

Trappen between disaster and uncertainty:
A quantitative study of mental health of unaccompanied minor asylum-seekers
in Norwegian reception centers.

Kristian Andreas Lunde Slagsvold



Master Thesis in Developmental Psychology,

Department of Psychology

University of Oslo

May 2014

Kristian A. L. Slagsvold

Trappen between disaster and uncertainty.

2014

<http://www.duo.uio.no/>

Abstract

The present Master thesis documents an exploratory survey study based on quantitative data from 37 unaccompanied minor asylum-seekers between 15 and 18 years of age in Norway. The purpose of this study was to investigate past traumatic events, present everyday hassles and mental health problems in the lives of these adolescents awaiting decision on their asylum-applications. The associations between the traumatic events, hassles and mental health problems were explored. The potential mediator effect of hassles on the link between past traumatic events and mental health problems was also investigated. Results indicated high occurrence of past traumatic events and high prevalence of posttraumatic stress symptoms, depression and anxiety. Externalizing was recorded to be relatively low, consistent with similar studies of unaccompanied minors. Mediator effect of Hassles on the association between traumatic events and depression was found. The study is unique in exploring a group argued to be scarcely studied in international and Norwegian context. The study aims at broadening the focus from a predominantly trauma-focused to a more psychosocial framework in the assessment of mental health among unaccompanied minor asylum-seekers. The present study is based on a relatively small sample, hence more work with larger samples is needed to understand these processes and validate findings, as well as looking at intergroup differences. Also, longitudinal studies of this group may produce indications of causal pathways between adversities and pathology, from past to present.

Acknowledgements

First of all, I want to dedicate this thesis to the brave young people in the two asylum-centers surveyed in this study. Without your valuable experiences, and truthful, possibly painful acknowledgements of past events, this thesis would never have been possible. Thank you for sharing your vulnerabilities, strengths and dreams for the future.

Secondly, the staff members at these two centers deserve great appreciation for enabling the impractical venture of letting outsiders interview this group of youths within their facilities, some of you after working hours. I know this came on top of many other activities, and I thoroughly appreciate the extra effort.

Thirdly, I would like to thank my supervisor Brit Oppedal for invaluable and competent input, friendly support and company, and the occasional much needed proverbial kick in the behind. May your laughter roam the halls of The Institute of Public Health for years to come. A big appreciation goes to Pål Ulleberg at PSI for untangling the intrinsic nature of quantitative psychology. I would also like to thank Serap Keles for theoretical and psychosocial support, also Laura, Visnja, Daniele and the rest of my colleagues at, Division of Mental Health.

Last, but not least, I would like to thank Hilde for untiringly supporting this academic odyssey of trial and tribulation, resulting in this, the pinnacle of my educational achievements. Thanks also to my father Pelle, my sister Marie, and study colleagues Runar and Ida Sofie for moral support.

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In every conceivable manner, the family is link to our past, bridge to our future.

Alex Haley

Introduction

The most vulnerable group of immigrant children are the ones who migrate without their parents or other legal guardians to seek asylum in foreign countries – the unaccompanied minor asylum-seekers (Halvorsen, 2002). The term unaccompanied minor asylum-seekers refers to being separated from parents or adult caretaker, being under 18 years of age, and having applied for asylum in a receiving country (Jensen, Fjermestad, Granly, & Wilhelmsen, 2013). The five most common reasons for flight have been recorded to be: 1) parents, siblings or other family killed; 2) persecution for reasons of ethnicity, religion or sexual orientation; 3) forced military recruitment as child soldiers; 4) war in the home country; 5) human trafficking (Thomas et al., 2004). Though these traumatic experiences are reported to be the most common reasons for flight, they can be considered widely different backgrounds when starting new lives in the receiving countries. Hence, unaccompanied minor asylum-seekers represent a heterogenic group, though the common denominator can be argued to be lack of adult caretaker, exposure to high rates of potential traumatic past events, little or no social support and networks, and worries about the future. The most predominant mental health problems among unaccompanied minor asylum-seekers have been reported to be posttraumatic stress disorder, anxiety and depression (Jensen et al. 2013).

