their clients overcome trauma and distress.
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2.1. Introduction

I begin this chapter with an overview of the methodological concerns that have arisen when conducting mental health research with refugees: the advantages and disadvantages of some approaches used in previous studies and the challenge of ensuring cultural appropriateness to avoid the ‘category fallacy’ described by Kleinman (1977). I have then elaborated the narrative method used to collect and analyse 25 refugee life stories (Research Project I) and an overview of the thematic qualitative data analysis method utilized in Research Project II and reported as empirical studies in Chapters 6 and 7. Thereafter I introduce my refugee participants and present aspects of the political, historical and sociocultural background of the two refugee communities I studied, to better understand ‘how’ they told their stories, ‘what’ they said and possible explanations as to ‘why’ they told these particular stories. I conclude the chapter with my personal reflections.

People tell stories of their lives and live the stories they tell.
Catherine Kohler Riessman (2008)
on my motivations for embarking on this research endeavour and possible linkages between the research I conducted and my experiential, sociocultural and historical background that would have undoubtedly influenced research outcomes.

2.2. Methodological concerns in refugee mental health research

Traditionally, mental health research with refugees has utilized symptom checklists or structured clinical interviews to determine the prevalence of psychiatric sequelae such as PTSD, depression and anxiety. According to Miller et al. (2002) these studies have been useful in documenting and identifying the ‘recurring and often enduring patterns of distress found among refugees’ (p.2). However as a result, the literature failed to adequately give voice to refugees’ stories and utilize a rich source of data available to explore the distress associated with the refugee experience, their unique coping strategies and experiences of psychological growth.

Accordingly, Miller and colleagues set out several justifications for deviating from traditional methodology by using exploratory narrative methods to inquire into the post-migratory distress experienced by Bosnian former refugees living in the US. Because Miller et al.’s rationale strongly influenced my decision to use qualitative methods for my research with refugees; I briefly discuss their justifications as follows.

First, the focus on psychopathology failed to capture the plethora of other types of distress in the lives of refugee people; that were in turn influenced by their unique historical, social and cultural contexts. For instance, the patterns of distress experienced by refugees as a consequence of being separated from family, friends and community, social isolation, lack of social support, discrimination and racism, unemployment and economic
hardship were not captured by traditional symptom focused instruments. Moreover, neither the phenomenon of cultural bereavement experienced by immigrants and refugees grieving for their lost culture, community and society (Bhugra & Becker, 2005) nor the existential crisis in meaning, faith and identity often resulting from experiencing mass human rights violations, forced migration, multiple displacement and cultural isolation were examined by approaches focusing on psychiatric symptoms (Silove, 1999).

Furthermore, the predominant use of western language (in questionnaires) and illness constructs (PTSD, MDD) of western psychiatry failed to assess the cultural variations in the experience and expression of suffering of refugees who are mostly from non-western societies. For example there has been some ambiguity of the applicability of western illness constructs such as PTSD to non-western populations (Nickerson et al., 2011). Although several clinicians working with refugees or survivors of massive violence (Mollica et al., 1999; Silove, 1999; Somasundaram, 1993) have argued that the main elements of PTSD (hyperarousal, flashbacks, emotional numbing) remained relatively constant across cultures, others have insisted that PTSD is a ‘culture bound’ diagnosis of western psychiatry that is either inadequate or, at worst, irrelevant to the refugee experience (Bracken, Giller, & Summerfield, 1995; Summerfield, 1999). Most importantly, symptom focused methods failed to reveal how the vast majority of refugees overcame their initial trauma and distress because as observed in Chapter 1 (Fazel et al., 2005), a considerable proportion of refugees studied did not meet the criteria for psychological illness; they managed to adapt to a new environment and went on to lead productive lives.

Second, in order to understand the experiences of refugees, it is essential to gain some familiarity with their historical and sociocultural context both before migration and afterwards; and psychiatric assessments are insufficient in this regard. For example, the
literature review in Chapter 1 indicated how an urban versus rural background, level of education, socioeconomic status and knowledge of the host country language prior to migration, could impact on the resettlement experiences of refugees (e.g. Colic-Peisker & Tilbury, 2003). The refugee experience was also historical and temporal in nature with distinctively identifiable stages. It was usually a journey embarked by people fleeing their home country, to a refugee camp or exile in a country of first asylum and much later on, to a resettlement/host country. The initial stressful period after migration could be distinguished from later more stable years; and life in the home country could also be divided into before versus after war or conflict. Hence, the temporal nature of the refugees’ journey was more likely to be captured by a narrative method that afforded a sequential description and evaluation of experience (Miller et al., 2002; Riessman, 2008; Squire, 2008).

Third, according to Miller and colleagues (2002), essentially reductionist, quantitative methods did not convey the multidimensionality as well as interaction between multiple levels inherent in the refugee experience. For instance, how post-migration resettlement factors (e.g. employment, housing, social support) interacted with pre-migration trauma and other pre-migratory experiences (socioeconomic status, education, culture) in complex ways to aggravate or ameliorate refugees’ resettlement distress, was not revealed (Silove, Steel, McGorry, & Mohan, 1998). Other aspects traditionally identified as exacerbating distress (e.g. social isolation) may in certain circumstances, for some cultural groups be a coping strategy helping to reduce stress (Miller et al., 2002). Traumatic stress symptoms could be of less concern to refugees who learn to ‘live with it’ and instead struggle to address settlement needs while simultaneously grieving personal and cultural losses (cf. Jeppsson & Hjern, 2005). However a counterargument was proposed by Nickerson and colleague (2011) in that it may be necessary for refugees
suffering from distressing psychiatric symptoms to address these symptoms first, in order to move forward and effectively address resettlement concerns. Finally according to Miller et al. (2002) self-report questionnaires used in quantitative research included a priori assumptions about the range of variables to be assessed. Such methods were less satisfactory in assessing variation in under researched areas. All the reasons set out above influenced my decision to use a narrative method to explore the coping strategies and meaning-making of two African refugee communities.

2.3. Narrative research and working with silences

2.3.1 Introduction to narrative methods

In the empirical studies with refugee people presented in Chapters 3 and 4, I used an experienced-centred narrative method supplemented by attention to the interpersonal, positional, structural and contextual influences as set out by Squire (2008 see also, Josselson, 2011; Riessman, 2008). The principle of narrative research is that people tell stories of their lives and the stories they tell represent their attempts to make meaning of various life events. Hence the objective of narrative research is to understand the lived experiences of people from the meanings they create about their experiences as contained in their stories. Eventually people will try to live the stories they tell in accordance to the meanings they construct (Riessman, 2008). According to Squire (2008), experience-centred narrative research is based on phenomenological assumptions that through storytelling, experiences become part of a person’s identity.

Riessman (2008) defined ‘a narrative’ as a ‘bounded segment of talk that is temporarily ordered and recapitulated a sequence of events’ (p.11). To elaborate on this
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definition, ‘a narrative’ encompasses four essential elements: (1) it is temporarily ordered and meaningful; (2) it is an essential yet basic human activity; (3) it re-presents experience; and (4) it portrays a transformation or turning point in the narrator’s life (Riessman, 2008). However, there are other types of narrative methods that utilize slightly varying descriptions of what a narrative entails, in order to guide the decision of what portions of written text to include in analyses (Labov, 2008).

Narratives are temporally ordered and may contain descriptions of a sequence of past events, present happenings, future expectations, as well as imaginary or hypothesized events and experiences. In contrast, event-centred narrative research (e.g. Labovian narrative analysis; Labov, 2008) focuses on past events. Narratives may be contained in written accounts such as transcribed interviews, letters, biographies and autobiographies—or more recently, in visual and online material such as films, photographs and artwork; blogs and social media. Narratives are inherently meaningful because they incorporate the narrators’ personal reflections and evaluations as well as details of their sociocultural and historical background. They can also include contradictions, difficult to transcribe narrative fragments; and gaps, silences, and paralinguistic features that help researchers to decipher meaning (Riessman, 2008). References to the larger cultural, historical, or nationally shared narrative (i.e. master narrative) may also be included in people’s stories, for example to the historical and political context of pre-migration civil conflicts, cultural practices and beliefs of an ethnic community, as well as institutionalized discrimination in refugee stories.

Storytelling is an essential human activity or an activity that makes us human. The narrative psychologist, Bruner (1990) coined the phrase ‘homo narrans’ to refer to what he considered as the deeply ingrained human predisposition for storytelling. Narratives provide a rich source of the narrator’s identity as well as of the alterations to identity that
occur across time and changing context. Because narratives are ‘human’, and human beings are essentially social creatures, narratives inevitably depict the social dimension of the narrator’s identity while simultaneously telling the individual story of the storyteller. According to Goffman (2002), narrators do not construct their identities in isolation, but rather, perform their identities with a wide audience in mind including the story’s immediate recipients. Reference to narrative performance does not suggest that people’s identities are somehow false or unauthentic; or that identity construction is an attempt at deception. Instead it depicts the polyphonic or multivoiced nature of identity, influenced by historical, political, cultural, social, psychological factors, as well as the past, present and future (Riessman, 2008).

Narratives re-present experience and need not be factual accounts of the narrator’s experiences. Similar to memory—which is not considered a photographic reproduction of an observed event (Van der Kolk & Fisler, 1995)—narratives are also constructions and reconstructions of stories people tell within multiple layers of context—personal, historical, political, sociocultural and so forth. Because of the audience’s influence, a narrative may also be considered a co-construction between an interviewer and interviewee, or an author and his or her readers or viewers. Not taking into consideration social imagination in the construction, interpretation and assessment of narratives can be a major limitation of the immigration interview to determine refugee status (e.g. Kirmayer, 2003).

Riessman (2008) proposed that an essential function of a narrative is to depict transformation or change in the narrator’s life. According to Bruner (1990), a narrative is the storyteller’s attempt to restore normality in the face of deviation from that normality as represented for instance in the cultural master narrative (described in the next section). Thus a narrative may be an attempt to ‘save face’ (Squire, 2008) or to portray as more
bearable, a lived life perceived as being too hard or mediocre. It can also contain stories ‘in-the-making’, those that have not yet been told (further explained in the section ‘working with silences’). After listening to stories of people suffering from illness, Frank (2010) proposed that illness narratives depicted narrators’ attempts to repair the damage caused to their identities by the consequences of illness (see also Riessman, 2008). Likewise it is plausible that refugee people too may need to reconstruct their identities to encompass their personal and collective losses, embrace new environments and find their position between home and host cultures. Telling stories could restore the disruption to their identities, restore order in the aftermath of chaos, help gain control of current lives and facilitate the effort to find meaning in the incomprehensible. Finally, because of the emphasis on transformation and change, some experience-centred narrative research has used social or clinical psychology to analyse people’s narratives (Squire, 2008).

2.3.2 Narrative analysis

At present narrative research has evolved to accept for analysis, stories that are structurally deficient, fragmented, incoherent or even narratives that are left untold (Josselson, 2011). Although the narrative method used in the empirical studies in Chapters 3 and 4 go well beyond Labovian narrative analysis, I believe it is important to begin by setting out the essential elements of a fully-formed narrative, for a number of reasons, but also in order to identify structurally incomplete narratives and to reflect on possible reasons why some stories contain both structurally complete and incomplete narrative segments to describe different parts of lived experience (as depicted in Chapter 4).

Labov and Waletzky (1967 see also Labov, 2008) identified six structural elements required for a segment of written speech to be considered ‘a narrative’. These essential
features of Labovian narrative analysis namely, the abstract, orientation, complicating action, evaluation, resolution and the coda are briefly described as follows:

1. **Abstract:** is the precursor to a narrative that notifies the listener or reader that a story is about to be told. It generally comprises a summary or the main gist of the story. In an interview setting, the interviewer’s question can also become part of the abstract.

2. **Orientation:** is the narrative segment identifying the protagonists of the narrative performance. It orients the listener or reader to the time and place within which the story is to be situated. The orientation generally provides answers to the ‘who, when, and where’ of the story.

3. **Complicating action:** is considered the most important part of the narrative. This is usually the plot of the story describing the transformation or turning point of the story being told.

4. **Evaluation:** describes the ‘soul’ of the narrative (cf. Squire, 2008) and most narratives contain various devices narrators utilize to evaluate their stories. For instance, narrators may pause their narrative to describe their thoughts and feelings during the ‘turning point’ or at the time of narration; or evaluative elements can be included as part of an unfolding narrative. Evaluative elements provide justification for the telling of the story and tend to answer the ‘so what?’ question of a hypothetical listener or reader.

5. **Resolution:** is the outcome of the story’s plot. However not all stories have a resolution because some stories are on-going, continuing into the present and future.

6. **Coda:** signifies the end of a narrative. It usually has the effect of returning the listener or reader back to the present after being led by the narrator on a journey into
the narrator’s past. The coda usually precludes the question ‘and what happened then?’

The search for a valid frame to interpret and analyse is the research stage that causes the most argument and concern in narrative research (Squire, 2008). Some narrative analysts use a ‘bottom-up’ approach and commence with the identification of narratives according to the structural elements proposed by Labovian analysis whereas others start by looking for large-scale meanings and then work downwards towards identifying corresponding narrative segments in a ‘top-down’ approach. In a study with people living with HIV in South Africa, Squire (2008) approached the analysis by initially describing the interviews thematically, identifying stories within the themes, and then gradually testing theories that best predicted the stories. Squire also suggested moving back and forth between the interviews and generalizations about the interviews, as well as using both bottom-up and top-down interpretive procedures. Although the procedure described in Squire (2008) considerably overlaps with other qualitative procedures (e.g. thematic analysis) the distinguishing feature of narrative analysis is the attention afforded to the sequencing of events, progression of themes, and the focus on transformation and resolution (for examples see Chapters 3 and 4).

There are several criticisms of experience-centred narrative analysis that require consideration. Firstly, there is a risk of researchers privileging some stories over others, in that forward or future oriented stories are more attractive and likely to be selected for analyses over more stagnant stories. Secondly, a delicate balancing is required to minimize the tension between considering experience as subjective or as being socially determined. Third, focusing on experience could reduce the significance of examining language patterns within narratives, although narrative research generally recognizes that language reconstructs experience and does not directly translate it. Fourth, as aforementioned,
confusion may also arise whether to focus exclusively on fully-formed narratives or to also include fragmented, incoherent, or contradictory narratives in an analysis.

In my two narrative research studies with refugee participants presented in Chapters 3 and 4, I followed a similar analytical procedure to that described by Squire (2008; see also Josselson, 2011; Riessman, 2008). That is, interviews were orthographically transcribed, subjected to line-by-line coding, and analyzed for major and subordinate themes. I attended to the content (‘the told’) and to the structure (‘the telling’), in order to identify either fully-formed or partial narratives within each identified theme.

To avoid privileging certain narratives (first criticism), I also attended to the historical, social and cultural aspects of personal stories. However I was less concerned about unduly privileging participants’ stories because as other authors have observed, when stories are told by the less powerful or more marginalized groups in society (as one may perceive refugees in a western country to be), one person’s story or a few stories could represent the collective narrative of a group. The telling of these stories can bring people together, build collective identities, and contribute towards changing the prevailing political and social discourse; thereby empowering people and enhancing their status (Chase, 2011). For instance collecting, retelling and publishing refugee narratives of altruism, coping and meaning-making (Chapter 3) can change social perception of refugees from being weak, psychologically damaged and a burden on society, to being resilient agents of their own destinies.

Regarding the dichotomy between experience as subjective or as socially constructed (second criticism), in Research Project I (Chapters 3 and 4), I attempted to find a position somewhere in between so as to benefit from the psychological literature that focuses more on individual psychological processes in addition to research taking a more complex
approach to subjectivity. Concerning the emphasis on language patterns (third criticism), I used slightly varying approaches in the two aforementioned studies. In Study 1 (Chapter 3), more emphasis was placed on experience and content to decipher refugees’ altruism, coping and meaning-making. Also sometimes in this study, refugee participants’ narratives about their individual and collective altruistic behaviours may seem to indicate an incontrovertible acceptance of the actions reported; nonetheless my primary focus is on the stories told and how meaning was constructed through the stories participants told. In Study 2, exploring how refugees made sense of past and present experiences through their stories of trauma and loss (Chapter 4) I focused more on the narrative; and narrative structure including the fragmentation of language and the silences within. In each study a flexible approach to narrative selection was followed to include both fully-formed and structurally deficient narratives (fourth criticism).

Additionally, I also tried to find a linkage between refugee participants’ individual narratives and their group narratives incorporating historical, cultural religious, political, and social aspects. This dualism according to Squire (2008) is depicted by both top-down (usually social, religious and cultural) and bottom-up analyses (usually individual) or counter-narratives told against the master narrative of a collective (Tankink & Richters, 2007). A counter-narrative is a narrative or segment of narrative that challenges the dominant or accepted view in a particular society or cultural setting, for example the view that refugees are traumatized, psychologically damaged or a burden on their host societies. Counter-narratives enable narrative research to be utilized for liberation and emancipation of a hitherto oppressed or marginalized social group (Bamberg & Andrews, 2004).
Also because narratives may contain multiple interpretations, I discussed ambiguities arising from my analysis and interpretation of the interviews with key informants including resettlement agency staff as well as community leaders/elders (cf. Squire, 2008; Riessman, 2008). I also conducted two studies with service providers to refugees and asylum seekers, comprising Research Project II (presented in Chapters 6 and 7), with the primary aim of supporting findings from my research with refugees.

2.3.3 Researching silences

As mentioned above, in my research with two refugee communities I attended to fully formed narratives and also to the incomplete and fragmented ones told by participants including the unsaid or unsayable stories. This task was accomplished by attending to the structural elements of participants’ narratives and the absence thereof, discourse markers and markers of omission, as well as paralanguage and non-verbal cues such as facial expressions and body posture. In their study with South Sudanese women who had been sexually violated, Tankink & Richter (2007) proposed several reasons for the narrative reluctance of participants including how they utilized silences to make meaning of their traumatic experiences and their lives. Several of the reasons set out in that study are also applicable to the silences and fragmented narratives observed in Sierra Leonean and Burundian narratives in Research Project I.

A primary reason for narrative ‘silence’ according to Tankink and Richter (2007) was the cultural master narrative fostering silence. Every cultural group had a cultural master narrative developed from culturally based assumptions about matters impacting group members such as its collective past, social roles of men and women, how best to deal with order and chaos, and how to gain control over the environment. These cultural discourses offered clues about the meaning of life; about what was inspiring, dangerous or
risky; and about what was worth taking a risk for. For refugees, their cultural master narrative was often what they brought from the home country, especially during the initial years of resettlement when they were likely to feel that they were still in transition in a culturally and socially alien world. Obviously not everyone in the cultural group subscribed to the master narrative and some people developed contradictory narratives or ‘counter-narratives’ in private. In public however, people often continued to support the dominant narrative of the group, in order to avoid rejection, exclusion, or humiliation, or to demonstrate group unity to outsiders (Tankink & Richter, 2007).

The difference between Burundian silences and Sierra Leonean elaborate narratives is highlighted in Chapter 4. Accordingly, it is plausible that leaders and members of two historically antagonistic subgroups (such as Hutu and Tutsi people within Burundian communities), could be striving to establish a cultural and political master narrative of unity and peace—may be in the hope that such a dominant narrative would lead to tangible unity and peace in the future. And if such a master narrative offered people the most meaning vis-à-vis a valued collectivist society, Burundian narratives might attempt to make meaning of previous genocidal experiences by portraying current unity, harmony and collective helping. With regards to a bitter and destructive historical past however, the best way to foster the new cultural master narrative of unity and peace being collectively constructed, would be to maintain silence about the past. However, for people with little concern about ethnic or religious intragroup differences, and who may have other explanations for the violence and conflict within their society (e.g. greed for national resources, marginalization of a vast segment of the population, as in Sierra Leone) affording elaborate narratives could be immensely helpful to make sense of the violence that clouded their past.
According to the concept of cultural censorship (Sheriff, 2008) psychological motivations underlying suffering could also be socially shared. Similarly emotional upheaval associated with traumatic experiences can be immensely painful prompting people to suppress thoughts and actions related to the corresponding events. In addition, if sharing past experiences of human rights violations and massacres is perceived as negatively impacting collective identity and a sense of collective worth, the tendency to avoid or repress is further validated (Tankink & Richter, 2007). Gradually individual preferences for silence could with time, develop into a master narrative of maintaining silence regarding painful events and experiences of the past.

Although creating, retelling and revising stories may enable people to integrate their fragmented memories, develop coherent narratives, and avoid the debilitating consequences of posttraumatic distress (Herman, 2001), there are certain circumstances in which disclosure does not bring about healing. Some types of trauma for instance are incredibly complex and confusing; and instead of being contained in the past overflow into the present (e.g. childhood trauma; Sorsoli, 2010). Likewise it is possible that if certain aspects of the refugee experience are painful both individually and collectively; negatively impact individual and collective worth; or if these events contradict the existing or desired cultural master narrative (group unity), refugee narratives will also contain silences and blank spaces similar to those of survivors of sexual violence and childhood trauma described in Tankink & Richter’s (2007) and Sorsoli’s (2010) studies respectively.

Other possible explanations for fragmented narratives and silences within narratives include: inability to incorporate various narrative segments into the collective history or memory of a group (pre-conflict intra community harmony); shame as a response to the violation of a cultural or social value (as intra-community violence is to group unity); and/or disclosure negatively impacting family and community (e.g. refugee children who
were born or raised in the host country, learning about the violence in the home country). Moreover, refugee studies have described how forgetting the past and focusing on the present and future is often utilized as a coping device by diverse refugee groups (cf. Goodman, 2004; Khawaja et al., 2008). Another coping device, attributing everything to ‘God’s will’ (Christians and Muslims) or to ‘karma’ (Buddhists), may also render the consequences of past traumatizing events more sufferable or bearable. Consequently, there may be little narrative space available within the group for retelling stories of past events and experiences, giving rise to a social memory of silence and a blank space within personal narratives.

In a study of Israeli war veterans, Spector-Mersel (2011) observed that the ‘end point’ (EP) of a narrative revealed important aspects of the narrator’s identity. The author utilized a narrative interpretive model to decipher the narrative end point by attending to both what was included in stories and what was excluded. The researcher found that the ‘excluded’ comprised silences, omissions and flattening. Silence was the failure to mention salient life experiences or events, omissions were aspects of the life narrative that were considered irrelevant to the story being told, and flattening was those aspects that were mentioned briefly but not elaborated or evaluated. The author contended that silence, omission and flattening were different devices narrators used to maintain or reconstruct suitable identities for themselves (Spector-Mersel, 2011). Similarly it is likely that refugee narratives are replete with such devices that foster meaning-making and identity construction.

Finally, Ghorashi (2008) suggested that the relatively unstructured narrative method was especially suitable when facilitating marginalized groups in society to tell their stories at their own pace and in a manner most conducive to them. This is because the life narrative method afforded the opportunity for lengthy conversations and allowed narrators
the opportunity to reveal the less visible levels of their stories including counter-narratives. It also gave interviewers and researchers opportunity to move beyond words and listen to the silences and blank spaces of the stories untold. In this study, the author was exploring the narratives of former Iranian female survivors of political violence, living in the Netherlands and the US. The author discovered that although women in both the Netherlands and the US struggled to articulate personal abuse suffered in Iran (so that they had not developed fully-formed narratives for these past events), women living in the Netherlands were also silent about their futures in the host country. It was suggested that the Dutch master narrative of conferring immigrants a temporary status precluded the women from envisaging a future in the Netherlands (Ghorashi, 2008).

As aforementioned, there were several reasons that propelled me towards selecting a narrative method to interview people with refugee experiences and to analyse their interviews. To recapitulate, storytelling is an essential human activity and provides a rich source of the storyteller’s identity including transformations or changes to that identity—most likely associated with the refugee experience across home country, refugee camp and resettlement. Because the narrative method used incorporated the narrators’ personal reflections and evaluations as well as considered narrators’ sociocultural, political, ethnic and historical background; it could be said to belong to the critical theory paradigm described in Lincoln, Lynham, and Guba (2011). For these reasons narratives are also inherently meaningful and suitable to investigate how people make sense of their experiences. A narrative may also depict a refugee person’s attempt to restore normality in the face of upheaval or deviation from normality (e.g. horrendous human rights violations, institutional discrimination). Another primary reason for utilizing a narrative method was that it is a relatively unstructured method that minimizes taken-for-granted assumptions about the refugee experience and prompts a marginalized group of people (refugees) to tell
their stories at their own pace and in a manner most conducive to them. It also gives interviewers and researchers opportunity to attend to the silences and blank spaces of the stories too painful to be told (Ghorashi, 2008).

However service providers to refugees and asylum seekers may be assumed to be more powerful actors in society (although five participants were from refugee backgrounds). I was also less interested in workers’ life stories and their identities reconstructed through their stories. Rather it was the service providers’ experiences of working with their refugee and asylum seeker clients that interested me; hence my decision to take a critical realist or postpositivist stance (for a good explanation of the critical realism/postpositivist paradigm see Lincoln et al., 2011) and utilize a relatively more straightforward qualitative analytic method (cf. thematic analysis) to analyse worker interviews. (More details of thematic analysis used in the studies presented in Chapter 6 & 7 are afforded below).

2.4. Qualitative thematic analysis: an overview

As aforementioned, the analytic studies presented in Chapters 6 and 7 utilized qualitative thematic analysis to analyse the interview data collected from service providers working with refugees and asylum seekers in South Australia. Although thematic analysis is widely used in qualitative research one potential problem is that it is often not clearly defined or described giving rise to the criticism that ‘anything goes’ in qualitative research. Hence in this section, I offer a brief overview of the thematic analysis method as proposed by Braun and Clarke (2006) and developed in their recent text (Braun & Clarke, 2013).

According to Boyatzis (1998) coding qualitative data according to themes is a foundational method in qualitative research. It is a tool that can be used across different
qualitative methods and as such is often identified with prominent theories such as grounded theory or Interpretative Phenomenological Analysis (IPA) rather than recognized as a specific approach. However Braun and Clarke (2006) in their seminal paper argued that thematic analysis qualifies to be considered in its own right independent of any particular theoretical framework.

Basically, thematic analysis is a method used to identify, analyse and report patterns within the data. Within this definition a range of analyses may be conducted—from minimally organizing a data set to interpreting various aspects of the data. Braun and Clarke (2006, 2013) argue that many analyses are thematic in nature but claim to be something else such as discourse analysis (DA), grounded theory or IPA. The advantage of identifying a method as ‘thematic analysis’ is that analysis can proceed without the theoretical requirements of DA or IPA especially if researchers do not intend to explore such theoretical concepts.

Braun and Clarke (2006, 2013) proposed a decision-making process to be considered ideally before thematic analysis began. The first step was to decide what counted as a pattern or theme. They emphasized that more instances in the data set did not necessarily amount to the prevalence of a theme. A theme could be prominent across a data set or appear only in a few instances, affording flexibility in identifying themes. What was required however was the consistent application of decisions; hence the researcher/s’ judgment and active participation was required in theme selection. The second decision concerned whether to produce an overall description of the entire data set or a more detailed account of one or a few selected themes; this depended on the interests of the researcher. For instance, if the research area was relatively novel, some researchers elected to afford a less in-depth but overall description of the data.
The third decision was whether to identify themes/patterns as inductive and ‘bottom up’; or deductive and ‘top down’. Deductive thematic analysis is data driven and strongly connected to the data. It involves coding the data without trying to fit into any existing coding frame or the researchers’ analytic preconceptions. Alternatively, inductive thematic analysis is motivated by the researchers’ interests; consequently there is less description of overall data and more in-depth description of one or few specific research questions. The fourth and final question involves identifying themes at a semantic or explicit level of analysis; or at a more latent/interpretative level (Boyatzis, 1998). A semantic or explicit analysis involves focusing exclusively on surface level or obvious meanings arising from the data whereas latent/interpretative level analysis extends beyond the semantic content of data to identify underlying assumptions and conceptualization. Latent analysis has a constructionist basis and is sometimes referred to as thematic DA. In a realist approach one may theorize motivations, experience, and meaning of the individual whereas for constructionists meaning and experience are socially produced. Hence, they do not focus on motivation or individual psychology but rather on the sociocultural context.

In Research Project II with service providers, initially, data was coded without trying to fit into any pre-existing coding frame or analytic preconceptions. Through this deductive, ‘top down’ approach, several themes were identified. Thereafter a more in-depth analysis of the selected themes of interest was conducted for example, Vicarious Traumatization (VT), Vicarious Resilience (VR), talk therapies and therapeutic silences. Hence, the analytic studies presented in Chapters 6 and 7 are essentially inductive and ‘bottom up’. They afford detailed accounts of the selected topics, and focus on the semantic or explicit level of analysis. Chapter 6 specifically focuses on the VT and VR experiences of service providers working with refugees and asylum seekers; and Chapter 7
focuses on service providers’ experiences of working with ‘talk therapies’ and ‘therapeutic silences’ of their clients.

Braun and Clarke (2006, 2013) also specified six steps to be followed when conducting thematic analysis. These steps were adhered to in the analytic studies contained in Chapters 6 and 7. A brief description of each of the six phases is contained in Table 2.1 below:
Table 2.1. Six essential steps in conducting thematic analysis as propounded by Braun and Clarke (2006).

<table>
<thead>
<tr>
<th>Analysis step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Familiarising oneself with the data set</strong></td>
<td>Includes thorough transcription of data set either using orthographic transcription—a verbatim account of all verbal and sometimes nonverbal sounds—or the ‘Jefferson’ system used in conversation analysis.</td>
</tr>
<tr>
<td><strong>2. Generating initial codes</strong></td>
<td>A code is the most basic element of raw data. It is information that can be organized into meaningful groups and eventually to form themes.</td>
</tr>
<tr>
<td><strong>3. Searching for themes</strong></td>
<td>Involves sorting codes and combining them into potential themes. Different devises are used to aid this process such as mind maps, tables, writing theme names on different papers and rearranging them; or using data analysis software such as Nvivo³.</td>
</tr>
<tr>
<td><strong>4. Reviewing themes</strong></td>
<td>Involves two levels: (i) reading and re-reading all the codes under a theme and assessing whether they form a coherent pattern/ theme. (ii) Assessing the validity of developed themes vis-à-vis entire data set.</td>
</tr>
<tr>
<td><strong>5. Defining and naming themes</strong></td>
<td>Involves identifying the essence of each theme.</td>
</tr>
<tr>
<td><strong>6. Producing report</strong></td>
<td>This is the writing up of the story revealed by the data supported by representative or vivid examples from the data or ‘data extracts’.</td>
</tr>
</tbody>
</table>

³ The analytical studies in Chapters 6 and 7 used a combination of data software and manual analysis. That is, the raw data set was read, familiarised with and coded using Nvivo V.9. Thereafter the codes were printed and manually arranged and rearranged into themes with the aid of tables and diagrams. (See also Appendix J for a sample of the analysis conducted via Nvivo).
As aforementioned, thematic analysis does not necessarily require a theoretical or epistemological commitment by the researcher. However, according to Braun and Clarke this flexibility can sometimes be deceptive, leading to several potential pitfalls that need to be avoided. These pitfalls include: (i) failing to analyze data but limiting analysis to collecting extracts; (ii) using questions used to collect data as themes; (iii) weak and unconvincing analysis where themes overlapped or were inconsistent; (iv) mismatch between data and analytic claims; and (v) mismatch between theory and analytic claims (Braun & Clarke, 2013). In the analytical studies presented in Chapters 6 and 7, such potential pitfalls were avoided by the author conducting the initial analysis based on the six steps for thematic analysis aforementioned. The analysis, selected data extracts and match between extracts, analysis and theory were discussed with and revised by three academic supervisors of varying professional backgrounds and academic expertise. Hence they were able to look at the initial analysis I produced and offer advice from different perspectives (i.e. ‘clinical psychology’, ‘qualitative methods’ and ‘refugee research and practice’ perspectives).

Chapter 6 and 7, based on journal manuscripts (currently under review), provide a description of participants as well as further details on the collection and analysis of data in the two studies conducted with providers of services to refugees and asylum seekers in South Australia.
2.5. Participants, measures and procedure

2.4.1 Research criteria

Twenty five people with refugee experiences participated in Research Project I: which comprised the empirical studies 1 and 2 presented in Chapters 3 and 4 respectively. Participants were from two African communities, Sierra Leone or Burundi, who had been accepted for resettlement in South Australia under Australia’s humanitarian program as refugees or women at risk, or had been sponsored by family or friends in Australia. Criteria for selecting participants for my research included: (1) being from Sierra Leone or Burundi and being from a refugee background; (2) Australian residency of at least one year; and (3) the ability to understand and converse in English. Exclusion criteria were: being an asylum seeker or other whose immigration status remained undetermined, being under 18 years of age, or indicating severe physical or mental illness or disability.

The selection of the Burundian and Sierra Leonean communities was largely based on the convenience of recruiting participants according to the selection criteria. In order to recruit participants, I began volunteering at a resettlement agency funded by the SGP and offering resettlement assistance to refugees who had lived in Australia for a duration of six months to five years. This agency also employed several bicultural workers with refugee backgrounds. The purpose of my voluntary work was to establish connections with refugee communities and their leaders/ key informants as well as to enhance my understanding of the complexities involved in the refugee experience. My voluntary work, as well as

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4 Initially the selection criterion was being a refugee and sharing a common cultural heritage. The final selection of the community or communities to be studied depended on my ability to establish links with a community/ies; availability of participants; and their willingness to share their life stories.
assistance I received from acquaintances and friends with whom I had discussed my proposed research project, enabled me to network with and begin a dialogue with leaders of several refugee communities. Our discussions revolved around several basic queries: did my ‘storytelling’ research project interest the leaders of these communities? Would community members be willing to share their life stories? And what was the general level of English proficiency within the community? Eventually two communities—Sierra Leoneans and Burundians—were selected for research participation based on the responses I received to my initial queries.

Notwithstanding convenience of recruitment, I had also been interested in documenting the stories of a less researched group or groups. A perusal of the literature had already informed me that the vast majority of refugee mental health research had been conducted with larger, more prominent refugee communities such as the Sudanese (Goodman, 2004; Khawaja et al., 2008; Marlowe, 2010; Tempany, 2009); former Yugoslavians (Colic-Peisker & Tilbury, 2003; Miller et al., 2002; Weine et al., 1998); or Southeast Asians—Vietnamese and Cambodians (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012; Mollica, McInnes, Pham, et al., 1998). There were few if any published psychological studies conducted with Sierra Leoneans or Burundians resettled in third countries, although a few studies had been conducted with survivors of war displaced within these countries or adjoining countries of first asylum (De Jong & Kleber, 2007; De Jong, Scholte, Koeter, & Hart, 2000). One of my research objectives was to ascertain whether coping resources and strategies identified within other larger communities were also being utilized by the Sierra Leoneans and Burundians who, similar to more researched groups, were also settling into societies throughout the western world. However I was also interested in exploring how their unique sociocultural and historical milieu impacted coping and meaning-making of the two selected communities.
My second research criterion was for participants to have been living in Australia for at least one year prior to being interviewed. This was because the literature had indicated that refugees in earlier phases of settlement could be struggling to address basic resettlement needs such as housing, health and education; and also be encumbered with acculturation stressors such as learning English. I envisaged that such stressors would interfere with people’s willingness to be interviewed as well as with the quality of their narratives. People with longer periods of residency would also be more proficient in English and could offer more elaborative post-migratory narratives including their vision for a future in Australia, as some agency staff and community leaders suggested.

Next it was important that participants were sufficiently fluent in English to be able to talk about complex topics such as how they constructed meaning in their lives. Several reasons guided my decision to conduct interviews in English compared to interviewing via interpreters as recommended by some agency staff but not necessarily by the community leaders. Firstly I was reluctant to conduct narrative analysis through the lens of translation—the problems arising from doing so had been exhaustively discussed by Riessman (2008) with reference to her study with women in South India. Secondly, my small graduate student budget precluded me from employing interpreters on any sustainable basis. Thirdly I was also concerned about my ability to ensure participant confidentiality and thereby enhance their confidence to afford me rich narratives, in the presence of interpreters from the same communities.

5 A Sierra Leonean leader insisted that members of his community were amply conversant in English; whereas a Burundian leader said that although a large section of his community was not fluent in English, those who were more educated or currently pursuing tertiary education were adequately conversant in English.
Participants’ English proficiency was assessed in several ways. Initial contact with participants at community functions and later on the telephone (more details are given later in this chapter) gave me an indication of their ability to converse in English. I began the interview by filling in a 25-item sociodemographic questionnaire with each participant and this was also a good opportunity for me to gauge their English communication skills. Question 15 Part I specifically required participants to describe their knowledge of English on a five point scale from very poor (1) to fluent/very good (5). Question 15 part II required the interviewer to indicate an estimation of participants’ English proficiency on the same scale. All participants indicated their knowledge of English to be either very good (5) or good (4) and did not differ from my rating by more than 1 scale point. (See Table 2.1 for details).

The criterion of participants being at least 18 years of age was important due to the nature of my study: exploring meaning-making. I could not expect children and adolescents to discuss how they made meaning of their past and present experiences in an interview lasting several hours.

Lastly, it was vital to ensure that participants were not unduly distressed or in any way retraumatized by recalling painful events and experiences of the past. One precaution I took to safeguard against this potential problem was to inform my principal academic supervisor who is also a clinical psychologist, of each interview in advance, so she could be on standby to afford advice or make referral if required. Next, I assessed participants’ psychological status before each interview, to ensure that they met with the research criteria. I did this by administering two internationally well-known psychosocial instruments prior to each interview and scrutinizing participants’ responses. The two instruments were: the 26-item World Health Organization Quality of Life-Brief version (WHOQoL-Bref) and the Kessler-10 (K-10) assessing general quality of life and
psychological distress respectively (Kessler et al., 2002; WHOQOL Group, 1997).

Participants were given the choice to either fill in a paper-based version of the instruments or do so with the assistance of the interviewer. Most participants preferred that instrument items be read out to them together with the answer choices, so that they could indicate their response to each question. Hence filling in the WHOQoL-Bref and K-10 together with the sociodemographic questionnaire (including age, date of arrival in Australia, country of birth, details of family and community, language proficiency, religion and so forth) was an intensely time consuming activity.

The K-10 is a short measure of non-specific psychological distress containing 10 items each scored on a scale from 1 to 5 (1 = none of the time; 2 = a little of the time; 3 = some of the time; 4 = most of the time; and 5 = all of the time) (Kessler et al., 2002). Scores range from 10 to 50 with higher scores indicating greater distress. That is, a score of 10-19 indicates no or low current distress, 20-29, mild distress and above 30, severe distress. The rating period is for the past four weeks. All questions appeared to be self-explanatory and easy to understand (Australian Mental Health Outcomes and Classification Network (AMHOCN), 2005). For instance Q1 asks: ‘In the past 4 weeks, about how often did you feel tired out for no good reason?’ The instrument had been previously used in a variety of contexts including surveys with indigenous people in Australia and is available in several community languages (AMHOCN, 2005). My observations of participants’ reactions to the K-10, including the ease with which they comprehended and answered individual items, confirmed the suitability of the K-10 for assessing psychological distress in refugee participants. However it must be noted that the English or other versions of the K-10 had not been validated with these two particular participant groups and hence I used it only as a guide to assess participants’ psychological status. K-10 outcomes for study participants are provided in Chapter 4.
In contrast, administering the WHOQoL did not proceed as smoothly as envisaged mainly because of its length, the limited time some participants could afford for the interview, and my preference to obtain elaborative narratives in preference to filling out questionnaires when faced with time constraints. Moreover, three participants declined to answer question 21: ‘how satisfied are you with your sex life’. One participant said it was against his religious beliefs to talk about sex, and the other two said that the question was irrelevant to them because they currently did not have a sexual partner. Consequently, due to missing data, the WHOQoL measure could not be meaningfully analyzed and had less utility value than the K-10 in ascertaining participants’ mental health status. In hindsight a shorter measure with less intrusive items could have been more successful in assessing participants’ quality of life.

2.5.2 Participants’ characteristics

Accordingly, 25 members from the Sierra Leonean and Burundian communities living in South Australia participated in the research interviews which form the basis of Chapters 3 and 4. They included 11 men and 14 women between the ages of 18 to 56 years. Participants had resided in Australia between 3 and 10 years. There were no statistically significant differences between the mean ages or length of Australian residency of Sierra Leonean and Burundian participants although it appeared that overall the Sierra Leoneans had lived in Australia slightly longer than the Burundians. The Sierra Leonean sample was also more heterogeneous than the Burundian group with regards to religion (4 participants were Muslims) and educational level. The difference in educational level between the communities was primarily due to the relationship between education and English proficiency among Burundians as previously noted by key informants. All Burundians identified themselves as Christians and spoke Kirundi and French, and some also spoke Swahili learned in a Tanzanian refugee camp. In contrast, most Sierra Leoneans
arriving in Australia were already fluent in English or spoke Krio, a blend of English and their local dialect that probably assisted them to learn English quickly.

I have set out overall participant characteristics in Table 2.1 as well as in Chapters 3 and 4. Chapter 4 also contains a breakdown of participants’ sociodemographic details according to community/group (Table 4.1). A more exhaustive account of participants’ historical, cultural and social context follows in Section 2.5 of this chapter.
Table 2.2 Overall sociodemographic characteristics of refugee participants

<table>
<thead>
<tr>
<th>Community¹</th>
<th>Gender²</th>
<th>Age³</th>
<th>Length of residency⁴</th>
<th>Marital status⁵</th>
<th>Education⁶</th>
<th>Occupation⁷</th>
<th>Religion⁸</th>
<th>English_P⁹</th>
<th>English_R⁹</th>
</tr>
</thead>
<tbody>
<tr>
<td>SL = 16</td>
<td>F = 14</td>
<td>18-29 = 7</td>
<td>3-5 = 6</td>
<td>U = 3</td>
<td>GrA = 6</td>
<td>Carer = 5</td>
<td>Christian = 21</td>
<td>Very Poor = 0</td>
<td>Very Poor = 0</td>
</tr>
<tr>
<td>Bu = 9</td>
<td>M = 11</td>
<td>30-44 = 14</td>
<td>6-8 = 18</td>
<td>M = 16</td>
<td>GrB /stud. = 7</td>
<td>Resettlement work = 5</td>
<td>Muslim = 4</td>
<td>Poor = 0</td>
<td>Poor = 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>45-59 = 4</td>
<td>9-10 = 1</td>
<td>W/S = 6</td>
<td>Dip. /sec. = 11</td>
<td>Other work = 11</td>
<td>Other = 0</td>
<td>Adequate = 0</td>
<td>Adequate = 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None = 1</td>
<td>Student only = 2</td>
<td>Unemployed = 2</td>
<td></td>
<td></td>
<td>Good = 5</td>
<td>Good = 7</td>
<td></td>
</tr>
</tbody>
</table>

¹ = SL = Sierra Leonean; Bu = Burundian
² = F = Females; M = Males
³ = denotes age range.
⁴ = number of years in Australia at the time of interview.
⁵ = U = unmarried; M = married; W/S = Widowed, Separated or Divorced
⁶ = GrA = Graduated from an Australian University; GrB/Stud. = Graduated prior to arrival in Australia and/or current university student; Dip./sec. = Diploma from TAFE college or secondary education; None = No education either in home country or Australia.
⁷ = Carer = Disability or Aged care worker; other work = construction, private business, cleaning, meat works, correction services.
⁸ = Indicates religion as identified by participants; all Burundians were Christians; the 4 Muslims were Sierra Leoneans.
⁹ = English_P = participant’s evaluation of English proficiency; English_R = Researcher’s evaluation of participant’s English proficiency.
2.5.3 Ethical approval and research procedure

Before embarking on my research project, I sought and received ethical approval for my research project with refugees from the University of Adelaide Human Research Ethics Committee. Initially I utilized a passive snowballing technique to recruit participants as recommended by the Ethics Committee. That is, I planned to distribute the Information Sheet pertaining to the study together with my contact details among the targeted communities as well as resettlement agencies requesting prospective participants to contact me if they were interested in participating in the study. However early on, community leaders informed me that even if community members were interested in sharing their life story with me, it was highly unlikely they would initiate contact with a stranger. Instead my key informants suggested that I attend a community event, meet with community leaders and members, and ascertain interest in study participation. Hence, upon invitation, I attended a sports festival organized by a local council for the Burundian and Congolese communities and a Boxing Day outing to an amusement park organized by the Sierra Leonean community. As I envisaged that attending these functions alone as a single woman would be culturally inappropriate, I also took my husband who kindly agreed to accompany me.

At each of these events, we spent time mingling with community members, sharing food and joining in the activities. In between, community informants introduced me to their colleagues and friends, so I could explain my research project, answer their queries and afford copies of the Information Sheet to anyone interested in participating. This strategy proved quite useful in igniting the interest of prospective participants who usually exchanged contact details with me and requested me to contact them later to organize a date and time for an interview. Some participants later referred me to friends they believed would be interested in telling their story. In these instances the referrer usually approached
the prospective participant on my behalf, and if he or she agreed, facilitated contact between myself and the participant via the teleconferencing facility on their mobile phone.

Thereafter I conducted face-to-face interviews, administered my questionnaires and recorded participants’ life stories between January and October 2012. Interview venues included participants’ home (if participants were caring for their children at home); a public library near to their homes (usually I booked a private room at the library in advance to ensure privacy and also recording quality); or sometimes their workplaces. I was hugely grateful to my participants for allocating time for the interview despite their enormously hectic schedules; most were juggling employment, sometimes two or three jobs, family, study and community commitments. Hence I strove to conduct interviews at participants’ convenience, waiting and rescheduling as required. All participants consented to their interviews being audiotaped, except one Burundian man who said he felt uncomfortable being recorded and preferred to discuss his experiences informally. In that instance, my interview notes were included in Study 2 as study data6 (see Chapter 4).

Because participants’ communities were relatively small, I took particular precautions to safeguard participants’ confidentiality and ensure anonymity by altering their names and omitting reference to the specificity of their individual circumstances whenever I thought such details risked participants being identified. Such measures may have somewhat reduced the richness of the analysis, but were essential to ensure participant confidentiality (cf. Squire, 2008). The Information Sheet and Consent Forms

6This data however was not included in the empirical Study 1 on altruism, coping and meaning-making (Chapter 3).
were explained to participants and the Consent Form was signed prior to each interview. (The Consent Form is in Appendix E).

Furthermore, because there were almost twice as many Sierra Leonean (16) as Burundian (9) narratives, to minimize possible bias in the analysis of Burundian narratives and to lend support to findings, I also elected to analyze six additional stories of Burundian former refugees residing in Melbourne, Australia using the same narrative method that I used to analyse interview data. These narratives formed part of a documentary film titled: ‘Ubuzima Bushasha’ (New Life) produced in collaboration with Multicultural Arts, Victoria (2012). Chapter 4 includes the outcome of the film analysis.

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7 Ubuzima Bushasha meaning "new life" in Kirundi, the main language spoken in Burundi, is also the title given to a short documentary film that includes seven stories of men and women of the Burundian community in Victoria, Australia. According to an interview conducted by the African Media Australia (AMA) with two Burundian community leaders Hilari Bucumi and Belthrand Habiyakare, and uploaded to YouTube, The idea for the film arose out of the interviewees’ desire to inform and educate their children about the experiences of some of the initial Burundian ‘settlers’ in Australia. This was also an opportunity for the leaders to learn a new skill of producing, directing and editing short films. Ubuzima Bushasha was made available on YouTube on 11 April 2013.
Figure 2.1 illustrates the sequence of actions I engaged in as part of my PhD.
2.6. Background of the communities

2.6.1 The Sierra Leonean Community

_Historical and sociocultural background_. Sierra Leone is a small country (71,740 sq km) in West Africa, bordered by Guinea, Liberia and the Atlantic Ocean. It has a population of about 6 million and its capital city is Freetown. The country has been famous for its rich mineral resources, such as rutile, bauxite, titanium, gold and raw diamonds. The name Sierra Leone originated from the Portuguese for ‘Lion Mountains’ (Peters, 2011).

During the eighteenth and nineteenth centuries large numbers of Africans were removed to Britain and the Americas as part of the trans-Atlantic slave trade. With the abolition of slavery (1807) and the rise of an anti-slavery movement in Britain and elsewhere, hundreds of freed slaves settled in Freetown, Sierra Leone. They included people who had been living in London, who had fought on the side of the British in the American War of Independence, or who were rescued from slave ships crossing the Atlantic Ocean. These people had originated from many parts of Africa and despite their diverse backgrounds, they shared common experiences of western culture, including Christianity and the English language (Wyse, 1987). Over time they integrated to form Sierra Leonean society, developing a distinctive Creole (or ‘Krio’) identity, language and culture. At present there are 18 ethnic groups in Sierra Leone and a corresponding variety of languages. Although their official language is English, the language of communication between the different ethnicities is Krio (a mixture of English and African dialect) which appears to act as a unifying force among the various groups. Sierra Leone is also known as a religiously tolerant country because although it is a predominantly Muslim country (70%) with an influential Christian minority (10-20%), interreligious conflict is rarely reported (UN News Centre, 2013).
Nevertheless there have been tensions between the indigenous African groups, and the more recently arrived Krio settlers who with British colonists dominated the Freetown area. These differences were solidified in 1924 when Freetown became a British colony under British law whereas indigenous laws and customs including the patrimonial system continued in the surrounding areas (the ‘Protectorate’). The continuing sociocultural divide between the urban elite and the rural masses, combined with abuse of the patrimonial system and marginalization of rural youth, is cited as an important precursor to the country’s brutal civil war (Peters, 2011).

After independence from Britain in 1961, Sierra Leone continued to experience political instability throughout the following decades until the outbreak of civil war in 1991. The conflict was not based on ethnic or religious animosities. Competing explanations for the conflict include: a neo-Malthusian theory of rising populations and diminishing resources; greed for the country’s massive diamond reserves; and corruption of state officials and marginalization of the vast population (Peters, 2011; Sierra Leone Truth & Reconciliation Commission (SLTRC), 2004). Large numbers of children and disaffected youth were abducted, forced or induced with promises of education and jobs to join the rebels (RUF) who then initiated fighting in the diamond-rich areas and smuggled diamonds to neighbouring Liberia and other countries in return for weapons and training.

The rebels including their young recruits became notorious for their extreme violence including mass murder, sexual slavery and rape, and the burning and looting of homes, hospitals and schools. The trademark of their violence was the amputation of people’s

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8 The motion film, Blood Diamond (Zwick, 2006) was filmed in the diamond rich Kono province and the Capital, Freetown. The film affords a good depiction of Sierra Leonean participants’ pre-migration context and formed a part of several participants’ narratives.
limbs (SLTRC, 2004). The conflict was also notable for the unprecedented number of warring factions including the rebels, army, army renegades, civil defence forces, mercenaries and foreign parties, most of whom perpetrated violence of varying types and intensity on the civilian population (SLTRC, 2004). The conflict resulted in more than 50,000 deaths and displaced almost two million people (two fifths of the population at the time) who fled to neighbouring countries such as Guinea, Liberia and Ghana.

The conflict lasted from 1991 to 2002. After several failed attempts to secure peace, eventually with the help of the largest UN peacekeeping force to be deployed anywhere in the world, key rebel figures were arrested and the end of civil war was declared in 2002. The Sierra Leonean Truth and Reconciliation Commission was enacted and conducted its proceedings in 2002-03, attempting to bring perpetrators and victims together and also to integrate former child combatants into society. Together with the UN, the Sierra Leonean Government also established a war crimes tribunal (the Special Court for Sierra Leone) to prosecute the people most responsible for war crimes and crimes against humanity. In May 2012 the court convicted and sentenced former Liberian President Charles Taylor to 50 years of imprisonment for his involvement in the Sierra Leonean conflict; thus affording some closure to the survivors of the country’s bloody conflict (as indicated from personal communication with a Sierra Leonean key informant on 15 June, 2012; see also UN High Commission for Human Rights (UNHCR) (2012).

More than a decade later, Sierra Leone struggles to come to terms with the death, destruction and devastation caused during the war years. Today it is one of the ten least developed countries in the world according to the Human Development Index (HDI) which includes measures of life expectancy, literacy, education, standards of living and quality of life (UN Development Programme (UNDP), 2013).
The Sierra Leonean Community in Australia. The Sierra Leonean community in Australia is relatively small. The 2001 census recorded 363 people whose country of birth was Sierra Leone (DIAC, 2007). However, between 2001 and 2010, Sierra Leoneans were among the leading ten nationalities accepted by Australia’s humanitarian program. Currently there are around 4000 Sierra Leoneans living in Australia with the vast majority likely to have arrived as refugees, women at risk, or sponsored by family or friends in Australia (DIAC, 2013).

According to the Sierra Leone profile prepared by the Australian Department of Immigration and Citizenship (2007), newcomers from Sierra Leone have settled in all states and territories. In 2006, around 10 percent of Sierra Leonean refugees resettled in Australia were living in the State of South Australia with the majority identifying themselves as Christian (65%). The diverse number of main languages spoken by entrants to Australia reflected the ethnic and linguistic diversity in Sierra Leone but, as at home, the vast majority was also proficient in Krio, even if it was not their first language (DIAC, 2007). Also in 2006, about 36 percent declared their knowledge of English as ‘very good’ or ‘good’; and only about 16 percent indicated that they spoke no English. As aforementioned, it is plausible that proficiency in ‘Krio’ facilitated the learning of English compared to newcomers who spoke other non-English languages.

Young adults comprised the majority of newcomers with around 44 percent aged between 18 and 34. These statistics reflected a similar age pattern to the home country, where low life expectancy (39 years in 2000; 48 years in 2012; UNDP, 2013) has contributed to young people forming a large percentage of the population.
2.6.2 The Burundian Community

Historical and sociocultural background. Burundi is a small landlocked country (27,816 sq km) in East-Central Africa sharing national borders with Rwanda, Tanzanian, the DR Congo and Lake Tanganyika. It has a population of 8.7 million and the majority is Christian (80%). Burundians speak three main languages, Kirundi, French (official) and Swahili, and belong to two main ethnic groups, Hutu (85%) and Tutsi (14%) who together with the Twa people (1%) have lived together for at least 500 years, according to historical records (Lemarchand, 1996).

Traditionally a kingdom, from the beginning of the 20th century Burundi was occupied by Germany and Belgium respectively and together with Rwanda became known as Ruanda-Urundi. They were separated again at independence in 1962. Apparently Burundi’s push for independence and separation from Rwanda was influenced by the ethnic tension and persecution prevailing in Rwanda (Lemarchand, 1996). For instance, in 1959 the Hutu people in Rwanda had attacked and killed thousands of their Tutsi compatriots who fled to Burundi. At the 1960 elections, the Hutu people secured power in Rwanda. In Burundi in contrast, a multiethnic unity party (UPRONA) was set up and won elections paving the way for independence in 1962. A constitutional monarchy was established and both Hutus and Tutsis were represented in parliament (Queensland Multicultural Health Services (QMHS), 2011). However, when the king appointed a Prime Minister from the Tutsi community, a disgruntled Hutu majority agitated only to be violently suppressed by the Tutsi-dominated military. This was the beginning of a series of bloody post-independence conflicts between the Hutu majority and the more affluent and powerful Tutsi minority. For instance in 1972, conflict between the ruling Tutsis and the majority Hutu population led to an estimated 200,000 deaths and 150,000 people displaced to Tanzania, Rwanda and Zaire (now DR Congo) (QMHS, 2011). Again in 1988, violent
conflict between the army and the people resulted in death and displacement. Ironically, unlike the diversities of Sierra Leone, in Burundi the Hutu and Tutsi communities shared the same language, religion and culture and lived alongside each other (International Commission of Inquiry for Burundi (ICIB), 2002). Hence Lemarchand (1996) suggested that intergroup violence was a result of mutual fear: Tutsi people feared annihilation by the Hutu majority as in neighbouring Rwanda, and the Hutu people were wary of being attacked by the Tutsi dominated Army.

Eventually in 1993, Burundi seemed poised to enter a new era of interethnic coexistence when it democratically elected its first Hutu leader. However hope was short lived when the newly elected president was assassinated by the Burundian Army leading to another wave of violence between the Tutsi and Hutu people in which around 100-150,000 lives are recorded as having been lost. The next year, parliament quickly elected another Hutu president; but within a few months, he died alongside the president of Rwanda when their plane was allegedly shot down. This incident sparked interethnic violence of genocidal proportion in Rwanda claiming the lives of an estimated 800,000 people9. Meanwhile Burundi continued its attempts at democracy and interethnic unity amid a coup-d’état and recurrent violence. Protracted peace talks were conducted with the assistance of the then Tanzanian and South African leaders. Peace agreements with most but not all, warring factions on both sides were signed by 2003. In 2004 a UN peace mission stepped in to enforce the fragile peace agreed upon the previous year.

9 A comprehensive account of the intensity and ferocity of the war in Rwanda during 1994 is depicted in motion films such as ‘Hotel Rwanda’ (George, 2004) and ‘Sometimes in April’ (Peck, 2005).
Again in contrast to Sierra Leone, not until December 2011 did Burundian leaders enact law for a Truth and Reconciliation Commission, and as yet it has not been established. There has also been no attempt to create a legal body to prosecute those guilty of more serious crimes including war crimes, crimes against humanity, and genocide (Human Rights Watch (HRW), 2013). As of 2012, refugee camps in the vicinity were closing and hundreds of thousands of refugees were returning to Burundi. However, like Sierra Leone, Burundi is among the ten least developed countries in the world today (UNDP, 2013).

Unlike Sierra Leoneans, survivors of the Burundian conflict have not been afforded closure in the form of justice or reconciliation although Burundian leaders have reportedly been promoting a theme of national unity and a common Burundian identity. Apparently one argument against a Reconciliation Commission and a criminal tribunal was the possible repercussions that evoking the past could have on the current drive towards national unity (Vandeginste, 2012). Hence it is possible that Burundians within the country and outside could be adhering to this theme of national unity and thus choosing to be silent about previously experienced violations (explained more in the empirical study in Chapter 4). These patterns are also identifiable in the aftermath of conflicts in other places such as Rwanda where there was a decade-long gap between genocide and national consideration of past violations (Vandeginste, 2012).

The Burundian Community in Australia. In Australia, Burundians were among the leading ten nationalities to be accepted by Australia’s humanitarian settlement program between 2004 and 2008. At the end of 2013, there were around 2100 Burundian born persons in Australia (DIAC, 2013). There is little information about the Burundian community resettled in Australia. According to the 2006 census 36 percent of men and 19 percent of women born in Burundi indicated English proficiency, and only 18 and 32
percent of men and women respectively said they did not speak any English (QMHS, 2011). It may be hypothesized that English would be more difficult to learn for Burundians, unlike Sierra Leoneans who had greater familiarity with English prior to migration. Somewhat similar to the Sierra Leonean community, around 46.8 percent of former Burundians were aged between 20-39 years with 37.8 percent aged below 19 years.

According to a Community Profile prepared for healthcare workers in Australia (Queensland Multicultural Health Services (QMHS), 2011), many Burundians underwent traumatic experiences in their home country including witnessing killings, rape, extortion and forced labour, prolonged detention, harsh prison conditions, torture and beatings. Some have fled their countries multiple times. They have also spent long years in refugee camps in overcrowded, primitive and unhealthy conditions and have experienced the insecurity and paranoia involved in living with strangers. In addition, they have been negatively impacted by changing family dynamics and concern for people left in the refugee camps. Hence they were likely to suffer from mental health problems upon arrival in Australia. For example, one study using the General Health Questionnaire (GHQ) found 50 percent of Burundian refugees in a Tanzanian refugee camp indicating serious mental health problems (De Jong et al., 2000).

Figure 2.2 shows the home and host countries of my refugee participants.
Figure 2.2 Refugee Participants’ home countries and destination
2.7. Personal reflections

As a researcher, I conducted all interviews and recorded participants’ life stories. According to the dialogical performance analysis of narrative research (Riessman, 2008) because a narrative is a co-construction between the narrator and his or her audience (or interviewer and interviewee in this instance) it is plausible that similar to participants’ historical and sociocultural backgrounds influencing their narratives and the meaning depicted in those narratives; the telling and the interpretation of their stories were also influenced by my historical, cultural and social background. Hence in this section, I will briefly set out my personal circumstances that could have influenced their narratives as well as my choice of topic and methodology.

I was born and lived most of my life in Sri Lanka, a small (65,000 sq km) Island nation, situated to the southeast of India. Formerly known as the pearl of the Indian Ocean (for its geographical shape as well as its exquisite gemstones), three decades of internal armed conflict between the government (comprised mainly of the majority Sinhalese) and members of the Liberation Tigers of Tamil Eelam (LTTE) vying for a separate homeland on behalf of the country’s main minority group (the Tamils), had left a trail of suffering and death. The acclaimed end of this conflict in May 2009 was especially bloody with up to 40,000 people killed during the last stages of war according to a UN Panel of Experts (Daily Mirror, 2011). Consequently, over the decades and continuing into the present, an exodus of immigrants, refugees and asylum seekers has sought refuge around the world including Australia. I am one such immigrant, arriving in Australia on 2 April 2009.

Although living in the relative security of the capital city Colombo, from a young age I had been sensitized to the conflict in the country’s north and east. Adding to the complexity of growing up in an ethnically divided society, I was also of mixed parentage, necessitating a somewhat delicate positioning of my identity between the two ethnicities.
To add to confusion, my surname was affiliated to one ethnicity, but the language I was most fluent in and most of my acquaintances and friends belonged to the other. Later on in my professional capacity as a lawyer and project coordinator in the non-governmental sector, this balancing act continued: I legally represented and worked to uphold the rights of people from both communities. However I found myself gradually withdrawing from cultural discourses in favour of universal ideals of human rights and freedoms. For some time, I strove to become ‘acultural’ (I later realized that everyone has some form of culture) because for me, identification with any particular cultural group inevitably led to prejudice, discrimination and much suffering.

While documenting the grievances of Sri Lankan survivors of human rights violations, who were often people from marginalized communities, I was constantly aware of the great divide I had to traverse to win their trust and convince them to share their personal stories of violation and abuse, in the fullest possible detail. Our differences pertained not merely to ethnicity, religion or language; but also to lifestyle, urban-rural origin and socioeconomic status; and also sometimes educational level, gender and age. However an invaluable lesson I learned from my work experiences (also validated by several service providers working with refugees described in detail in Chapters 5 to 7) was that there was no divide so wide that human decency, openness, empathy and understanding could not overcome it. My interest in storytelling and narrative analysis developed from my human rights work, listening to the testimonies of marginalized people of Sri Lanka.

When I first embarked on my PhD, my objective was to research the coping strategies and meaning-making of former Sri Lankan refugees living in Australia. However, there were several limitations to conducting such a study: Sri Lankan refugees resided in the more populous Australian states of New South Wales and Victoria; whereas
those in South Australia were mostly awaiting a decision on their immigration status and were considerably distressed by the prevailing uncertainty, making them unsuitable for my study. Some also feared to tell their story in case it negatively impacted the decision pertaining to their immigration status. Hence I began to look to other more established communities with whom I could conduct my research studies. I was aware of the many challenges involved in networking with and building trust with a community (or communities) I had not previously been acquainted with; understanding their historical and sociocultural context; recruiting an adequate number of participants and recording their narratives in sufficient evaluative and elaborate detail. Nevertheless, my previous work experiences gave me the confidence that with sensitivity and mental flexibility I could overcome these challenges, as I had done before. I was also aware that my success (or otherwise) in building linkages with the participant communities and narrators would be reflected in the stories they shared with me. It was a challenge that excited me and it was with optimism that I embarked on the process described in Section 2.4 above.

However, I could not ignore the potential distortion in data collection and interpretation that could arise because of differences in language and culture between participants and me as interviewer and researcher. Extensive discussions with community leaders and service providers helped safeguard against this constraint. Moreover, I believe that the potential power imbalance between participants—who could be perceived as belonging to a marginalized group in society (i.e. refugees)—and more powerful mainstream Australian researchers was reduced by my also belonging to a visible minority group, being a recent migrant to Australia, and being a student. In fact, some participants had resided for a longer time in Australia than I had, and I freely shared my personal circumstances with participants upon their inquiry (see also Hydén, 2008).
In addition, an unexpected advantage may have accrued from this cross-cultural relationship as referred to by one refugee participant. She observed that whereas my culturally diverse background enabled me to understand her struggle to overcome the ‘culture shock’ and ‘fit in’ to Australian society, I could not gossip about her, because I did not belong to her community. Hence my unique position appeared to have enhanced the trust, confidence and comfort of at least one participant to share her story; and this may also be true of others, given the in-depth and elaborate stories they told me. Conversely, it may have also prevented some participants (e.g. Burundian participants but not the Sierra Leoneans) to afford detailed accounts of their conflict related experiences to an ‘outsider’ in order to safeguard the perception of community unity prompted by their cultural and political master narrative (cf. Vandeginste, 2012). A more detailed discussion of the methodological limitations of the four empirical studies presented in this thesis together with my efforts to overcome or reduce these limitations is provided in Chapter 8.
Chapter 3. Altruism, Coping and Meaning-making

Chapter contents

3.1 Preface
3.2 Abstract
3.3 Key points
3.4 Introduction
3.5 Method
3.6 Findings and discussion
3.7 Conclusion

3.1. Preface

Chapter 3 comprises a manuscript accepted for publication in *Australian Psychologist*—a peer-reviewed journal. The manuscript was provisionally accepted for publication on 19 February 2014 pending minor revisions. The revised manuscript was accepted for publication on 1 June 2014 and subsequently published in the *Australian Psychologist* in October 2014. Details of the manuscript are:


In order to maintain conformity in formatting throughout this thesis and also for the convenience of the readers of this thesis, in Chapter 3, I have presented a reformatted

’I’m their Centrelink (social security in Australia)’
Miriam, Aged care worker & refugee participant (2012)
version of the manuscript accepted by *Australian Psychologist*. In the main manuscript
text, I have re-numbered headings, and also changed all instances of ‘*we*’—as referring to
all authors—to ‘*I*’ and incorporated manuscript references into the main reference section
(p. 271 onwards). In other aspects the chapter corresponds to the published manuscript.

**NOTE:**
This publication is included on pages 98-125 in the print copy of the thesis held in the University of Adelaide Library.

It is also available online to authorised users at:

Chapter 4: Narrative & Silence

Chapter 4. Narrative and Silence: How former Refugees talk about Loss and Past Trauma

Chapter contents

4.1 Preface
4.2 Abstract and key words
4.3 Introduction
4.4 Method
4.5 Analysis
4.6 Discussion
4.7 Conclusion

4.1. Preface

This chapter consists of a manuscript that was sent for publication to the Journal of Refugee Studies in September 2013. The manuscript was accepted for publication after revisions on 23 April 2014 and later published online in July 2014.

The details of the manuscript are:


Similar to Chapter 3, in Chapter 4, in order to main conformity in formatting and for the convenience of the readers, I have presented a reformatted version of the manuscript accepted by the Journal of Refugee Studies. I have also changed all instances of ‘we’— as

‘I don’t think I have ever sat (.) and just talked about Mom [before]’
Stacy, resettlement worker & refugee participant (2012)
Chapter 4: Narrative & Silence – 127

referring to all authors—to ‘I’ and incorporated manuscript references into the main reference section (p. 271 onwards). In other aspects the chapter corresponds to the published manuscript.

4.2. Abstract and key words

Using narrative methodology this paper analyses the life stories of 25 former refugees from two African countries, resettled in Australia. Study findings demonstrated a salient divergence between the stories of the two communities; within which there were also individual differences in structure and content of participants’ narratives. Five narrative types were identified along a continuum from detailed disclosure to near-complete silence about traumatic events and experiences: they were: (1) avoiding narratives; (2) struggling narratives; (3) prompted narratives; (4) narratives exceeding demarcated boundaries of disclosure; and (5) returning narratives. I discuss these differences in narrative structure, narrated experience, identity reconstruction, and meaning-making within the context of the personal, interpersonal, sociocultural and historical influences that have shaped the lives of participants. Findings were supported by interviews with 25 resettlement agency staff. Broader implications of the study’s findings for therapists and researchers working with refugees are also discussed.

Key words. Refugee, trauma, identity, meaning, narrative, qualitative, Australia

4.3. Introduction

Storytelling is an essential human activity; an activity that makes us human, according to Bruner (i.e.homo narrans, 1990). Consequently, the stories we tell become
rich sources of ourselves, our identities, as well as of the changes to identity that occur across time and context. Identity construction, however, does not happen in isolation but is an interactive process directed towards the story’s recipients and also performed for a wider audience (Goffman, 2002). This does not suggest that peoples’ identities are somehow false or unauthentic; instead it depicts the pluri-vocal nature of identity influenced by the historical, political, cultural, social, psychological, as well as the narrator’s past, present and future (Riessman, 2008).

As much as people tell stories about their lives, they also live the stories they tell (Riessman, 2008). When faced with disruptions to life including violence to self and others, separation from family and friends, and the loss of home, community, and country, refugees may need to reconstruct their identities to encompass their losses, embrace new environments and position themselves between home and host cultures. Telling stories can repair the ruptures to refugees’ identities, thereby assisting them to recreate new and more acceptable self-identities, restore order in the aftermath of disruption, gain control of their present lives and find meaning in the incomprehensible (Frank, 2010; Lieblich, McAdams, & Josselson, 2004).

Nonetheless, it is hypothesized that emotional upheaval associated with traumatic experiences interferes with memory and psychological functioning, preventing the integration of associated memories and giving rise to an inability to afford coherent accounts of events and experiences (Van der Kolk, 2004; Van der Kolk & Fisler, 1995). Because traumatic memories can be unpleasant, people may suppress thoughts and actions related to the corresponding events (Herman, 2001); and if sharing their experiences negatively impacts upon self-identity and self-worth, the tendency to avoid or repress is further validated (Tankink & Richters, 2007). According to Herman (2001), creating, retelling and revising stories enable people to integrate their fragmented memories,
develop coherent narratives, and avoid psychiatric sequelae such as posttraumatic and depressive symptoms. This is because memory is a dynamic process that allows the past to be selected, filtered and restructured in accordance with present needs and future goals. People may also need to reconstruct their own counter-narratives of healing and control, preserving the value of their self, their family and their community. A counter-narrative is a narrative or segment of narrative that challenges the dominant or accepted view in a particular society or cultural setting, for example the view that refugees are traumatized, psychologically damaged or a burden on their host societies.

Marginalized groups in society need adequate space to tell their stories at their own pace and in a manner most conducive to them. It is also essential for interviewers and researchers to move beyond words to listen to the silences and blank spaces of the stories untold (Ghorashi, 2008; Sorsoli, 2010). The relatively unstructured life story method is especially suited for researching counter-narratives because it affords the opportunity for lengthy conversations and allows narrators the opportunity to reveal the less visible levels of their stories, including the silences (Ghorashi, 2008).

In the narrative interpretive model proposed by Spector-Mersel (2011), to ascertain the narrator’s identity that is revealed by the narrative’s end point (EP), one should attend to both what is included in stories and what is excluded. What is ‘excluded’ comprised the failure to mention life experiences, events or periods that contradicted the EP (silences) or were irrelevant to the EP (omissions), or which were mentioned but not elaborated (flattening). Spector-Mersel (2011) contended that silence, omission and flattening were different devices narrators used to maintain or reconstruct suitable identities for themselves.
Using a narrative method, the present study aimed at exploring the coping resources and meaning-making devices of two African communities with refugee experiences, resettled in Australia. I also interviewed 25 service providers from healthcare, mental health and resettlement agencies in South Australia, to triangulate study findings.

4.3.1 Participants’ Background

The larger participant group came from Sierra Leone, a small West African nation rich in diamonds and other minerals. After independence from Britain in 1961, Sierra Leone experienced continuing political instability until the outbreak of civil war in 1991. The conflict was not based on ethnic or religious animosities. Competing explanations include: neo-Malthusian theory of rising populations and diminishing resources; greed for the country’s massive diamond reserves; and a failing state replete with corruption and marginalization of Sierra Leonean youth (Peters, 2011). The conflict lasted from 1991 to 2002 and involved numerous warring factions including the Revolutionary United Front (RUF, popularly referred to as the ‘rebels’), the army, army renegades, civil defence forces and mercenaries (Sierra Leone Truth & Reconciliation Commission (SLTRC), 2004). The victims were mostly civilians and the atrocities committed against them included killings, shootings, forced recruitment of children, sexual slavery and rape. A hallmark of the conflict was the forced amputation of victims’ limbs (SLTRC, 2004). The conflict resulted in more than 50,000 deaths and displaced almost two million people (two fifths of the population at the time) who fled to neighbouring countries such as Guinea, Liberia and Ghana.

The smaller participant group was from Burundi, another small nation in East-Central Africa. Since independence from Belgium in 1962, the country had been plagued with frequent outbreaks of violence between its two main ethnic groups, the Hutu majority
and the more affluent Tutsi minority (e.g. in 1972 and 1988). The two communities shared the same language, religion and culture, and had lived alongside each other for centuries (International Commission of Inquiry for Burundi (ICIB), 2002). There is some indication that violence was a result of mutual fear: the Hutu people believed they would be attacked by the Tutsi-dominated military, and the Tutsi people feared annihilation by the Hutu majority (85%; Lemarchand, 1996). Further violence began with the assassination of the first democratically elected Hutu leader in 1993, resulting in about 50,000-100,000 deaths. In 1994, both the Burundian and Rwandan leaders were killed in a plane crash, leading to more violence in the two countries. In Burundi, an estimated 300,000 people were killed and 550,000 (9 per cent of the population) displaced during the decade of war that followed.

Hundreds of thousands of civilians were made destitute by each conflict; many undertook perilous journeys to neighbouring countries. Almost two decades on, these people have either been repatriated, continue in exile, or have been accepted into developed countries on humanitarian grounds. Accordingly, the Sierra Leoneans and Burundians were among the leading ten nationalities to be accepted by Australia’s humanitarian settlement program during 2001–2010 and 2004–2008 respectively. Currently there are around 4,000 Sierra Leoneans and 2,000 Burundians in Australia (Department of Immigration and Citizenship (DIAC), 2011, 2013b).

4.3.2 Self-reflection

The first author (Puvimanasinghe) conducted all interviews and recorded participants’ life stories. According to the dialogical performance analysis of narrative research (Riessman 2008), because a narrative is a co-construction of the narrator and his or her audience (or interviewer and interviewee in this instance) it is plausible that
participants’ narratives and the interpretation of their stories could be influenced by the interviewer’s own historical, cultural and social background. Hence Puvimanasinghe’s personal circumstances are briefly described. She was born and lived most of her life in Sri Lanka, where three decades of internal armed conflict between the government (composed mainly of the majority Sinhalese) and members of the Liberation Tigers of Tamil Eelam (LTTE) struggling for a separate homeland on behalf of the main minority group (the Tamils), led to an exodus of immigrants, refugees and asylum seekers. Puvimanasinghe is one such immigrant, arriving in Australia in April 2009.

Although the interviewer does not have firsthand experience of war, as a Sri Lankan lawyer and human rights advocate she worked with survivors of human rights violations documenting their grievances and addressing their legal and other needs. As a nominal Christian of mixed (or unclear) race living in the capital city, Colombo, she often had to transcend differences in ethnicity, religion, lifestyle, urban/rural origin and socioeconomic status between herself and her clients to build trust and enable them to share their personal stories of violation and abuse. In the present study, her recent migrant status (many participants had lived longer in Australia than the interviewer) together with her previous work experience gave her confidence to establish relationships and conduct research with two communities of diverse sociocultural backgrounds. She felt a special connection with research participants who had suffered massive human rights violations, similar to the people she had worked with in Sri Lanka. Her interest in storytelling developed from listening to the testimonies of marginalized people of Sri Lanka.
4.4. Method

4.4.1 Participants

Refugee participants (25) were from Sierra Leone (16) or Burundi (9), and settled in Australia under its humanitarian program. There were 11 men and 14 women aged 18 to 56 years (Sierra Leonean M=35.69; Burundian M=35.0). They had resided in Australia between three and 10 years (Sierra Leonean M=7; Burundian M=5.75). There were no significant differences between the groups on age and years in Australia. More details of participants are included in Table 4.1. However individual details are not afforded, to ensure confidentiality of participants from two small communities.
Chapter 4: Narrative & Silence

Table 4.1 Participants’ Characteristics according to their national group

<table>
<thead>
<tr>
<th></th>
<th>Sierra Leoneans N = 16</th>
<th>Burundians N = 9</th>
<th>Total N = 25</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>11</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>men</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
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<tr>
<td>18-29 years</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>30-44 years</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>45-59 years</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Length of Australian residency</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-5 years</td>
<td>3</td>
<td>3</td>
<td>6</td>
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<tr>
<td>6-8 years</td>
<td>12</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>9-10 years</td>
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<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Education a</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grad.(Aus.)</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Grad.Stu.(Aus.) / Grad.(before Aus.)</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Diploma / Secondary</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
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<td>0</td>
<td>1</td>
<td>1</td>
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<tr>
<td><strong>Employment b</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Resettlement worker</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Other work</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Tertiary Student only</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Unemployed</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

\( a = \text{Grad.(Aus.) = Graduated from an Australian university; Grad.Stu.(Aus.) / Grad.(before Aus.) = a student at an Australian university or a graduate before arriving in Australia; Diploma / Secondary = Diploma from vocational college or secondary education; None = No education either in home country or Australia.} \\
\( b = \text{Carer included disability and aged care; other work included construction, meat works, cleaning, private business and correction services.} \\

Burundians and Sierra Leoneans were recruited in similar ways. Most participants were recruited directly from the two communities after Puvimanasinghe established
contacts with community leaders/key informants, and at their suggestion participated at community events (a sports festival organized by the Burundian and Congolese communities and a Boxing Day outing to an amusement park organized by the Sierra Leoneans). Some participants also referred friends they believed would be interested in sharing their story with the interviewer. In these instances the referrers usually approached the prospective participant and if he or she agreed, facilitated contact between interviewer and participant via the teleconferencing facility on their mobile phone.

All participants consented to audiotaping except one Burundian who preferred to discuss his experiences informally with the interviewer, who took notes. The Sierra Leonean group was more heterogeneous as regards religion, urban or rural origin in their country and education level. Burundian participants were generally more educated (graduates, university students), because of the link between English proficiency and education level. However, the only participant without education was also from Burundi. Most Burundians arriving in Australia spoke Kirundi and sometimes, French, and Swahili. Conversely, most Sierra Leoneans either spoke English or Krio—a blend of English and local dialect—that enabled them to learn English quickly.

### 4.4.2 Data Collection

The study began after receiving approval from the University of Adelaide Human Research Ethics Committee. Individual face-to-face interviews were conducted between January and October 2012 at a venue of each participant’s choice (e.g. homes, public library or workplace), enhancing their familiarity and comfort with the interview setting and thereby facilitating storytelling. Each interview took about one to three hours to complete and some interviews were conducted over two or three sessions. At the beginning of each interview, signed informed consent was obtained and participants completed a
sociodemographic questionnaire. Additionally, I selected two widely and internationally-used psychosocial instruments: the 26-item World Health Organization Quality of Life-Brief version (WHOQoL-Bref) and the Kessler-10 (K-10) to assess participants’ general quality of life and psychological distress (Kessler et al., 2002; WHOQOL Group, 1997). Participants readily completed the K-10 (10 items each scored 1–5) and the vast majority indicated no current distress (score 10–19). Three indicated mild distress (20–29) and only one, a Sierra Leonean woman, indicated severe distress (range 30–50). There were no significant differences between Sierra Leonean and Burundian K-10 scores ($t=0.24$, $p=.816$, Cohen’s $d=0.1$). In contrast, some participants found some WHOQoL items intrusive or irrelevant, and declined to complete all items. Due to significant amount of missing data, the WHOQoL measure could not be meaningfully analyzed.

Participants’ life stories were collected in unstructured interviews comprising an opening statement and several follow-up questions to make clarifications or promote further elaboration. Each interview began with the following statement:

Now [name], I would like you to tell me your life story in your own words and in a way most comfortable for you. I suggest that we begin from life in your home country and proceed to the time after leaving Sierra Leone/Burundi until you came to Australia; the initial years in Australia, the later years and what life looks like to you in the future.

Both interviewer and participants rated participants’ English proficiency as either ‘very good’ or ‘good’ in response to a sociodemographic question. Each participant received an A$20 gift voucher as a token of appreciation. All interviews except one were audio-recorded. Data were supplemented by interviews with 25 resettlement agency staff (approved by the University and South Australia Health Department Ethics Committees) as
well as six additional stories of Burundian former refugees residing in Melbourne, Australia as contained in a documentary film titled: ‘Ubuzima Bushasha’ (New Life) and produced in collaboration with Multicultural Arts, Victoria (2012).