Taking into account the wide attention among politicians, media and non-governmental organizations in Norway and the rest of Europe for the hardships of unaccompanied minors (both asylum-seekers and refugees), the research output on their psychological adjustment in the receiving countries may appear relatively scarce. Studies in Norway have involved: unaccompanied children still in the asylum-seeking process (Jensen et al., 2013); mixed groups of unaccompanied minor refugees and asylum-seekers (Dittmann & Jensen, 2010); and children who have been granted asylum and are resettled in their country of destination (Seglem, Oppedal, & Raeder, 2011). A majority of the research at hand on *unaccompanied minors* (as unaccompanied minor refugees and asylum-seekers are commonly called in tandem in the literature) is typically done with unaccompanied minor *refugees* (Eide, & Hjern, 2013, Oppedal, & Idsoe, 2012; Seglem, Oppedal & Raeder, 2011; Bean et al., 2006; Lustig et al., 2004). Studies of children still in asylum-seeking stage are limited (Jensen et al., 2013), and the extant studies on mental health problems in post-conflict populations are based on a trauma-focused framework

describing association between number and type of trauma and mental health problems (Miller & Rasmussen, 2010).

To expand our knowledge about children in a stage of their flight that may be described as “trapped between disaster and uncertainty”, the present study aims to examine the mental health of unaccompanied minor asylum-seekers, between 15 and 18 years of age, still living in Norwegian asylum centers, awaiting decision on their asylum application. The focus is both on past traumatic events and resettlement hassles.

Background

Refugees & asylum-seekers on a global scale

According to a recent report from the United Nations High-Commissioner for Refugees (UNCHR), the first half of 2013 had been one of the worst periods for forced displacement in decades, and the size of UNHCR’s population of concern reached an all-time high in this period (UNHCR, 2013). The 1951 United Nations Convention Relating to the Status of Refugee, the so-called Geneva Convention, defines a “refugee” as someone who has “well-founded fear of persecution for reasons of race, religion, nationality, memberships of a particular social group or political opinion” (UNHCR, 1951). Asylum-seekers are on the other hand defined as individuals who seek international protection and whose claim for refugee status has not yet been determined (UNHCR, 2013). For the sake of this thesis, it is noteworthy to point out that *not* every asylum-seeker will ultimately be recognized as a refugee, but every refugee was initially an asylum-seeker (UNHCR, 2013). Refugees and asylum-seekers, often collectively named “forced migrants” (Ager, 1999, ref. in Sam & Berry, 2006: 30) face great challenges: they frequently do not want to leave their country of origin, and if they do, is not always possible to be granted rights to stay and settle in the receiving country (Berry, Poortinga, Breugelmans, Chasiotis & Sam, 2012).

Asylum-seekers in Norway

Approximately 12.000 asylum applications were registered in Norway in 2013, the estimations for 2014 is around 14.000 (UDI, 2014). As the numbers of asylum-seekers rise, more

knowledge of how to adequately support this vulnerable group is warranted. People fleeing persecution, war and conflict to settle in new countries, often face physical and mental challenges along the way, but also severe difficulties after arriving in the destination country. Most of them come from geographically distant, low income countries (UNHCR, 2013), and the social, cultural and linguistic differences between the former setting and the new surroundings are often severe (Fazel, Reed, Panter-Brick & Stein, 2012). A report by Jakobsen and colleagues on mental health in recently arrived asylum-seekers in Norway found that the adult asylum-seekers in the sample reported symptoms of posttraumatic stress disorder (PTSD; 46.2 %), depression (33.8 %), anxiety (26.2 %) and psychosis (1.5 %), and noted that 46 out of 65 respondents met the criteria for a clinical diagnose (Jakobsen, 2007).