### 4.4.3 Data Analysis

A case-centred narrative approach with a comparison across cases was used to analyse all refugee stories (Josselson, 2011; Riessman, 2008; Squire, 2008). Analysis contained several stages. First, the audiotaped interviews were transcribed orthographically and checked for accuracy. Second, all interviews (including notes from the interview not audiotaped) were described thematically and stories that broadly contained the structural elements of narratives were identified including: (1) the abstract or the gist of the story; (2) the orientation or the ‘who, when and where’ of the story; (3) the plot or complicating action; (4) the evaluation or the narrators’ emotional and cognitive perspectives; (5) the resolution of the story; and (6) the coda, when the listener is returned to the present (Labov, 2008).

The researchers attended to the content of narration (‘the told’), the structure of narration (‘the telling’) as well as to what was left unsaid, with the aid of the narrative structure and markers of omission (Josselson, 2011). The analysis aimed at a holistic interpretation of each story including the personal, interpersonal, positional and sociocultural influences (Spector-Mersel, 2011). Ambiguities arising from the analysis and interpretation of the study were discussed with key informants from the two communities and during interviews with resettlement workers. Participants’ names and circumstances were altered or omitted to ensure confidentiality.

Additionally, the 25 interviews with resettlement agency staff used a semi-structured questionnaire and inquired into the experiences of working with refugees and asylum...
seekers in South Australia. These interviews were also recorded, orthographically transcribed and coded. An inductive thematic analysis (Braun & Clarke, 2006, 2013) was used to analyse data, with prominent and recurring patterns in the data identified at a semantic or explicit level of analysis. Several themes relevant to working with refugees were identified, of which ‘diversity in trauma processing’ was further analyzed for the purpose of the present study.

Puvimanasinghe conducted the primary analysis of the data. Denson, Augoustinos and Somasundaram assisted in the secondary analysis of data including selecting and refining themes, selecting appropriate extracts and linking themes to theoretical concepts.

4.5. Analysis

At the outset of each interview the participant was requested to share their life story, in their own words and in a manner they felt most comfortable with. The two participant groups, however, responded to the interviewer’s request differently. The Sierra Leonean narratives were fairly chronologically ordered and proportionately distributed along their life storyline from home country, through exile, to Australia. They contained vivid accounts of events and experiences, and evaluative narrative elements of thoughts and feelings relating to the three stages of their lives. Burundian stories by contrast, were asymmetrically distributed along their life storyline from homeland to host land. The majority of their stories contained relatively sparse accounts of life in the home country, especially regarding war and conflict-related experiences. With the assistance of prompts and probing questions their stories gained momentum in exile, to become spontaneous and fully-formed only after reaching Australia.
Within this generally observed group variability, there were individual differences regarding the structure and content of participants’ narratives. Accordingly, five narrative ‘types’ were identified as: (1) avoiding narratives, (2) struggling narratives, (3) prompted narratives, (4) narratives exceeding demarcated boundaries of disclosure, and (5) returning narratives. These narrative types can be positioned along a hypothetical continuum from near-complete silence to detailed disclosure as depicted in Figure 1. Table 2 depicts the transcription notations use in the selected extracts.

Table 4.2 Transcription notations used in analysis of participants’ narratives

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Transcription notations</th>
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<tbody>
<tr>
<td><strong>underline</strong></td>
<td>Emphasis or stress on the speech via pitch and/or amplitude.</td>
</tr>
<tr>
<td>*</td>
<td>Whisper, reduced volume, or quiet speech.</td>
</tr>
<tr>
<td>()</td>
<td>A brief pause usually less than 2 seconds</td>
</tr>
<tr>
<td>&gt;text&lt;</td>
<td>Enclosed speech delivered more rapidly than usual</td>
</tr>
<tr>
<td>&lt;text&gt;</td>
<td>Enclosed speech delivered more slowly than usual</td>
</tr>
<tr>
<td>(hhh)</td>
<td>Audible exhalation / sigh</td>
</tr>
<tr>
<td>((italic text))</td>
<td>Annotation of non-verbal activity</td>
</tr>
<tr>
<td>[text]</td>
<td>Text inserted by the interviewer/researcher</td>
</tr>
<tr>
<td>...</td>
<td>Speech/text omitted by interviewer/researcher</td>
</tr>
</tbody>
</table>
Figure 4.1 Continuum of narrative types relating to participants’ disclosure of traumatic experiences
4.5.1 Avoiding narratives: ‘I lived in Burundi...then I went to live in Tanzania’

As mentioned above, Burundian narratives contained meagre accounts of life in the home country and conflict-related experiences. One reason could have been that Burundians were less articulate in English than their Sierra Leonean counterparts, because English was their fourth or fifth language of proficiency. However, their pre-migration narrative reluctance appeared to go beyond language, because in comparison they afforded substantially more elaborative and evaluative narratives of life in the refugee camp and in Australia. For example, when Edward, who was around 22 years old when the Burundian conflict began, was requested to ‘tell his story’ he described the first two decades of his life in a few sentences as follows:

Extract 1

1.  …I will start from when I was student, living home with my family.
2.  After that, then a war happened, a civil war happened in my country,
3.  and I was obliged to leave the country...
4.  When I left my country, I found myself ending in refugee camp.

As can be seen, reference to this period of his life was brief and the narrative was not well-formed. There was a hint of an orientation to his story in line 1 indicating that he was living with his family when war broke out. There is mention of the story’s plot regarding the conflict and its consequences (ll.2-4) but no elaboration of events and no evaluation of his experiences; only a brief chronological account of a few facts. This could be contrasted to the many descriptive accounts he offered of his initial months in Australia, as in Extract 2:
Extract 2

1. And when I was here, the first 6 months was really tough...because
2. first you don’t know English, you don’t know anyone,
3. there is no [one] who can help you, and no one can understand you...
4. And this is a new country. It’s really hard to express how you feel. And how to
5. express what you think because you don’t have the same language and [it is a]
6. different culture. So that’s why things were tough,
7. because everything is totally different.

In contrast to Extract 1, here Edward described the many difficulties encountered during the first six months in Australia, including the inability to express his thoughts and feelings and the struggle to be understood because of language and cultural barriers (ll.3-7). The loneliness and isolation of those initial years recalled by other participants was also alluded to. The distress caused by the cultural difference during the initial years in Australia were described in words as well as expressed through added emphasis in his voice (l.6). Language limitations did not hinder him from sharing lengthy accounts of his experiences, his thoughts and feelings about those experiences, and later on, his hopes and aspirations in Australia.

Although Edward’s narrative did return to the homeland to explain that he was alone because his family had been killed and that his only surviving brother was a soldier away at war, his comments were brief with minimum description and evaluation of thoughts and feelings. Edward never offered another narrative about his life in Burundi before, during or after the conflict.
Likewise, many Burundian participants indicated a reluctance or incapacity to afford a narrative of war and conflict, including participants who responded to the interviewer’s introductory question by briefly describing life in the homeland, and proceeded to life in exile, without mentioning the war. For instance, Candy said: ‘I lived in Burundi when I was 10 12 and then I went to live in Tanzania in the refugee camp.’ Gentle probing around the topic, typically failed to elicit elaboration, but sometimes prompted brief narratives of participants’ arduous journeys of escape into exile as illustrated by Candy’s following account:

Extract 4

1. TE: So can you remember your journey?
2. CA: Yeah I remember...
3. TE: Tell me something about your journey?
4. CA: It was not easy because when we were about to reach Tanzania there were people who catch [you] and take everything you have...sometimes they let you go, and sometimes they can kill you.
5. TE: So it was a dangerous journey?
6. CA: Yes it was a dangerous journey. Yeah.

Extract 4 recounted Candy’s journey with her older siblings from an interior province in Burundi to the Kigoma refugee camp in Tanzania. Although there were some details of the journey (ll.4-6) nonetheless, there was a conspicuous difference between these early narratives and her later accounts of life in Australia where she described striving to learn English, attending the local vocational college, tending to her children and enthusiastically engaging in her community’s activities. Similarly, most Burundian narratives shared lengthy accounts of how they overcame challenges in exile, the initial
loneliness, confusion and apprehension in Australia, as well as their future hopes and dreams for themselves and their children. But regardless of their age at the time of conflict or at the interview, or the number of years they had lived in Australia, they avoided talking about their traumatic experiences and about the violence and loss they had presumably witnessed or experienced; and they barely recounted life before that.

4.5.2 Struggling narratives: ‘some people were killed...running, burning, everything’

Because most Burundian narratives about life in their home country were threadbare or virtually non-existent, sometimes the interviewer used probing questions and prompts, to elicit more description. In doing so, she was mindful to respect people’s narrative willingness and capabilities, in order to prevent them becoming uncomfortable or distressed. Carefully attending to non-verbal cues such as facial expressions and body posture, and verbal aspects such as rapid speech and change in intonation, assisted this endeavour. Another technique was to facilitate participants’ recall of life in the homeland before the conflict, on the assumption that people who may not want to talk about distressing experiences may still have readily-accessible and pleasant memories of life in the home country that they could be accessing as a coping device (cf.Ghorashi, 2008).

Although this hypothesis was supported by the Sierra Leonean interviews as well as by informal conversations with refugee clients at the resettlement agency, Burundian narratives deviated from this generally observed pattern, as illustrated by the following extract:

Extract 5

1. TE: ...can you remember Burundi?

2. CA: Yeah, I remember...
3. TE: Can you remember your life at home?

4. CA: Yeah (.) my life was not bad. But because we left...during the war...it was
5. not so good because some people were killed...running, burning, everything

6. TE: Do tell me what you remember before that time?

7. CA: In my family, my life was good because my dad was working and my
mom too...

8. But after he died, it was a big problem °

9. TE: He died because of the war or?

10. CA: Yeah, because of the war...

11. TE: Then...?

12. CA: I went to the refugee camp with my brothers and sisters...

Candy’s pre-migration narrative had to be assisted with several probes and prompts as she struggled to find the requisite language to complete her story; possibly because she was describing fragmented, conflict-related images for which she had not yet developed an associated narrative incorporating those experiences (Van der Kolk & Fisler, 1995). Upon observing Candy’s inability or reluctance to continue (l.5) the interviewer attempted to prompt a pre-war narrative of life in the homeland (l.6). Although Candy could very well have had the requisite language, the unspeakable experiences of war, conflict and death associated with her home country (ll.4, 8) could have rendered pre-war memories less accessible or painful to recount. Again, there is neither evaluation nor willingness to elaborate an obviously painful event, her father’s death (l.8). Candy did not describe the circumstances surrounding the event; her emotions at the time and afterwards; and what the ‘big problems’ were that were caused by his death. However her emotional turmoil is adequately conveyed through her lowered intonation (l.8). Faced with repeated failure to talk about these experiences, Candy’s narrative drifted into exile (l.12), utilizing the
interviewer’s open-ended query (l.11). It is likely that any further probing would have increased her discomfort. The interviewer offered her the freedom to continue the way she wanted and she chose to progress to the refugee camp—as if talking about Burundi was too painful. Similar to Edward and most other Burundian participants, there was a remarkable difference in narrative structure, quality and willingness to narrate, between Candy’s Burundian stories and her well-formed narratives of the refugee camp and Australia.

4.5.3 Prompted Narratives: ‘it’s a long story’

An exception to the sparse accounts of life before the war in Burundian narratives was Aminata’s narrative. She began her narrative similarly to her colleagues—rushing through the initial decade of her life in a sentence or two and quickly concluding with the discourse marker ‘dunno much about it’ (Ext.6a/ll.1,2). However, when prompted to describe her childhood (ll.3,5) using a strategy similar to what was used with Candy, Aminata switched into narrative mode somewhat reluctantly at first (ll.6) to afford a nostalgic account of a carefree childhood spent among family, friends and community (ll.6-11). Gradually her narrative was imbued with thoughts and feelings, and contained elements of a well-formed narrative as follows:

Extract 6a

1. AM: ...I left Burundi in 1993 when the war broke out.
2. That was pretty much it, I was 10 years old; dunno much about it.
3. TE: Can you remember your childhood?
4. AM: Oh yeah, it was always great, really, really great.
5. TE: Tell me something you can remember?
6. AM: (.) (hhh) What I can remember is…the fact that we were living free…
7. we had parents there; we had neighbours there;
8. we used to play with other friends from the neighbourhood...
9. There was always...a lot of fun...just run around with other children…
10. It was just great. Lot of friends and…
11. great community environment in which to grow up.

Similar to Candy, the natural progression of Aminata’s narrative led to the outbreak of war and afforded in the next extract a glimpse of the chaos she experienced. Aminata’s fragmented language and her attempts to overcome her narrative deficiency are illustrated below:

**Extract 6b**

12. AM: Yeah, the other part [of the story] is when the war broke out...in 1993
13. running without knowing where you’re going
14. TE: Do you remember that?
15. AM: I do...Sometimes…I can actually switch on and start, almost like
16. revisiting…just all the scenes, how everything evolved
17. TE: is it like putting on a video?
18. AM: Yes and watching it. I did it a couple of times when I was working in the
19. city...I just closed my eyes on the bus. And pretty much I was shut off..
22. AM: ...I nearly got killed oh for coming back
23. Anyway it’s a long story.
Aminata’s second account of the Burundian war began when she introduced the interviewer to her conflict-related storyline and simultaneously oriented to when it began (l.12). The narrative segment is short and the interviewer prompted her to continue (l.14). In response, she switched to describing how she recalled and relived traumatic experiences (ll.15-20) using the analogy offered to her of watching a film (l.17), instead of affording a narrative description of what she recalled and re-lived. Thereafter, there is one final attempt at describing the plot or turning point of her narrative—her experiences during the war—but this seemed too effortful indicated by the repeated breaking of language (l.22). Hence, she abandoned the attempt at narration and returned to the present (ll.23).

It may be hypothesized that Aminata’s young age (similar to Candy) precluded her from remembering events and experiences during the Burundian conflict, prompting the interviewer’s query on line 14. In response she insisted that she remembered (‘I do’) and proceeded to describe how she recalled without describing what she recalled. Hence, it seems more plausible that Aminata has not integrated conflict-related episodes into her narrative memory but instead utilized a technique whereby she can revisit the events that had overwhelmed her, in a relatively safe and secure place namely—‘on the bus’, in Australia (l.19). This could be one way she regained control of a perceivably uncontrollable situation she encountered two decades ago, because now, she can switch off her video whenever she desires, just like she can ‘switch on and start’ it (l.15).

4.5.4 Narratives exceeding demarcated boundaries of disclosure: ‘I don’t wanna talk about it now’

Although Sierra Leonean participants elaborated the traumatic events they experienced and witnessed, their stories almost always contained an expressed or implied caveat: participants would share their experiences, but would refrain from going into detail
to avoid becoming distressed. For example 38-year-old Rolland demarcated his narrative boundaries at the inception of his story thus:

Extract 7

1. RO:  My name is Rolland...My lifetime in my country during the 10 years

2. of war was really terrible. I am not able to give you

3. all the information but I am going to give you the basics.

4. TE:  Whatever you are comfortable with.

5. RO:  I don’t want to go into detail; I will feel stress at the end of the day.

Notwithstanding his caveat, Rolland utilized the initial 8–10 minutes of his interview to afford a descriptive narrative of some of his most traumatic and devastating experiences as a young man during the Sierra Leonean conflict, including being tortured, witnessing killings, abduction and rape of his relatives, and the looting and burning of his home. As if to validate his account, Rolland even revealed the marks of torture, still visible on his lower leg. Interspersed with this account is a detailed narrative orienting his audience to his affluent upbringing in the capital, Freetown and his family’s political connections—the context of the conflict. In support, Peters (2011) writes that some of the worst violations took place when the rebels entered Freetown during the early months of 1999 and targeted supporters of the ruling political party as well as the relatively prosperous inhabitants of Freetown who were rarely aware of the dire socio-economic plight of the poor and exploited rural youth.

Hence, Rolland’s extensive orientation to the context of war could be an indication of his search for meaning underlying an otherwise senseless sequence of events that had such devastating impact on his life. He concluded his homeland narrative by recounting
how he fled to a neighbouring country with the help of God; and a substantial part of Rolland’s life narrative was intertwined with his continued attempt to make sense of his experiences through his religious beliefs (cf. Puvimanasinghe, Denson, Augoustinos, & Somasundaram, Accepted for publication, June, 2014). The demarcation of his narrative boundary (ll.3, 5) at the onset of the interview may have been a protective device against potentially invasive questioning. Affording him the space to select and form his own narratives (l.4) could have prompted his subsequent elaboration and evaluation.

4.5.5 The returning narratives: they returned in time to tell us more

A hallmark of the Sierra Leonean narratives was the struggle to describe conflict-related experiences, their perseverance to tell their story despite the fragmenting language and in spite of any protective narrative boundaries they may have set. Notwithstanding the initial descriptive accounts however, many a narrative returned repeatedly in time, sometimes prompted by the interviewer’s queries, other times spontaneously, to elaborate their trauma narratives. For instance, in response to the request to tell his story, Mark, who said he was about 16 or 17 years at the time, described rebels storming into his house, killing his mother and brother and how he fled for his life—unaware to this day of what happened to the rest of his family. He continued on his narrative journey into the refugee camp and to Australia. Halfway through his post-migration narrative however, he returned to elaborate his escape from the chaos in Sierra Leone, in response to a probing question.

Extract 8

1. TE: ...after you left Sierra Leone. Did you think back...did that bother you?
2. MA: Having nobody around always bothers me...I wish my mom was here.
3. I wish my dad was here. I wish I knew what happened to them...
4. And sometimes you have these flashbacks...where people are being killed...
5. stepping on bodies...walking on dead bodies, walking through dead bodies...

6. They [the flashbacks] always keep coming [to me]

Mark’s account began with an evaluative segment about his present loneliness without his loved ones, without knowledge about their whereabouts or their fate (ll.2,3). He then progressed to recount the events that occurred more than a decade ago. Although not a fully-formed account, his effort to develop a more coherent and fluid narrative can be observed by his illustrative description of the ‘flashbacks’ of his experiences that kept seeping into his consciousness even now (ll.4-6). Next the interviewer asked how he managed to ‘get past that’—influenced by the research objective of exploring refugees’ coping resources and strategies. In response Mark described his first experience with psychological counselling after crossing the border from Sierra Leone to Guinea as follows:

Extract 9

1. It [counselling] doesn’t work.
2. [...] some things I just can’t remember them. I [p] I can’t touch my elbow;
3. you [the counsellor] can see that. Coz they nearly cut my hand off...
4. they kept hitting it. You don’t want me to tell you who did it?
5. ... when I talk about it I go back...like it’s happening all over again.
6. I feel someone physically hitting my hand. That memory that I’ll probably be
7. without a hand now...it’s something I don’t always want to deal with...
8. it was silly the way she asked the question...
9. That was it; that was the last time.

According to Mark, his initial encounter with counselling was such a negative and difficult one that he never sought professional psychological assistance again, as indicated
on lines 1 and 9. Interspersed with his descriptive disapproval of counselling he again shifted into narrative mode about his conflict-related experiences. Indeed Extract 9 appeared to be a hypothetical conversation with the counsellor explaining the inappropriateness of the counselling technique used (ll.2-7).

Towards the end of his lengthy and descriptive interview, and in response to a question about how his religious beliefs helped him cope with adversity, Mark returned to reveal additional details of his escape from Sierra Leone hitherto undisclosed. Unlike Extracts 8 and 9, there is no reference to flashbacks or an indication of merely putting segments of flashbacks into words. Instead Extract 10 appeared to have progressed to a more advanced stage of narrative fluidity. In the process Mark also revealed how he resorted to a seemingly invaluable coping strategy and meaning-making device for him: the unfailing faith in his religion and his God (ll.1, 5-7), not only during his flight from war, but throughout exile and in Australia as indicated by his entire life narrative. The relevant extract is as follows:

**Extract 10**

1. ‘Because you pray...you are thinking, you don’t even know that you are going to
2. make it, in the midst of bombs...you are running and people are falling
3. by the wayside...and they are shouting to be shot...
4. It is a **terrible** sight to see, someone **begging to be killed**?
5. coz they don’t have any hope.
6. So our hope is Christianity: ‘Oh God, I know you have a purpose for my life;
7. so I’m just going to keep running...(.) I know there is something somewhere’.

At the conclusion of lengthy narratives to which Sierra Leonean participants sometimes returned repeatedly to afford additional description and evaluation, they also
indicated explicitly or implicitly that their stories had never been told before. For instance according to Stacy’s narrative, she was an adolescent when she fled a war-ravaged Sierra Leone. Her interview contained many elaborative narrative segments about her family’s escape into exile, her experiences going to school in Ghana, her first boyfriend, her indecision about her studies in Australia and her choice of social work propelled by her future goal of returning to Sierra Leone. However, one of the most poignant moments of Stacy’s interview was her detailed description of the events preceding her mother’s death in exile. Her narrative concluded with the following dialogue:

Extract 11

1. ST: And I couldn’t cry. I was just standing there, staring....
2. I don’t know...I couldn’t do anything...I was in shock...
3. And I think I realised the last minute when we were going to bury my mom,
4. and I realised Mom is gone and it was really hard coz ((she cries))
5. 
6. ST: Sorry.
7. TE: that’s ok, take your time.
8. ST: So Mom passed away and then I realised yeah she’s gone.
9. TE: [...] 
10. ST: I don’t think I have ever sat (. ) and just talked about Mom [before].

The disjointed language in lines 1 and 2 conveyed the numbing she could have felt at the news of her mother’s death followed by a jolting awareness that ‘mom is gone’ (ll.3, 8). Through her fragmented language and incomplete sentences she also indicated her unresolved grief. Momentarily her emotions overwhelmed her and her narrative broke
down (ll.1-3, 4). Finally, she confided that she had never talked about her mother before. Ironically the mother’s death narrative began with a statement: ‘I might get a bit emotional with this’, indicating her awareness of the emotional pain involved in narrating it. She continued nonetheless as if she was also aware of the comfort it might bring her, sharing her pain with another person (Herman 2001). Similarly, in his extended and frequently ‘returning’ narrative, Mark explained that he rarely had the opportunity to share his trauma story with his community members because they had their own trauma stories and did not necessarily want to be burdened with his stories as well.

### 4.6. Discussion

The analysis of participants’ interviews revealed five narrative types: (1) avoiding, (2) struggling, and (3) prompted narratives, (4) narratives exceeding demarcated boundaries of disclosure, and (5) returning narratives. Whereas most participants shared elaborative and evaluative narratives of life in Australia and in the refugee camp, Burundian stories were relatively silent about war and conflict compared to the descriptive accounts of conflict-related experiences of the Sierra Leoneans.

Avoiding narratives (narrative type 1) were mostly afforded by Burundian participants who either remained silent or afforded sparse details of their conflict-related experiences as well as of life in the home country. Members of both groups somewhat struggled to describe their traumatic experiences and this is supported by the literature regarding the negative impact of trauma on narrative memory and the fluidity of trauma narratives (cf. Herman 2001). However, Burundian participants appeared to give up the struggle to tell their trauma story and quickly moved on to the next narrative segment—life in the refugee camp (narrative type 2). Conversely Sierra Leonean participants persevered
to share their traumatic experiences either by initially drawing boundaries on what they were willing to share and then exceeding self-imposed narrative boundaries (narrative type 4); or by repeatedly returning in time to reveal more description and evaluation of traumatizing events and experiences (narrative type 5). One Burundian participant, Aminata, deviated from the general observed asymmetric trend of Burundian narratives to afford a descriptive account of life in the home country after she was prompted to do so (narrative type 3). Although this participant also struggled to talk about past trauma similarly to her Burundian colleagues, she said that she still recalled these events and shared with the interviewer how she remembered (via visualization) without disclosing what she remembered.

In accordance with the relevant literature, Sierra Leonean participants’ narrative persistence could be assisting them to integrate their fragmented traumatic narratives, gain narrative fluidity, reconstruct more acceptable self-identities and make sense of their incomprehensible violence and loss (cf. Frank 2010). They could also be utilizing this and similar opportunities to share their traumatic story with an empathetic listener as implicitly indicated by Rolland’s ‘narrative that exceeded demarcated boundaries of disclosure’ and explicitly revealed by Mark and Stacey at the conclusion of their ‘returning narratives’ (Herman, 2001; Van der Kolk & Fisler, 1995). Well-established principles of psychotherapy emphasize the importance of processing traumatic memories, for integration, narrative formation and identity reconstruction (Herman, 2001). Avoidance and distraction are considered short-term protective devices during the initial stages of trauma exposure to enable people to get on with basic survival tasks such as fleeing. However in the longer term these strategies are likely to become maladaptive unless integrated into memory (Goodman, 2004). In support, Sierra Leonean participants appear
to be striving to produce evaluative and elaborative narratives despite the effort it took to do so.

Conversely, avoidance and silence about traumatic events and experiences could have become a coping strategy for Burundian participants, similar to findings in other cross-cultural studies (e.g., Klingman, 2007). The adaptive function of avoidance and silence for Burundians is supported by their relatively high quality of life and minimal psychological distress as indicated by their narratives and their low K-10 scores. Burundian participants could be utilizing non-verbal devices such as visualization as indicated by Amanita’s prompted narrative and also found in non-western, traditional societies (cf., Wilson, 2007). Alternatively, the cultural distance between interviewer and interviewee could have hindered the voluntary narration of conflict-related events either because participants did not feel comfortable doing so or they wanted to protect their self-worth by avoiding its possible defilement by the association with violence and conflict (Tankink & Richters, 2007). These memories could have been suppressed for so long, both individually and collectively (cultural censorship; Sheriff, 2008), that they may have not developed the language to form such narratives. Hence through their silences they could have been reconstructing a narrative identity that was more acceptable to them (Tankink & Richters, 2007). It also explains the apparent Burundian narrative contradiction: how thriving narratives of exile and post-migration could be interspersed with a relative breakdown of pre-migratory narratives, among people indicating low levels of psychological distress.

Interviews with resettlement agency staff offering services to refugees and asylum seekers confirmed that non-verbal techniques such as visualization, progressive relaxation, mindfulness, and religious rituals facilitated psychological healing. Some service providers were using innovative therapeutic projects such as ‘theatre of the oppressed’ or ‘art
therapy’ involving enacting one’s life story through body movements or via the medium of art respectively, when talk therapies were less successful. According to the service providers non-verbal devices could be more culturally familiar and hence more acceptable; or they circumvented the need to be exposed to emotional turmoil in order to heal.

Another possible explanation for the narrative difference between the two groups could be the divergent natures of the two conflicts as perceived by participants. The collectivist communities that both Burundians and Sierra Leoneans described in their home countries could have become an important part of participants’ self-identity (cf. Hofstede, 1984). Inter-ethnic conflict can also be perceived as intra-community conflict especially when communities have lived side-by-side in relative harmony prior to the conflict. Narratives of intra-community violence as occurred between the Hutu and Tutsi people in Burundi could lead to the devaluation, if not shattering, of this communal part of self-identity. Hence avoiding conflict-related narratives could be self-protective; and together with community-enhancing narratives that elaborated engaging in community activities through a shared Burundian Community Centre in South Australia (Puvimanasinghe et al., Accepted for publication, June, 2014), may contribute to the reconstruction of a new, more acceptable collective identity.

Conversely, although it has been acknowledged that much of the violence in Sierra Leone was committed by fellow countrymen (SLTRC 2004), the Sierra Leonean narratives appeared to engage in the ‘othering’ of rebels who resorted to violence versus the narrators, the victims of the conflict. Hence affording elaborative narratives of the violence experienced did not negatively impact upon their communal identity.

There were no significant differences between the Sierra Leonean and Burundian groups regarding age, K-10 scores or length of Australian residency, indicating that
cognitive immaturity at the time of war, severity of distress, or the passing of time did not satisfactorily account for the observed narrative difference.

There were several limitations to the study. Interviews were conducted in English because of a limited budget and the unreliability of conducting narrative analysis through the lens of translation (Riessman, 2008). The language and cultural distance between the interviewer and participants may have interfered with data collection and analysis including preventing Burundian participants from freely discussing their traumatic experiences. Triangulation of study findings with discussions with community leaders and interviews with service providers, however, to a large extent safeguarded against this constraint. The power imbalance (and thereby distortion) that can arise when narrators from visible minority groups discussed sensitive topics with mainstream Australians, was reduced by the interviewer also being a recent migrant to Australia (cf. Hydén, 2008). Due to missing data, the WHOQoL measure could not be meaningfully analyzed.

Additionally, at the close of the recruitment period, the study included almost twice as many Sierra Leonian (16) as Burundian (9) narratives. To minimize possible bias in the analysis of Burundian narratives and introduce some triangulation, the authors analyzed six additional stories of Burundian former refugees contained in the documentary film titled: ‘Ubuzima Bushasha’ (Conellan et al. 2012). Despite the limitations of analyzing data not specifically collected for the present study, the six additional narratives appeared to support the narrative reluctance of Burundians regarding traumatic events and experiences. For example, in a narrative subtitled: ‘Walk with me’ the narrator offered descriptive accounts of the good life in Burundi before war broke out; the long and perilous journey into exile; and the hardship, desperation and hopelessness of the refugee camp. However only a couple of sentences were devoted to conflict-related experiences as follows:
1. In 1993 civil war broke out and everything changed.

2. It became an impossible life and I had to escape the country with family.

There was neither description of how ‘everything changed’ nor reference to his thoughts and feelings about that period of life. Similarly, although other narrators in the film use different devices to tell their trauma story (e.g. metaphor of a crashing tree), the civil war was the least elaborated phase in narrators’ life storyline from home country to Australia.

4.7. Conclusion

Using narrative methodology, this paper explored the life stories of 25 participants from two African communities resettled in Australia. The most significant and unexpected finding was the discrepancy between the stories of the two communities within which five narrative types were identified as capturing the variety of accounts shared. Study findings demonstrated the different pathways to identity construction and to psychological healing taken by the two communities.

These findings highlight the importance for people working with refugees and other migrants to gain competence in the sociocultural and historical origins of their culturally diverse clients. It also indicates the complex relationship between talk therapies and psychological healing because in certain circumstances, disclosure may negatively impact the collective self, sometimes more painful than individual emotional distress. Therapeutic interventions incorporating culturally familiar and less intrusive methods of exposure may be more useful in these circumstances (cf. Hinton et al., 2012; Somasundaram, 2010).
Finally, in terms of the overall research objective, all refugee participants offered lengthy and evaluative stories of struggling, striving and thriving amidst the almost-impossible odds stacked against them, both in exile and in Australia. These narratives of success may help them regain control over their lives and their environment, and to reconstruct more acceptable self-identities both individually and collectively. On a collective level, ownership of such narratives has the potential to enhance understanding among community members about their shared struggles, heal divided communities and promote collective, problem-solving coping. Finally it can contribute to the construction of an alternative narrative in mainstream society regarding people with refugee experiences—from that of traumatized victims to resilient and resourceful citizens of Australia.
Chapter 5. Working with Refugees and Asylum Seekers

Chapter contents

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5.2 Reviewing research with service providers
5.3 Vicarious traumatisation
5.4 Vicarious resilience
5.5 Therapeutic interventions
5.6 Research Project II: Aims and objectives
5.7 Research Project II: Method

5.1. Introduction

Chapter 5 begins with a review of research conducted with diverse categories of service providers working with refugees and asylum seekers (medical and mental health professionals, social workers and interpreters) followed by an exploration of the literature specifically relating to service providers’ experiences of vicarious traumatization (VT), vicarious resilience (VR) and related concepts. Presented next is an overview of some of the salient therapeutic interventions commonly used and found to be effective with people indicating refugee trauma; including the more traditional psychotherapies effective with non-refugee populations and adapted for use with refugees with some success, as well as

Mainstream healthcare institutions often did not consider it their responsibility to be accessible to their non-English speaking refugee clients.

McKeary & Newbold, 2010
more innovative interventions having some potential but with limited or no evidence base.

Finally I present the aims and objectives of Research Project II.

5.2. Reviewing research with service providers

Several research studies have been conducted with people providing services to refugees and asylum seekers in resettlement countries. Of these studies, many focused on a single group of service providers such as doctors, nurses, social workers or language interpreters (cf. Guilfoyle, Kelly, & St Pierre-Hansen, 2008; Phillips, 2013; Suurmond, Seeleman, Rupp, Goosen, & Stronks, 2010). For example, Johnson, Ziersch, and Burgess (2008) documented the challenges faced by General Practitioners (GPs) in South Australia when providing initial medical care for refugees. They identified difficulties such as unfamiliarity with refugee health issues, communication difficulties, and the structure of general practice that hindered doctors attending to refugees’ complex needs. The researchers recommended that refugees with complex healthcare needs and/or resettlement challenges should receive initial healthcare at the specialized refugee health service in Adelaide.

Other studies have utilized single or multiple categories of service providers to explore the systematic and cultural barriers encountered by refugees in host countries. McKeary and Newbold (2010) interviewed health and social service providers including executive directors, program managers, nurses, doctors and settlement workers to explore the systematic barriers to healthcare access experienced by refugees resident in Ontario, Canada. They hypothesized that problems faced by refugees were substantially different to those of economic immigrants and those sponsored by their families. Using thematic discourse analysis to analyse service provider interviews, the researchers identified barriers
such as interpretation and language, cultural competency, healthcare coverage, unavailability of services, isolation, poverty, and transportation issues. They also noted that language difficulties and lack of interpretation services could have serious repercussions on patients’ health especially when doctors failed to adequately communicate medical instructions for follow-up and prescription. Participants had also reported that mainstream healthcare institutions did not consider it their responsibility to be accessible to clients by providing interpreting services (McKeary & Newbold, 2010).

Unlike some other resettlement countries (e.g. Canada, New Zealand), Australia offers cost free, 24-hour translating and interpreting services—either via the telephone or for face-to-face consultations—to all medical and mental healthcare providers. However even in Australia where interpreting services are available, problems relating to language and communication arise such as the unavailability or non-reliability of interpreters, or health professionals not utilizing available interpreting services. Instead healthcare providers often requested patients to bring along family members or friends to interpret (either being unaware of such services or, more likely, for convenience) thereby jeopardizing clients’ confidentiality and safety (Farley, Askew, & Kay, 2012). Language barriers also extend to considerations of literacy levels. Often refugees had lower literacy and educational levels than other migrants; their vocabulary was insufficient to describe their conditions or their explanations were entwined with cultural beliefs and expectations (Farley et al., 2012; McKeary & Newbold, 2010). Healthcare providers concerned about language difficulties, cultural differences, and consequently of the extended consultations required with refugee clients were reluctant to accept such clients or attempted to find shortcuts (getting family members to interpret). This situation could amount to institutional and systemic discrimination in that different ethnic groups received differential treatment thus counteracting the principle of equitable delivery of healthcare (cf. Guilfoyle et al.,
Similarly, (Johnstone and Kanitsaki (2009)) referred to the ‘spectrum of new racism’ in Australian public hospitals against people of minority racial and ethnic backgrounds including indigenous and refugee people. The authors opined that ‘the illusion of non-racism’ was a key reason for such discrimination and advocated for racism to be ‘unmasked and managed’ to improve equitable delivery of health services.

Another important lacuna identified in the healthcare system has been the unavailability of culturally competent care for refugee people and their families. Cultural competence is defined as the ability of systems, agencies and individual service providers to afford care and deliver services to effectively meet the needs of culturally, socially and linguistically diverse people (cf. Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Affording a culturally competent service involves getting to know clients and their histories as well as an awareness of the difference between refugees and other clients (McKeary & Newbold, 2010). The medical practitioners in Farley et al.’s (2012) study acknowledged that their limited knowledge of refugee healthcare impeded effective healthcare delivery. Additionally, concepts such as trust, confidentiality and counselling, familiar to the majority of clients could be alien concepts to CaLD clients.

According to Kirmayer (2012), cultural competency can be achieved by ethnocultural matching at institutional, practitioner and service levels. At the institutional level, mental health services can be provided in community settings. At the practitioner level there can be matching of clients’ ethnicity with that of their workers; and at the service level, clinicians/workers could modify their interactions with clients. However, the concept of cultural competence has been criticized for assuming a rather fixed cultural characteristic of groups based on the historical and political context in which it was developed in the US; and not being representative of the differential and ever-fluctuating
multiculturalism evident in other countries (Kirmayer, 2012). Although criticized for its non-applicability to the Australian context (see Johnstone & Kanitsaki, 2007) nonetheless, cultural safety has been advocated as being more appropriate and going beyond cultural competence to also address the power imbalances and institutional discrimination (Papps & Ramsden, 1996). One important aspect of cultural safety is the need for healthcare and other workers in multicultural settings to examine their own realities and the attitudes they bring into healthcare and to be open-minded towards people different from them (Crampton, Dowell, Parkin, & Thompson, 2003).

Renzaho (2008) explored how government funding and service agreements negatively impacted on the achievement of cultural competence in services provided in the state of Victoria, Australia. Accordingly the author conducted a study with 50 workers from 26 agencies, together with conducting focus group discussions with nine different ethnic groups. He found that service providers’ tended to adopt a ‘one approach fits all’ model that limited the allocation of resources to address CaLD community needs; there was inadequate sharing of information, duplication of services and underutilization of available resources. The authors recommended ‘needs-led’ rather than ‘service-led’ programs to enhance cultural competency and address the unique requirements of refugees.

In the next two sections I discuss two potential consequences for service providers of working with people from refugee backgrounds.

### 5.3. Vicarious traumatisation and similar concepts

Refugee people often experience extremely traumatizing experiences such as threats to life and loved ones, witnessing mass killings, mutilations and dead bodies, and the
destruction of homes, villages and communities. They may languish for years or decades in unhygienic and unsafe environments with the minimum of resources. Hence working with people with such traumatizing histories could involve considerable psychological risk for service providers.

The negative consequences of trauma work have been variously described as countertransference, burnout, secondary traumatic stress, compassion fatigue and vicarious trauma (VT). For instance, countertransference describes the fear, grief and helplessness felt by a therapist corresponding to what clients detail in their trauma story (McCann & Pearlman, 1990b); whereas burnout is the psychological strain, progressive state of fatigue or apathy experienced by therapists working with trauma survivors (Figley, 2002; McCann & Pearlman, 1990a). Symptoms identified as contributing to burnout included feeling hopeless, depressed, discouraged; emotional exhaustion; disillusionment; reduced compassion; experiencing work as a heavy burden; and becoming alienated, uncaring, impersonal and cynical towards clients (McCann & Pearlman, 1990a; Pross, 2006).

Countertransference has been distinguished from burnout in that the literature regarding countertransference has mostly emphasized the personal characteristics of a therapist as determining his or her response to a client’s trauma story, whereas burnout depends more on the characteristics of the traumatic event or events described (McCann & Pearlman, 1990b). In comparison, VT is the combination of the trauma worker’s characteristics, the situation described and the context in which work is done.

Another conceptual term devised to describe the negative impact of trauma work is secondary traumatic stress which comprises almost exclusively the observable symptoms of PTSD, namely hypervigilance, intrusion, and avoidance or emotional numbing (Figley, 2013). Similarly, compassion fatigue is defined as the consequence of working with people who had experienced stressful events; representing a convergence of traumatic stress,
secondary traumatic stress and burnout (Figley, 2002). Additionally, Weingarten (2003) introduced ‘empathic stress disorder’ to include burnout, VT and secondary traumatic stress. However unlike VT, compassion fatigue and empathic stress disorder do not appear to be unique to trauma work but afforded a more general description of the consequences of working with distressed people. Hence, according to Dunkley and Whelan (2006) VT is the most appropriate term to describe the consequences of working with clients with traumatic experiences and specifically refers to the impact of trauma work.