International regulations regarding asylum seekers

Children are defined by UNHCR as individuals who are below the legal age of majority and are therefore not legally independent, which also applies for adolescents. More specifically the Convention on the Rights of the Child defines a “child” as a person who is below the age of 18, unless the applicable law sets a lower age (OHCHR, 1989). There are several relevant international regulations concerning unaccompanied minor forced migrants. The 1951 Convention relating to the Status of Refugees is the key legal document in defining who is a refugee, their rights and the legal obligations of states (UNHCR, 1951), all though this convention does not mention children as an own category, but rather stipulates children’s rights to education as refugees (Lidén et al., 2013).

The Convention on the Rights of the Child came into force in 1990, and acknowledges children’s right to legal protection, and specifies what the principles of the United Nations Universal Declaration of Human Rights entails for children (Office of the High-Commissioner for Human Rights, 1989; United Nations, 1948). Regarding the target group of the present study, some main principles of the Convention on the Rights of the Child are relevant. Article 2 defines children’s rights to not be discriminated against; while article 3 postulates that the best interests of the child shall be a primary consideration. Article 6 recognizes every child’s inherent right to life, and obliges the conventions’ parties to “ensure to the maximum extent possible the survival and development of the child” (Office of the High-Commissioner for Human Rights, 1989, article 6). Article 20 stipulates that a child temporarily or permanently deprived of his or her family

environment shall be entitled to special protection and assistance provided by the State in question, while article 22 acknowledges the rights of children with refugee status to appropriate measures to ensure protection and humanitarian help. Article 24 proclaims children's right to the highest attainable standard of health, and to treatment of illness, while article 27 recognizes "the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development" (Office of the High-Commissioner for Human Rights, 1989, article 27).

The Dublin II Regulation. The Dublin II Regulation by the European Council was completed 18th of February 2003, and has been ratified by Norway. The Dublin Regulation restricts the rights of refugees and asylum-seekers, and stipulates that the application of an asylum-seeker must be processed in the first country of arrival, assuming that country can be deemed as secure. Norway and other member countries are obliged to make an independent inquiry whether the country in question adheres to human right regulations (Lidén, Eide, Hidle, Nilsen, & Wærdahl, 2013). In terms of ensuring access to a fair asylum-procedure, the Dublin II Regulation reveals a number of problems. While the aim of the regulation was to process asylum-applications more effectively, the numerous bureaucratic steps in the process are practically stretching over several months. In addition, there are disagreements about the interpretation of the regulation, including the criteria for responsibility of applicants, the obligation to inform the applicants about the process and their legal entitlements, and the grounds for transfer of children. There are also differing views about the level of entitlements to basic reception conditions for the applicants, such as financial support, education for children, and adequate treatment of vulnerable and traumatized asylum-seekers, leaving some claimants to spend long periods lacking in basic minimum conditions (Garlick, 2006).

Eide & Hjern (2013) note that "The Scandinavian countries have had a reputation for being world champions of human rights and contributed greatly to the creation of the Convention on the Rights of the Child". However, the researchers note, asylum-seeking children have tested the boundaries of these "beautiful principles", where the best interests of the child are weighed against the (hard realities of) regulations of immigration and policies for integration (Eide & Hjern, 2013, p. 666).

Stages in flight

Several researchers have proposed models of assessment for refugee children using an ecological and chronological framework highlighting displacement related events during three stages; 1) pre-flight; 2) in flight; and 3) on arrival (Hodes, 2000; Miller & Rasco, 2004; Fazel & Stein, 2014).

1) Pre-flight. Before flight many refugees experience considerable trauma in their countries of origin. They have often been forced to abandon their homes because of persecution, war or combat and thus witnessed violence, possibly torture, and losses of close family and friends (Hodes, 2000). Refugee children might have no memory of stability; their school education is either lacking or disrupted, and parental distress and general insecurity are common features (Russel, 1999).