Accordingly, VT has been defined as the cumulative effect of working with trauma survivors, negatively impacting workers’ emotions (anger, sadness, fear), memory (giving rise to the PTSD symptoms of hyperarousal, re-experiencing and avoidance), and cognitive schemata resulting in the transformation of their overall beliefs and worldviews (McCann & Pearlman, 1990a). Several signs and symptoms of VT as suggested by Pross (2006) are set out in Table 5.1 below.
Table 5.1 Signs and symptoms of Vicarious Traumatisation (VT)

<table>
<thead>
<tr>
<th>Denial of client’s trauma</th>
<th>Loss of confidence that trauma work can be beneficial or even possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over-identification with client and client’s problems</td>
<td>Cynicism</td>
</tr>
<tr>
<td>Increased sensitivity to violence</td>
<td>Feeling insecure</td>
</tr>
<tr>
<td>No time and energy for oneself</td>
<td>Feeling disillusioned by humanity</td>
</tr>
<tr>
<td>Feelings of great vulnerability</td>
<td>Disrupted frame of reference</td>
</tr>
<tr>
<td>Feelings of alienation</td>
<td>Changes in identity, worldview and spirituality</td>
</tr>
<tr>
<td>Social withdrawal</td>
<td>Alternations in sensory experiences (intrusion, dissociation, depersonalisation)</td>
</tr>
<tr>
<td>Disconnection from loved ones</td>
<td></td>
</tr>
<tr>
<td>General despair and hopelessness</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Pross, 2006

McCann and Pearlman (1990a) developed the Constructivist Self-Development Theory (CSDT) in order to illustrate how the nature of traumatic events as shared by clients can interact in complex ways with the worker’s personal characteristics, needs and wants, to result in the inner psychological turmoil experienced by service providers. According to these researchers, people construct their own realities through a complex configuration of beliefs, assumptions and expectations of themselves and of the world. Also referred to as mental frameworks, patterns or schemas, these cognitive structures become increasingly complex along the lifespan, and are used to interpret events. McCann and Pearlman (1990a) also refer to five fundamental psychological needs—safety, dependency/trust, power, esteem, intimacy—that are manifested via mental schemas. Working with trauma survivors can disrupt and transform the cognitive schemas of trauma
workers just as directly experiencing traumatic events can disrupt the thought patterns of trauma survivors. Hence, each worker will have a unique reaction to his or her client’s story depending on how important the corresponding mental schemas are to the worker (McCann & Pearlman, 1990a).

For instance, therapists working with survivors of domestic violence have reported feeling less secure and powerless or being more aware of gender power and control, with female therapists reporting less trust towards men when forming new relationships (Iliffe & Steed, 2000). Similar sentiments have been reported by therapists working with survivors of sexual assault, rape, and AIDS. Clinicians working with victims of random violence or accidents have reported an increased sense of vulnerability and heightened awareness of life’s uncertainties. The interaction between personal characteristics and situation may be explained by the example of a helper having a strong need for security, being privy to stories where innocent people get harmed and identifying with his or her client. In this instance the worker’s sense of safety may be challenged, and they may experience related nightmares (e.g. of being violated by a home invader) or more indirectly experience increasing thoughts and images of personal vulnerability (e.g. a loved one in a car accident; McCann & Pearlman). Eventually each worker’s vulnerability to VT depended on his or her ability to process, integrate and transform the traumatic experiences, similar to their clients. To date, VT has mostly been studied with survivors of sexual abuse and assault (Dunkley & Whelan, 2006).

An important limitation of the CSDT model is that it cannot explain the overall impact of trauma on workers especially the positive aspect of trauma work that can co-exist with distress, as also reported in the literature (i.e. posttraumatic growth, VR) (cf. Tedeschi & Calhoun, 2004). Nor does the CSDT model distinguish between enhanced awareness (e.g. of the nature of human rights violations suffered by survivors) and
changes to one’s overall patterns of thinking or worldview (VT) prompting (Dunkley & Whelan, 2006) to suggest a continuum from enhanced awareness to exaggeration and paranoia, following trauma exposure both directly (by survivors) or vicariously (by helpers). They also suggested that factors such as therapists’ personal trauma story, caseload and level of experience could influence the development of VT, although there was limited evidence in this regard.

An important factor influencing the development of VT is the coping strategies resorted by trauma workers. According to (Dunkley & Whelan, 2006) workers utilize both passive and active coping devices to minimize or ameliorate the negative impact of their work. Passive coping includes: suppression of emotions, distancing and dehumanizing; whereas active coping strategies include seeking out colleagues to share their experiences, seeking emotional or instrumental support, planning, and the use of humor. Medical professionals and therapists have adopted various measures to prevent or minimize the impact of VT and burnout (Pross, 2006): self-care measures such as avoiding ‘workaholism’ and making time for hobbies, family and friends; engaging in spiritual or leisure activities; enhancing self-awareness of the negative consequences of trauma work; reflection with the help of colleagues or during supervision; maintaining a professional distance from clients to prevent over-identification with clients; diversification of work (i.e. seeing non-trauma clients; taking sabbaticals for research projects and publications; continuing professional education, and limiting caseloads (Pross, 2006). Finally, although most research on VT has been conducted with mental health workers (therapists) helping sexual abuse/assault survivors, there is also limited evidence of VT among other categories
of workers such as social workers, doctors, lawyers, nurses, emergency service
professional helping and caring for survivors of various types of traumas.\textsuperscript{10}

Engstrom et al. (2008) proposed that researchers and practitioners working with
torture and trauma survivors cannot be neutral, that they must take a position against the
wider culture of oppression, intimidation, injustice and violence, and commit to changing
the status quo in some manner. Hence some therapeutic models include discussions around
injustice and raising awareness of the methods utilized by state authorities to perpetuate
terror and fear among populations. Reynolds (2011) advocated the therapist’s role as an
‘ally’ to the client and of the necessity to take a stand against all forms of oppression
whether racism, homophobia or torture. According to Reynolds, therapists cannot be allies
by being neutral and maintaining objectivity. This challenges more traditional approaches
to mental health teaching and practice which promote neutrality and objectivity within an
individualistic framework (see also Prilleltensky & Nelson, 2002, as cited in Engstrom et
al., 2008). Instead, Reynolds asserts, therapists need to take a stand and even go further by
taking action against discrimination, violence and oppression.

Flowing therefrom, Weingarten (2003) described four possible positions that people
working with trauma survivors could take depending on the workers’ awareness of the
violations suffered by clients and their own level of empowerment. Some workers are both
aware of the implications of the violence and have the capacity to take action to prevent
future violations (Position 1). Others may have the power to take action but not be fully

\textsuperscript{10} For example traumatic experiences may be classified as Type I = single event traumas (vehicle accidents, 
home invasions) or type II = multiple event traumas (domestic violence, child abuse, war trauma). Type II
traumas can be further classified as Type IIA = where trauma survivors retained some control over their
environment; and Type IIB = where survivors feel totally overwhelmed similar to what is experienced by
people fleeing protracted war and conflict (Rothschild, 2000).
aware of the violations suffered by survivors (Position 2) or have neither the awareness nor the power to take action (Position 3). Conversely some workers may be aware and knowledgeable about the violence and injustice but are unable to bring about any change to the oppressive status quo (Position 4). According to Weingarten, workers who were aware but lacked empowerment were most at risk of experiencing symptoms of VT. The four witnessing positions are depicted in Table 5.2 below.

Table 5.2 The four witnessing positions that can be occupied by trauma workers.

<table>
<thead>
<tr>
<th>Awareness &amp; knowledge</th>
<th>Lack of awareness</th>
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</thead>
<tbody>
<tr>
<td><strong>Empowered</strong> <strong>b</strong></td>
<td>Position 1</td>
</tr>
<tr>
<td><strong>Not empowered</strong></td>
<td>Position 4</td>
</tr>
</tbody>
</table>

\[\text{a} \text{ Possessing awareness or knowledge about the implications and meaning of violations perpetrated against trauma survivors.} \\
\text{b} \text{ Having the capacity and/or power to take effective action with regards to the violation.}

5.4. Vicarious resilience

As discussed in Chapter 1, resilience is the ability of a person to successfully adapt to or recover from stressful or traumatic experiences (Crawford, Wright, & Masten, 2006). Initially, resilience theory focused on personal attributes such as self-esteem, self-efficacy and hardiness, but resilience is currently recognized as a multidimensional construct including personal characteristics and skills (e.g. active problem-solving) and also external protective factors such as a supportive family and social environment (Hjemdal, Vogel, Solem, Hagen, & Stiles, 2011). Resilience has also been conceptualized as a dynamic process that fluctuates according to age, gender, individual circumstance, and developmental, historical and cultural context (Connor & Davidson, 2003, see also
Crawford et al., 2005). However according to Pickren (2014) because developmental scientists have dominated the field of resilience and focused on children and youth, there is a noticeable gap in understanding resilience in adulthood. Accordingly, there is also a dearth of studies regarding resilience in migrants and refugees (Simich, Pickren, & Beiser, 2011).

The construct of Vicarious Resilience (VR) depicts the reciprocal process within trauma work. That is, how clients’ resilience, strength and growth in the face of extreme adversity has the potential to positively impact on trauma workers’ attitudes, emotions and behaviours, thereby counteracting the negative aspects of working with trauma survivors including VT, burnout, compassion fatigue, or secondary traumatic stress (Hernández, Engstrom, & Gangsei, 2010). In their seminal study with psychiatrists and psychologists assisting traumatized individuals and families from Colombia, Hernández et al. (2007) used grounded theory and phenomenology to explore how clients’ resilience and strength in the face of multiple traumatic events as depicted in their trauma testimonies impacted on mental health providers. The analysis of interviews with clinicians confirmed that alongside VT, trauma work could also in some instances result in positive consequences for workers. The therapists had described numerous instances of witnessing the resilience of clients during therapy, how they were affected by their clients’ ability to cope with extreme traumas and consequently how they learned about coping with adversity from their clients. According to Hernandez et al., these initial findings depicted the inner positive transformation of therapists in response to their clients’ trauma stories (i.e. VR). The benefits of VR could be enhanced by bringing its occurrence into conscious awareness. They also reported that VR and VT could occur together and be experienced together, similar to posttraumatic growth and distress in survivors of trauma (as explained in Chapter 1).
In their next study with refugee survivors of torture and trauma, Engstrom et al. (2008) attempted to identify the elements of VR. For this purpose they conducted in-depth interviews with mental health providers working at a torture treatment centre in the US, and analyzed data utilizing grounded theory. They identified three main components/elements of VR. The first identified component was workers’ recognition and appreciation of their clients’ enormous capacity to thrive amid adversity. Study participants described being amazed by their clients’ ability to withstand the most horrendous kinds of torture, escape persecution; maintain their spiritual beliefs; and strive to make a new life in the US. They also admired the heroic courage of some clients who had stood up to persecution and oppression in their countries despite the knowledge that their work would probably result in torture and incarceration. The second component of VR was how workers altered their personal perspectives on life after witnessing their clients’ resilience. For instance, workers reported a renewed appreciation for what was previously taken for granted (i.e. the freedom in US society compared to the oppression clients had described). They described how they reframed personal troubles and became appreciative of the positive things of life; and became emotionally stronger and more motivated in life. The third VR element was associated with how workers reaffirmed the value of therapy by maintaining commitment to clients and regaining hope for making positive change. Reportedly clients’ strength and resilience motivated therapists to continue providing services. A particularly important manifestation of VR was when service providers reported taking home the life lessons they learnt from their clients, reassessing their own problems in the light of clients’ stories of perseverance, strength and growth, and modifying their personal worldviews. Additional features of VR included understanding the spiritual dimension of healing and the power of community healing, as contrasted with individualistic models of therapy. VR was also inferred when service providers took a subjective stance vis-à-vis their clients’ predicaments and articulated professional and personal positions on human rights and
violence or ventured further to take action themselves to mitigate violence and injustice – i.e. when service providers became human rights activists (Hernandez et al., 2010).

Although VR has some similarities with PTG (Post Traumatic Growth; see Chapter 1) they are different processes. PTG is the transformation and personal growth of the client following traumatic experiences; with the person moving to a higher level of psychological functioning, flourishing and growth compared to pre-trauma experiences. Conversely VR is experienced by service providers who become witnesses to clients’ resilience and strength in the face of trauma and adversity (Engstrom et al., 2008).

However VR does appear to be similar to Vicarious Posttraumatic Growth (V-PTG) as defined by Arnold, Calhoun, Tedeschi, and Cann (2005) who conducted the first systematic study with 21 clinicians working with trauma survivors in order to identify the positive consequences and benefits of trauma work. Study findings revealed how participants’ lives had been changed in profound and positive ways by their work, with the authors conceptualizing their findings as V-PTG. Among the benefits of trauma work were: experiencing and observing elements of PTG in clients; increased sensitivity, compassion, insight, tolerance and empathy; appreciating a spiritual pathway to growth; experiencing deeper faith; heightened awareness of their own relatively good fortune; and their recognition and appreciation of the resilience, strength and capacity of the human spirit in general (Arnold et al., 2005).

Hence it appears that the conceptual constructs of VR and V-PTG share many common elements (e.g. appreciation of the clients’ resilience, strength and growth and the appreciation of the human being to thrive). Like VR, V-PTG can be experienced together with the negative effects of trauma work (i.e. compassion fatigue, vicarious trauma and so forth). The primary difference between the two concepts appears to be that V-PTG
specifies enhanced growth compared to service providers’ previous state but there is no such requirement for VR. In addition, whereas V-PTG has mostly been studied in relation to Type I traumas such as sexual assault, physical assault and traumatic divorce; VR was specifically identified among service providers helping survivors of systematic and prolonged traumas—Type II (for a further description of Type I and II traumas see Rothschild, 2000). However a recent study with clinicians, administrative and managerial staff working with refugee trauma survivors also reported V-PTG including experiences of forming new relationships, increased self-understanding and a greater appreciation of life (Barrington & Shakespeare-Finch, 2013).

The relationship between VR and PTG, and related constructs is depicted in Figure 5.1 below adapted from Hernandez et al., (2010). VR is portrayed as the parallel experience, for workers, to trauma survivors’ experiences of PTG and ABS—the motivation to reach out and help others as a result of traumatic and other related experiences and psychological reactions (see Chapter 1) (Arnold et al., 2005; Staub & Vollhardt, 2008).
Posttraumatic Growth; altruism born of suffering; indicates how personal characteristics inevitably influence the experiences of trauma and VR.

Figure 5.1 Relationship between vicarious resilience, vicarious traumatization and related concepts adapted from Hernandez, Engstrom, & Gangsei, 2010

Not much is known about the precise relationship between VT and VR or the different pathways to these concepts, although some workers reporting VR have also described elements of VT; similar to how some trauma survivors simultaneously report both distress and personal growth (Arnold et al., 2005). Continuing investigation and exploration into VT and VR potentially has significant consequences for service providers’ welfare, training, the quality of the services provided, and ultimately for clients’ lives (Hernández et al., 2010) (detailed in Chapter 8).

5.5. Therapeutic interventions with refugees
According to Robjant and Fazel (2010) the prolonged and recurring experiences of multiple trauma almost inevitable in the refugee experience, render refugees at special risk for complex patterns of trauma-related mental health problems. The complexity of the refugee experience has been introduced and explained in Chapter 1 (Figure 1.3). Nonetheless, as highlighted in the meta-analyses conducted by Fazel et al. (2005) and Steel et al. (2009), (see Chapter 1) the majority of refugees appear to be resilient, cope with their past traumatizing experiences and current difficulties, and go on to lead successful lives. Hence accurate psychological assessment is vital, inter alia, to avoid needlessly anthologizing individuals’ normal reactions to abnormal situations (i.e. war); or conversely to facilitate vital assistance such as disability support and in determining immigration status.

5.5.1 Assessment

Psychological assessment of refugees is underdeveloped partly because of the controversy attached to the development and assessment of appropriate tools to assess culturally and linguistically diverse populations. Some experts have suggested that constructs such as PTSD are culture-bound syndromes specific to Eurocentric/western populations and have little or no validity for others (Bracken et al., 1995; Summerfield, 1999). These experts have suggested that assessing the experiences of refugees should extend beyond PTSD and psychopathology to include a holistic view of resettlement experiences, and span multiple disciplines and services (schools, disability evaluation, cognitive functioning, mental health, evaluation of refugee claims) (e.g. see also Murray et al., 2008). Pain, Kanagaratnam, and Payne (2014) proposed five reasons why it is difficult to decide whether a refugee has a mental health disorder namely: (1) differences between the explanations given to illness by refugees and western clinicians; (2) limited culturally valid assessment tools; (3) communication distortion arising out of using interpreters; (4)
the questionable validity of the PTSD construct vis-à-vis refugees; and (5) the dearth of research regarding the psychiatric/psychological treatment for refugees. Nonetheless several measures have been developed, validated and since used in research with refugees. A summary of the ten psychometric tools commonly used is presented in Table 5.2 (Murray et al. 2008).

Psychological assessment of refugees is vital in an era of limited resources to decide who is afflicted by debilitating traumatic symptoms or other psychological distress, and if so, the nature of intervention most appropriate (e.g. services of a clinician, a counsellor or resettlement worker). However assessment has also been utilized to evaluate asylum seekers’ claims for permanent residency in host countries. This is because whereas accurate memory and recall are essential at the immigration interview, traumatizing experiences and PTSD have been associated with poor cognitive functioning and memory, which in turn are also impacted by psychological stress and changes to brain structures arising from brain injury, malnutrition and torture experiences (Kirmayer, 2003). Hence past traumatic experiences that qualify people for refugee status may be the very factors negatively impacting upon their refugee claim evaluation. For example, Rousseau, Crépeau, Foxen, and Houle (2002) reviewed 40 cases negatively evaluated by Canadian immigration authorities. They identified several problems with the evaluation and decision making process including: problems in evaluating evidence, assessing credibility and conducting hearings; immigration officers coping with vicarious traumatization and becoming emotionally overwhelmed; ignorance of political context; and cultural misunderstandings and insensitivities.
### Table 5.3 Psychometric tools commonly used with refugee populations

<table>
<thead>
<tr>
<th>Measure</th>
<th>Format</th>
<th>Sample</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Harvard Trauma Questionnaire (HTQ)</td>
<td>3 sections: traumatic experiences (17 items); subjective description of most traumatic event/s; symptoms (30 items)</td>
<td>91 Indochinese refugees</td>
<td>Mollica, Caspi-Yavin, Bollini, Truong, Tor, &amp; Lavelle (1992).</td>
</tr>
<tr>
<td>2. Hopkins Symptom Checklist (HSCL)</td>
<td>25 items; anxiety (10 items) and depression (15 items)</td>
<td>231 refugees outpatient clinic</td>
<td>Lavik, Hauff, Solberg, &amp; Laake (1999).</td>
</tr>
<tr>
<td>5. Afghan Symptom Checklist</td>
<td>22 items; 3 factors (sadness with social withdrawal and somatic distress, ruminative sadness without social withdrawal and somatic distress, and stress-induced reactivity)</td>
<td>324 adults in 8 districts of Kabul</td>
<td>Miller, et al. (2006).</td>
</tr>
<tr>
<td>7. Comprehensive Trauma Inventory (CTI-164)</td>
<td>164 items, war-related events</td>
<td>36 Kurdish and 31 Vietnamese refugees; focus groups</td>
<td>Hollifield, et al. (2005).</td>
</tr>
<tr>
<td>8. Child Behavior Checklist (CBCL) for unaccompanied minors</td>
<td>118 problem behavior items; internalizing and externalizing behaviors (8 subscales)</td>
<td>920 guardians of unaccompanied refugee minors</td>
<td>Children and Youth Services Review</td>
</tr>
<tr>
<td>10. Reactions of Adolescents to Traumatic Stress</td>
<td>22 items; 3 factor (intrusion, avoidance/numbing, hyperarousal)</td>
<td>3,535 refugee and control adolescents;</td>
<td>Bean et al. (2006).</td>
</tr>
</tbody>
</table>

*Adapted from Murray, Davidson, and Schweitzer (2008)*
Additionally as Rousseau et al. (2002) observed, immigration authorities assess asylum seekers’ narratives against a truthful story considered as a fixed sequence of events. Any deviation from this fixed account is considered as attempting to obtain refugee status dishonestly. However Kirmayer (2003) opined that not taking into consideration social imagination in the construction, interpretation and assessment of the truth-value of narratives of identity was a serious limitation of the refugee evaluation process in Canada (identity construction via personal narratives was discussed in Chapter 2).

5.5.2 Interventions

Despite the controversy regarding the applicability of western concepts of psychopathology such as PTSD, MDD and GAD to non-western cultures whence most refugees originate, the majority of mental health interventions with refugees have focused on PTSD. Nonetheless only a few studies have evaluated the efficacy or effectiveness of treatments for PTSD among refugees compared to other traumatized populations using adequate sample sizes and methodological rigour (Nickerson et al., 2011); with the majority of studies being conducted in the past 10-15 years (Murray et al., 2008).

Some of the earliest psychotherapeutic interventions reported to be effective with refugees and other survivors of torture were Cognitive Behaviour Therapy (CBT) and prolonged exposure (Nicholl & Thompson, 2004). CBT is the traditional treatment for PTSD with non-refugee populations (Foa, 2000) and hence it was hypothesized to benefit refugee populations notwithstanding the narrow focus on PTSD. Accordingly several studies support the effectiveness of standalone CBT or in combination with other therapeutic approaches such as psychopharmacology (Otto et al., 2003). CBT and exposure therapy were found to be equally effective in ameliorating symptoms of PTSD, generalized anxiety and depression among refugees, the positive effects lasting up to 6 months after intervention (Paunovic & Öst, 2001).
Nickerson et al. (2011) systematically reviewed 19 intervention studies to compare the efficiency of trauma focused interventions and multimodal methods in reducing PTSD in refugees. ‘Trauma-focused interventions’ were operationalized as those based on (i) extinction learning or repeated and prolonged exposure to the traumatizing events until fear associated with past stimuli or events were dispelled; and (ii) the correction of distorted cognitions and memory (Nickerson et al., 2011). Most trauma focused therapies involve the in-depth narration, discussion and processing of past traumas (Murray et al., 2008). Nickerson et al. hypothesized that trauma focused treatment would reduce PTSD symptoms and improve functioning by helping survivors to process and integrate traumatic memories into their normal, day-to-day memory repertoire; change maladaptive thoughts and appraisals, and overcome avoidance behaviours (e.g. learning that environmental phenomena associated with intense fear such as loud noise were no longer dangerous and need not be avoided; Nickerson et al., 2011).

More recently, the use of multimodal methods has become popular especially within organizations assisting refugees and asylum seekers. The multimodal method is based on the assumption that because refugees face a range of adversities—fleeing from war, long-term stays in refugee camps, and continuing problems in resettlement—they will also require multiple interventions to address a complex array of traumas, stressors, acculturation issues and resettlement problems. The assistance afforded at such organizations commonly includes a combination of trauma counselling, resettlement assistance and advocacy, help with residency status and family reunion and referral to medical doctors or psychiatrists (Carlsson, Mortensen, & Kastrup, 2005; Carlsson, Olsen, Mortensen, & Kastrup, 2006).

In their systematic review, Nickerson and colleagues identified a range of trauma focused therapies: Narrative Exposure Therapy (NET) (Bichescu, Neuner, Schauer, &
Elbert, 2007; Catani et al., 2009; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004; Robjant & Fazel, 2010; Schauer, Neuner, & Ebert, 2005); culturally adapted Cognitive Behavioural Therapy (CA-CBT; Hinton, Hofmann, Pollack, & Otto, 2009; Hinton, Hofmann, Rivera, Otto, & Pollack, 2011; Hinton et al., 2004; Hinton et al., 2012); Testimony Psychotherapy (Agger & Jensen, 1990; Weine et al., 1998); Cognitive Processing Therapy (Resick, Monson, & Chard, 2008; Schulz, Resick, Huber, & Griffin, 2006) and trauma-related cognitive therapy (Kruse, Joksimovic, Cavka, Wöller, & Schmitz, 2009).

Nickerson et al. (2011) found some support for the benefits of trauma focused therapies in reducing PTSD symptoms. However because the reported studies contained serious limitations such as no control or non-equivalent controls, small sample sizes and no follow up, the authors avoided making definitive recommendations. Conversely there was no support for the use of multimodal methods for the alleviation of PTSD symptoms (Carlsson et al., 2005). It seems reasonable to hypothesize that whereas trauma focused interventions specifically addressed PTSD symptoms, multimodal approaches addressed other psychosocial problems encountered by and more salient to refugees. Such ongoing problems and their resolution were difficult to measure quantitatively and were not assessed in the studies included in the review. Additionally many trauma focused therapies had multiple components that were not adequately described in order to assess which component/s contributed to treatment success (Nickerson et al., 2011).

Earlier Crumlish and O'Rourke (2010) also conducted a systematic review of the literature and found only 10 randomized control trials reported in the last 10 years to assess the evidence base for interventions for refugee trauma. Most of these trials were sufficiently flawed for the researchers to conclude that no treatment had overwhelming support, although there was some support for NET and CA-CBT. Additionally they noted
that there were no studies designed or led by professionals who were refugees or belonged to the cultural groups being studied, thus echoing Summerfield’s (1999) observation that ‘social healing and the remaking of worlds cannot be managed by outsiders’ (p. 1461).

Similarly Palic and Elklit (2011) evaluated 25 intervention studies mostly conducted with refugees from the former Yugoslavia, and Southeast Asia and a few mixed group studies. The researchers categorized interventions selected for their review as (i) CBT treatments (incl. standard CBT, CBT component studies, special variants of CBT, NET and culturally sensitive CBT/ CA-CBT); (ii) multidisciplinary treatments similar to the multimodal approach in the review by Nickerson and colleagues; and (iii) treatments other than CBT. Palic and Elklit also concluded that the therapies that had the best documented effects were NET and CA-CBT.

In recent years, NET has emerged as one of the most effective therapies for refugee trauma. NET involves intense and prolonged exposure of trauma survivors to the most traumatizing events in their lives together with the documentation of trauma survivors’ human rights violations (Schauer et al., 2005). Like other trauma focused CBT approaches, NET is based on extinction learning and incorporating the traumatic events into the person’s life narrative; and is considered a combination of CBT and testimonial psychotherapy (Schauer et al., 2005). NET is designed for use by either professionals or trained non-mental health personnel in war or other emergency situations involving multiple and sometimes ongoing violations. NET has been successfully utilized in low and middle incomes countries (Uganda, Romania, Sri Lanka) as well as high income countries (Germany) with refugees, IDPs, or asylum seekers living in their home, neighbouring or resettlement countries (Neuner et al., 2010; Neuner et al., 2004). In their systematic review of the NET literature, Robjant and Fazel (2010) identified ten studies conducted with adults, and an additional six studies conducted with children in conflict zones using an
adapted version of NET—KIDNET. NET has been found to be superior to control conditions using psychoeducation only or treatment as usual (TAU), and to other therapies such as supportive counselling and Interpersonal Psychotherapy (IPT) in alleviating PTSD symptoms in refugee populations (Robjant & Fazel, 2010).

Although not identified as a limitation of NET, according to Hinton and colleagues (2012) a major problem with traditional exposure techniques is that they are poorly tolerated by recipients, leading to high dropout rates from studies and programs. Hence these researchers adapted the traditional exposure based CBT technique to improve its cultural appropriateness, relevance to and tolerance by, recipients (i.e. CA-CBT). The special features of CA-CBT were highlighted by Hinton and colleagues (2012) as including: (i) being easily understood by trauma survivors with limited English and education; (ii) focusing on symptoms that are specific to particular cultural groups (culture-bound syndromes; Griffith, 2014); (iii) combining emotional exposure with emotional regulation techniques taken from clients’ religious or cultural tradition such as meditation and yoga (for Southeast Asians); (iv) promoting participants’ emotional and psychological flexibility, for example through mindfulness—attending to sensory experiences in the present moment.

Earlier, Hinton and colleagues (2005) had examined the efficacy of CA-CBT for treatment resistant PTSD and culturally associated panic attacks among 40 Cambodian survivors of the 1975-1979 genocide in that country. In one of the few reported randomized controlled trials with refugees, they compared a treatment group receiving CA-CBT with a delayed treatment group that initially received a combination of supportive counselling and medication (N1=N2=20). They found that people who received CA-CBT improved on all measures including PTSD severity, panic attacks, anxiety and depression related distress. Statistically significant improvement was also noted in the treatment group
compared to those on the waiting list. In another study Hinton et al. (2011) afforded CA-CBT to 24 migrant Latina women with treatment resistant PTSD (i.e. they continued to indicate symptoms despite receiving counselling or medication for at least six months). A comparison of CA-CBT with applied muscle relaxation (AMR) indicated that people receiving CA-CBT vastly improved compared to the AMR group. Worth noting was that in this study, CA-CBT which had been developed for Southeast Asian trauma survivors was successfully adapted for Latina women incorporating Christian meditative practices.

Other therapies have also revealed some promise although evaluated using less rigorous methods. For instance, testimony therapy (TT) involves recording clients’ stories and bearing witness to the most traumatizing events of their lives. It also includes creating a written document during the course of sessions which can be used for documentary purposes or for awareness raising among the UN and other international human rights organizations. TT has been manualised and adapted to be used as a brief therapy method including mindfulness exercises and cultural rituals for calming the body and regulating emotions. Similar to NET, TT can be conducted by trained non-professionals in developing countries alongside the search for justice for human rights violations (Agger, Igreja, Kiehle, & Polatin, 2012; Perera, Puvimanasinghe, & Agger, 2008; Puvimanasinghe & Price, Currently under review).

Another intervention indicating some potential is Eye Movement Desensitization Reprocessing (EMDR). This requires clients to keep the most traumatizing events in mind while conducting systematic eye movements. In a pilot study with 20 refugees and asylum seekers, ter Heide, Mooren, Kleijn, de Jongh, and Kleber (2011) compared EMDR with ‘stabilization’ (focusing on the ‘here and now’, establishing safety etc. in accordance with the counselling model of Herman, 1992). A dropout rate that was above 50 percent precluded these authors from making definite conclusions, but there was some indication
of the enhanced efficacy of EMDR in self-reported PTSD, anxiety and depressive symptoms as well as on the social dimension of the WHOQoL measure. In a recent pilot study, biofeedback (BF) combined with NET was shown to significantly reduce PTSD and pain and improve quality of life among refugees complaining of persistent bodily pain especially those who had experienced torture (Morina et al., 2012). Additionally, the researchers opined that biofeedback increased motivation for subsequent trauma-focused therapy, which in turn reduced PTSD symptoms. However, much more research is required to establish the efficacy of BF for refugees.

Other innovative interventions have been developed to recognize the special concerns and priorities of refugee communities. Low literacy and education levels among refugee communities might indicate the potential benefit of expressive and non-verbal therapies such as music, art, theatre and other similar types of therapies. Such interventions maybe utilized as standalone or incorporated into mainstream interventions to enhance their relevance and cultural acceptability. Non-verbal interventions such as psychomotor therapy and music therapy are based on the understanding that the body encodes and stores memories of trauma expressed subsequently as somatization (Drozdek & Wilson, 2004).

Family therapy has also been found to be effective among refugee communities because of their collectivist and family-oriented cultures and especially when intergenerational and family conflict is their presenting concern. For instance, provision of seven sessions of family support and psycho-education intervention was associated with increased social support, utilizing psychiatric services, positive changes in trauma mental health knowledge and family hardiness among a group of Kosovo refugees (Weine et al., 2006). Some clinicians have considered group therapy to be indicated for asylum seekers and refugees because it addressed survivors’ loss of trust, social isolation, multiple traumatization as well as being more conducive to their communal identity. However
individual therapy has been considered more appropriate for survivors of sexual torture and abuse (Drozdek & Wilson, 2004).

In concluding this section, I refer to the recent suggestion of Pain et al. (2014) that PTSD diagnosis and CBT as a treatment of choice should be reconsidered regarding refugees. These researchers opined that although many refugees indicated symptoms of PTSD, they had more persistent problems during resettlement that should be addressed in therapy. Moreover, PTSD symptoms could reflect post-migration trauma and distress (e.g. prolonged detention of adults and children seeking asylum, violence, discrimination, racism) instead of being related to past traumatic events.

5.6. Aims and objectives of Research Project II

The initial aim of Research Project II (empirical studies 3 and 4 in Chapters 6 and 7), conducted with service providers, was to explore the overall experiences of three groups of service providers, namely, mental health, physical healthcare and resettlement workers assisting refugees and asylum seekers in South Australia. One objective was to support the findings of Research Project I (empirical studies 1 and 2 presented in Chapters 3 and 4) conducted with former refugees of two African communities in South Australia. Consequent to interviewing 28 service providers and analyzing interview data using qualitative thematic analysis (see next section) I was able to identify several prominent and recurring patterns in the interview data.

The identified patterns or themes in the service provider data set are reported in Chapters 6 and 7. Chapter 6 focuses on the concepts of VT and VR together with cultural adaptation and work satisfaction. Chapter 7 focuses on service providers’ experiences of: (i) establishing safety, trust and connection with refugee clients; (ii) talking about trauma;
(iii) working with silence; and (iv) promoting coping and growth. Detailed descriptions of each theme supported by relevant extracts from participants’ interviews are contained in the next two chapters.
Chapter 6. Vicarious Resilience and Vicarious Traumatization

It's not a job. You have to be committed and passionate about working in this area and with this client group.

AB, nurse and service provider participant (2013)

Chapter contents

6.1 Preface
6.2 Abstract and key words
6.3 Introduction
6.4 Method
6.5 Findings
6.6 Discussion

6.1. Preface

This chapter consists of a manuscript that was sent to the Journal of Transcultural Psychiatry in March 2014 and resubmitted with responses to reviewers’ comments on 20 May 2014. Subsequently the manuscript was accepted for publication.

The details of the manuscript are:

Similar to Chapters 3 and 4, Chapter 6 contains a reformatted version of the manuscript and references are included in the main reference section (p. 271 onwards).

6.2. Abstract and key words

The negative psychological impacts of working with traumatized people are well documented and include vicarious traumatization (VT): the cumulative effect of identifying with clients’ trauma stories that negatively impacts on service providers’ memory, emotions, thoughts and worldviews. More recently, the concept of vicarious resilience (VR) has been also identified; the strength, growth and empowerment experienced by trauma workers as a consequence of their work. VR includes service providers’ awareness and appreciation of their clients’ capacity to grow; maintaining hope for change, as well as learning from and reassessing personal problems in the light of clients’ stories of perseverance, strength and growth. This study aimed at exploring the experiences of mental health, physical healthcare and settlement workers caring for refugees and asylum seekers in South Australia. Using a qualitative method (data-based thematic analysis) to collect and analyse 26 semi-structured face-to-face interviews I identified four prominent and recurring themes emanating from the data: VT, VR, work satisfaction and cultural flexibility. These findings – among the first to describe both VT and VR in Australians working with refugee people – have important implications for policy, service quality, service providers’ wellbeing, and refugee clients’ lives.

Key words: vicarious traumatization, vicarious resilience, refugee, asylum seeker, service provider, mental healthcare, cultural competence, qualitative research, thematic analysis
6.3. Introduction

The negative consequences of working with traumatized people, described in terms such as secondary traumatic stress, burnout, empathic stress and compassion fatigue are well documented (cf. Figley, 2002; McCann & Pearlman, 1990a). A related concept, vicarious traumatization (VT) has been defined as the cumulative effect of identifying with clients’ trauma stories, which can profoundly and negatively impact on service providers’ thoughts and emotions, memory systems and schemas, self-esteem, locus of control, sense of safety, and worldviews. Manifestations of VT in people working with refugees can be compared to refugees’ reactions to traumatizing events such as war, mass killings, torture, rape and dispossession. VT has been widely researched among carers in diverse fields such as therapists working with survivors of sexual violence and people with AIDS, as well as other professionals—doctors, nurses, social workers, disaster relief workers and lawyers—caring for a range of trauma clients (Dunkley & Whelan, 2006). According to Dunkley and Whelan (2006), VT is the most appropriate term to describe the consequences of working with clients with traumatic experiences and refers specifically to the impact of trauma work.

Conversely, research on the positive consequences and benefits of trauma work is relatively recent in nature. Vicarious Resilience (VR) encompasses the positive consequences of working with trauma survivors and bearing witness to their stories. It includes experiencing personal strength, psychological growth and empowerment consequent to listening to clients’ accounts of resilience, perseverance and growth (Engstrom et al., 2008; Hernández et al., 2007). VR has been described as the parallel experience, for workers, to trauma survivors’ Post Traumatic Growth (PTG) and Altruism Born of Suffering (ABS) (Arnold et al., 2005; Staub & Vollhardt, 2008). PTG is the experience of personal growth following exposure to traumatic events; whereas ABS is the
motivation to reach out and help others as a result of traumatic and other related experiences and psychological reactions (e.g. receiving help from others in times of need, identification with others’ suffering).

However VR appears to be similar to Vicarious Posttraumatic Growth (V-PTG). Arnold et al. (2005) conducted a study with 21 clinicians working with survivors of diverse traumas. Study findings revealed how participants’ lives had been changed in profound and positive ways by their work, with the researchers conceptualizing their findings as V-PTG. More recently Barrington and Shakespeare-Finch (2013) also identified VT and V-PTG among people working with refugees. Hence it appears that the conceptual constructs of VR and V-PTG share many common elements (e.g. appreciation of the clients’ resilience, strength and growth and the appreciation of the human being to thrive). The main difference between the two concepts appears to be that V-PTG specifically implies growth or improvement over and above workers’ pre-work situation; and also the presence of the five components of PTG; namely, increased appreciation for life, more meaningful interpersonal relationships, increased sense of personal strength, changed priorities, and a richer existential and spiritual life (Tedeschi & Calhoun, 2004). However there is no such implication for VR, a concept that is still in the exploratory phase of research.

Nonetheless, several characteristics of VR have been identified in the literature. They are: service providers’ awareness and appreciation of their clients’ capacity to thrive; reaffirming the value of therapy by maintaining commitment to clients and maintaining hope for change; and including spirituality and community-based interventions in therapy. An important manifestation of VR is when service providers take home life lessons from their clients, reassess their own problems in the light of clients’ stories of perseverance, strength and growth, and modify their personal worldviews. VR can also be inferred when service providers take a subjective stance vis-à-vis their clients’ predicaments by

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articulating their personal and professional positions on human rights violations, or by venturing further to take action themselves to mitigate this violence and injustice (Hernández et al., 2007).

VT and VR are not universally experienced, nor are they mutually exclusive: workers reporting VR may also describe experiencing elements of VT similar to how trauma survivors can report both distress and personal growth simultaneously (Arnold et al., 2005). Much more needs to be known about the precise relationship between VT and VR and the different predictors and pathways that may facilitate VR and protect against VT for different service providers. Nonetheless continuing investigation and exploration into VT and VR can potentially contribute to workers’ welfare and training; to service quality; and thus ultimately to their clients’ lives (Hernández et al., 2010).

To my knowledge this is the first study to describe VR and VT in a cross-section of Australian service providers working with refugees and asylum seekers, although a recent Australian study reported identifying VT and V-PTG within a single refugee service agency (Barrington & Shakespeare-Finch, 2013). Most research with service providers to refugees has explored the barriers to accessing healthcare or successful resettlement of their clientele (e.g. McKeary & Newbold, 2010). Other studies have focused on the experiences of particular worker categories such as doctors or interpreters (Farley et al., 2012; Johnson et al., 2008; Phillips, 2013). My initial aim was to explore the experiences of three groups of service providers (mental health, healthcare and resettlement workers) assisting refugees and asylum seekers in South Australia and report the emergent themes I identified.
6.3.1 Background

In 2012, 45.2 million people were displaced worldwide with more than 15 million refugees and almost 1 million asylum seekers (United Nations High Commission for Refugees (UNHCR), 2013). In 2013 Australia accepted approximately 20,000 people under its offshore and onshore refugee programs\(^\text{11}\) and about 10 percent of this intake was resettled in the state of South Australia. These new arrivals were from diverse countries including Afghanistan, Bhutan, Burma, Iran, Ethiopia, and several other African, Middle Eastern and Asian nations (Multicultural SA, n.d.). It is worth noting that migrants to Australia often elect to settle in the large cities (Sydney or Melbourne) which offer more employment and training opportunities and have larger migrant communities (Hugo, 1995). The Australian Government therefore actively encourages settlement in other states and regional areas, including South Australia which has a population of 1.65 million people of whom around 77 percent live in or near the state capital, Adelaide (Australian Bureau of Statistics, 2011).

In Australia, humanitarian entrants (people recognized as refugees according to the UN Refugee Convention of 1951 excluding asylum seekers and others whose immigration status remained undetermined) are eligible for two main programs: the Humanitarian Settlement Services (HSS) and Settlement Grants Program (SGP) (DIAC, 2013). The HSS operates for the initial 6 to 12 months and newly arrived refugees are afforded accommodation, an initial food and household package, case management, and assistance to register with social security, Medicare, health services, banks, and schools. After that

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\(^{11}\) Australia’s previous intake of approximately 13,500 refugees was increased subsequent to the recommendations of the Expert Panel on Asylum Seekers in 2012-13.
period and up to 5 years of arrival, less intensive support is offered to eligible persons under the SGP. New settlers are offered 510 hours of free English language classes and free access to 24-hour telephone translating and interpreting services. Trauma counselling and specialized healthcare services are afforded under separate federal and state level funding arrangements but eligibility is assessed according to stringent criteria.