2) In flight. Experiences during flight are often stressful, as it can take many months and expose the refugees to dangerous situations. Many are forced to travel slowly to avoid detection, have to stay in intermediate countries, in detention or even prison. Persecution may continue during this stage (Hodes, 2000). Refugee children can also experience separation from parents at this stage, either by accident or as a strategy to ensure their safety, and some are subjected to human trafficking to ensure their arrival in the target country (Ayott, 2001, ref. in Fazel & Stein, 2002).

3) On arrival. Within this stage there are challenges in continual movement within the receiving country seeking accommodation or a sense of home. The experiences of separation and loss of family, community, and cultural reference may prevail. Families are often dispersed internationally, or missing. Many experience difficulties concerning asylum- and settlement policies (Fazel & Stein, 2002), while dealing with poverty, inadequate housing, and restriction of legal rights, welfare benefits and employment (Hodes, 2000). The additional strains of exposure to new language, culture and religion are commonly experienced, as well as discrimination from majority culture, persecution from members of the society of origin, and long-term difficulties in visiting original country and communities (Hodes, 2000). Refugee children will need to settle into new schools settings and develop peer relationships, and some must assume adult roles to cope with the new settings. As the problems multiply, this final stage is increasingly referred to

as a time of “secondary trauma” (Fazel & Stein, 2002). The present study aims to investigate the mental health situation of unaccompanied asylum-seeking adolescents in the final stage of Hodes’ (2000) three-part stage model of refugee stressful experiences, while also taking into account the traumatic experiences before and during flight.

The need to screen for mental health problems

Nearly half of the world’s forcibly displaced people are children, and whether they are refugees, internally displaced, seeking asylum or stateless, they are in a greater risk of abuse, violence, and exploitation, trafficking or forced military recruitment (UNHCR, 2014). A report on unaccompanied minor refugees in Norway found that 52 % of the boys and 60 % of the girls in a group of unaccompanied minor refugees showed so many signs of depression that they needed help and support measures (Oppedal et al., 2009). In a comparative study of access to health care services for asylum-seekers in the EU, the researchers found that medical screening of this group (for diseases such as tuberculosis) was provided in all but one EU country, as opposed to screening for mental health problems, which was done in less than half of these countries (Norredam, Mygind, & Krasnik, 2006).

High thresholds for reporting mental health problems

A study in Holland by Bean et al. (2006) found that unaccompanied minor refugees had a higher threshold of reporting the need for mental health treatment as opposed to Dutch minors. Meanwhile, the caretakers and teachers of the unaccompanied refugee minors consistently underreported the mental health problems of the children compared with the children’s own reports. Some of the health problems in this group of unaccompanied refugee minors were left undetected by the caretakers and teachers, and since reference to psychological counselling was governed by caretakers’ reports, these children were hence never referred to mental health treatment. The researchers noted that almost half the unaccompanied minors in the study were inadequately treated for mental health issues (Bean et al., 2006).

Oppedal et al. (2009) recorded that a mere 30 % of the unaccompanied minor refugees who reported war-related posttraumatic stress symptoms had undergone medical or psychiatric treatment because of these problems during the last three months (Oppedal et al., 2009). A study, this time with unaccompanied minor asylum-seekers in Norway proposed that the respondents

might be underreporting psychosocial problems, such as externalizing, to improve the chances of obtaining residency (Jensen et al., 2013). This is supported by Derleuyn & Broekaert (2007), who note that the struggle to obtain a new future can be the explanation for avoiding misbehavior, or reporting to do so (Derluyn & Broekaert, 2007).

Unaccompanied minor asylum-seekers in Norwegian context

In Norwegian context “unaccompanied minor asylum-seekers” is a term defining children and youth under below the age of 18 years that arrive in the country without parents or other adults with parental responsibility (Oppedal, Seglem, & Jensen, 2009). Some of these children obtain residency and are called unaccompanied refugee minors, while the unaccompanied minor asylum-seekers are the ones waiting for decision on their asylum application.

Norway has been one of the major receiving countries of unaccompanied minor asylum-seekers in Europe (UNHCR, 2005). Of the total number of applicants for asylum in Norway during 2013, about 9 % were unaccompanied minors (UDI, 2014). The relatively increasing number of unaccompanied minor asylum-seekers in Norway (from 964 registered in 2012 to 1070 in 2013) is believed to reflect the growing number of asylum applicants in total (UDI, 2013).

Treatment of unaccompanied minor asylum-seekers in Norway

In an asylum-center, the residents have to adapt to new surroundings, in a new country with a foreign culture, while simultaneously living close to people in similarly difficult situations, but often with quite different backgrounds (Andrews, Anvik, & Solstad, 2014). The experience of lacking knowledge about society in the receiving country, and the expectations therein, strip many asylum-seekers of their personal and social skills, leaving them without social networks and status, possibly in need of help measures. Other challenges concern economy, living conditions, passivity, gender roles, and socializing outside of or within the center, in addition to loss, loneliness and worry for family and friends in their country of origin (Andrews, Anvik, &

Solstad, 2014). This is especially salient for unaccompanied asylum-seekers, and even more so for unaccompanied *minor* asylum-seekers (Oppedal et al., 2011).

Norwegian asylum centers are managed by private investors, municipalities and associations, but they are all governed by UDI regulation. From 1990 to 2012 the percentage of asylum centers owned by private citizens and companies increased from 12.5 % - 76.8 % (Aftenposten, 2013; Lidén et al., 2013). The structural implications of this shift in ownership in the last decades are beyond the scope of this thesis, but the numbers are noteworthy. The asylum centers in this study were privately owned. Directorate of Immigration (UDI) is responsible for the care of unaccompanied minor asylum-seekers between 15 – 18 years of age, while the Norwegian Directorate for Children, youth and family affairs (Bufetat, 2014) are responsible for children under 15 years of age. The Directorate of Integration and Diversity (IMDi) is responsible for the resettlement of asylum-seekers in the municipalities. In the cases where unaccompanied minor asylum-seekers are granted unequivocal permission to stay, establishing a basis for permanent residency, the asylum-seeking minor is eligible for resettlement within three months, so-called “direct resettlement” (The Ministry of Children, Equality and Social Inclusion, 2011).

“A reception center is a voluntary housing facility for people waiting to get their asylum application examined. In reception centers the residents are responsible for shopping and cooking. The asylum-seekers contribute in washing and cleaning their rooms and take part in the cleaning of common areas. The time in the center is also used for personal development, exercise, games, study and work. All asylum seekers living in reception centers go through an information program to give them a picture of the Norwegian society and an understanding of the values it is based upon. The information given is thought to prepare the asylum seekers for the life in the reception center and in the community, the asylum process, health issues, law and crime, conflict prevention, repatriation and settlement. Children and adolescents, who will probably remain in the reception longer than three months, are entitled to primary education. Young people between 16 and 18 years are entitled to tuition in Norwegian and social studies, and may also have right to education in primary school subjects. Center residents who have documented their identity, have the opportunity to apply for a temporary work permit and get a job, thus acquiring vocational skills. All reception centers have a program of activities that will facilitate various recreational activities. Unaccompanied asylum-seekers organize several activities themselves and some participate in voluntary work in the center. Some spend time and effort as language assistants, while others again organize internet usage or activities. Reception centers often tie bands to the local sports club, and some asylum-seekers can make an important contribution to local clubs.”(UDI, 2011).

The preceding excerpt is collected from UDI's homepage, and is supposed to describe everyday life of asylum-seekers in Norwegian centers according to the UDI. A report on living conditions in asylum-centers for unaccompanied minors notes that the material standards, staffing and competence of the child protective services in Norway were considerably better than that of asylum-centers, thus recommending a shift of responsibility from UDI to child protective services for the unaccompanied asylum-seekers between 15-18 years of age. The report assumes that the relatively limited conditions in asylum-centers provided by the UDI are products of restrictive immigration policies. The researchers go on to pose the question of how limited these conditions can be and still be considered justifiable, and whether such conditions borders to discrimination of this group (Lidén et al., 2013).