Australia’s policy of mandatorily detaining asylum seekers has been condemned as a violation of international human rights treaty law (Australian Commission of Human Rights (ACHR), 2012). Research with asylum seekers has revealed mandatory detention to be a negative socialization experience that aggravates past trauma (Murray et al., 2008). It has also been associated with significantly high rates of suicidal behaviour for men and women (41 and 26 times the national average respectively) and high prevalence rates of psychiatric disorders such as MDD, PTSD, anxiety (Murray et al., 2008). Immigration detention has especially serious consequences for child and adolescent asylum seekers. It reduces their potential to recover from past trauma, increases developmental risks, and disrupts education, thereby multiplying the negative personal, economic and social consequences of trauma, as well as making it more difficult for them to bond with caregivers (Murray et al., 2008). The negative psychological impact of Australia’s harsh asylum seeker policies over the years has been amply documented (Newman & Steel, 2008; Silove et al., 1998; Steel et al., 2006). Although the decision to transfer some asylum seekers into the community has been commended on humane grounds (ACHR, 2012), asylum seekers continue to face severe disadvantages such as: being unable to seek paid employment; little or no access to English classes or vocational training; and income support which is inadequate to maintain basic living standards. The recently elected government’s rhetoric of ‘stopping the boats’ and ‘illegal arrivals’ (Hall, 2013), combined
with the media blackouts recently engulfing the subject of asylum seekers, are likely to have further deleterious consequences for people seeking asylum in Australia.

6.4. Method

6.4.1 Participants

Study participants were 26 service providers working with refugees and asylum seekers in Adelaide, South Australia. They were women and men who worked in organizations providing services mainly under the SGP, trauma counselling (for both refugees and asylum seekers), or healthcare programs. Participants included doctors, nurses, counsellors, psychologists, managers, project coordinators, and case workers. Their work experience ranged from 1 ½ to 30 years with the majority reporting 2-5 years’ work experience with refugees. About one third of participants belonged to visible minority groups including former refugees and recent immigrants. The remaining two thirds were from mainstream/White Australian society. The organizations participants worked at were affiliated either to the state health department, or were not for profit organizations with or without religious affiliation. I have not provided further details of participant organizations, to ensure participants’ and organizations’ confidentiality. Table 6.1 contains a description of participants.
Table 6.1. Characteristics of service provider participants

<table>
<thead>
<tr>
<th>N = 26</th>
</tr>
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<tbody>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Women 18</td>
</tr>
<tr>
<td>men 8</td>
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<tr>
<td><strong>Previous experience working with refugees</strong></td>
</tr>
<tr>
<td>Less than 2 years 3</td>
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<tr>
<td>2-5 years 10</td>
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<td>5-10 years 5</td>
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<td>More than 10 years 6</td>
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<td>Not specified 2</td>
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<tr>
<td><strong>Profession/ current position (^a)</strong></td>
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<tr>
<td>Doctors 1</td>
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<td>Nurses 3</td>
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<td>Psychologists 2</td>
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<tr>
<td>Counsellors 9</td>
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<tr>
<td>Managers 3</td>
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<tr>
<td>Program officers/ coordinators/ case workers 8</td>
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<tr>
<td><strong>Nature of Organization (^b)</strong></td>
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<tr>
<td>Healthcare 5</td>
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<tr>
<td>Mental health 11</td>
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<tr>
<td>Settlement 10</td>
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<tr>
<td><strong>Background</strong></td>
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<tr>
<td>Mainstream 16</td>
</tr>
<tr>
<td>Refugee (^c) 5</td>
</tr>
<tr>
<td>Recent Immigrant (^c)/ CaLD(^d) background 5</td>
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</tbody>
</table>

\(^a\) Denotes either profession (doctor, nurse, psychologist) or current position (e.g. counsellors, included people qualified in social work, nursing or psychology)

\(^b\) Denotes the main service provided by the organization to which a worker was affiliated and not necessarily the worker’s specialization (e.g. a social worker at a mental healthcare service was considered a ‘mental healthcare worker’).

\(^c\) refugee background included people from Asia, Europe and Middle East; ‘recent Migrant/CaLD background’ included those from Asia, Europe, Middle East and South America.

\(^d\) CaLD = Culturally and Linguistically Diverse
6.4.2 Data Collection

The study began after receiving approval from the Ethics Committees of the University of Adelaide and the State Health Department. Participants were offered an option to be interviewed individually or participate in a group discussion. Apart from two participants, all opted for individual interviews, conducted between December 2012 and May 2013. Signed informed consent was obtained from participants before interviews began. Participants were interviewed using a semi-structured interview format comprising several open-ended questions. Interviews lasted about 1-2 hours, were audio-recorded and subsequently transcribed. Interview data were supplemented by brochures, reports and other documentation shared by participants—which were referred to and noted for additional information about services offered by organizations, workers’ roles, and also to explore ‘institutional memory’. However systematic analysis was not conducted on these documents and they did not form part of the primary data analysis.

6.4.3 Data Analysis

Qualitative methods, namely inductive thematic analysis (Braun & Clarke, 2006, 2013) was used to identify prominent and recurring patterns in the data at a semantic or explicit level of analysis. First, the audiotaped interviews were transcribed orthographically and checked for accuracy. Second, interviews and interview notes were read and re-read to gain familiarity with the data set. Third, interviews were coded and the initial codes generated were searched for overarching themes that were reviewed, defined and named. Analysis involved moving between the data set, the generated codes, analyses being produced, and relevant theoretical concepts found in the literature. Through this iterative process, several themes and subthemes were identified. Interviews were conducted by the first author who also performed the initial analyses. All authors were involved in producing
the final analyses. Participants’ identities and their organizational affiliations were altered or concealed to ensure confidentiality.

6.5. Findings

We identified several major and subordinate themes, derived from the analysis of participants’ interviews. The four identified major themes were: commitment and work satisfaction, cultural awareness and adaptation, vicarious resilience and vicarious traumatization. Results of the data analysis including the potential relationships between identified themes and subthemes are depicted in Figure 6.1 below.

![Figure 6.1 Diagram of study findings and the potential relationships between themes and subthemes](image-url)
6.5.1 Commitment and work satisfaction

In general, participants indicated enthusiasm, commitment and work satisfaction despite personal and systemic challenges they encountered. AB, a healthcare worker with more than 25 years of experience working with refugees, represented the sentiments of most of her colleagues by explaining:

It’s not a job; you have to be committed and passionate about working in this area and with this client group.

Most participants had been motivated to work with refugees by their previous work experiences with diverse cultural groups, in various capacities: as doctors, nurses, interpreters, teachers or volunteers. Nine participants had worked overseas in refugee source or receiving countries—in Africa, the Middle East, or Asia. Several had lived and worked in aboriginal communities in remote parts of Australia. Three participants said they were motivated by empathy and humanitarian concern towards refugees and the dire circumstances of asylum seekers in Australia. Working with refugees was a natural transition for four participants who valued their memories of growing up or living in multicultural European, Middle Eastern or Asian cities.

Five workers had arrived in Australia as refugees themselves, having become displaced and losing all their possessions during war and conflict; or after prolonged periods in refugee camps. They were sensitized to the challenges faced by their communities, identified with the refugee’s struggles, and indicated a desire to lighten the burden of those most vulnerable. One former refugee described how she had been motivated to work at the refugee agency by her personal experiences and her desire to repay to humanity the help she had received in times of need (i.e. ABS). Participants’ levels of commitment towards their clients and their work satisfaction also appeared to
have been strengthened by more experienced workers sharing, guiding, mentoring, and motivating others through supervision and mentoring of trainees; and by teaching workshops and professional development sessions. Shared experiences of mentors and trainers had become integrated into the narratives of lesser-experienced workers as portrayed in several interviews.

Only one participant, CD indicated less work satisfaction than his colleagues, despite his interview generating the longest transcript of the study. Specifically, he did not appreciate case work as part of his counsellor’s workload and he also worried that his clients were too disempowered to benefit from the challenges he posed them as a counsellor—to be assertive, independent and to take initiative in life. As he somewhat hesitantly explained:

…I don’t, I didn’t, I haven’t had a huge passion for asylum seekers or refugees or anything like that. I didn’t come here thinking ‘I’ll fix the world’. I just came here to be a counsellor.

6.5.2 Cultural awareness and adaptation

Changing client profiles. According to participants, the composition of their client caseloads constantly changed depending in part at least, on global contingencies. This variability required frequently updating their cultural knowledge and adapting to the needs of men and women from diverse ethnic, language and religious backgrounds; age and education levels; pre-migratory histories, family disruptions, and resettlement experiences.

Cultural differences. Most participants had taken steps to develop their cultural understanding. Resettlement agencies were increasingly employing workers with refugee and other CaLD experiences, to reach out to their communities and deliver services in
culturally appropriate ways. These bicultural workers were encouraged to share their cultural knowledge, with their input on parenting, child raising practices, and family relationships in their communities often sought by colleagues. Clients were another rich source of cultural knowledge: participants listened to and learned from clients’ stories, asked questions and made clarifications about their cultural practices. Participants also improved their cultural awareness by reading, watching films and participating in training workshops.

Mental and physical healthcare workers acknowledged that language differences were a barrier to communication during consultations. They utilized interpreters as a source of cultural knowledge but also indicated awareness that they only had indirect access to clients’ voices via interpreters’ cultural perceptions. Hence, participants described monitoring clients’ responses, facial expressions, and bodily postures, and asking for feedback to minimize miscommunication. More experienced participants engaged in training of interpreters, to prevent unprofessional conduct such as prompting clients or rebuking them for culturally unacceptable disclosures. Although several participants emphasized the importance of being sensitive to and accepting of cultural differences, others also noted the significance of self-reflection on their own cultural standing and understanding; as EF explained:

To me, to work transculturally is to be very, very sensitive…that cultures are different…but also to be very sensitive to [my]self as a culturally situated individual…it’s not this is mainstream and you’re a quaint little culture. I’m a quaint little culture; you’re a quaint little culture. They are different. I’m willing to understand the meaning you put on from your cultural perspective. I’m trying to be ultra-sensitive to my cultural understandings…I think
cultural awareness starts at home. To be aware of yourself as a culturally bound person.

Other differences. Mental healthcare workers were often aware of their clients’ unfamiliarity with, or different understandings of, psychotherapy and counselling. They described the stigma attached to mental illness, necessitating counsellors to afford a ‘little bit of education’ about counselling; then to navigate around their clients’ unfamiliarity until symptoms improved and there was more acceptance. Therapists usually avoided mentioning mental illness and instead focused on physical symptoms (headache, backache, sleeplessness) which seemed more acceptable to clients. Some attempted to draw analogies between the services they offered and the type of support clients would previously have received from community elders or religious leaders. However when clients wanted advice or specific directions consistent with these previous experiences, counsellors had to find a compromise between the client-centred model they adhered to—involved guiding clients to find their own solutions—and their clients’ expectations.

A few participants referred to clients’ diverse understandings of ‘treatment’; necessitating linking western concepts of illness and health to that of the clients’. For instance, GH, a counsellor from a CaLD (Culturally and Linguistically Diverse) background explained that the most accepted mode of pain management for his clients was medication; whereas acupuncture or relaxation methods had little meaning. Mindfulness, meditation and yoga, were more accepted by South Asian clients but herbal remedies were more meaningful to Middle Easterners.

Another issue confronting almost all interviewees was clients’ inability to keep appointments or to be punctual, because they were overburdened with settlement demands, and/or past trauma negatively impacted on their ability to attend to multiple tasks.
Participants indicated sensitivity to possible conceptual differences between their understanding of time and that of their clients. They accommodated lateness and missed appointments, gave repeated reminders and sometimes even expressed disapproval because, as one counsellor explained, tardiness could be a serious disadvantage in Australian society.

6.5.3. Vicarious Resilience

**Empowering and being empowered.** All participants emphasized the importance of establishing independence and confidence in their clients to enable them to overcome initial resettlement difficulties and successfully navigate the Australian system. They described striving to enhance clients’ independence and confidence, and the personal satisfaction they experienced when they observed clients gradually gaining in independence and confidence.

Many resettlement, healthcare and mental health workers described making efforts to counteract the disempowerment of their clients and reduce the cultural insensitivity of the local healthcare system. For instance, a female resettlement worker described how she intervened on behalf of a female client who had complained that the staff at her local General Practitioner’s (GP’s) clinic were not utilizing the telephone interpreting service (TIS) available at no cost to medical practitioners, but instead were asking her to bring her adolescent son to interpret for her, much to the embarrassment of the client. This also inconvenienced her son who had to miss school every time his mother had a doctor’s appointment. Hence the resettlement worker had visited the clinic, and informed the staff how to utilize TIS services. A mental health worker explained how he empowered his clients by prompting them to question their GP about vital health information, such as precautions during pregnancy or the side effects of medicines that had not been adequately
explained to or understood by clients. Resettlement staff also consulted specialized health agencies to identify ‘refugee-friendly’ GPs to whom to refer their clients.

This process of empowering clients and observing them gradually become more independent and confident; overcome ‘resettlement hurdles’, and move on in life, also in turn empowered service providers as they witnessed the effectiveness and value of their interventions. This rewarding and empowering experience was reported by many participants.

According to mental health workers, advocating on behalf of their clients to address resettlement needs enabled counsellors and therapists to establish safety and trust, and build relationships with their clients, thus laying a vital foundation for the therapeutic process later on. Mental healthcare workers also described striving to empower their refugee and asylum seeking clients through innovative group projects such as ‘theatre of the oppressed’, art therapy and storytelling. These therapies were typically utilized when one-to-one counselling was less effective with particular clients or groups. For instance MN, a counsellor explained that certain young men with refugee and asylum-seeking experiences had difficulty engaging with the counselling process. Hence he and his colleagues started an art class with the help of a professional artist from a similar cultural background to the clients. During the art session, participants were afforded a variety of materials (crayons, paints, clay) and prompted to create artwork on a particular theme. At the end of each session, the clients, instructor and counsellors would discuss the significance of the artwork created. The outcome of these sessions, MN’s appreciation of his clients’ capacity to grow, and the reciprocal impact on him was emotionally described by MN in the following extract:
We run an art group for men...we focus on a theme every fortnight and get the guys to draw or paint or do whatever...relevant to that theme. And most themes are around how they resisted and how they survived what they went through...how they see themselves as now than before. And these processes and outcomes are magical. I am beginning to well up. And I think, what you have is this real building of strength that you witness consistently week over week over week. So what you see is their growth...from where they’ve been to where they’re heading. They have this capacity to understand so much more than they did before. And that is a privilege, a total privilege to be able to be involved in that. Yeah, I don’t see it in any other way.

*Learning from each other.* Participants recognized their clients’ enormous resilience, strength and coping in times of adversity (escaping war, surviving in the refugee camp, torture or other terrible experiences). A mental health worker assisting refugee children expressed her incredulity at her clients’ capacity to study, work and send money back home despite missing family and ongoing acculturation difficulties. Healthcare and mental health workers providing services to women detailed their clients’ perseverance amidst a plethora of adverse circumstances—separation from family, grief for missing or killed loved ones, struggle to find housing, ill health and other problems. OP a mental health worker explained how refugees’ determination and perseverance was personally motivating to her, as follows:

In my experience people are so resilient...There are terrible situations like...mothers who are longing to be reunited with their sons...lost due to war [and] they don’t know what happened to them...And then the suffering of that mother or that father is so intense. But despite that, they wake up the following day, they try to learn English, they try to deal with all these papers
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(bureaucracy)...they have a million of appointments. How can you not learn from that? How can you not learn from the fact that a person can be so unable to sleep but still cares about the children, still tries for the children to be the best that they can? Sometimes I feel “oh I’m so tired” but then I think [about them].

Some participants explained that because refugees were weighed down with settlement stressors, health problems, cultural bereavement and language barriers, it was difficult for them to see beyond their current predicament and remind themselves of their incredible journeys of coping and survival. Nonetheless, service providers were inspired by the resilience, personal strength and perseverance of their clients in the face of seemingly insurmountable obstacles and appeared to learn life lessons by listening to clients’ stories. In the following extract OP explains the reciprocal process involved when counselling refugee people, that is, how service providers can learn from their clients, simultaneously as they assist clients to heal from past trauma and resettle into Australian society.

…and sometimes I am so sorry we always see what we can teach them, never what we can learn from them. We [don’t] ask what these people have to offer our society…So that’s why I see this unique opportunity [of] counselling…that we are able to learn from each other…People must realize how much they will be able to learn.

Mental health and healthcare workers described using a strengths-based approach to remind clients of their past resilience and explored potential sources of support (e.g. ‘what did you do when you were locked up and systematically tortured?’). They strived to understand people’s psychological and physical strengths, including their ability to feel
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love and empathize with their abusers. They utilized the strengths from clients’ formative years and upbringing and promoted these cultural coping strategies (prayer, connecting to dead ancestors, religious rituals) to motivate them to move forward. They also taught their clients new coping strategies such as progressive muscle relaxation, visualization, and mindfulness exercises that could help overcome ongoing stress.

**QR**, a counsellor who is also a recent migrant to Australia described her clients’ enormous psychological resources and the potential for others to learn from refugees about survival and problem solving. Referring to the common perception in many host societies that refugees were weak, psychologically damaged and a burden, this participant became emotionally overwhelmed during the interview:

They have gone through things I [can’t] even think…how I could survive or how psychologically to go through all that. This is amazing; this is huge. So then we are here in this western country, western culture and then we judge people?…I am not going to swear because we’re [on record]…but who the [she swears anyway] are we to even dare to judge people? So you know, they are very strong…and they are very rich inside as well…We can learn so many things from them…There is so much rich knowledge about survival; about humanity; about how to deal with issues and problems.

**Reconnecting and bonding.** All participants considered establishing a relationship with clients to be important. For mental health workers, it was a hallmark of a successful therapeutic relationship and they described spending many months labouring to bond with their clients. Many described the dual function of advocating on clients’ behalf—both to empower clients and also to build that vital trust. **ST**, a mental healthcare worker,
described the positive outcome for both his client and himself from a successful worker-client relationship, in the following extract:

…I think there is a real growth in me through what I hear. The same way I see them grow once they share their experiences. And that happens with being able to make a connection with someone. You know, feeling…that you have built this trust and now they are in a position to share some of the most intimate tragedies that they have been through…And to witness that resilience or to witness that resistance…this is a privilege for me. And this relationship allows that growth [in both of us].

As aforementioned, when individual therapy was less successful, participants introduced clients to group work—establishing women’s and young men’s groups, art and theatre therapy to promote socialization, collective sharing and problem solving. These group sessions were especially beneficial to those more vulnerable clients who disconnected from family, isolated from society and struggling to settle, as observed by healthcare, mental health and resettlement workers. Groups were also useful for workers to disseminate information about the availability of vital services (health, mental health, resettlement) as well as for workers and clients to share and benefit from each other’s coping resources and strategies. For instance as UV, a resettlement worker with refugee experiences explained, she would encourage group members to share with each other their coping strategies (religious rituals, gardening); and she too shared the coping strategies she had utilized when she arrived in Australia. Group interaction also enabled her to ascertain clients’ needs and the best way to assist them address those needs.

However when people were estranged from family, community and their religious faith; were feeling desperate and hopeless; and nothing else seemed to work, some
participants described how they offered themselves as a scaffold for their clients to lean on. **KL**, a healthcare worker recalled how she continued to give hope, when participants appeared to have lost all hope and could not see a future in Australia. She did so by sharing the success stories of other refugee communities such as the Vietnamese, who had come to Australia decades ago, had overcome similar challenges, and were holding prominent positions and contributing to Australian society today\(^\text{12}\).

6.5.4 Vicarious traumatization

**Frustration.** Almost all participants shared their frustrations about the difficulties clients encountered when resettling in Australia: difficulty securing private rental accommodation, the seeming arbitrariness and inordinate delays in obtaining public housing, and the insensitivity of the healthcare system (mentioned above). Many participants expressed their disappointment with what they saw as the unpreparedness of Australia’s humanitarian program and its failure to live up to the political rhetoric of multiculturalism, creating systematic barriers for refugees and asylum seekers. Participants reiterated that most refugees required intense settlement support over and beyond the assistance provided under the HSS program in the first 6-12 months. Mainstream healthcare services followed a general practice model that failed to address clients’ unique requirements (e.g. interpreting, diverse understanding and expression of illness) and mainstream schools were easily overwhelmed by refugee children’s plight (e.g. past trauma, family disruptions).

\(^\text{12}\) This participant also recommended that the interviewer read ‘The Happiest Refugee’, the inspirational life story of Anh Do, an Australian stand-up comedian, who came to Australia from Vietnam by boat in 1980. The book has won many awards including 2011 Australian Book of the Year.
Participants also said that separation from family members and prolonged delay in reunification of families was especially difficult for refugees and asylum seekers. This is mainly because clients’ collective lifestyles and communal identity meant that separation from immediate or extended family led to feeling ‘as if part of their self was missing’. Many clients were separated or alienated from family, community and society in Australia, and depended on service providers for vital social contact. Thus some service providers worried about the undue weight of responsibility they felt, being the only significant person in their clients’ lives: the only person to visit them, inquire after their health and show that someone cared.

In the following extract YZ described a client’s desperation to reunite with family, expressing his own frustration at what he considered an unjust and uncaring Australian immigration system. He said:

…worst of all is…the hopelessness people are experiencing…especially when people are experiencing problems that this society creates such as…people who can’t sponsor families…for example there is a client whose family is in another country…the son is sick and needs dialysis. He is here, he is sending every bit of money he can…he’s trying to sponsor his family but…he does not have the money to sponsor; the program for family reunion is being reduced; governments don’t believe that they are suffering…

Almost all participants were aware of the potential negative consequences of working with asylum seekers, refugees or other trauma survivors. All had access to supervision, counselling, and other supportive services in their workplace and many acknowledged the vital function of supervision and mentoring. Some also described the personal strategies they used to avoid getting emotionally overwhelmed by clients’ trauma
stories or resettlement distress, such as reducing their caseloads or making a conscious effort not to get emotionally overwhelmed.

Although feelings of frustration and disappointment do not typically amount to VT, nonetheless the cumulative impact of such negative feelings appeared to lead to VT especially among service providers working with asylum seekers—either in the community or in immigration detention centres.

*Identifying with helplessness and hopelessness.* Most service providers had worked with both asylum seekers and refugees. They observed that the circumstances of asylum seekers were far bleaker than that of refugees given the multiple causes and consequences of their mental trauma. They spoke at length about the uncertainty and insecurity plaguing their asylum seeking clients who were often left languishing in detention centres or in the community for an indeterminate period of time. These people were afforded little information about how long it would take for their immigration claims to be determined and lived in constant fear of being deported. Some participants appeared to have identified with the desperation, helplessness and hopelessness of asylum seekers and became emotionally overwhelmed when discussing their clients’ predicaments. According to mental health workers the insecurity and uncertainty surrounding asylum seekers made it impossible to establish the safe environment required for counselling, vitiating meaningful psychological intervention. Hence most counselling was limited to short-term work focusing on symptom management. The following account by AC, a counsellor represents the helplessness and hopelessness expressed by many other participants regarding what they considered the unacceptable treatment of asylum seekers in Australia. She said:

So I kind of feel that my job is to relieve people’s stress and worry and sadness, but the system is increasing that faster than I can help. So…I see
people becoming more and more distressed the longer the process goes. And for me I guess it makes me feel a bit helpless; it makes me feel [my] work is not successful…And it’s on the news all the time: you go home, you turn on the TV, it’s ‘asylum, asylum, asylum’. So don’t get a break from that. So it can be pretty draining.

To reduce work-related stress, AC had reduced her caseload; nonetheless, discussing her clients still appeared to be emotionally overwhelming her. Similarly another mental health worker described how several interpreters working with him had had to take compassionate leave because of being ‘vicariously traumatized’.

A resettlement worker BD also expressed feelings of helplessness for her inability to afford more certainty and address the most urgent needs of clients. She recognized the danger of unduly empathizing and identifying with her clients to the extent that clients’ stories negatively impacted her worldview. In summary, the disempowerment, distress and helplessness of asylum seekers appeared to have negatively impacted their service providers who had come to connect with their clients and see them as human beings in need of protection and care as described with some difficulty by BD as follows:

…what they (asylum seekers) want is the visa. And I can’t do anything about that…And this thing of wanting to give someone a hug and say ‘of course come here; come and live in my house’. So…feeling like a heart connection with clients; but not being able to do what they really want…So that definitely; the helplessness is something I have struggled with.

Finally CE, a senior mental health worker with much experience working with refugees and asylum seekers described how he identified with his clients’ difficulties. Consequently he continued to carry ‘little scars’ left by his clients over the years. An
example of identification with clients’ problems is highlighted in CE’s interview as follows:

...It’s much harder...when you got children of your own. [Earlier] people could talk to me about anything. Now...it’s not easy...So when a mother says her child died of asthma because she did not know he had asthma...I think ‘my God, I have a child that age’. The identification with that is so much. So you can defend against that and just not listen, and the person feels that you don’t care about the child...I care, I do care. Those are the hardest things I think.

6.6. Discussion

The present study explored the experiences of three categories of service providers working with refugees: mental health, physical healthcare, and resettlement workers. Through data analysis I identified two recurring patterns in the data, namely of VR and VT, together with related themes and subthemes (see Figure 6.1).

As aforementioned, VT is the negative psychological impact of working with trauma survivors and identifying with their trauma stories. According to the Constructivist Self-development Theory (McCann & Pearlman, 1990a), people construct their own realities through a complex configuration of beliefs, assumptions and expectations of themselves and of the world. Continuous exposure to stories of despair can disrupt and transform these patterns of thinking. Hence, VT is the cumulative effect of traumatic events as shared by clients, and the resultant inner psychological turmoil experienced by service providers.
Several study findings appear to support this theoretic conceptualization. Most service providers were familiar with the concept of VT and were concerned that identification with clients’ accounts of torture and trauma could change their view of the world as a safe and secure place. Their belief in justice and fair play appeared to give rise to frustration and discontentment at the perceived inadequacy of Australia’s humanitarian program, impeding clients’ integration into Australian society, exacerbating their current distress, and triggering past traumas. They were disappointed, even incredulous at the cultural insensitivity of some healthcare providers, and the continued application of standard practice models by government and other agencies to people who rarely fit the established script.

In the present study, caring for asylum seekers appeared to be the most emotionally challenging for participants. People working with asylum seekers seemed negatively impacted by the injustice and inhumane treatment of people who had already suffered so much, the seeming hopelessness of their clientele and their psychological deterioration over a short time span. The prolonged uncertainty, inadequate services and seeming ineffectiveness of counselling within the asylum seekers’ context led to feelings of helplessness. According to Weingarten (2003), trauma workers occupy one of four ‘witnessing positions’ depending on: (i) the extent of their awareness and knowledge of the human rights violations and injustices described by their clients and (ii) their ability or power to take action against the violence. Of these witnessing positions, workers who are aware but feel helpless to do anything about their clients’ plight are most at risk of VT. Hence in the present study, service providers working with asylum seekers indicated the most distress arising from identifying with their clients’ situation.

Nonetheless, participants’ narratives also revealed appreciation for the enormous personal resources of the men, women and children they worked with as well as of clients’
unique coping strategies involving family and community observed to be lacking in more individualist Australian society. Clients’ capacity to build relationships, participate and grow during individual or group therapy was repeatedly observed. According to Hernández et al. (2007), emotional reactions of service providers alone do not amount to VR. However study findings revealed how participants’ appreciation and awareness of clients’ strengths, resilience and capacity to grow extended to include internalizing and benefiting from their clients’ positive qualities and experiences. Hence, participants referred to the lessons society could learn from the perseverance, resilience, humanity, love and trust of clients; and sometimes indicated that they were incorporating these lessons into their personal lives. They were also forcefully articulating their subjective positions regarding the perceived injustices faced by their clients in Australia (cf. Engstrom et al., 2008; Hernández et al., 2010; Hernández et al., 2007).

Most participants appeared to be utilizing a strengths-based model to empower clients and thus facilitate successful resettlement and ameliorate acculturation stress (Berry, 1997). Advocating, educating, and assisting with settlement and healthcare needs, they promoted independence and confidence and prevented clients from being disempowered by local bureaucracies. Empowering clients also enabled mental health workers to establish safety and stability for clients, a prerequisite for a successful therapeutic process (Herman, 2001). Witnessing clients’ transformations in independence, confidence and trust enabled mental health workers to experience personal growth themselves, reaffirming the reciprocal effects of therapy (Engstrom et al., 2008).

Participants also communicated a deep awareness of the cultural, religious and social diversity of their clients. Most interviewees had acquired sensitivity, even appreciation, of culture-based conceptualizations and practices of different people from previous life and work experiences with less-experienced participants receiving guidance and mentoring that
inculcated cultural understanding and sensitivity. Cultural competence is defined as the ability of systems, agencies and service providers to provide care and deliver services to effectively meet the needs of a culturally, socially and linguistically diverse clientele (cf.Betancourt et al., 2003). Some experts opine that cultural competency can be achieved by ethnocultural matching at institutional, practitioner and service levels (Kirmayer, 2012). Hence institutions can provide mental health services in community settings; workers of certain ethnicities could be matched with their clients; and clinicians/workers could modify their technique of interaction with clients. This study indicated that agencies in South Australia and their staff were utilizing all three levels of cultural competence.

Although most participants acknowledged the need to be culturally competent, their emphasis varied. Some interviewees considered cultural awareness and knowledge as an essential prerequisite to working with refugees. To others basic human decency, openness to differences and a willingness to learn from clients were the overriding requirement. These differences regarding the emphasis placed on cultural awareness may be linked to participants’ nature of work / occupation (e.g. medical doctor, nurse, counsellors) although no such link was established in the present study. Several workers of all three categories also indicated reflexivity about their cultural and social positioning vis-à-vis their clients. Conversely, the lack of cultural competence or safety in the wider Australian context together with the insensitivity and non-reflexivity of service providers such as medical practitioners appeared to be of concern to participants (cf.Renzaho, 2008). In this study cultural competence/safety and reflexivity appeared to be a prerequisite to participants’ experiences of VT and VR together with commitment and work satisfaction (see Figure 6.1). Conversely, lack of cultural competency/ safety may have also led to VT, although study findings did not support this contention.
In Simich & Andermann’s recent book on refugee resilience, Vasilevska (2014) referred to four principles of incorporating ecological factors into resilience namely, decentrality, complexity, atypicality and cultural relativity (Ungar, 2011, as referred to in Vasilevska, 2014), to demonstrate how Canadian settlement workers promoted resilience in refugees.

Likewise in the present study participants from healthcare, mental health and resettlement agencies also recognized the importance of environmental factors such as assisting clients to secure settlement needs (e.g. housing, food, legal assistance) in appreciation of the interconnectedness of various needs and their impact on clients’ psychosocial wellbeing (complexity). Most participants adhered to a client-centred approach that focused on individual clients’ needs in recognition that a protective factor for one client (e.g. religious belief, community contact) may not be so for another person (atypicality). Participants were also striving to be culturally flexible and reflective in their work lending support to the principles of ‘cultural relativity’. Striving to promote clients’ resilience and coping, and observing client grow, enhanced participants’ resilience within the reciprocal worker-client relationship described by study participants.”

6.6.1 Study limitations

There were several limitations to the study. First, participants’ attempts to portray themselves and their work in a positive light in a university research interview cannot be discounted. However this potential bias was to a large extent mitigated because no direct questions regarding VT and VR were put to participants. Instead, VR and VT were identified as emerging themes of the interview data. In addition, adopting an informal interview strategy that prompted elaboration and discussion further safeguarded against this potential limitation.
Second, the interviewer’s obvious CaLD status (the first author is a recent migrant to Australia from South Asia), could have prompted participants to be more vociferous in expressing their disappointment and frustration at Australia’s treatment of refugees and asylum seekers. Despite this, I suggest that any additional information of this type provided by participants strengthened study findings by elaborating the possible reasons for VR and VT experiences. Third although I identified the positive and negative consequences of working with trauma clients as VR and VT, I cannot deny that other researchers might use similar but different concepts to identify comparable study findings (e.g. V-PTG). Fourth, interview procedure slightly varied across participants in that when given the choice, two service providers opted to be interviewed together. However the analysis did not reveal any differences between their interviews and that of the others. I also found no noticeable differences between the three categories of workers regarding the identified themes—either because of the small sample size, or perhaps because although participants’ organizations could be broadly delineated as ‘healthcare’, ‘mental health’ and ‘resettlement’, this did not totally correspond to workers’ professional disciplines (see Table 6.1).

Finally, the exploratory and cross-sectional nature of the study and purposive sampling precluded me from making causal linkages within study findings. Nonetheless, the elaborate data shared and collected and the insights into VT and VR, cultural flexibility, and work satisfaction undoubtedly add to the literature on refugees and their service providers. Future researchers could focus on identifying the moderators and mediators of VT and VR, and the different pathways to VR and VT, as well as exploring the link between these concepts and cultural competence/ safety.
6.6.2 Implications

The study findings have implications for policy and practice. Emphasizing the rewards of working with refugees can positively impact the motivation of existing workers and encourage others to enter the field. Such a positive focus can also minimize the negative consequences of trauma work, safeguard workers’ welfare and enhance the quality of services provided. Training, supervision and mentoring programs for service providers can raise awareness about VR and prompt workers to share their positive work experiences with each other, as well as incorporating the various elements of VR into training modules (Hernández et al., 2010).

A continuing focus of the risks of VT as well as mechanisms to prevent or address the negative impact of VT (e.g. reducing caseloads) is also vital. In this context, the study also highlighted the importance of continued supervision and mentoring for workers caring for refugees and asylum seekers in Australia. These programs need to be frequently evaluated and updated vis-à-vis their efficacy and adequacy considering the volatile nature of the work involved, such as the worsening situation of asylum seekers. Considering that cultural flexibility can be a pre-requisite for this type of work, the importance of reflexivity of one’s own cultural standing needs to be emphasized in training and mentoring programs for persons working with refugees and other immigrants. Future research could explore the potential differences in VR and VT between workers with different professional disciplines and/or different personal backgrounds (e.g. refugee or migration experiences) utilizing larger samples of service providers. Future research could also explore VT as experienced by workers in different resettlement countries (Australia, Canada, European Union) with varying policies, regulations and law pertaining to the entitlements of refugees and asylum seekers.
Although the major focus of refugee mental health studies has been on trauma and psychopathology, a smaller proportion have emphasized the importance of social and cultural factors (addressing settlement needs, community connections, cultural rituals and practices) that have been found to play a more vital role in psychological wellbeing and adaption of refugees (Simich, 2014). Utilizing a strengths-based approach including adhering to Ungar’s (2011, referred to in Vasilevska, 2014) four principles of resilience aforementioned appear to benefit not only refugees but also their service providers. Future research could focus on developing an evidence base on the impact of promoting resilience among refugees including designing new and innovative interventions that include a component of promoting refugee resilience; as well as exploring the association between service providers’ experience of vicarious resilience and the improvement of their clients’ psychosocial and physical wellbeing.

Finally, this study contains an important message for the Australian government: harsh and inhumane immigration policies have dire consequences, even beyond the psychological and physical wellbeing of refugees and asylum seekers. This study indicates that such policies, regulations and laws also take a psychological toll on workers providing healthcare, mental health and resettlement services to refugees and asylum seekers.
Chapter 7. Talking Therapies and Therapeutic Silences

...when we work with [them], it is hard because [they] had come from generations of wars...they have confronted so much suffering, so much pain...

GH, senior counsellor and service provider participant (2013)

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7.1. Preface

Chapter 7 contains a manuscript in preparation, to be submitted for publication in June 2014. In the same way as for Chapters 3, 4, and 6, Chapter 7 contains a reformatted version of the manuscript and references are included in the main reference section (p. 271 onwards). Details of the manuscript are:

7.2. Abstract and key words

Traumatic refugee experiences such as threats to life, torture and multiple losses can lead to posttraumatic symptoms (hyperarousal, intrusion, emotional numbing), depressive and psychotic states, substance abuse, existential problems, and identity crises. Post-migratory stressors can also exacerbate posttraumatic symptoms, and worsen settlement outcomes. The present study aimed at exploring how service providers in South Australia assisted refugees and asylum seekers to ameliorate psychological trauma and ease distress. Using qualitative methods to collect and analyse data, I identified four prominent and recurrent patterns in the data: (1) establishing safety, trust and connection; (2) talking about trauma (3) working with silences and (4) promoting coping and growth. Study findings underscored the complexity of working with people from diverse experiential and sociocultural backgrounds, and the skill and flexibility required in this type of work.

**Key words.** Refugee, asylum seeker, counselling, culture, safety, qualitative, strengths-based, client-centred.

7.3. Introduction

Traumatic experiences such as threats to life, serious injury, sexual violence, torture and other human rights violations, multiple losses, and separation from loved ones, home, community and culture can give rise to posttraumatic symptoms (e.g. PTSD), depressive and psychotic states, substance abuse, existential problems, and identity crises (Drozdek & Wilson, 2004). Research has identified a positive relationship between increasing traumatic encounters associated with more severe distress (Mollica, McInnes, Poole, et al., 1998); sometimes lasting for decades after the events (Steel et al., 2002). Nonetheless only a
fraction of refugee adults and children develop lasting mental health problems. Despite their traumatic past histories the majority appears to adapt and recover with time (Fazel et al., 2012; Fazel et al., 2005).

Several posttraumatic symptoms have been identified: intrusion or the reliving of past traumas as flashbacks during waking hours and nightmares during sleep; hyperarousal or hypervigilance; and avoidance or emotional numbing in an attempt to avoid distressing memories of external reminders of the trauma (DSM-5; American Psychiatric Association, 2013). An individual with posttraumatic symptoms may for example experience intense emotion without a clear memory of any associated events; or remember traumatizing events in detail without emotion; or be in a continued state of vigilance, irritability or rage without knowing why. According to the literature, although human beings are endowed with a complex, organized and well-integrated system to deal with stressors encountered in the ordinary course of life, traumatic events can render people helpless and terrified; overwhelming and disorganizing this self-protection system (Herman, 2001).

Traumatic experiences also interfere with memory. Although trauma survivors may frequently relive their traumatic past (via flashbacks and nightmares), associated memories are usually not integrated into normal memory leaving survivors without a fluid narrative of events that can be assimilated into their life story. Hence, trauma not only destroys actual security (e.g. threat to life), it can shatter trauma survivors’ assumptions of the safety and predictability of the world, their trust in others, sense of self-worth and control, as well as the construction of self in relation to others, resulting in alienation and social disconnection (Linley & Joseph, 2004). Research has found that creating, retelling and revising trauma stories enables people to integrate their fragmented memories, process their traumas, ameliorate psychiatric symptoms and reconnect to society (Agger & Jensen, 1990; Drozdek & Wilson, 2004; Schauer et al., 2005).
Although trauma recovery is far from being a straightforward process, Herman (2001) identified three stages: establishing safety and security, acknowledging and consolidating traumatic memories, and moving away from isolation to social connection. Highlighting the importance of creating a safe sanctuary within the therapeutic setting, Van der Veer and Van Wanig (2004) identified four aspects of establishing safety—safety from the past, safety in present living conditions, safety in the therapeutic setting and safety for the therapist. In this context, socioeconomic difficulties in resettlement or the perception of living in an alien culture can perpetuate a sense of insecurity among refugees, maintaining or worsening their trauma; or sometimes even trigger their traumatic symptoms (Pain et al., 2014). For instance, one study by Steel and colleagues (Steel et al., 1999) demonstrated how pre-migration trauma interacted with post-migratory stressors to exacerbate posttraumatic symptoms, and worsen settlement outcomes. Silove (1999) has also suggested that post-migratory factors impacted on five core adaptive systems including systems of safety, attachment, justice, identity-role, and existential meaning.

Indeed, refugees are faced with a plethora of stressors in resettlement. They are required to learn a new language, adapt to new cultural values, food, traditions and worldviews, as well as navigate through new systems of healthcare, governance, transport, and trading (Murray et al., 2008). Of the four modes of acculturation identified by Berry (1997)—integration, assimilation, separation and marginalization—those who integrated into mainstream society, by maintaining some of their cultural values while taking on aspects of the new culture, had the greatest well-being. Learning the language of the host country is also vital for successful integration, but can be hindered by posttraumatic symptoms such as difficulty in concentrating.

Most traditional psychological interventions for traumatized people involve intense re-exposure to their most traumatizing experiences within a safe and secure environment
with the main objectives of consolidating memories and developing coherent narratives. Examples of such evidence-based therapies include: Culturally Adapted Cognitive Behavioural Therapy (CA-CBT), Narrative Exposure Therapy (NET) and Testimony Therapy (TT-- Agger & Jensen, 1990; Hinton et al., 2012; Schauer et al., 2005). These therapies generally included culturally accepted techniques for calming the body and regulating emotions such as meditation, mindfulness exercises, progressive relaxation, visualization, or locally accepted rituals. There is also growing interest in the application of therapies such as Acceptance and Commitment Therapy (ACT; Thompson, Arnkoff, & Glass, 2011) and Eye Movement Desensitization & Reprocessing (EMDR; ter Heide et al., 2011) for refugees and asylum seekers. Less traditional, non-verbal interventions (e.g. psychomotor therapy) are based on the understanding that the body encodes and stores memories of trauma expressed subsequently as bodily ailments (somatization; Drozdek & Wilson, 2004). Some experts have suggested that group therapy was more acceptable to asylum seekers and refugees because it addressed their loss of trust and social isolation and was more conducive to their sense of collective identity, whereas individual therapy was appropriate for survivors of sexual torture and abuse (Drozdek & Wilson, 2004).

7.3.1 Refugees and asylum seekers in Australia

Of the more than 15 million refugees in the world, in 2012-2013, Australia accepted and resettled approximately 20,000 refugees\(^\text{13}\). Refugees in Australia are assisted by two main programs: the Humanitarian Settlement Services (HSS) offering newly arrived refugees essential services for the initial six to twelve months (accommodation, household

\(^\text{13}\) This was an increase from the 13,500 refugees accepted in the preceding years; the increase was consequent to the recommendations made by the Expert Panel on Asylum Seekers, 2012. However from 2014, the new Abbot government has reduced the number of refugees accepted, to 13,500.
goods, assistance to register with social security, government health insurance, banks, and schools) and the Settlement Grants Program (SGP) affording less intensive support from 6-12 months up to five years after arrival (Department of Immigration and Citizenship (DIAC), 2013a). Settlers are also offered 510 hours of free English language classes as well as access to 24-hour telephone translating and interpreting services (TIS). Trauma counselling and specialized healthcare services are available under separate federal and state funding arrangements for those assessed to be most in need.

Australia’s harsh policies towards asylum seekers\textsuperscript{14} including the policy of mandatory detention of people in often inhuman and squalid conditions have been strongly criticized by both local and international human rights communities (Australian Commission of Human Rights (ACHR), 2012; UN High Commission for Human Rights (UNHCR), 2013). Over the years numerous refugee experts have documented the devastating psychological impact of Australia’s asylum seeker policies on already vulnerable adults and children (cf. Newman et al., 2008; Silove et al., 1998; Steel et al., 2006). Periodically some asylum seekers are transferred into the community (e.g. on bridging visas) pending decision on their immigration applications, but they continue to face severe difficulties pertaining to obtaining paid employment, housing, adequate nutrition; access to English classes or vocational training (Murray et al., 2008). Worst of all are the effects of the new Liberal-National Coalition government’s policies of transferring asylum seekers from onshore to offshore detention centres on Nauru and Manus Island, Papua New Guinea. The prolonged delays in processing refugee claims and

\textsuperscript{14} People who are not yet recognised as ‘refugees’ according to the UN Refugee Convention of 1951 and whose status is undetermined; including people arriving by boat or by plane without valid documentation.
the uncertainty and confusion faced by asylum seekers will undoubtedly exacerbate the trauma and distress of an already vulnerable group of people (e.g. Mares & Zwi, 2014).

**7.3.2 Study aims**

The present study was part of a larger project exploring the experiences of healthcare, mental health and resettlement workers caring for refugees and asylum seekers in South Australia. This study aimed at exploring how service providers ameliorated the psychological trauma and distress of their refugee and asylum seeking clients, and helped them process their trauma.

**7.4. Method**

**7.4.1 Participants**

Twenty eight service providers working with refugees and asylum seekers, in Adelaide, South Australia were interviewed for this study. They were women and men providing services in three sectors: mental health, healthcare and resettlement services including doctors, nurses, psychologists, counsellors, service managers, coordinators, and case workers. Their work experience ranged from 1 ½ to 30 years with the majority reporting 2-5 years of experience working with refugees. Most participants were from mainstream Australian society but about one third were former refugees or recent immigrants (Table 7.1 contains a description of all interviewees). Because relatively few agencies provide services to refugees and asylum seekers in South Australia (compared with larger Australian states such as NSW and Victoria), organizational affiliations and participant descriptions that could lead to identification in any way have been omitted to ensure participant and organizational confidentiality.
# Table 7.1 Characteristics of all service provider interviewees

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<td>9</td>
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<td>Previous experience working with refugees</td>
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<td>2-5 years</td>
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<tr>
<td>Not specified</td>
<td>3</td>
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<td>Profession/ current position a</td>
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<td>Nurses</td>
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<td>Psychologists</td>
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<td>Counsellors</td>
<td>9</td>
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<td>Managers</td>
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<td>Program officers/ case workers</td>
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<td>Nature of Organization b</td>
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<td>Healthcare</td>
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<td>Mental health</td>
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<td>Settlement</td>
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<td>Background c</td>
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<td>Mainstream</td>
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a Refers to participants’ profession (doctor, nurse, psychologist) or current position (e.g. counsellors included people qualified in social work, nursing or psychology).

b Refers to the main service provided by the organization to which a worker was affiliated and not necessarily the worker’s profession (e.g. a social worker at a mental healthcare service was considered a ‘mental healthcare worker’).

c Refugees background included workers from South Asia, Middle East and Europe; Recent Migrant/CaLD background included those from South Asia, Europe and South America.

d CaLD = Culturally and Linguistically Diverse
7.4.2 Data Collection

Approval for the study was received from the Ethics Committees of the University of Adelaide and South Australian Health Department. I contacted and personally met the managers or team leaders of organizations working with refugees and after discussing details of the research study requested permission to interview staff. Usually the managers/team leaders circulated my request to staff members and those interested in participation contacted me via telephone or e-mail. This procedure complied with the passive snowballing technique of participant recruitment. Three participants were approached directly: one was a team leader and two were interviewed in their personal professional capacity independent of their organizational affiliation.

Participants were offered the option to be interviewed individually or participate in a group interview. Except for two participants all others opted for individual interviews which were conducted from December 2012 to May 2013. Signed informed consent was obtained from participants before the interview commenced. Interviews lasted between 1 to 2 hours. Participants were interviewed using a semi-structured interview format comprising several open-ended questions and all interviews were audio-recorded. Interview data were supplemented by brochures, reports and other material shared by participants. Two more service providers were interviewed but later excluded from the study and the data analysis, being deemed ineligible for participation. One was an Australian-trained mental health worker assisting Rohingya refugees in South East Asia (i.e. not providing services in Australia) and the other was a psychiatrist in Australia who was involved in the design of the research project and hence not blind to the study aims. Instead, their interview transcripts were utilized as sources of expert information.
7.4.3 Data Analysis

An inductive thematic analysis (Braun & Clarke, 2006, 2013) was used to identify prominent and recurring patterns in the interview data identified at a semantic or explicit level of analysis. The Nvivo version 9 qualitative data analysis program was used to facilitate analysis. Data analysis comprised the following stages: first, the audiotaped interviews were transcribed orthographically and checked for accuracy. Second, interviews (including interview notes) were read and re-read to gain familiarity with the data set. Third, interviews were coded and the initial codes generated were searched for themes which were then reviewed, defined and named. Analysis included moving between the data set, the generated codes, analyses being produced, and theoretical concepts (Braun & Clarke, 2006, 2013). As the first author, I conducted all interviews and primary analysis. All authors participated in subsequent analyses including refining themes and extracts, as well as linking to theoretical concepts. The themes and subthemes revealed by the analysis together with their relationships with each other are depicted in Figure 7.1.
Figure 7.1 The theme and subthemes revealed by data analysis

7.5 Analysis

As depicted in Figure 7.1, four major themes were identified: (1) establishing safety, trust and connection, (2) talking about trauma, (3) working with silences, and (4) promoting coping and growth. Detailed analyses are set out below.
7.5.1 Establishing safety, trust and connection

Participants described the importance of establishing safety, security, trust and rapport with their clients. There was a consensus that refugees’ primary concerns usually revolved around settlement issues: housing, healthcare, employment, children’s schooling and learning English. Inability to find affordable rental properties and the serious shortage of public housing in South Australia were considered major problems leading to a sense of insecurity and instability among refugees. As one service manager explained, people with refugee experiences had already faced multiple displacements and had lost their homes, families, possessions and livelihoods. Securing safe and affordable housing was essential to establish a sense of security and stability. Thus, most participants’ work tasks included advocating on behalf of their clients’ settlement needs or referring clients to other agencies for assistance.

Advocating on behalf of clients and assisting them to secure practical needs enabled mental health and healthcare workers to build trusting relationships with clients, considered essential for successful outcomes including trauma processing. Hence, counsellors and therapists spent the initial months and sometimes years striving to connect with their clients. A counsellor described how he created trust with clients by offering ‘the counselling room as their space and the counselling time as their time’, ‘working with people at their own pace’ and ‘addressing their concerns at any given time’. Others visited clients at home, met their families and shared food and common activities (cooking, sewing) to overcome the barrier of strangeness. A resettlement worker explained the importance of her mediatory role in creating a trusting relationship between refugees, mainstream services (health, housing, social security) and other agencies.
Some counsellors considered establishing safety, stability and trust with clients as the main focus of their work together with addressing clients’ immediate needs and managing symptoms of trauma such as sleeplessness, nightmares, loss of appetite and concentration, nervousness and irritability. According to AB a mental health worker, restoring safety and trust was more important than processing trauma; as he explained:

We all experience trauma of some kind. I don’t think the magic or the mystery is in being able to process that event as much as the consequences of that event—that is that people don’t feel safe anymore. They don’t feel that the world is predictable, they don’t feel that their rights or the things that they hold really valuable are safe. And it’s those feelings that need to be restored. And we restore them in different ways such as letting people know that…therapy is a choice, that it has a beginning and an end, they can leave any time you know, [and] tell that you are there for them. So lot of little experiences add up to restore a sense of safety and a sense of trust in people.

CD who worked at a healthcare agency shared a strategy he employed to develop a trusting relationship with clients—to bring himself into the therapy including his weaknesses such as feeling angry, nervous or the sense of ‘being lost’. He said:

…yesterday, a woman I’m working with; I was actually feeling quite angry in some ways because I couldn’t get my point through to her very well. And I said to her at the end ‘we had a bit of a fight today didn’t we?’ and she said ‘yes we have’. And this was a real opening. We built a bridge, a conduit that we were able to open up to connect much better even if we had to do it through the interpreter. But it really worked very well.
Many participants said that once safety and trust were established refugees usually felt more comfortable and confident to disclose past traumatic experiences. Healthcare workers also observed clients’ gradual willingness to share their past life story as they progressed through the health assessment pathway. However participants working with asylum seekers complained about their inability to establish safety, stability or trust because their clients’ circumstances were imbued with uncertainty and instability as explained by EF, a mental health worker as follows:

…one of the really important things…before talking about traumatic memories is the idea of safety and stability. And asylum seekers don’t have that. So because they don’t know when they’re going to be sent back; if they’re going to get their visa, if they’ll be deported, if they’ll be sent to Nauru, even at the moment there is so much uncertainty about where people are gonna go, it’s really hard to establish that sense of safety to be able to start talking about trauma.

Developing a trusting relationship with asylum seekers was also hindered because of the uncertain duration of the counsellor-client relationship. Mental healthcare workers were reluctant to expose clients to past traumatic experiences in case clients were deported or transferred half-way through their work. Hence counselling work was largely confined to limited advocacy and symptom management unless the client voluntarily indicated a willingness to discuss his or her past experiences (detailed below: ‘Talking about trauma’).

Upon the interviewer’s request several participants cautiously described differences between client groups regarding their ability to feel safe and build a trusting relationship with their service providers. One such difference was between older women, who sometimes had difficulty engaging with the counsellor and the counselling process, and
younger women seen as more assertive, articulate and ready to establish relationships. GH
an experienced counsellor, described the difficulties encountered with a group of older
women in the following extract:

…when we work with [them], it is hard because [they] had come from
generations of wars. It’s not just one war; it’s series of ‘wars’…they were kind
of forced to get married at 11, 12 years old. And sometimes…they had their
husbands being abusive…women who had lived in remote villages…inserted
into this society and expected to do many things. And so…it was quite hard to
establish that sense of safety and to develop a relationship because they…have
confronted so much suffering, so much pain…that once here, some of them
initially were paralyzed by pain…and [indicated] profound depression and
sadness.

7.5.2 Talking about trauma

The benefits of processing past trauma through verbalization or disclosure were
recognized and articulated by the majority of mental healthcare workers, and also by
physical healthcare and settlement workers. Participants identified three categories of
clients depending on their ability and willingness to talk about past traumatic experiences:
clients who willingly elaborated traumatic events and experiences; clients who were
initially unwilling or incapable of verbalization, but gradually with time and the
establishing of safety, security and trust disclosed the most traumatic experiences of their
lives; and others who never wanted to, or could not, talk about it.

Almost all participants indicated that they had encountered clients who readily
disclosed elaborate details about past traumas. Mental health, healthcare and resettlement
workers described how some people would tell their entire life story despite not being
required to do so (e.g. during initial assessment). Some participants observed that people
told stories not necessarily because they wanted to do so, but because they considered it a
‘necessary evil’ in order to obtain vital practical assistance or because they believed that
divulging past trauma would motivate workers to obtain the required assistance for them;
like a supporting letter for public housing or disability payments. It was a survival
technique or active coping strategy used by clients that was not necessarily a ‘bad thing’
according to one counsellor. A mental health worker revealed that now he simply asked
clients during the first session what letters they wanted so he could write them and then
maybe begin the therapeutic work. Most often people did not want to continue therapy
once the letters were prepared or practical help obtained. However some clients returned 5
to 10 years later, requesting therapy.

Nonetheless, several participants acknowledged that sharing trauma stories was
beneficial for trauma survivors because they had little opportunity to do so, and they
needed validation of their previous traumatic experiences and to find meaning for those
events. Even those who had families and community refrained from confiding in
significant others because inter alia, they did not want to burden them. Counsellors said
that the privacy and confidentiality of the counselling room facilitated disclosure.
Sometimes trauma narratives occurred spontaneously, taking counsellors by surprise and
creating some difficulty as described by IJ in the following extract:

So during assessment…someone will just come in and ‘blah’ just tell you
everything in the first two hours, absolutely everything, to the point that…I’m
not ready and I’m quite upset from what I’m hearing. And when you finish the
session, they are visibly quite happy because they’ve purged; just got rid of all
this information that they wanted to talk about for so long because no one has
ever asked them. And then suddenly you say ‘ok, this is a process that can be
ongoing for several months; are you interested?’ ‘Oh no, no; I don’t want to see anyone else again…thank you so much’. And they are gone; because they’ve done what they wanted to do.

Participants indicated both individual and group differences in clients’ ability and/or capacity to talk about trauma in response to interviewer questions, although many said they were reluctant to do so because they did not want to stereotype clients or be influenced by prior assumptions about clients. When they did identify cultural and other group differences, they emphasized that their observations were broad generalizations and that individual differences usually surpassed group differences.

According to one counsellor, if clients’ past experiences of human rights violations had received international recognition they were more inclined to describe the details of their torture and trauma. However another counsellor was of the opinion that sometimes torture trauma became clients’ predominant identity, and consequently there was an unwillingness to move on, be more proactive and benefit from the opportunities available to heal and to carve out a new life in Australia. Conversely others whose stories of violations, deprivation and suppression were relatively unknown or had not received public validation (e.g. asylum seekers), were less willing to elaborate on their past. One counsellor working with a group of male asylum seekers observed a slightly varying trend among his clientele, who often made the perilous journey to Australia by boat, and spent several years in detention centres before being released into the community. According to him, these young asylum seekers were proud to describe their stories of escape, endurance and bravery.

Several mental health and healthcare workers reported cultural distinctions they found: African women were identified as being more articulate, assertive, and willing to
engage with the therapeutic process whereas Middle Eastern and Asian women were more hesitant to share intimate details of their traumatic experiences possibly because of cultural restrictions against such disclosure. According to a psychologist sexual traumatization was the most difficult topic to discuss, for both women and men but for different reasons. For men, sexual violence perpetrated against them brought about a personal sense of shame about masculinity and manhood. In some cultures sexually abused women were considered unclean or as dishonouring the family. Hence he observed that women were doubly traumatized: first by the perpetrator/s and then by their own families and communities.

In the following extract KL, a counsellor from a Culturally and Linguistically Diverse (CaLD) background shared his opinion of the benefits of culturally appropriate disclosure of past trauma despite silence being a coping strategy in many cultures.

Suppressing the issues is one technique and in some communities it’s common. … [in] some Eastern or African cultures, having balance is one of the conflict resolution techniques… just keep it quiet. It means you don’t disturb the issue; you don’t talk about it. You just keep quiet. But I don’t believe it. We are talking about human beings; culture is second…first is human being. [So] I believe in verbalization…it is very useful but it has to become part of the culture…if that woman or man is from that culture you can’t expose them to those techniques [immediately]. So you have to be careful.

Most participants agreed that counselling, which involved revealing one’s inner-most personal thoughts and feelings with a stranger usually in the counselling room, was a western concept not necessarily familiar to people from diverse cultures. Although most refugees would have experience discussing their problems with family, friends, religious leaders, or tribal elders, counselling was still an alien concept to most clients with many
languages not including a word for ‘counselling’. Interviews with settlement workers from two South Asian communities confirmed their communities’ unfamiliarity with the counselling concept and their discomfort with its practice.

Hence an initial step of mental health work with refugees involved educating them about counselling and ascertaining their willingness to participate. A healthcare worker described taking the opportunity to introduce clients to counselling when they complained of physical ailments (headaches, backaches, shoulder pain), suggesting that maybe it was their worry and distress that was causing the physical pain. However she would refer them for counselling only if she observed willingness in clients because she explained that counselling was similar to giving up smoking; one had to be willing and ready to change and do the hard work involved. Contrastingly a mental health worker said he preferred to ‘give the tablet’ most clients expected for their physical pain, so he could continue with the therapeutic process. Although there was never a complete acceptance or understanding of counselling among clients, participants said that increasing familiarity and reduced distress enhanced the willingness to talk and to share. However when certain participant groups appeared not to benefit from individual sessions, mental health and healthcare workers were called upon to expand their imagination and design unique and innovative programs for their clients (detailed below: Working with silences).

Most participants also discussed the stigma attached to mental illness in many communities and the barriers to accessing mental healthcare faced by refugees. That is, sometimes, people were wary to seek assistance for fear of being labelled ‘crazy’ or ‘mad’. Confidentiality was also a concept not totally comprehended despite explanation; people worried that what they disclosed during counselling—especially via interpreters—would reach their communities. While a close-knit community was considered an important coping strategy (see under ‘promoting coping and growth’) it also afforded less privacy to
community members. These perceptions were validated by several workers from CaLD and refugee backgrounds.

7.5.3 Working with silences

Most participants said they had met clients who were reluctant to talk about their past traumatic experiences. Some clients did not want to return to the darkness of the past instead wanting to focus on the present and future. For mental health workers who utilized a client-focused approach\(^{15}\) this was acceptable and they continued to address clients’ day-to-day needs, giving information, empowering them to access essential services, connecting them to services, and facilitating their resettlement in Australia.

However the ultimate goal of most workers was to establish a trusting relationship through advocacy and intervention, thereby encouraging clients to process the trauma by verbalizing their past. With some clients however little progress was made in the months and years of individual counselling within traditional settings. Hence it was imperative to come up with innovative and culturally more acceptable alternatives for trauma processing. In the following extract MN, a counsellor, described how she successfully used non-verbal techniques with people who were unable or unwilling to talk about past trauma:

…when there is a block… then the person will just repeat the same thing again and again…So I use relaxation and meditation and visualization and metaphors…like talking about a tree you know…And it works really well. It

\(^{15}\) A client-focused approach is where the client became the centre of the counselling process and the focus is on affording the support the client needed at any given time (Joseph, 2004).
works really well. Because it’s a way of expressing differently. I use art therapy as well which is externalization and metaphors as well.

Observing the lack of progress with a group of clients in individual counselling sessions, mental health workers had started group sessions for older women and younger men. For instance in a women’s group, despite the women’s earlier distrust of counselling and fear that their stories would be revealed to their communities, they actively participated in group sessions, readily taking turns to share their experiences with each other. The women’s groups were later developed into ‘theatre therapy’ involving women depicting their trauma and distress collectively through body movements without using words. The success of group work was enthusiastically explained by OP in the following extract:

…we found that with the group it was fantastic. At [agency name] we started an even more challenging process…We started a theatre group…based on Augusto Boal’s ‘Theatre of the Oppressed’…and this kind of theatre…is more than talking; it is working with the body but to liberate people…women initially were fearful…a woman may sit and talk but will not move the body…During the theatre group the women would do things…like these body movements that were incredible.

Women’s groups organized by settlement agencies were also quite successful in promoting the sharing of coping strategies, overcoming isolation and providing a venue for women to learn from each other as well as for settlement workers to understand the challenges faced by the women.

Participants working with young refugee and asylum seeker men also encountered similar problems. According to counsellors, some Middle Eastern and African men,
regarded talking about feelings as a weakness and this, together with the stigma attached to mental illness, led to an unwillingness to verbalize their traumatic experiences. Moreover, unaccompanied youth, without family and estranged from community, were socially isolated. Hence a young men’s group was established for the men to meet and socialize with each other and with a counsellor in a group setting. This also allowed the counsellor to periodically monitor any deterioration or change in clients’ circumstances.

The flexibility extended to their clients by participants and their organizations was also portrayed in the services offered to children. According to a mental health worker, refugee children exposed to trauma had accelerated heart rates, were quick to react and get angry, and were getting into trouble and being expelled from school. Because she found sitting and talking to individual children about their trauma to be less meaningful, this worker together with colleagues had started an innovative program to teach refugee children to calm their bodies through drumming. During a lengthy interview, she described setting up a drumming group for children identified by schools as difficult to manage and with the assistance of an instructor teaching children to drum to the rhythm of the heartbeat. The results of the program were described by the worker, OR as follows:

…I remember doing it once at a school with a group of boys, and they picked all the difficult boys in the school…They were put into this drumming program…as I was watching them drumming, some of them were getting quite glazed in their eyes and looking a bit tired; and some asked if they could just lie down for a while. It was really funny…because the teacher… said to me: “Oh, this is not good; nobody is participating… and she was panicking because at least five boys were lying on the floor and having a bit of a nap. And I said to her ‘this is fantastic’. Because basically we were seeing right in front of us, all those systems that need to calm down or regulate are actually doing that.
Whereas some mental health workers preferred specific therapies such as Acceptance and Commitment Therapy (ACT), Eye Movement Desensitization and Reprocessing (EMDR), or Narrative Exposure Therapy (NET), others utilized an eclectic approach also including narrative and art therapy, writing in journals, relaxation and meditation, visualization, and so forth. Psychologist ST found ACT especially useful for trauma processing because he explained that ACT recognized that people’s thoughts and feelings were not necessarily dysfunctional, unlike ‘pure’ cognitive behavioural therapy. Instead ACT assisted them to accept and manage their uncomfortable thoughts and emotions. According to him, telling clients: ‘you should not feel like that’ would be abusive because sometimes people were justified in feeling the way they did, like the hopelessness felt by asylum seekers who were simultaneously dealing with trauma from their past and on-going trauma created by the Australian immigration system.

7.5.4 Promoting coping and growth

The majority of participants highlighted the importance of assisting trauma survivors to process their trauma whether through disclosure or non-verbal methods. They also recognized that people’s ability to feel safe again, and to have a sense of predictability in the world and trust in humanity, needed to be restored. According to a manager from a refugee background, it was appreciation for the beauty of life and the freedom that this new land offered that enabled refugees to rebuild their lives, overcome trauma, and continue despite past struggles.

Several participants said they utilized a strengths-based approach; not merely to teach clients coping strategies, but also observing and uncovering the strengths clients already possessed; because most refugees had enormous resilience although they were not always able to see beyond their present predicaments. Listening to refugees’ stories was a
good way of exploring potential sources of strength and resilience and to remind them of
their past achievements (escaping wars, safeguarding children, overcoming obstacles and
surviving). Participants also continued to encourage clients by giving positive feedback on
current achievements (e.g. learning English).

The enormous resilience of refugees and asylum seekers was readily identified and
elaborated upon by several participants. This sharply contrasted with a separate interview
(excluded from this data analysis but utilized as contextual information) with a mental
health worker in South East Asia who struggled to identify any strengths or coping
strategies among a clientele of ‘Rohingya’ refugees living a pitiable existence in an
neighbouring country after fleeing from Burma. According to most study participants,
refugees and asylum seekers underwent tremendous stressors settling into a new society,
navigating through a strange system and, learning an alien language. Simultaneously they
could also be suffering the consequences of past traumas and continuing to be distressed
about separation or loss of immediate family members, home country culture and
community. Yet they continued to care for their children, educate themselves and find
employment much to the admiration of participants who found their clients’ perseverance
personally inspiring (how service providers learned lessons from their refugee clients is
described in a forthcoming manuscript).

Participants working with asylum seekers especially unaccompanied minors
marvelled at how their clients had left their families to make the perilous boat journey to
Australia, had been in detention, and were constantly worrying about deportation, but still
managed to enthusiastically learn English, communicate via social media, attend school,
visit the gym and engage in activities similar to other adolescent boys. Thinking about their
families, financially supporting families overseas whenever possible and maintaining hope
to be reunited with family, were coping strategies for most refugees according to
participants, but official barriers to family reunification led to desperation and hopelessness.

**Community factors.** Participants from all three categories (mental health, healthcare and resettlement) considered community an important source of strength for refugees, to get a sense of belonging, maintain communal identity, associate with others from a similar culture, speak the same language, share food and prevent social isolation in a new environment. Social networks were also important for newcomers to get practical help, receive information and ease the burden of resettlement. For example a resettlement worker described how the Afghan community in Adelaide came to the aid of asylum seekers, welcoming and sharing their homes with them. The support received by Tamil asylum seekers from their community in Victoria was also mentioned. According to mental health workers, this sense of community also enhanced the therapeutic relationship between counselor, interpreter and client in the counselling room. Hence counsellors said they promoted a communal spirit in the counselling room by for instance booking the same interpreter for all sessions with a client. Mental health and resettlement workers facilitating group work described how group members shared their stories and their coping strategies with each other (praying for family overseas, religious rituals, gardening). Three resettlement workers also explained the benefits for refugee communities of living in a small country town in South Australia as opposed to being isolated in the outer suburbs of a city. They explained the symbiotic relationship between clients and the town’s inhabitants where refugees contributed to the town’s industries and in turn the town’s inhabitants offered refugee families, communal support and friendship. The local health centre organized meetings where Italian and Greek immigrant women from previous generations shared their own migration experiences with the newcomer women, giving hope for the future.
Community could however be a double edged sword. Participants explained that communities could be divided on past ethnic and religious antagonisms, people could be stigmatized for deviating from cultural norms; and inter-generational tensions emerged between younger and older generations within communities and families. Some communities were working to unify their diverse members. Nonetheless, some people remained isolated leaving agency workers and volunteers to befriend and support them.

**UV**, a nurse, described the dual aspects of community as follows:

Some people want to connect to community; and other don’t. And it depends a lot on their circumstances. So sometimes connecting to community can mean…connecting to home; but it can also mean taking the problems from home and planting them in a new country...[they] absolutely don’t want to…meet people here that back home were responsible for the very trauma they have.

**Religion/ spirituality.** Holding on to religious values and beliefs was identified as a protective factor, sometimes preventing desperate people from committing suicide (because suicide was against most religious precepts). Many participants drew a distinction between religion and spirituality: rigid religious beliefs could defeat the therapeutic objective because people could become resistant to change whereas a personal relationship with a higher power was identified as a consolation in times of need. However, religion and culture intersected in many ways connecting clients to their past and afforded a sense of belonging to a religious community including benefits of socializing at religious festivals and participating in religious rituals. As **WX** a counsellor described:
Though religion was a powerful source, rigid fatalistic religious beliefs are difficult to work with in the counselling room; because sometimes clients’ fatalistic religious beliefs become an uphill battle against God.

Organisational support. A manager explained that organizational assistance was vital for refugees’ confidence and support. It was a consolation to have a place where refugees were understood, a place they trusted and could visit and talk to someone and where they received social support (‘my counsellor will come to visit me today and make sure I am alright’). A settlement agency had a volunteer program with around 150 volunteers who assisted newcomers in numerous ways, especially people who had little social support elsewhere. These volunteers provided their clients with the necessary skills and information to be confident to resolve their own resettlement problems. Sometimes however participants explained that when people had no coping strategies left, workers offered themselves as a scaffold for clients to lean on with the reassurance that things will improve.

7.6 Discussion, limitations and conclusion

The analysis of interview data above, identified four prominent and recurrent patterns relevant to the research aims, namely how service providers in South Australia assisted refugees and asylum seekers to ameliorate psychological trauma and distress. The four identified themes were: (1) establishing safety, trust and connection; (2) talking about trauma (3) working with silences and (4) promoting coping and growth.

As highlighted in the literature, study findings afforded ample support for the importance of establishing safety, stability and trust with refugee clients. Almost all
participants considered resettlement as a major obstacle in establishing a sense of safety and stability. Despite the services provided to refugees via the HSS, SGP and other programs such as free interpreting services sometimes not afforded in other countries (e.g. New Zealand; Phillips, 2013), services were considered inadequate especially for the more vulnerable clients with complex problems. Inability to secure essential needs such as housing necessitated mental health workers to spend long hours advocating on behalf of clients and establishing a sense of basic security. Sometimes that was all they could do because of the multitude of needs and the recurring nature of problems clients faced. Creating a ‘safe therapeutic sanctuary’ was considered the most important aspect in therapy in that safety and trust had to be established before any psychological intervention could begin (Van der Veer & Van Waning, 2004). Although former refugees may have obtained safety from the past, this did not extend to asylum seekers who continued in perpetual fear of being returned to their countries of origin. Service providers were striving to create a sense of safety in the present by advocating and assisting clients address essential resettlement needs (e.g. affordable housing). Mental health workers were utilizing advocacy to build a safe and trusting relationship in the counselling setting. The mostly harmonious and cooperative relationship between mental health, health and settlement agencies in South Australia referred to by participants, also facilitated the creation of safety and stability for refugees in the present (Van der Veer & Van Waning, 2004).

According to participants, working with asylum seekers was far more arduous than working with refugees; resulting in feelings of frustration and helplessness (described in a forthcoming manuscript). Clients’ uncertain plight, intense fear of being deported and restrictions placed on their entitlements were not conducive to establishing safety and stability. Hence mental health workers were left with little option but to limit their work to addressing basic survival needs and managing posttraumatic symptoms. One settlement
agency’s strategy of addressing asylum seekers material and psychosocial needs through their volunteer program was especially useful in this regard—mainly because volunteers were not restricted by funding mandates that extended to providing assistance to refugees only.

Another important strategy of establishing safety in the present, as well as safety in the therapeutic setting and for the therapist, was maintaining culturally appropriate behaviour because being in a culturally alien place was a potential cause for insecurity and mistrust (Murray et al., 2008). Accordingly, participants of all three categories (mental health, healthcare and resettlement) elaborated the measures taken to enhance cultural relevancy of services they provided: being sensitive to the cultural, conceptual, gender, age and experiential differences of their clients; being accommodating and responsive to their differential expectations; and maintaining flexibility in service delivery. Additional ways of enhancing safety included normalizing clients’ responses to their distress; that is, intimating to clients that most migrants and refugees faced similar issues during the initial years of resettlement and responded like them. Also encouraging them that like others, their situation was bound to improve; and by giving them choices and opportunities in the therapeutic process (Van der Veer & Van Waninge, 2004).

Notwithstanding that most people required a sense of security and stability to share their most traumatic and intimate experiences, some clients made spontaneous disclosures despite their continuing insecurity and instability. This finding lends support to the narrative impulse of human beings (Bruner, 1990) where people told stories about their lives as an essential exercise of making meaning of otherwise incomprehensible and meaningless events. Apparently, the mere fact that there was someone willing to listen, bear witness and validate refugees’ stories was sufficient for some people, to feel the safety and trust they required to share their experiences. The benefits of disclosing traumatic
experiences in a safe and secure environment, described by participants lends support to the efficacy of many of the traditional psychological interventions which involve prolonged exposure to past trauma with the main objectives of consolidating memories and developing coherent narratives (e.g. CA-CBT, NET, TT).

However it was especially important to be sensitive to a particular individual’s needs as advocated by the client-focused approach (Joseph, 2004). This is because many participants had recognized individual and group differences associated with refugees’ willingness or unwillingness to talk, as well as their capacity to feel safe and establish a trusting relationship with service providers (e.g. cultural, gender and age variations, recognition received for the violence perpetrated against them etc.). This study highlights the adaptability and innovation utilized by participants in designing therapies and strategies for clients unable to benefit from the traditional western approach to health and mental health that some participants considered archaic and unsuitable. The benefits of group work and therapies for people from collectivist cultures, as well as working with the body (e.g. drumming, relaxation techniques), has been previously acknowledged (Murray et al., 2008).

There was also some indication from participants that at least for some clients, verbalizing their past traumatizing experiences was unimportant either because they had not established the basis (safety, stability, trust) for doing so or they had alternative coping strategies to process trauma. Previous research had found kinesthetic measures and culturally based rituals to be more important for some groups of people than ‘talk therapies’. For example Somasundaram (2010) utilized cultural and religious rituals in therapy to bring about positive remissions in a group of Muslim refugees and asylum seekers in South Australia. Although Somasundaram measured study outcomes qualitatively, these findings have the potential to be utilized to develop standalone
interventions or for adapting established therapies for culturally diverse populations (e.g. CA-CBT; Hinton et al., 2012). Finally findings regarding refugees’ preference for either talk or non-verbal methods were also supported by a narrative study I conducted with former refugees from two African communities living in South Australia (Puvimanasinghe, Denson, Augoustinos, & Somasundaram, in press). Whereas participants from one community afforded elaborate and evaluative narratives of past trauma, the other group largely preferred to remain silent about their most traumatizing experiences.

Most participants utilized a strengths-based approach that focused not only on teaching new skills but listening to clients’ stories to explore and learn about people’s strengths and coping strategies. They identified a range of coping resources and strategies such as family and community support, spirituality and religious rituals, and agency support, thus supporting previous research (cf. Goodman, 2004; Khawaja et al., 2008; Tempany, 2009). Nonetheless participants also described how potential coping resources (community connections, religious beliefs) could become stressors in certain situations. These findings reiterate the complexity and diversity involved when working with refugees and asylum seekers. Whereas learning about people’s cultural and national backgrounds was important, there was also an indication against simplistic assumptions: highlighting the need for flexibility, openness, and the ability to work with cognitive complexity and learn on-the-job from clients.

7.6.1 Study limitations.

First, participants’ attempts to portray themselves in a positive light especially regarding their commitment to their clients and their work cannot be discounted. However I believe, the strategy of using open-ended interview questions, adopting an informal
interview approach that prompted elaboration and discussion of thoughts and ideas; and the request for stories, to some extent, safeguarded against this limitation.

Second, the snowballing technique of participant recruitment and purpose sampling utilized in the study may have resulted in the findings being unrepresentative of observations and experiences of the general population working with refugees and asylum seekers in South Australia. Participants who volunteered for an interview could have had more positive experiences than others who did not. Relevant in this regard is that participants from one leading local agency working with refugees did not participate. Several requests made to the organization requesting a discussion about the research study went unanswered. Possibly workers at this particular non-governmental agency may have alternate experiences to that of participants in the present study.

Third, the exploratory nature of the research precluded me from making causal linkages within study findings. Nonetheless, the rich data shared and collected; and the insights into the importance of establishing safety and trust, trauma processing, and coping strategies undoubtedly added to the literature on refugees, asylum seekers and their service providers.

7.6.2 Conclusion

The present study explored the experiences of mental health, healthcare and resettlement workers in South Australia in ameliorating the psychosocial trauma and distress of their refugees and asylum seeker clients. Four prominent themes were identified: establishing safety, trust and connection, talking about trauma, working with silences, and promoting coping and growth. The study underscored the complexity of working with people from diverse experiential and sociocultural backgrounds, and the flexibility required in this type of work. Participants indicated numerous challenges
including, but not limited to, the negative impact of government policies for asylum seekers’ mental health, and the consequences of their training in standardized talk therapies when applied in this multicultural context of trauma and resettlement. However the rewards of such work were also highlighted.

Study findings indicate the importance of developing an evidence base for various non-traditional psychosocial interventions found to be of benefit refugee adults and children (drumming, ‘theatre’ therapy) utilizing innovative tools to evaluate the effectiveness of such interventions. Findings could be also utilized for training programs for workers caring for refugees and asylum seekers, to raise awareness of the skills, commitment, flexibility and constant reflexivity required to work in this area; setting criteria for recruiting workers into the field as well as to motivate existing workers about the rewards of being involved in making real and lasting changes in people’s lives. Future research could focus on designing larger studies of service providers to refugees and asylum seekers using more representative sampling.
Chapter 8. Summary, Implications, and Conclusion

Chapter contents

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8.1 Introduction

In this thesis I have explored various responses to the refugee experience of adult women and men who have encountered multiple, repeated and prolonged trauma; and the experiences of people providing services to refugees and asylum seekers in Australia. For this purpose, I used a combination of qualitative research methodologies. I used narrative analysis (Riessman, 2008; Squire, 2008) to collect and analyse data pertaining to my first research project with members of two African communities resettled in South Australia; and thematic analysis (Braun & Clarke, 2006, 2013) in the second research project with a cross section of service providers working with refugees and asylum seekers. The overall study was motivated at least in part, by a desire to explore refugee narratives and go further; to challenge the predominantly negative master narrative of refugee people as ‘traumatized’ or psychologically damaged and hence a burden on society. The study was
also an attempt to contribute to the literature on the counter-narrative of resilience, adaptation, psychological growth and meaning-making.

In brief, my initial aim was to explore the coping and meaning-making of two understudied communities of refugees living in Australia, by recording and analyzing their life narratives (Research Project I). This developed into two studies pertaining to: (i) altruism, coping, meaning-making, and (ii) how these communities talked about loss and past trauma. Research Project II, a study of service providers to refugees and asylum seekers, followed. Here my initial aim was to discover whether service providers observed their clients’ strengths and capacity to cope with adversity; and if so, how they utilized these strengths and coping strategies to assist their clients overcome trauma and distress. Alongside a rich description of therapeutic strategies, themes of vicarious resilience and vicarious trauma, work satisfaction and cultural competence also emerged.

In this final thesis chapter, I review the key findings of the four empirical studies reported in Chapters 3, 4, 6, and 7. Where relevant, I also compare and contrast the findings of Research Project I (Studies 1 and 2) conducted with refugee participants from two African communities with that of Research Project II (Studies 3 and 4) with service providers working with a socio-culturally diverse group of refugees and asylum seekers. Additionally, I discuss the methodological strengths and limitations of the two Research Projects; then discuss the implications of the Projects’ findings for service provision, policy implementation and for future research. Chapter 8 concludes with the overall theme running through this thesis: the importance of moving beyond the negative focus on refugee people; to recognise, embrace, and enhance their potential to heal from past trauma, overcome current distress, and become active citizens of their new countries.
8.2 Summary of findings

The initial objective of Research Project I was to explore the coping resources and strategies accessed by people with refugee experiences to overcome past and ongoing distress; and how they find meaning in their life experiences. For this purpose 25 refugee participants’ life stories were collected and analyzed using qualitative narrative methods. There is ample support from previous research regarding the resources, strategies and skills of refugees that can protect them from debilitating psychological illness despite harrowing past experiences and highly stressful encounters in resettlement. These protective factors include individual, familial, communal and societal factors (cf. Goodman, 2004; Schweitzer et al., 2007; Tempany, 2009) (for further details see Chapter 1).

Past research has also shown that altruism and helping behaviours can be motivated by positive experiences preceding or following adverse life experiences together with psychological processes such as empathy, identification with suffering or a sense social responsibility (Hernández-Wolfe, 2011; Staub & Vollhardt, 2008; Vollhardt & Staub, 2011). Altruism and helping may in turn become a protective factor safeguarding and enhancing mental well-being; or can assist in the recovery from psychological distress (Mollica et al., 2002).