Mental health screening after arrival in destination countries

A report on living conditions in Norwegian centers for unaccompanied minor asylum-seekers found that the initial health examination in the transit centers were expected to capture disease and mental health problems in need of immediate care. These examinations were done by nurses, but in cases of acute signs of recent traumatization or torture the regulations stipulate examination and follow-up by a medical doctor. The subsequent placement of the adolescents in asylum-centers after the initial transit centers was regulated to take into account the health issues of the individual (Lidén et al., 2013). Immediately after moving to more long-term asylum-centers for unaccompanied minors waiting for decision on their asylum-application, the adolescents are again supposed to consult a nurse, and a doctor, where the question of traumatic events and personal history before arrival is mapped. Interviews with the unaccompanied asylum-seeking youth indicated that “Dubliners” (asylum-seekers under the Dublin Regulation) who reside in transit over long periods, are in need of mental health care (Lidén et al, 2013).

“Dubliners don’t have the right to, but often need psychiatric care. To get this treatment covered, the asylum center management must apply for economic means. Then we wait for a positive response” (Nurse at a transit center for asylum-seeking adolescents, ref. in Lidén et al, 2013, p. 186).

The preceding excerpt reflects some of the difficulties in getting appropriate care and treatment for asylum-seekers as stipulated by the previously mentioned conventions for children’s and

refugees' rights, but is in adherence to the Dublin II regulation that restrict these rights for immigrants waiting for asylum-decision. Studies have shown that many strive with health issues and mastering daily life (Berg, & Valenta, 2008).

Traumatic Events and Mental Health

What is trauma? Some clarifications within the field of trauma-psychology are warranted. Firstly, what is psychological trauma? In an earlier definition by the American Psychiatric Association, trauma was defined as a horrific event “beyond the scope of normal human experience” (APA, 1980). For an event to qualify as traumatic, an event is subjectively experienced as threatening to an individual’s life or physical integrity, and includes a sense of helplessness, fear, horror, or disgust. These unpleasant feelings are most commonly connected to first-hand experiences of subjective danger or risk; such as car accidents, house fires, earthquakes, being raped or assaulted (Greenwald, 2005). Nevertheless, the field of trauma psychology has learned to identify a wider range of events as possibly traumatic, such as witnessing family members or other loved ones being beaten, killed or otherwise hurt, but also experiencing being diagnosed with a life-threatening illness (Greenwald, 2005).

Normality in trauma. Unluckily, it seems that traumatic events are not beyond the scope of normal human experience (as implied by the APA definition), when as much as 84 % of a group of second year college students in the US (N=440) had at least one major trauma experience, and where 9 % of the same sample reported seven or more traumatic events in their lifetime (Vrana, & Lauterbach, 1994). Further support for the notion of “normality in trauma” can be found in a randomized survey study done in the Netherlands (N=1087), where the reported prevalence of *any trauma* during the participants lifetime was 80.7 % in the sample (de Vries, & Olf, 2009). A study of traumatic events in the lives of children and adolescents noted that the events described in the DSM as *extreme stressors* were not rare, even in the lives of children, with an occurrence of 25 % in their sample of children living in relatively remote and peaceful rural area of the USA (Costello, Erkanli, Fairbank, & Angold, 2002). Immigrant children fleeing from war and conflict can consequently be expected to carry many past experiences of such extreme stressors as noted above, something that was duly recorded in a study of 78

unaccompanied asylum-seeking adolescents between 13-18 years, who reported an average of 6.83 (SD 3.87, range 0-16) traumatic events with the Harvard Trauma Questionnaire (Hodes, Jagdev, Chandra, & Cunniff, 2008). Psychological trauma during childhood and adolescence can thus be considered more normative than uncommon, though it is important to note that also *adverse* life events can be considered traumatic. Distress can follow after a range of events, such as a flood, a sexual assault or death in the family (Greenwald, 2005).