In the first empirical study (Study 1, Chapter 3) altruism and helping behaviour were identified as prominent and recurring themes of refugee participants’ narrated lives. In this study ‘altruism and helping’ encapsulated four subthemes: (1) surviving war and exile; (2) adapting to Australian society; (3) reaching back home; and (4) meaning-making through religious beliefs. Study findings demonstrated how participants reached out to others both individually and collectively, or had future aspirations of doing so, prompted by the help they themselves had received in times of desperate need. Close and supportive family
relationships and the communal spirit within collective societies; being called upon to help
and ‘learning by doing’; identification with helpful role models, empathy and identification
with the suffering of others; and a sense of responsibility for the welfare of family,
community members and friends also promoted altruism. Helping, cooperating, and
sharing were entwined with participants’ coping strategies and meaning-making of
experiences (e.g. via religious beliefs/ spirituality). Furthermore, refugee participants’
socio-historical, cultural and religious context influenced the interpretations they gave to
their past and current experiences. Taken together, I believe the study contributed to the
creation of a counter-narrative regarding the potential of refugee people beyond trauma and
psychopathology.

In the second analytic study (Study 2, Chapter 4) I described several prominent and
recurring patterns identified in the data relating to how refugee participants talked about
their past traumatic experiences and strove to make meaning of their past, present and
future lives. Previous research indicated that people made sense of their life experiences
through the stories they told—including the silences and incomplete narrative segments
within those stories (Bruner, 1990; Ghorashi, 2008; Riessman, 2008; Sorsoli, 2010; Squire,
2008). This was especially so when people’s lives were disrupted (illness, war)
necessitating the reconstruction of new and more acceptable self-identities, restoration of
order and control in the aftermath of chaos, and finding meaning in the seemingly
inconceivable (Frank, 2010; Lieblich et al., 2004).

Consistent with these findings, I observed salient differences between the structure
and content of the collective stories shared by the two refugee communities interviewed
(the Sierra Leoneans and Burundians). That is, Sierra Leonean stories were largely
chronologically ordered, evenly distributed along their life storyline from home country to
refugee camp to life in Australia, and contained fully-formed narratives of all stages of
their narrated lives. Conversely, Burundian narratives were largely silent, or only offered sparse details about earlier life stages (i.e. in the home country). These stories gradually gained momentum in exile to become elaborate and evaluative after reaching Australia.

Within those two distinctive narrative styles, individual differences in structure and content of participants’ narratives were also identified along a continuum from detailed disclosure to near-complete silence about traumatic events and experiences. The narrative types I identified were: (1) avoiding narratives; (2) struggling narratives; (3) prompted narratives; (4) narratives exceeding demarcated boundaries of disclosure; and (5) returning narratives. As in Study 1, I analyzed the personal, interpersonal, sociocultural and historical influences together with the differences in narrative structure and content, to offer several hypotheses as to how participants were engaging in identity reconstruction and meaning-making through the stories they shared (for further details see Chapter 4).

**Research Project II** was conducted with a cross section of service providers including physical healthcare, mental health and resettlement workers caring for refugees and asylum seekers in South Australia. I interviewed 28 participants using semi-structured interviews and systematically analyzed the interview data using a thematic qualitative method (Braun & Clarke, 2006, 2013). The overall objective of Project II was to explore the experiences of service providers working with refugees and asylum seekers.

In the third analytic study (Chapter 6) I identified the concepts of VR and VT as prominent and recurring themes emanating from service provider interviews. Previous research had already indicated the negative psychological impact of working with traumatized people (VT) when workers over-identified with their clients’ plight; impacting on the memory, emotions, thoughts and worldviews of these service providers. More recent research had also suggested the positive consequences of identifying with the
strength, growth and empowerment of traumatized clients (VR). Nonetheless few if any studies had inquired into VT and VR in a cross section of service providers similar to the present study.

Accordingly Study 3 described service providers’ experiences of VR including how they were influenced by their refugee clients’ resilience, coping and perseverance in the face of seemingly insurmountable odds. Study findings also emphasized the reciprocal nature of the worker-client relationship as experienced by service provider participants. Hence VR was encapsulated within the sub-themes of: (1) empowering clients and being empowered; (2) learning from each other and (3) reconnecting and bonding.

The study also included workers’ experiences of VT when they identified with the helplessness, hopelessness, uncertainty, and injustice encountered by clients, especially by asylum seekers. The study highlighted the complexity of working with people from diverse experiential and sociocultural backgrounds, the cultural flexibility required and the work satisfaction reported by the vast majority of service providers.

In the fourth analytic study (Chapter 7) I explored how service providers intervene to ameliorate their clients’ psychological trauma and ease their ongoing distress. Research has suggested that traumatic refugee experiences (i.e. threats to life, torture and multiple losses) resulted in psychological distress and posttraumatic symptoms; existential problems and identity crises; and despite this, the majority of refugee trauma survivors did not develop mental illness (Fazel et al., 2012; Fazel et al., 2005; Steel et al., 2009).

Through the analysis of worker interviews, I identified four major themes of the data: (1) establishing safety, trust and connection; (2) talking about trauma (3) working with silences and (4) promoting coping and growth. Service providers described the importance of establishing safety, trust and connection with their clients and the various strategies
utilized to do so vis-à-vis their diverse clientele. Whereas some clients were quick to establish safety and trust, and found sharing elaborate accounts of their traumatic experiences meaningful, others were reluctant or unable to talk about their traumatic experiences. Hence findings included the innovative strategies utilized by service providers to work with their clients’ silences. The study also described how participants explored, promoted and enhanced the resilience, strengths and capacity of clients based on a strengths-based model of therapeutic intervention.

**Research Project I** findings with refugees were to a large extent supported by the findings of **Research Project II** with service providers. Workers providing services to refugees and asylum seekers highlighted the enormous resilience, coping and growth capacity of refugees. Mental healthcare and other workers described how they utilized these strengths and capacities in their work with their clientele (Chapter 7), and in return were positively impacted by their clients (VR; Chapter 6). These findings lent support to the results of **Research Project I** empirical studies conducted with refugees depicting their resilience, perseverance, and capacity to find and make meaning both individually and collectively (Chapters 3 and 4). Several service provider participants described their clients’ altruistic motivations to reach out and help families and friends in Australia and back home. A few who had been refugees themselves also attributed ‘wanting to return to society’ as a motivation for working in this field (Chapter 6). However I did not identify ‘altruism and helping’ as a salient finding of **Research Project II**.

Findings of the second analytic study (Chapter 4) were amply supported by **Research Project II** (Chapter 7) regarding the differential capacity or willingness of refugee and asylum seeker clients to establish safety, build trusting relationships as well as to disclose past traumatic experiences. According to service providers, whereas some refugee clients required little motivation to share their stories similar to the ‘returning narratives’ and
'narrative exceeding demarcated boundaries of disclosure' (Chapter 4), others never wanted to or could not, talk about their traumatic experiences (avoiding and struggling narratives as per Chapter 4). Hence service providers discussed the necessity for flexibility and innovation in service delivery utilizing talk therapies—both individual and in group format—as well as other less verbally expressive interventions (drumming, art, music and so forth) (see Chapter 7 for more details).

It is noteworthy that two qualitative research methods were utilized for the Research Project with refugees and their service providers. As explained in Chapter 2 (p. 68), a narrative method situated in a critical theory paradigm (Lincoln et al., 2011), was used to capture the life stories of refugee participants as this method was particularly conducive to: observing how participants’ negotiated and reconstructed their identities across the transformation and trajectory of the refugee experience; including attending to the sociocultural, political and historical dimensions. Another benefit of the narrative method is that it is especially conducive to research with marginalized groups of people, as refugees resettling into western society can reasonably hypothesized to be, to promote people to tell their stories in their own words, at their own pace and a manner most conducive to them; thereby minimizing taken-for-granted assumptions about their experiences. This method also afforded an opportunity to attend to the silences of stories too painful to be told. Conversely a more straightforward thematic qualitative method situated in a postpositivist paradigm (Lincoln et al., 2011) was used to analyze interviews with service providers because of my primary interest in their experiences, as described by participants, of working with refugees and asylum seekers. Additional benefits of the thematic analytic method I selected (cf. Braun & Clarke, 2006, 2013) included: its independence from any particular theoretical and epistemological approach (grounded theory, IPA).
Admittedly, the use of two qualitative methods based on seemingly divergent research paradigms, could be open to criticism by some qualitative researchers. Nonetheless, this decision was supported by the convergence of the overall findings of Research Project I and II; namely depicting the resourcefulness and capacity of refugee people; to heal from past trauma, cope with current stressors, reach out to others and inspire their service providers.

8.3 Strengths and limitations of analytic studies

8.3.1 Research Project I with refugee participants

*Strengths.* Although the literature on altruism and helping behaviour spans more than four decades (Batson & Powell, 2003) and there is some preliminary work on altruism in the aftermath of trauma and suffering (ABS; Hernandez-Wolfe, 2011; Staub & Vollhardt, 2008; Vollhardt & Staub, 2011), Study 1 (Chapter 3) is among the first empirical studies to explore ABS in two small, relatively under-researched refugee communities. This study is also an initial attempt to utilize qualitative narrative methods to explore the interconnection between altruism, coping and meaning-making among refugee populations—in this instance, two small and under-studied refugee communities in Australia. The advantages of using narrative methods to explore under-researched topics among marginalized groups such as refugees, and facilitate their storytelling are elaborated in Chapter 2. The benefits of narrative methodology for this type of research were especially demonstrated in Study 2 (Chapter 4) when attending to the structure and content as well as the personal, interpersonal, positional and sociocultural elements of refugee participants’ stories assisted me to identify important aspects of how participants individually and collectively engaged
in identity reconstruction and meaning-making. The potential implications of Studies 1 and 2 for practice, policy and future research are set out in section 8.4 below.

**Limitations.** Notwithstanding the aforementioned advantages, *Research Project I* contained several methodological shortcomings. I enumerate these limitations below including the various strategies used to overcome or minimize the impact of those limitations (see also Chapters 3 and 4).

Firstly, although English was at least the second language of most refugee participants (and sometimes the third or fourth language of proficiency), I conducted all interviews in English. My decision to do so was based on two considerations: firstly, the limited graduate student budget at my disposal precluded me from utilizing interpreters and other translation facilities. Secondly I was reluctant to conduct narrative analysis via the translations of an intermediary (i.e. interpreter) considering the problems that could arise by doing so as extensively elaborated by Riessman (2008; see also Chapter 2).

A potential concern about interviewing participants in a less familiar language is that it could hinder narrative expression and evaluations especially regarding matters that interviewees already find difficult to talk about (e.g. past traumatic experience). This limitation could also dilute refugee participants’ explanations based on cultural metaphors and meanings. Arising from this, a potential criticism of the Study 2 findings was that the narrative difference between the two groups could be a consequence of Burundians being less fluent in English than Sierra Leoneans, resulting in less descriptive narratives. However I have presented a counter-argument to this contention, namely, that notwithstanding potential language limitations, Burundians afforded elaborate and evaluative post-migratory narratives of their lived experiences in Australia (see Chapter 4).
Secondly, the cultural and language difference between the interviewer and refugee participants could have interfered with data collection (e.g. establishing trust and confidence, participants being less willing to share personal stories with a ‘stranger’) and data analysis (i.e. the interviewer may have failed to grasp various culturally significant meanings and implications contained in the data). I attempted to minimize the negative impact of this potential limitation by discussing study findings with expert informants; refugee community leaders and resettlement agency staff including workers with refugee experiences. To support Study 1 and 2 findings, I also conducted a second research project with service providers. To some extent the potential distortion of data arising out of power differences between researchers investigating sensitive topics, and respondents perceived as marginalized, was reduced by the interviewer being a recent migrant to Australia, and a student, from a visible minority group—hence enabling refugee participants to better identify with my personal circumstances (Hydén, 2008) (see Chapter 3).

Thirdly, a potential bias plaguing many qualitative research projects is the impact interviewers have on their participants. Thus, refugee participants’ attempts to create a favourable impression of themselves and their communities to the interviewer, cannot be totally ignored. Furthermore, the Information Sheet (Appendix A) explained and afforded to refugee participants mentioned that Research Project I was inter alia, an attempt to understand ‘how they overc[a]me their stressful experiences … [and] what helped them to overcome their difficulties and to move forward…’ This emphasis could have given rise to a potential bias by motivating refugee participants to give a ‘positive slant’ to the stories they told. However this potential problem was mitigated by requesting refugee participants to share their life stories ‘in [their] own words and in a way most comfortable for [them]’ as well as the interview schedule not having any predetermined questions about coping and adaptation other than to prompt and/or probe the life narratives in order to reveal added
elaboration and evaluation (see interview schedule, Appendix G). This open approach to
data collection also mitigated against the potential impact of my own biases.

Furthermore, because the initial aims and objectives of research (coping, growth and
meaning-making) did not coincide with the ultimate study findings of altruism and helping
(Chapter 3) no direct questions were presented to participants about their altruistic
motivations or helping activities, unless the topic was volitionally introduced by
participants. Exploring different narrative styles (Chapter 4) was also not an initial
objective of Research Project I but was an emergent topic identified later after analyzing
refugee participants’ narratives. A further safeguard against potential interviewer effects
and bias, and participants’ self-presentation bias, was the triangulation of Research Project
I with Research Project II findings: with refugees and service providers respectively (see
section 8.2).

Fourthly, with regard to purposive sampling (i.e. having refugee experiences,
belonging to the Sierra Leonean or Burundian community), together with employing a
passive snowballing technique to recruit participants had the potential of reducing the
representativeness of the study sample to the general population that they belonged to.
Consequently although the Sierra Leonean sample seemed to represent their population in
Australia, the Burundian sample appeared not to (vis-à-vis educational levels).
Nonetheless, the lengthy, elaborative and evaluative stories people shared contained rich
and diverse descriptions of participants’ individual and communal strategies of coping,
identity construction and meaning-making. Furthermore, there was no between-group
difference in participants’ psychological distress, length of time in Australia or age; nor
were differences in narrative structure or content directly associated with age or length of
residence (see Study 2, Chapter 4). Moreover, sociodemographic differences did not
appear to impact on participants’ helping and coping although it is likely that more recent
arrivals may have had less time and energy to focus on others’ welfare (see Study 1 Chapter 3).

Fifthly, Research Project I included almost twice as many Sierra Leonean (16) as Burundian (9) narratives, giving rise to a possible bias in the analysis of Burundian narratives. To minimize the negative impact of this imbalance and also to introduce some triangulation, I analyzed six additional stories of Burundian former refugees contained in a documentary film produced in collaboration with Multicultural Arts, Victoria (Conellan et al., 2012). Despite the limitations of analyzing data not specifically collected for the research at hand, the additional narratives lent independent support to the finding that Burundians were reluctant to talk about traumatic events and experiences (see Chapter 4).

Another potential concern regarding the two studies with refugee participants was the possibility that people with mental health problems or heightened resettlement distress did not volunteer their participation. The exploratory nature of research also precluded making definitive predictions of relationships indicated by the temporal sequence of participants’ narratives as well as the facilitators of ABS. However as aforementioned, using the relatively unstructured narrative method enabled the collection and analysis of rich, descriptive and evaluative data concerning numerous aspects of participants’ lived experiences and narrated lives.

8.3.2 Research Project II with service providers

Strengths. Study 3 (Chapter 6) which identifies and focusses on VR and VT is one of the few published studies reporting and exploring such concepts within a cross section of healthcare, mental health and resettlement workers. The findings regarding the importance of cultural adaptation and work satisfaction also have important implications for service provision and policy implications in this field of work (for details see section 8.4 below).
The importance of cultural flexibility and, innovation in service delivery, and the benefits of pursuing a strengths-based approach that explores, validates and enhances the strengths and capacities of clients were highlighted in the second study with service providers (Chapter 7). Importantly, an objective of this thesis, namely the triangulation of findings between Research Project I and II was achieved to a considerable extent.

Limitations. Similar to Research Project I, participants’ attempts to portray themselves in a positive light to a university researcher (herself a recent migrant) especially regarding their commitment to their clients and their work, cannot be disregarded. However I strove to minimize this potential limitation by using open-ended interview questions; adopting an informal interview strategy that prompted service provider participants to elaborate and discuss their thoughts and ideas; and requesting stories about their work experiences and their personal lives.

The passive snowballing technique of participant recruitment and purposive sampling utilized in Research Project II may have resulted in the findings being unrepresentative of observations and experiences of the population of service providers working with refugees and asylum seekers. Participants who volunteered for an interview could, for example, have had more enriching or longstanding experiences working with refugee people than others who did not (for more details see Chapter 7). Conversely, people who had left this occupation were not eligible for the study – hence their experiences, which may have been informative, were not included.

Finally, the exploratory nature of the research did not allow for making causal linkages within study findings. Nonetheless, similar to Research Project I, I believe that the rich data shared by participants and the insights into VR and VT as well as the
importance of establishing safety and trust, trauma processing, and coping strategies undoubtedly adds to the literature on refugees and their service providers.

8.4 Implications for practice, policy and future research

8.4.1 Creating counter-narratives

Overall the findings from Research Project I and II depicted the enormous personal and collective coping resources and strategies of refugee people; their capacity to grow and reach out to help others; extending to the positive impact on their service providers (VR). Although there is a growing literature challenging the master narrative of refugees as psychologically damaged and victims of their adverse experiences (e.g. see Marlowe, 2010), there appears to be a lingering tendency among researchers and practitioners to continue to focus on a deficit model of trauma and psychopathology. Hence study findings about altruism and helping, coping, meaning-making and VR can contribute to a counter-narrative; within the research literature—as I have endeavoured to do in this thesis—but also in political and media discourses, in order to dissipate the negativity associated with refugees and asylum seekers in many social settings in Australia. If mainstream politics and media seem less accessible, such counter-narratives can contribute to alternate media, social and political discussions more welcoming to refugee counter-narratives.

Dissemination of refugee counter-narratives is especially important to dispel the negativity and antagonism towards asylum seekers within sections of Australian society. Here such counter-narratives may be able to counteract the dominant narratives propagated by the two main political parties in Australia (the Australian Liberal-National and Labor Parties) which appear to be engaging in ‘a race to the bottom’ to do whatever it takes to
prevent desperate and vulnerable people seeking asylum in Australia (McAdam, 2013). Findings contained in this thesis can contribute to alternate narratives already available in different sectors of society. According to Bamberg and Andrews (2004), counter-narratives bring narrative research closer to practical application and offer the venue for narrative research to be utilized for a liberating and emancipating agenda. Two examples of counter-narratives in the Australian context are the television series titled: ‘Go Back To Where You Came From’ (SBS Television, n.d.) that followed six mainstream Australians on the journey of a refugee from home country through a refugee camp to Australia; and a song titled: ‘I want to be free’ composed by two members of the Australian Greens Party in the Northern Territory and performed for asylum seeker adults and children incarcerated at the Darwin Detention Centre (Williams & Williams, 2014).

8.4.2 Storytelling

The study findings underscore the importance of telling, promoting and sharing refugee stories of struggling, striving and thriving amidst almost impossible odds as a powerful way of constructing counter-narratives in mainstream society regarding people with refugee experiences—from that of traumatized victims to resilient and resourceful citizens. An example of such a storytelling project is the documentary of Burundian narratives aforementioned (Conellan et al., 2012). Service provider organizations can also promote storytelling in order to:

- Assist recently arrived refugees to maintain hope for the future while they strive to acculturate and resettle in the host country, when they hear the stories of other settlers.
- Help newcomers to regain control over their lives and their new environment, and to reconstruct individual and collective self-identities that incorporate aspects of
both home and host cultures (integration); thereby enhancing their psychological well-being (Berry, 1997).

- Enhance understanding among members of different communities about their shared struggles; heal divided communities such as the Burundian, Rwandan, former Yugoslavian and Sri Lankan communities; and promote collective problem-solving, coping and helping.

- Use storytelling for purposes of catharsis (emotional release) and to heal from trauma - as in testimony psychotherapy, NET, and other psychosocial interventions that utilize storytelling by trauma survivors and thereby

- Support the publicising and documentation of human rights violations. Importantly, such documentation can then be utilized to seek justice or to raise awareness about rights abuses, at local and international fora.

- Build resilience in refugees and asylum seekers (East, Jackson, O’Brien, & Peters, 2010); and help survivors make meaning of their past and present experiences as indicated in Studies 1 and 2 (Chapters 3 and 4).

8.4.3 Strengths-based approach

As demonstrated in this thesis, service providers can use a strengths-based approach that includes recognizing, appreciating, and enhancing the personal resilience, coping resources and strategies and meaning-making devices of refugees within the mental health, healthcare and resettlement spheres of service provision. Most often people from culturally diverse backgrounds have their own unique culturally based coping strategies and resources which include: their own religious and cultural beliefs; collective identities that embrace strangers into a communal family; and the capacity to reach out and help others precisely because of what they have been through.
Such strengths-based approaches can be designed to be utilized independently or incorporated into existing interventions used with communities with refugee experiences in keeping with Standard 5 of the Australian National Standards for Mental Health Services (Australia Government Department of Health, 2010) regarding the promotion of mental health and the prevention of mental health problems and/or mental illness.

For example, Grigg-Saito, Och, Liang, Toof, and Silka (2008) described utilizing people’s unique culture-based coping resources to reach older Southeast Asian refugees in the US in order to improve access to healthcare and eliminate health disparities. Accordingly, these researchers had invited community leaders to design the program; involved the potential beneficiaries of the program to organize events; integrated health promotion with socialization; used ties with Buddhist temples, and avoided reliance on literacy—instead utilizing local community-based media to disseminate program information.

8.4.4 Valuing cultural diversity

The findings of Research Project I and II highlight the importance for service providers of gaining competence in the sociocultural and historical origins of their culturally diverse clients. Standard 4 of the Australian National Standards for Mental Health Services (2010) specifies the importance of recognizing the cultural diversity of people accessing mental health services and the importance of providing culturally appropriate services. However adequately meeting the needs of a culturally diverse population may pose a challenge to most services and service providers because the rapidly increasing rate of multiculturalism in Australia may have outpaced investment in supporting cultural competent and flexible service delivery.
The overall thesis findings have suggested several ways to facilitate the attainment of Standard 4. For instance, this thesis alludes to the complex relationship existing between talking therapies and psychological healing. That is, although talking and evaluating past traumatic experiences is therapeutic for some clients, for others, disclosure may be detrimental especially if it negatively impacts upon the collective self. Incorporating culturally familiar and less intrusive methods of exposure may be more useful in these circumstances either as standalone interventions or incorporated into more traditional therapeutic approaches. Several such innovative methods were described in Studies Three and Four (Chapters 6 and 7). Alternatively prolonged exposure of trauma survivors to their past trauma may be unnecessary with some experts arguing that there is no clear evidence for the benefit of an exposure component to treatment of refugees who have experienced past traumas (Pain et al., 2014). Instead, what may be more beneficial is for therapy to focus initially on addressing refugees’ settlement needs and experiences (at least during the long phase of resettlement), while assisting them to adapt to the new society, construct a new identity, and find their unique place on the continuum between their past and present cultures.

### 8.4.5 Training and professional development

The thesis findings can be utilized to inform the design of professional development and training programs for mental health and other workers caring for refugees and asylum seekers. Such programs can potentially be adapted and extended to other workers engaged with survivors of diverse traumatic experiences (domestic violence, sexual assault, crime).

Similar to Hernández et al. (2010) who developed a training program for therapists and counsellors working with trauma workers based on their findings in previous studies, training modules for diverse service providers working with refugees and asylum seekers
could include: information about the reciprocal relationship between the worker and client that often impacts upon the power differential (i.e. privilege and marginalization) between service providers and the multicultural beneficiaries of their services. Trainees could be prompted to reflect on their own experiences of this reciprocal relationship and how such a relationship affects workers. They can also be encouraged to consider dimensions of multiple identities (gender, class, religion, and ethnicity), privilege, and marginalization including sharing personal experiences of how such aspects impacted on building connections with clients.

Training and supervisory programs can also involve reflection and discussion on the concepts of VT, VR, PTG and ABS, the relationship between these concepts, and the meaning-making process involved in clients’ growth and altruism. Trainees could consider the specific and general experiences of VT and also be afforded the opportunity to articulate their experiences of VR including how VR can counteract the possible distress arising from trauma work. Additionally, current study findings can be utilized to include modules of VR and VT within existing training programs or even to design new programs specifically focusing on the manifestations of such concepts. Study findings can also be used to raise awareness about the commitment, flexibility and constant reflexivity required to work in this area; as well as in general public health and service settings when assisting with people from refugee and other CaLD backgrounds. Experiences of VR can also be utilized to motivate existing workers and their supervisors by heightening awareness of the rewards of being involved in making real and lasting changes in clients’ lives; and to safeguard against VT and other negative consequences of work when considering criteria for recruiting workers into the field.
8.4.6 Implications for future research

Future research can build on **Research Project I** (Study 1) findings to further explore altruism and helping with diverse refugee groups; as well as the process of ABS including the facilitators and associated psychological processes that predict altruism in the aftermath of war and conflict. Such studies can also design appropriate intervention studies to investigate the potential impact of altruism and helping behaviours to heal trauma and ease distress among refugee survivors of mass trauma. A few studies have already suggested the advantages of exploring altruism and helping in therapeutic settings (Mollica et al., 2002). Alternatively altruism and helping could be incorporated into existing and established therapeutic interventions and other service provision models and the impact assessed.

Hinton and colleagues (cf. Hinton et al., 2009; Hinton et al., 2011; Hinton et al., 2004; Hinton et al., 2012) incorporated religious and culturally familiar practices into traditional CBT for Southeast Asian trauma survivors and Latino migrants with prolonged distress. Future research and practice can build on this initiative by investigating and assessing the impact of incorporating specific refugee communities’ unique coping resources and strategies into interventions to ameliorate trauma and distress for other and diverse groups of refugees. Such projects should not only assess traditional western constructs of psychopathology (e.g. PTSD) but also move beyond: exploring and assessing culture-bound syndromes and disorders that are thought to occur in certain cultural contexts or among particular ethnic groups (Griffith, 2014). Developing and utilizing innovative assessment techniques including qualitative assessments might also be beneficial when traditional methods of assessment appear to be less adequate.

Also flowing from **Research Project I** (Study 2) findings, future studies can expand on these preliminary findings to investigate different narrative types utilized by refugee
participants and the functions of diverse types of narratives in therapeutic work. For
example, future research could explore what types of narratives are associated with varying
traumatic experiences in different cultures. Here it is important to explore the unique
cultural and historical background of participants utilizing in-depth and inductive research
methods. In recognition of the uniqueness of qualitative narrative and life story methods,
future research studies should also utilize such relatively unstructured methods to conduct
research with marginalized groups in society (cf. Ghorashi, 2008)

As suggested by the findings of Research Project II (Study 4) future studies with
diverse cultural groups in differing contexts can inquire into what groups are likely to
benefit from talking therapies and alternatively who are more likely to benefit by non-
talking therapies (art, music and theatre therapy; and other complementary and alternate
remedies). Study findings support the need for studies to formally investigate the observed
benefits of non-talking therapies and develop an evidence-base for practice. In addition,
future research could focus on designing more rigorous studies with more representative
sampling. Likewise exploratory research can be conducted to specifically investigate
service providers’ experiences of using a strengths-based approach with their clientele of
CaLD backgrounds.

Future research should also expand on current research findings of VR and VR
(Study 3) to continue the exploration with various service provider groups working with
refugees in other settings and countries; as well as designing appropriate research tools to
investigate the predictors of VR and VT. Such research can be extended to service
providers in diverse settings, while longitudinal study designs can be used to assess the
changes in VR and VT with the progress of the therapeutic or other worker-refugee client
relationship and throughout service providers’ careers—perhaps also recruiting people who
have left this occupation.
8.5 Conclusion: bringing it all together

Finally, I wish to reiterate the overall theme of this thesis: the importance of moving beyond the deficit model commonly utilized in refugee research, policy and practice by service providers, policy makers, politicians and others; and re-focusing the lens on the enormous personal and collective psychological resources and coping strategies of refugees as depicted in these four empirical studies. Accordingly, there is an urgent need for service providers, to identify, appreciate, and utilize these strengths in the services they provide people with refugee experiences. It is vital for service providers, practitioners and policy makers to recognize and support refugees’ tremendous capacity: to heal from past trauma, to benefit from their unique coping abilities, to reach out to others and make meaning, to experience growth and to be an inspiration to their service providers and to society as a whole.
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602323\Desktop\ARTICLE1\&\ARTICLES\Zewdu_AFSAAP - ANU.mht. Abstract
only, unpublished. Paper presented at the The African Studies Association of
Australasia & the Pacific (AFSAAP) Conference, Australia National University.

and behavioural problems among refugee children and adolescents living in South

and its association with depression, emotional and behavioural problems, and
mental health service utilisation among refugee adolescents living in South

symptomatology and service utilisation among refugee children and adolescents


Appendix A: Information Sheet in Research Project I

created with refugee participants
INFORMATION SHEET FOR RESEARCH PARTICIPANTS

Title of study: Exploring meaning-making, coping and posttraumatic growth among new arrivals in Australia

My name is Teresa Puvimanasinghe and I am a PhD candidate of the School of Psychology, University of Adelaide. I am trying to understand how new arrivals in Australia (people from refugee backgrounds) overcome their stressful experiences, in their home country, during their journey from the home country to host country, and while in their new country of residence. To understand what helped them to overcome their difficulties and to move forward; and how religious or other beliefs, cultural practices, social networks, institutional support and other factors, may have assisted the transition.

In order to do this: First, research participants will be asked several simple questions about themselves (e.g. name, age, length of residence in Australia), and also about their feelings, health and other aspects of life (e.g. How much do you enjoy life?) This will take about 20 minutes to complete. Second, research participants will be invited to enter a discussion with the researcher regarding their experiences as new arrivals, what were the problems they faced before and after arriving in Australia, what helped them to face their problems, to survive and to move forward. Also, how they continue to find meaning in their lives in the new home country. This discussion is estimated to take about 60-90 minutes but can be adjourned and continued on another day if preferred. The decision about what to share and how much to share will be the participant’s decision.

A group session will also be organized for people who prefer a group discussion instead of individual interviews. A group will comprise 5-10 people from the same community / ethnic group and will take approximately 60-90 minutes.

Both individual and group discussions will be audio-taped after obtaining consent from the participant/s.

Sharing one’s story with other people who are willing to listen, can be comforting to the person telling the story; similar to that of telling one’s problems to a good friend. It may also help improve the cultural relevancy and quality of services provided to new arrival communities, as well as raise awareness among host country citizens about the difficulties faced by new arrivals and about their strength and resilience in overcoming these difficulties. However, these benefits are not guaranteed.

Remembering painful events in one’s life may also bring about sadness or discomfort to some people. If this happens, you can discontinue your participation. You may also withdraw your participation or refuse to participate any further without this affecting any
advice or assistance you may be receiving / will receive in the future. If further assistance is needed, you may contact any of the research team as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Linley A. Denson MPsych, PhD, FAPS</td>
<td>Senior Lecturer, School of Psychology</td>
<td>(08) 8303 4128</td>
</tr>
<tr>
<td>Dr. Daya Somasundaram, MD, FRCPsych, FRANZCP</td>
<td>Clinical Associate Professor, Discipline of Psychiatry</td>
<td>04 34 605 375</td>
</tr>
<tr>
<td>Registered Psychologist</td>
<td>The University of Adelaide</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Professor Martha Augoustinos BA Hons., PhD</td>
<td>Clinical Associate Professor, Discipline of Psychiatry</td>
<td></td>
</tr>
<tr>
<td>School of Psychology</td>
<td>The University of Adelaide</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teresa Puvimanasinghe, BA Hons.</td>
<td>PhD Candidate, School of Psychology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The University of Adelaide</td>
<td>(08) 8303 5693</td>
</tr>
</tbody>
</table>

All information gained during the study will be confidential. Privacy of participants will be ensured at all times. This information may be published but participants’ identity will not be divulged at any time.

Only the investigators will have access to the file for the purpose of the study. It will be stored electronically in the archives of the School of Psychology at the University of Adelaide for 7 years and then destroyed.

If you have any complaints regarding your research participation you may contact the Human Research Ethics Committee’s Secretariat on phone (08) 8303 6028. You may also access the University’s independent complaints sheet at the website link: http://www.adelaide.edu.au/ethics/human/guidelines/applications/#complaints

Please note that this research study is conducted by Teresa Puvimanasinghe as a postgraduate student of the University of Adelaide and not as a volunteer worker at the [Organisation name].
Appendix B: Information Sheet in Research Project II

conducted with service provider participants
INFORMATION SHEET FOR RESEARCH PARTICIPANTS

Title of study: Exploring meaning-making, coping and posttraumatic growth among new arrivals in Australia

My name is Teresa Puvimanasinghe and I am a PhD student of the University of Adelaide, in the School of Psychology. I am trying to understand how new arrivals in Australia (people from refugee backgrounds) overcome their stressful experiences, in their home country, during their journey from the home country to host country, and while in their new country of residence. To understand what helped them to overcome their difficulties and to move forward; and how religious or other beliefs, cultural practices, social networks, institutional support and other factors, may have assisted the transition.

To do this: I will like to interview you in your capacity as a person providing services to people from refugee backgrounds. The interview will take approximately 60-90 minutes, during which time, you will be asked 10-12 questions based on the following themes:

1. The challenges faced by refugee people in Australia;
2. The challenges faced by the service providers when working with their clientele;
3. Refugee people’s resilience and coping strategies that facilitate psychological healing and adaptation;
4. Recommendations for service improvement.

While an individual interview with you will be preferred, if this is not possible due to the constraints of time you may choose to participate in a group discussion together with a few of your colleagues for a time period that is convenient to you.

Individual interviews (and group discussions if any) will be audio-taped after obtaining your consent.

The objectives of this project include: to improve the cultural relevancy and quality of services provided to new arrival communities, as well as to raise awareness among host country citizens about the difficulties faced by new arrivals and about their strength and resilience in overcoming these difficulties. However, these benefits are not guaranteed.

Remembering the painful events in your clients’ lives that they have shared with you may cause you some discomfort or distress. If this happens or for any other reason you may discontinue your participation. You may also withdraw your participation or refuse to participate any further.
If you require any further information, you may contact the manager of your organisation, or any of the research team as follows:

Dr. Linley A. Denson MPych, PhD, FAPS  
Senior Lecturer, School of Psychology  
Registered Psychologist  
The University of Adelaide  
(08) 8303 4128

Dr. Daya Somasundaram, MD, FRCPsych, FRANZCP  
Clinical Associate Professor, Discipline of Psychiatry  
The University of Adelaide, Glenside Campus,  
043 4605375

Professor Martha Augoustinos BA Hons., PhD  
School of Psychology  
The University of Adelaide  
(08) 8303 4627

Teresa Puvimanasinghe, BA Hons.  
PhD Candidate, School of Psychology,  
The University of Adelaide  
040 9691194  
teresa.puvimanasinghe@adelaide.edu.au

All information gained during the study will be confidential. Privacy of participants will be ensured at all times. This information may be published but participants’ identity will not be divulged at any time.

Only the investigators will have access to the file for the purpose of the study. It will be stored electronically in the archives of the School of Psychology at the University of Adelaide for 7 years and then destroyed.

If you have any complaints regarding your research participation you may contact the Human Research Ethics Committee’s Secretariat on phone (08) 8303 6028. You may also access the University's independent complaints sheet at the website link:  
Appendix C: Ethical Clearance letter in Research Project I
30 November 2011

Dr. L Denson
School of Psychology

Dear Dr. Denson

PROJECT NO: H-277-2011

Exploring meaning-making, coping, and post-traumatic growth among refugee people in Australia

I write to advise you that the Human Research Ethics Committee has approved the above project. Please refer to the enclosed endorsement sheet for further details and conditions that may be applicable to this approval.

The ethics expiry date for this project is: 30 November 2012

Where possible, participants taking part in the study should be given a copy of the Information Sheet and the signed Consent Form to retain.

Please note that any changes to the project which might affect its continued ethical acceptability will invalidate the project's approval. In such cases, an amended protocol must be submitted to the Committee for further approval. It is a condition of approval that you immediately report anything which might warrant a review of ethical approval including (a) serious or unexpected adverse effects on participants; (b) proposed changes in the protocol; and (c) unforeseen events that might affect continued ethical acceptability of the project. It is also a condition of approval that you inform the Committee, giving reasons, if the project is discontinued before the expected date of completion.

A reporting form is available from the Committee's website. This may be used to renew ethical approval or report on project status including completion.

Yours sincerely,

PROFESSOR GARRETT CULLITY
Convener
Human Research Ethics Committee
Appendix D: Ethical Clearance letter in Research Project II
Dr Linley Denson  
School of Psychology  
University of Adelaide  
Level 4, Hughes Building  
North Terrace  
ADELAIDE SA 5005  

Dear Dr Denson,  

HREC reference number: HREC/12/SAH/4  

Project title: Exploring meaning-making underlying coping and posttraumatic growth among refugee people in Australia.  

RE: Ethics Application Approval  

Thank you for responding to the issues raised by the SA Health HREC in relation to the above project.  

I am pleased to advise that your application has been granted full ethics approval and meets the requirements of the National Statement on Ethical Conduct in Human Research.  

Please note the following conditions of approval:  

- The personal demographic information (e.g. name, address, other contact details) must not be collected from the refugees for the purpose of sending them a thank-you letter. The confidentiality of the participants must be maintained at all times. A generic thank-you letter could be given to all participants following completion of the interview or a verbal thank-you could be expressed.  

- The research must be conducted in accordance with the 'National Statement on Ethical Conduct in Human Research.'  

- A progress report, at least annually, must be provided to the HREC.  

- When the project is completed, a final report must be provided to the HREC.  

- The HREC must be notified of any complaints by participants or of adverse events involving participants.  

- The HREC must be notified immediately of any unforeseen events that might affect ethical acceptability of the project.
• Any proposed changes to the original proposal must be submitted to and approved by the HREC before they are implemented.

• If the project is discontinued before its completion, the HREC must be advised immediately and provided with reasons for discontinuing the project.

HREC approval is valid for 3 years from the date of this letter.

Should you have any queries about the HREC's consideration of your project please contact Sarah Lawson, Executive Officer of the HREC, on (08) 8226 6367 or hrec@health.sa.gov.au

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a SA Health site until separate authorisation from the Chief Executive or delegate of that site has been obtained via the completion of a Site Specific Assessment form. Please contact David van der Hoek via email at ResearchGovernance@health.sa.gov.au to discuss this process further.

The HREC wishes you every success in your research.

Yours sincerely

Andrew Stanley
CHAIRPERSON
HUMAN RESEARCH ETHICS COMMITTEE

25/6/12
Appendix E: Consent Form in Research Project I
CONSENT FORM FOR RESEARCH PARTICIPANTS

1. I,...........................................................................................................................(please print name) consent to take part in the research project entitled: Exploring meaning-making, coping and posttraumatic growth among new arrivals in Australia

2. I acknowledge that I have read the attached information sheet entitled: Information Sheet for Research Participants.

3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.

4. Although I understand that the purpose of this research project is to improve the cultural relevancy and quality of services provided to new arrivals such as myself, it has also been explained that my involvement may not be of any benefit to me.

5. I have been given the opportunity to have a member of my family, a friend or interpreter accepted by me, present while the project was explained to me.

6. I consent to my individual interview / participation in the group discussion being audio-taped.

7. I have been informed that, while information gained during the study may be published, I will not be identified or be identifiable, and my personal results will not be divulged.

8. I understand that I am free to withdraw from the project at any time and that this will not affect any type of advice and assistance I may receive, now or in the future.

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

.......................................................................................................................

(signature) (date)

WITNESS
I have described to................................................................................................ (name of participant) the nature of the procedures to be carried out. In my opinion she/he understood the explanation.

Status in Project:...................................................................................................

Name:...................................................................................................................

.........................................................................................................................

(signature) (date)
Appendix F: Consent Form in Research Project II
CONSENT FORM FOR RESEARCH PARTICIPANTS

1. I,..................................................................................................................................................(please print name) consent to take part in the research project entitled: Exploring meaning-making, coping and posttraumatic growth among new arrivals in Australia

2. I acknowledge that I have read the attached information sheet entitled: Information Sheet for Research Participants.

3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.

4. I understand that the purpose of this research project is to improve the cultural relevancy and quality of services provided to new arrivals. However, it has also been explained that my involvement may not be of any benefit to me.

5. I consent to my individual interview / participation in the group discussion being audio-taped.

6. I have been informed that, while information gained during the study may be published, I will not be identified or be identifiable, and my personal results will not be divulged.

7. I understand that I am free to withdraw from the project at any time and that this will not affect any type of advice and assistance I may receive, now or in the future.

8. I am aware that I should retain a copy of the Information Sheet and that I will be provided with a copy of the Consent Form after the interview/discussion.

..........................................................................................................................................................
..........................................................................................................................................................

(signature) (date)
Appendix G: Interview Schedule including sample probing and prompt questions in Research Project I
INTERVIEW SCHEDULE: PART ONE

INFORMATION, CONSENT AND DEMOGRAPHICS

- Handing a copy of Information Sheet to the participant.
- Explaining the contents of the Information Sheet.
- Asking whether he/she has any questions or clarifications.
- Reading and signing of consent form.

Before we begin our discussion, I would like you to ask you some simple questions about yourself—your name, age, etc.—and about your quality of life, health, feelings etc. there are no right or wrong answers. Just answer to the best of your ability. If you need any clarification please ask me. Thereafter I will ask you to tell me your story.

Demographic questions:

Self:
1. What is your name?
2. Where do you live now?
3. How old are you?
4. When did you come to Australia?
5. How long have you lived in Australia? [years]
6. In what country were you born and where did you live most of your life?
7. Would you mind sharing with me your contact details? phone no or e-mail?

Family:
8. What is your marital status?
9. How many members are there in your family?
10. Tell me something else about your family?

Community
11. Are there many members of your community in South Australia?
12. Are you in contact with them?
13. Tell me something more about your community in Australia?

Language:
14. What is your first language?
15. How would you describe your knowledge of English?

<table>
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<th>Very poor</th>
<th>poor</th>
<th>adequate</th>
<th>Conversant (good)</th>
<th>Fluent (very good)</th>
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16. Where did you learn English?
17. Did you attend the English classes you were referred to by Australian Immigration?
18. How satisfied were you with these classes?

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19. Can you explain a little more please?
20. What do you think about the importance of English in helping you to ‘fit in’ to Australian society?

Religion:
21. What is your religion?
22. How important is your religion to you?
23. Can you tell me some of the religious and other cultural practices that you engage in and why?

INTERVIEW SCHEDULE: PART TWO

The following questions ask how you feel about your quality of life, health, or other areas of your life. Please think about your life in the last 4 weeks. Now choose the answer that best describes your life in the last 4 weeks and draw a circle around the number corresponding to your answer.

Hint 1: If you are unsure about which response to give to a question, the first response you think of is often the best one.

Hint 2:

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<tr>
<td>1</td>
<td>How would you rate your quality of life?</td>
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<tr>
<td>2</td>
<td>How satisfied are you with your health?</td>
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The following questions ask about **how much** you have experienced certain things in the last four weeks.

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<th></th>
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<th>Not at all</th>
<th>A little</th>
<th>A moderate amount</th>
<th>Very much</th>
<th>Extremely</th>
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<td>3.</td>
<td>To what extent do you feel that physical pain prevents you from doing what you need to do?</td>
<td>5</td>
<td>4</td>
<td>3</td>
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<td>4.</td>
<td>How much do you need any medical treatment to function in your daily life?</td>
<td>5</td>
<td>4</td>
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<td>5.</td>
<td>How much do you enjoy life?</td>
<td>5</td>
<td>4</td>
<td>3</td>
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<td>6.</td>
<td>To what extent do you feel your life to be meaningful?</td>
<td>5</td>
<td>4</td>
<td>3</td>
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<td>1</td>
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<tr>
<td>7.</td>
<td>How well are you able to concentrate?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td>8.</td>
<td>How safe do you feel in your daily life?</td>
<td>5</td>
<td>4</td>
<td>3</td>
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<td>9.</td>
<td>How healthy is your physical environment?</td>
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<td>4</td>
<td>3</td>
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The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

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<th>Not at all</th>
<th>A little</th>
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<th>Mostly</th>
<th>Completely</th>
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<tr>
<td>10</td>
<td>Do you have enough energy for everyday life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>11</td>
<td>Are you able to accept your bodily appearance?</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>12</td>
<td>Have you enough money to meet your needs?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>13</td>
<td>How available to you is the information that you need in your day-to-day life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>14</td>
<td>To what extent do you have the opportunity for leisure activities?</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<td>15</td>
<td>How well are you able to get around?</td>
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<tr>
<td>16</td>
<td>How satisfied are you with your sleep?</td>
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<td>2</td>
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<td>5</td>
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<tr>
<td>17</td>
<td>How satisfied are you with your</td>
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<td>Question</td>
<td>Scale</td>
<td>None of the time</td>
<td>A little of the time</td>
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<td>26. How often do you have negative feelings such as blue mood, despair, anxiety, depression?</td>
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<td>4</td>
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<td>In the past 4 weeks, about how often did you feel</td>
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<td>1.</td>
<td>how tired out for no good reason?</td>
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<td>how often did you feel nervous?</td>
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<td>3.</td>
<td>how often did you feel so nervous that nothing could calm you down?</td>
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<td>4.</td>
<td>how often did you feel hopeless?</td>
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<td>5.</td>
<td>how often did you feel restless or fidgety?</td>
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<td>6.</td>
<td>how often did you feel so restless you could not sit still?</td>
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<td>7.</td>
<td>how often did you feel depressed?</td>
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<td>8.</td>
<td>how often did you feel that everything was an effort?</td>
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<td>9.</td>
<td>how often did you feel so sad that nothing could cheer you up?</td>
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<td>10.</td>
<td>how often did you feel worthless?</td>
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Do you have any comments about the assessment?
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[Would you like to take a little break before telling your story?]

PART THREE C—NARRATIVE

Main question: Could you now tell me in your own words the story of your life? And I want you to tell me about your life as if it’s a story with a beginning, and a middle, and then how things will look in the future for you. There is no right or wrong way to tell your story; you can tell me your story in the way that’s most comfortable for you.

Prompts, Probes and Encouragement
1. Prompts: Things you may need to remind the interviewee about.
2. Probes: Getting the interviewee to say more about a particular topic.
3. Verbal & non-verbal cues: encouraging the interviewee to continue

1. Prompts

These will be specific to your research design and the particular questions you are asking. You should have the different dimensions of possible answers to your questions in your mind, and if some are not mentioned, be prepared to say something like: “You haven't mentioned X: what do you feel about that?”

- Difficulties in home country and in transit
- How difficulties were overcome
- Difficulties in host country
- How difficulties were overcome
- How important is religion/spirituality/practices and rituals
- How important is culture
- How important is family/community friends/cross cultural friends
- What gives meaning in life? How did you find meaning?

2. Probes (Follow-Up questions)

Examples of Detail-oriented probes:
- When did that happen?
- Who else was involved?
- Where were you during that time?
- What was your involvement in that situation?
- How did that come about?
- Where did it happen?
- How did you feel about that

Examples of Elaboration probes
1. Would you elaborate on that?
2. Could you say some more about that?
3. That's helpful. I'd appreciate if you could give me more detail.
4. I'm beginning to get the picture: but some more examples might help.

Examples of Clarification probes
- You said the program is a "success". What do you mean by "success"?
- What you're saying now is very important, and I want to make sure that I get it down exactly the way you mean it: please explain some more.

3. Verbal and non-verbal cues to continue

These will be specific to different cultures, but could involve, for example, nodding, smiling, maintaining eye-contact, saying 'uh-huh' or 'I see' in an encouraging way.
Appendix H: Interview Schedule in Research Project II
INTERVIEW SCHEDULE FOR INTERVIEW WITH SERVICE PROVIDERS
[Adapted as required]

A1: Experience:
1. Can you share with me your experience working with people from refugee backgrounds?
   a. Position / capacity?
   b. Qualification?
   c. Length of experience?
   d. Nationality of clients worked with?
   e. Brief description of current tasks?

A2: Challenges faced by clients:
2. According to your experience working with people from refugee backgrounds in Australia, what are the most common problems and challenges faced by your clients?
   [give some examples]
3. Probes:
   a. Have you met people who indicated symptoms of traumatisation from past experiences? If so, give me some examples of how it impacted their current lives.
   b. Are they willing to talk about their past experiences?
   c. Do you think talking about past experiences helps them?
   d. Can you please explain with some examples how it helps them?
   e. What are the other coping strategies indicated by them?

A3: Challenges faced by service providers:
4. What are the problems and challenges faced by service providers when working with people from refugee background?
5. Especially what are the difficulties arising due to language, cultural and conceptual differences?
6. Have you noticed differences in the meaning of distress and illness? If so could you explain with a few examples?

A4: Strengths and resources of clients:
7. In your opinion, what are the strengths and resources you have noticed in your clients that may facilitate their recovery from trauma and/or adaptation?
8. Could you explain to me an example of this please?

A5: Cultural competency
9. What is the significance of cultural competency? Have you received any ‘cultural competency’ training/guidance?
10. Please describe any cultural competency training that you received and the importance of such training?

A6: Recommendations:
11. Can you share with me any recommendations you may have for improving the services offered to people from refugee backgrounds?
Appendix I: Excerpts of 3 refugee interviews coded for ‘Adapting to Australia’ (sub-theme) in Study 1 (Altruism, Coping and Meaning-making)
T: Finally tell me about your future hopes and aspirations, for you and for your family?

F: I want to continue my education at TAFE; I want to get into community studies and along the road get into social working...that’s what I want to do.

T: Why that area?

F: Because I feel that’s an industry I will be happy in because I like helping people and so I feel that if I have a job that I would love doing, even if I am getting paid for it, but my priority is to help people. And if I can help people and get paid at the same time, it’s just a bonus for me. You know, getting paid for what I love to do is just a bonus for me. That’s why I want to do social work in the future. I want to start from community studies and work my way up to it.

T: Why is that important to you?

M: Why? Because I was poor; I was [leading] poor life. Even now I’m poor but I try to see ... you know those people who are rich they don’t think about the people who are poor. So maybe if I am ... one day I have a position, I don’t have to be a leader, If I have a position where I can advocate for our people, I can help. That’s why I keep doing it even here ... for this organisation. So sometimes there is a job somewhere; but I don’t want to leave this. Yeah, I want to work for the organisation yeah.

T: You give me this indication that helping others is important to you? Why?

M: because there are some people in trouble, they need assistance, they need help. Sometimes they miss someone who can help. So that kind of ... helping each other, if you have someone so you save his life. so that’s why ... I have been helped even myself. So I want to help other people. I have been helped when I needed help; [I] would like to do that to others.

That’s why I chose social work as a degree; because I want to help people. Because I know, maybe if an Australian came to me and asked me questions, I wouldn’t really open up to them; because I feel that they don’t have that cultural knowledge or experience to know what I am talking about.

Because sometimes I think that if I did not go through this, maybe I will not be someone who understands people; or who wants to listen to people. Because of what I’ve gone through, I want to be there for other people. And maybe if I hadn’t gone through this, I wouldn’t have that personality.

Data analysis conducted with aid of the Nvivo Version 9 program
Appendix J: Excerpts of 3 service provider interviews coded for ‘Establishing safety, trust and connection’ (sub-theme) in Study 4 (Talk Therapies and Therapeutic Silence)
Appendices -- 339

Referencing 1 - 1.53% Coverage

The person comes and says: “look I’m very worried about housing; what can you help me” or “I’m worried because I heard [from] some friends that they saw my husband somewhere. What can I do?” they never come and say: “I want to talk to you, I was raped...” no, that is not the case. Usually it is a whole process of developing a relationship. And within developing that relationship... for example, I had a woman that after a year of seeing her and working with all these practical things she comes and says: “I can’t bear this anymore; my husband is hitting me”. She was experiencing domestic violence. But prior to that [T: for one year she might have gone through that?] that’s right; but till the end she didn’t feel confident to talk about that.

Referencing 2 - 0.63% Coverage

Even for people...there are many women under the 204 visas that have been raped and they have children from those rapes. [...] the children were born out of the rape. And you don’t hear that in the first or second session. It really takes the development of a relationship within a very, very safe framework.

Referencing 3 - 1.35% Coverage

This is part of the relationship. If you are going to have a relationship all of you comes into it; the doubts as well as the strengths. You know, we might be professionally psychologists. But we are still human beings. And the clients: they are the experts of their experiences. And I think we have to honour that. And we have to build that relationship; it’s got to be genuine; it’s got to be built on everything. The strengths as well as the doubts. I’ve always found that it’s been surprisingly effective. That it does ....it changes the dynamics in the room; you can see it. There is a far more trusting connection.

Referencing 2 - 2.49% Coverage

Once again, working with the clients I think it is essential for them to feel that they are in an environment where what they say are going to be understood in the way that they needed to be understood. And that can take a lot of time in establishing that safety and understanding and trust and it can be very unexpected so ... you might feel that you’re not getting anywhere and then one day they disclose a lot of things. So I think there is a buildup of an initial relationship that is necessary if the torture and trauma is something a sensitive or a close area to them. Some people you won’t hear talk about it at all. I have a supervisor externally outside this work and he specialises in cultural psychology. And he has told me about clients who after years of therapy have only been able to frame their experience in one sentence. And that’s to just say: “it was really horrible” or “it was really bad”. And that’s enough for them to capture what they’ve been through; and that’s enough for them to label it that way. So whatever works I guess.

Data analysis conducted with aid of the Nvivo Version 9 program
Appendix K: Copy of the letter of appreciation sent to participants in Research Project I
14th September, 2012.

Dear ...................................,

On behalf of the University of Adelaide, School of Psychology and the members of our research team, I am writing to thank you for participating in my research study – exploring meaning-making, coping and growth among people from refugee backgrounds.

I really appreciate the time you spent with me sharing your life story and answering my questions, despite your other commitments. It was really enjoyable talking to you and learning from your experiences, strengths, hopes and dreams.

If this research is able to highlight even in a small way, the enormous potential you and other members of your community have to contribute to Australian society, I think we will have achieved an important objective.

I wish you all the best for your future in Australia.
With thanks again,
Yours sincerely,

..............................................................
Teresa Puvimanasinghe
School of Psychology, Level 4, Hughes Building
University of Adelaide, North Terrace
Adelaide SA 5005
Ph: 08 8303 5693
Appendix L: Copy of the letter of appreciation sent to participants in Research Project II
From: Teresa Puvimanasinghe [mailto:teresa.puvimanasinghe@adelaide.edu.au]
Sent: Tuesday, 17 December 2013 11:17 AM
Subject: Season's Greetings from the University of Adelaide | Health Sciences

17 December 2013

Dear [Name],

As we approach the end of the year, I wish you and your loved ones a safe and joyous festive season.

Thank you for participating in my PhD research project and sharing your personal experiences of working with refugee people. Your dedication to your work and clients inspired me, and you enriched my research experience.

This year I have elected to send your greeting electronically, as an Ecoversity initiative.

Sincerely,
Teresa Puvimanasinghe
PhD Candidate
School of Psychology

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Appendix M: Dissemination of findings at Conferences and Invited Presentation


- ‘How Sierra Leonean and Burundian Refugees talk about Life and Past Trauma’. Invited Presentation to the Health Psychology Group on July 2, 2013, University of Adelaide, South Australia.

- ‘Narrative and Silence: How former Refugees talk about Life and Past Trauma’. Poster presented at the Faculty of Health Sciences Postgraduate Research Conference, August 29, 2013, Adelaide, South Australia.

Appendix N: Copies of Poster Presentations


2. Poster presented at the Faculty of Health Sciences Postgraduate Research Conference, August 29, 2013, Adelaide, South Australia [p.344]
Giving Back to Society: What Society Gave Us: Altruism, Coping and Meaning-making of Two Settler Communities Living in South Australia — A narrative study

Puvimanasinghe, T., Denson, L.A., Augustinos, M., & Somasundaram, D.

Introduction

- Refugee mental health research has largely focused on the psychopathological effects of traumatic life experiences (e.g., Fazel, Wheeler, & Danesi, 2005). However, some studies have explored refugees' coping resources and strategies, such as family and community support, religious beliefs and cognitive processes—distraction, suppression, downward comparison (e.g., Goodman, 2004; Raghallagh, 2011; Schwitzer, Greenfield, & Vageas, 2007).

- Altruism, defined in Sutinov’s (ABS, Sutinov & Vommnir, 2000) theory as the active support in situations of need, (a) such as war and exile, and (b) the promotion and support of people's rights, particularly the rights of refugees, are well documented in the literature.

Aims

- Initially, the study set out to explore how refugees perceived their coping resources and strategies to find meaning in their adversity.

Method

- 24 former refugees from Sierra Leone (16) or Burundi (8) participated. They were 10 men and 14 women aged 10 to 55 years (M=50.5) who had resided in Australia between 3 and 10 years.

- Participants’ life narratives were collected via unstructured interviews containing an opening statement and several follow-up, open-ended questions (Goodman, 2004).

- Interviews were conducted in English and all participants rated their ability to communicate in English as ‘very good’ or ‘good’. Each interview lasted 1 to 2 hours.

Findings

- Four main themes encapsulated participant-identified motivators and facilitators of helping behaviour: (1) Survival war and exile, (2) Adapting to Australia, (3) Reaching back home, and (4) Meaning-making through religious beliefs.

Discussion and conclusion

- Study findings supported a counternarrative in refugee research beyond that of trauma and distress.

- Participants’ narratives indicated an enormous personal and collective psychological burden that went unrecognised by practitioners, policy makers and mainstream society.

- Altruism and helping behaviour are a coping mechanism that extended beyond the individual to benefit families, communities, and entire societies. It ameliorated the distress of missing loved ones and of leaving family, community and country, and afforded them a ‘little bit of home’.

- Participants’ socio-historical context, cultural norms and religious beliefs underpinned the interpretations they gave to their experiences.

- In addition, the study provided a unique insight into the experiences of refugees living in Australia, which can be utilised to promote culturally relevant practices and interventions for refugee communities.
Narrative and Silence: How former Refugees talk about Life and Past Trauma

Teresa Puvimanasinghe, Linley Denson, Martha Augustinos, & Daya Somasundaram

School of Psychology, University of Adelaide, South Australia; Discipline of Psychiatry, University of Adelaide.

Contact: teresa.puvimanasinghe@adelaide.edu.au

Introduction

- Storytelling is an essential human activity; an activity that makes us human i.e. homo narrans (Bruner, 1986). It is a rich source of identity and identity change involves past silence and context.
- Having experienced violence, separation and refugee life, refugees often need to reconstruct their identities to address their losses, embrace new environments, and position themselves between home and host cultures.
- As with illness narratives (Fram, 2010), storytelling helps refugees create new and more acceptable identities, cope with past trauma and gain control over their present lives and find meaning in the seeming incomprehensible.

Aim

To explore how former refugee talk about life in Australia with adversity, reconnect identity and make meaning through the stories they tell and the ways they tell them.

Method

- 26 former refugees from Sierra Leone (16) or Burundi (10) living in Australia participated in the study. They were: 11 men and 14 women; aged 16 to 60 years; born in Africa or Asia.
- Unstructured interviews were conducted on participants' life stories. In addition to 6 Burundian stories in the documentary film 'Ubahazi Bukunan' (new life, Corbett et al., 2002) were also analysed.
- A case-based narrative approach with comparison across cases was used to identify and analyse stories. The analysis attempted to understand the content (the ‘tale’) and structure (the ‘telling’) of narratives as well as contextual, interpretative, position and discursive aspects (Rescher, 2005; Esquile, 2006).
- A thematic analysis of 25 interviews with resettlement agency staff further facilitated the study findings.

Findings

- There was a salient difference between Sierra Leonean and Burundian stories regarding narrative content and structure.
- Sierra Leonean narratives were generally chronological ordered and asymmetrically distributed along their life storylines from home country, refugee camp, to Australia.
- Burundian narratives were asymmetrically distributed and generally silent on confrontational experiences.
- Individual differences in narrative content and structure were observed or continuous from near-complete silence to complete narration of war-related and other traumatic experiences.

Avoiding narratives

- EC: I will start from when I was at school, living at home with my family. After that I was never happened a civil war happened in my country, and I used decided to leave the country. When I arrived in this country, I found myself staying in refugee camp.

Edward's reference to war and conflict was brief and his narrative was not fully-formed (undertold). There was no elaboration of events nor evaluation of experiences during war. This is contrasted with his numerous descriptive accounts of life in the refugee camps and in Australia. His narrative style was used by most former Burundians.

Snuggling narratives

- TE: can you remember Burundi? (E: Yes, remember...)
- TE: Can you remember your life at home?
- CA: Yes (Pause)...my life was not bad...But because we left during the war...it was not so good because some people were killed...running...burning...everything...

Candy's resilient Burundian narrative emerged only after several probing questions. She struggled to find the language to describe confrontational experiences (undertold). There was little prefiguration and no evaluation of other thoughts and feelings about the war.

Prompseq narratives

- TE: Can you remember your childhood?
- AFR: (pause) (Shy) What can I remember...the fact that we were living...we had parents there, we had neighbours there. We used to play with other children from the neighborhood...There was always...a lot of fun, just run around with other children...it was just great. Lot of friends...and great community environment in which to grow up.

When prompted, Anna described a wonderful life in the home country before the war. Her narrative contained many thoughts and feelings about growing up among family, friends and community back home. However, her war narrative that followed, was fragmented. This style contrasted most Burundian narratives.

Narratives exceeding boundaries of disclosure

- RC: (Name is Roland). My life my in my country during the 10 years other was really terrible. I can't able to give you all the information but I am able to give you the basic.
- TE: Whatever you are comfortable with.
- RC: (I don't want to go into details) I will feel stress at the end of the day.

Despite Roland's initial caution (undertold), his narrative detailed some of his most traumatic experiences during the Sierra Leonean conflict: burning of home, torture, killings, rape and abductions of relatives, menstruated with this elaborate account was his effortless subliming, the political ambitions of his family, and how he eventually escaped with the help of God. His narrative ditated an attempt to make sense of his experiences.

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References

Appendix O: Copy of a flyer prepared to recruit participants in Research Project I
Are you a New Arrival in Australia?

Have you lived in Australia for at least 6 months?
Are you 18 years or older?

If so, you are invited to participate in my research study about the experiences of New Arrivals in Australia.

My name is Teresa Puvimanasinghe and I am a PhD student at the University of Adelaide. I am trying to understand the experiences of new arrivals (people from refugee backgrounds) by listening to your story: What helped you to overcome your difficulties in your home country and in Australia? How have your religious or other beliefs, cultural practices, family, friends and others helped you?

Such research may help improve the services provided to other New Arrivals and also increase understanding of New Arrivals within Australian society.

Your participation is strictly confidential.
Interviews will take about 90-120 minutes.

On completion you will be offered a $20 gift voucher as reimbursement for your time.

If you are interested call me or SMS: 0409691194 or e-mail teresa.puvimanasinghe@adelaide.edu.au

This study has been approved by the University of Adelaide, Human Research Ethics Committee.
Examiners' Reports:

28 October 2014

Dr Teresa Puvimanasinghe
c/o School of Psychology
Level 4 Hughes Building
University of Adelaide
ADELAIDE SA 5005

Dear Dr Puvimanasinghe

Outcome of Thesis Examination

I am writing to advise you of the outcome of your thesis examination. I am pleased to inform you that, subject to the following conditions, you will qualify, academically, for the award of the degree of Doctor of Philosophy.

- complete the specified amendments to the thesis to the satisfaction of your supervisors and Head of School/Discipline or delegated Postgraduate Co-ordinator;

- deliver one hard-bound and one electronic copy of the suitably amended thesis to the Adelaide Graduate Centre together with the enclosed completed Final Thesis Lodgement form confirming that the required amendments have been made. You are permitted a maximum of three months from the date of this letter to undertake the required amendments and to lodge the copies and Final Thesis Lodgement form with the Graduate Centre. If, in exceptional circumstances, you require additional time to complete the revisions, you may apply to the Dean of Graduate Studies for permission. The application, setting out in detail the reasons for your request, must be endorsed by your Principal supervisor and the Head of School or the Postgraduate Co-ordinator.

- discharge any outstanding obligations to the University prior to the BPAY deadline for the Graduation Ceremony you have nominated.

Please note that until you have fulfilled the conditions stipulated above, you have not officially qualified for the degree. Only when the degree has been conferred can you use the academic title associated with your award.

For your information, I enclose copies of the examiners’ reports. In order to expedite your qualification please discuss the required thesis amendments with your supervisors and Head of School/Discipline as soon as possible.
Three soft bound copies of your thesis are available for collection from the Adelaide Graduate Centre. As storage space is limited, the Graduate Centre will dispose of any copies of the thesis which have not been collected within one month of the date of this letter.

On collection of your thesis copies, please ensure that you provide photographic identification in the form of, for example, a University card, driver’s licence or passport. Should you choose to authorise someone else to collect the copies on your behalf, that person will need to provide evidence of your authorisation (e.g. a signed letter from you) together with an acceptable form of photographic identification.

Congratulations on your achievements to date.

Yours sincerely

for ANNE WITT
Director, Adelaide Graduate Centre

Encs: Examiners’ reports
   Final Thesis Lodgement form
   Graduation Information Reminder
   AHEGS Information sheet

cc: Professor Anna Chur-Hansen, Head, School of Psychology
    A/Professor Amanda LeCouteur, PGC, School of Psychology
    Supervisor(s): Dr Linley Denson, Professor Martha Augoustinos &
                   A/Professor Dayanandan Somasundaram
    A/Professor Mark Nottle, Convenor, Faculty of Health Sciences HDC
The dissertation presented by Teresa Puvimanasinghe provides an exemplar of how qualitative approaches to refugee health and wellbeing can make an innovative and important contribution to documenting the experiences of refugees and those who work with them. As a long term follower and contributor to mental health research within the refugee and asylum seeker literature and also as a mental health clinician I found many of the insights documented by the interviews with Sierra Leonean and Burundian refugees to be highly insightful and helped me in understanding the different experiences of refugees. In assessing the PhD I have been mindful of the long held tradition that a PhD work should make an original contribution to advancing the field of study. I think the four empirical chapters forming the main component of the work of Teresa Puvimanasinghe meet this standard and I am grateful for the opportunity to read the helpful insights identified through the qualitative techniques applied as well having an opportunity to hear the voices of the participants documented within the work. I note that each of the chapters forming the empirical component of this thesis have been accepted for publication or are in the process of being submitted for publication with the Australian Psychologist and the Journal of Refugee Studies papers both recently published. As such it is not appropriate to request additional specific revisions to these chapters. I will however make general comments of some of the strengths and areas I thought might have been further developed.

I will commence with the empirical components of the thesis. I found it very interesting that the applicant chose two different qualitative strategies for the refugee and the key worker interviews. The use of a narrative analysis to the life stories told by the applications was very powerful. I have mainly been schooled in the use of thematic analysis as outlined by the applicant in 5.7. I must say that it was not however until I read this latter section that I was able to place the full value of the narrative perspective into focus. Before final submission I would recommend that the discussion of thematic analysis in Chapter 5 be moved to chapter 2 and there be a more formal discussion of the rationale for applying narrative analysis for the refugee interviews and thematic analysis for the key worker interviews. I think the use of the two approaches is innovative and a real strength of the work and it would be valuable to bring these descriptions together and expand on the rationale for the way the applicant has deployed them. Many qualitative researchers speak of reaching thematic saturation as an indicator that they have covered the core issues. Is this something that was relevant to the analyses undertaken in chapters, 3,4,6 & 7? It was also not clear to me how the additional source of Burundian interviews was integrated into the analysis or how the key worker interviews were used to inform the refugee chapters. Perhaps some additional description of this could be included in the methodology chapter. The final integrative chapter would also be enhanced by some reflection on the relative strengths and benefits of the two analytic strategies employed and possible recommendations arising from this for the field.

The qualitative work in chapter 3 identified narratives of altruism, gratitude and giving back to society. This is a theme I have encountered many times in my contact with refugee communities particularly those that have come through the Australian off-shore program as opposed to those who have been subject to some of the more harmful immigration policies directed at asylum seekers. I also thought it was particularly appropriate that his was published in an Australian journal as it is of direct relevance to much of the discussion in the popular media that refugees are entitled and just want to take from the Australian community. I was also struck by the sense of arbitrariness many of the refugees reported about their survival and resettlement.
One of the important observations that emerged from both of the refugee chapters was the different ways in which the themes explored manifested in the Burundian and Sierra Leonean refugees. This played out especially with the ability to focus on the trauma narrative and also commitment to family back at home. At first I wondered whether this may have been because the level of trauma that the Burundian refugees had encountered was even more severe than that reported by the Sierra Leonean refugees but as I continued to read the stories and how horrific the Sierra Leonean narratives were it probably is not plausible that this accounted for the observed difference. The other possible explanation that I reflected on was the more intertribal and intra-community nature of the violence that faced Burundian as opposed to the more militia based violence that faced the Sierra Leonean refugees. There is an emerging body of research that shows that intimate other violence has an even higher level of harmfulness and violation than non-relational interpersonal trauma. The fact that this is all embedded in the silence identified in chapter 4 seems salient but this might be something that would warrant further review of the narratives in case there is evidence of the reasons for the ethic differences observed. As a clinical who often works with traumatic memories I found Extract 9 in particular of critical importance in identifying the potential dangers that face all clinicians undertaking trauma and recovery work.

The empirical chapters documenting the thematic findings from the refugee community worker interviews were also rewarding were well supported by the more focused literature review reported in chapter 5. I found particularly interesting the description of the hopelessness vicarious traumatisation engendered by the harsh immigration policies that face the asylum clients that the refugee workers also support. The identification of vicarious resilience and growth an important theme to see documented and I look forward to this work be published. Chapter 7 represents a more focused assessment of the clinical aims and practices that inform the work with asylum seekers. I did wonder if there would be differences between the type of worker and the models of support and intervention being drawn on. If this chapter is still under preparation for publication it would be valuable to reflect on this issue as well as the other issues explored in chapter 7. It was also good to see documented the mix motives that sometimes impact on pressure to tell stories.

If I was to bring up any concerns regarding Teresa Puvimanasinghe's dissertation, which I do so reluctantly given the many positive contributions I have noted above, it would relate to the introductory literature review and the final section that aims to integrate the findings from the empirical chapters. It is my view that some revision of these chapters should be undertaken prior to the award of the PhD.

With regard to the literature review it is not clear how the sections of literature review in the introduction were building a foundation for the subsequent empirical work that was undertaken – even after completing reading the empirical chapters I found it hard to construct a narrative from the introductory review. A lot of my concerns may be addressed by a more explicit linking of literature as it is being reviewed to the key research questions addressed by the qualitative material in the dissertation. Section 1.3.2 contained a number of potential inaccuracies. It is not correct for instance that Australia is obliged under the Refugee Convention to run an offshore resettlement program – the key obligation is not to refoule persons who are refugees. I share the sentiments of the applicant expressed on page 8 paragraph 3 and page 9 paragraph 2, but I did not think that these sections were well written or given the space to be adequately supported or argued and I would suggest that while the issue is of importance to the findings documented in chapter 7 it is also a
potential distraction as this is not an issue that emerged in the refugee analyses. I was surprised that the review of the literature did not engage more with the now extensive body of qualitative research that has been undertaken with refugee populations – for example there are over 800 articles that are indexed by the key refugee/asylum seeker, mental health and qualitative research on Scopus with many articles that I think would be relevant to the themes and narrative experiences emerging though this research. There was also some possible inaccurate citation for example of Steel et al 2009 did not examine the language of the interviewer as a predictor in conflict related mental health. I am also not sure it is accurate to conclude as stated on page 14 that the cited researchers have postulated that there is a stable relationship between trauma and PTSD independent of culture. I would encourage the applicant to revisit these sections before final submission.

Recommended changes before final submission

1. Integrated the methodological discussion especially of thematic analysis from chapter 5 to chapter 2 with a more formal discussion of the theoretical rationale for applying the two analytic strategies
2. Include a discussion in chapter 8 of the methodological findings that arise from the use of the two
3. Revise the introductory literature review to address the issues noted above and include an ongoing narrative summary that links each section of the review to the aims/intent of the thesis – i.e spend time contextualising the relevance of the thesis.
4. I would strongly encourage the applicant to introduce a narrative review of the growing body of qualitative research undertaken with refugee populations and to position the current research within this research literature.
Surviving, Striving, and Thriving: A Qualitative Study with former Refugees and their Service
Providers in Australia
Teresa Puvimanasinghe

Thesis Report – Corinne Squire

1. This is a very well and clearly written and argued thesis, based on a considerable amount of theoretical and empirical work. The overall argument, for better understanding of refugees’ positive engagements with their personal, social and cultural worlds, is important and is well substantiated by the thesis, especially in chapter 3. The thesis pays useful attention to post-migration trauma, and its research with service providers as well as refugees themselves (and with some participants who fall into both categories) provides a helpful double perspective. The thesis takes a well-justified and appropriate approach to narrative work for the participant groups. Some interesting typological accounts of narrative and content emerge. The thesis makes some good and new points about particular narrative differences between national backgrounds and within them. The notion of a continuum rather than a category set of responses is particularly helpful.

2. Some points need to be addressed a little more fully, as listed below. Although there are a lot of points, I am only suggesting minor additions and revisions, not large scale rethinking or rewriting. I think that addressing these points will also help the thesis proceed towards further publication – although the thesis has already generated an impressive list of good and relevant papers.

a. In relation to the Burundi material, it might seem relevant to look at some of the research on the Rwandan aftermath also, in particular the decade-long gap between the genocide and the national consideration of the events, and continuing contemporary emphasis on silence about intra-country differences. As the author says, this is very different to the ‘othering’ situation in Sierra Leone. But this silence could also be argued to be a political perspective, not just a community or social one, as some would indeed argue in the Rwandan case – something not really considered here.

The author does usefully argue that Burundian participants’ particular and less verbal approach may be related to society-wide involvement in conflict and to the country’s long history of instability and war – rather different to the SI situation which might perhaps be closer to what has happened in Uganda?

I think some comparisons with the situation for refugees from countries with similar recent histories would be useful, perhaps at the end – for instance, Rwanda, Uganda, DRC, Somalia (which provides some similar evidence of internal divisions being treated silently in post-migration contexts).

b. Sometimes, there is little detail about number of participants responding in a particular way. It can be helpful with small studies to know how many ‘most’ or ‘some’ participants are. It would also be good to look at thesis sections that are under-illustrated with quotes – this was true in chapter 6.
c. Not much is said in the thesis about refugee camps and how identities/socialities are changed there. As an important, specific, and often long-experienced social situation in many refugees’ lives, this issue – and also the journey to Australia, considered specifically in some recent work on refugee experiences – could be given a little more attention, if only to explain the thesis’s concentration on the post-migration situation. A thesis can’t do everything, and it’s fine to maintain this concentration, while still registering the areas of the camps and the journeys, not much addressed.

d. The thesis seems at various points to be suggesting that refugee service workers don’t recognise national differences of the type found here. Maybe it could make some distinctions here; certainly NGO workers in some contexts will recognise these differences, even if more generalist counsellors do not.

e. It might be useful to relate your narrative typologies a little more to others, to aid the transferability (Lincoln and Guba) of the research.

f. Early on, the thesis needs to be clearer about relation between actions and talk about them – throughout, there are assumptions at times that narratives of certain actions uncontrovertially indicate something about those actions. Convergences in talk between interviewees or groups of interviewees, for example, do not necessarily indicate convergences in practices, as seems to be assumed at times. Another example: the thesis declares a strong interest in narrative content – but such content is not ‘what happened’, as seems to be assumed. Maybe thinking about narrative as resource/topic (eg as in Plummer) would help, though again, seeing narrative as a ‘resource’ does not necessarily assume its transparency. Once more: What people do in therapy, is not necessarily what they say they do! Relatdely, storytelling on its own is not a solution to refugees’ difficulties. A more precise account of what kinds of difficulties can be helped in what kinds of ways, would be good.

There is of course a great deal of debate about this issue in relation to many aspects of language, not just narrative. I think the author could make a strong argument about the importance of the relation but could also make qualifications about the strength and directness of the relation.

g. There is a great deal of other work that makes the thesis’s point about refugee ‘resilience’ and also about the dangers of refugee victimologies. I think more attention needs to be given to this other work (though it is mentioned early on) – for instance, at the end. It does not mean that the thesis is not making a valid and new contribution; but this contribution is within a field of work and not, as sometimes appears, the start of that field.

h. Scales’ epistemological relation to qualitative narrative work is not clear, even though they are both being used together. Relatedly: why is some of the research done using narrative and part of it using a thematic approach? A clear justification of this would be good. You need to say why you used the two approaches to the two different studies, and to what extent they are compatible. Could you really systematically integrate them?

i. The ‘additional’ or ‘supplemental’ material needs a slightly fuller account of its limits and benefits. Who were the people in the video? What were the processes involved in
interviewing for and making the film (eg editing - by whom and for whom/). To what extent did you rely on these additional resources? In places you are very nuanced about the use of this material; in other places, it seems as if you just use it alongside the primary data.

j. 

k. What about the possible biasing effects of asking for ‘life story’?

l. I am not not sure of the relevance of including Labov. Event narratives are not something that would be expected to take up most of the interviews (and they could not be said to be present in any simple way in a film). If you are using an adapted version of Labov’s framing, please explain it. It sounds, though, as if your idea of narrative goes way beyond any such adaptation. How much of the interviews were narratives, according to your definition - Labovian or not? Labov also thinks narratives translate cognitions (memories) rather directly and the thesis approach overall is not this.

m. I think there could be a little more attention to the overdetermined nature of ‘refugee stories’ esp the first one given; the ‘NGO story’; again, the way in which refugee camp experiences play into this

n. A number of concepts are used in the thesis which are highly debated but which the thesis treats uncritically, or only examines critically rather late on. I think that some awareness of the critiques needs to be shown early, in the first chapter – and in some cases, the critiques need a clear if brief direct address of a paragraph or two – I have marked these with an asterisk.

These concepts are:

i. VR and VT (can ‘vicariousness’ be given some critical formulation?),

*ii. Trauma (there is a vast critical literature here and the thesis does not adequately engage with it via Herman) and PTSD- addressed critically rather late. Type I and type II traumas - how conceptually (not to mention instrumentally) valid is this distinction?

iii. ‘Behavior’, and the divisions between cognitive, emotion, social realms (taken from mainstream psychology in some cases here) The individualisation critique raised at one point needs to be made in relation to all these points, otherwise the account seems, especially early on, psychologising and somewhat mechanistic. Splevins et al. is used as a reference, but there are many.

iii. ‘amelioration’ – according to who?

*iv. Resilience, coping, thriving, flourishing* etc- there is a lot of critical literature with which the thesis needs to engage, and of which it needs to show awareness earlier, in relation to all these terms.

v. Triangulation – this term is usually deployed in relation to different notions of ‘truth’ than those in play here, and if the term is going to be used, a different understanding of it needs to be presented early on. (For instance, it makes little sense in relation to notions of
narratives' co-construction). Why not just say that some kinds of material/data support other kinds?

*vi. Post-trauma growth and altruism born of suffering, while newly addressed here in relation to refugees, and quite feasibly good ideas, maybe need some more theoretical elaboration - not just in relation to trauma, as indicated above, but in relation to 'growth', 'altruism' and 'suffering'! Some terms are indeed examined critically as the thesis proceeds — again, I think this critical awareness needs to be shown early on.

vii. The 'dose effect' idea which both physicalises, medicalises and pharmacologises psychological distress (if not trauma) — needs some critical attention.

*viii. There is no careful theoretical consideration of acculturation theory which has a decades-long history of critical address. Lots of people have moved beyond a deficit model but this move is not consistently presented in the thesis.

ix. 'Repositioning' is a term not used consistently throughout the thesis — is this what the narrative study is analysing or not?

x. In places, terms with similar referents are usefully brought into relation with each other; this does not happen in the Just World section — what are the conceptual relations between the different approaches reviewed here (eg with cognitive dissonance reduction, which is mentioned later)? By contrast, there are good comparisons of VT with similar concepts.

xi. P128 variance should be variability I think — variance is a technical term and I don’t think you are using it in this sense.

xii cultural competence: needs critical address

xiii ‘fundamental needs’ — according to whom? Maslow? Sen? Nussbaum? What are the criticisms here?

xiv. Cf x. - What are underlying similarities/differences between interventions? Many forms are mentioned and lots of them are doing similar things. CBT itself is very diversely conducted. Some conceptual analysis is needed here.

*xv. Counternarratives: this can be a very useful concept in this context, but the category is disputed and a proper and critical account — albeit brief — is needed.

*Is the 'EP' really the best focus for analysis? Some further consideration and justification is required.

A few very small language issues appear in the thesis: another proofreading while addressing the above points, would be good.

p159 According to...the name following should be out of brackets, with just the date in brackets. I have not checked the thesis for other instances of this error, so there may be some.