What makes traumatic events harmful?

Is it the number of traumatic events or the type of traumatic events that influences and may predict the development of mental health problems? Logically one can expect that the number of traumatic events is closely associated with the emergence of mental health problems. Green et al. (2000) investigated symptom severity associated with single or multiple exposures to trauma, and found that multiple traumas predicted more severe trauma symptoms (Green et al. 2000). Other researchers point to certain characteristics of stressful life events in explaining potential negative mental health effect. Not every unpleasant event is as intense or overwhelming so as to be perceived as traumatic. The most important factors that seem to determine the negative effect of trauma exposure are severity of the event, proximity to the event, personal impact and post-event impact (Greenwald, 2005).

Severity of the event refers to the experienced influence of a traumatic event, though this is highly dependent on the individual. For example, hemophiliacs will probably perceive an open wound as much more severe and therefore more traumatic than people without this condition.

Proximity is another factor contributing to the impact of events, as children have a higher risk of posttraumatic stress symptoms when being closer to potentially traumatic events, such as a school shooting or an earthquake (Greenwald, 2005). In a large study of posttraumatic stress reactions in 2037 Greek children and adolescents after the Athens 1999 earthquake, the researchers point out that previous studies mostly concluded that proximity to the epicenter of the quake and the magnitude of disaster-related experiences were the most powerful predictors of PTSD in children (Giannoupoulou et al., 2006).

Personal impact is another potent aspect of traumatic events. Research generally indicates that most children recover quickly from exposure to traumatic events unless they are directly involved in harm to themselves or their family (Pine & Cohen, 2002). The Greek study of earthquake victims showed that the directly exposed group reported significantly higher anxiety and PTSD scores than the indirectly exposed group, though no significant group differences were found in depression scores (Giannoupoulou et al., 2006).

Greenwald notes that *post-event impact* is considered a critical element for the impact of a traumatic event, though it is widely overlooked. In other words, it is not just the event itself, but the circumstances surrounding and following an event that make it traumatic rather than merely unpleasant (Greenwald, 2005). This is in accordance with the “Mediation model” proposed by Miller & Rasmussen (figure 2), which takes into account the daily hassles following traumatic life events when trying to predict health outcomes of war-afflicted populations (Miller & Rasmussen, 2010). The Greek earthquake study supports this notion, though it’s most predominant effect of post-event impact seems to be in depression, not anxiety and PTSD (Giannoupoulou et al., 2006).

Trauma-focused approach and the direct effects model

Trauma-focused advocates consider direct exposure to traumatic events such as the violence and destruction of war as the critical factor for mental health problems in forced migrants. Advocates of the trauma-focused approach view war-related trauma experiences, such as death of a loved one, sexual abuse, physical maltreatment, as the main sources of distress, demanding specialized clinical treatment (Foy, Ruzek, Glynn, Riney, Gusman &, 1997; Ruf, Schauer, Neuner, Catani, Schauer, & Elbert, 2010). Trauma-focused approach suggests that amending symptoms of war-related trauma will improve mental health, while enabling people to cope with daily stressors in a more effective way (Miller & Rasmussen, 2010). The researchers go on to note that the research on the psychological impact of war-related trauma has quite narrowly focused on the association between direct war-exposure and mental health (Miller & Rasmussen, 2010), as illustrated in figure 1.



Figure 1. Direct effects model of the relationship between traumatic event exposure and health, adapted from Miller and Rasmussen (2010).

Trauma-focused versus Psychosocial approach to post-migratory mental health

According to Miller & Rasmussen (2010), there has been increasing interest in the psychological effects of organized violence over the last 25 years. This interest has sparked controversy in research and practice with populations affected by war, and a distinct division has emerged between advocates of *trauma-focused* and *psychosocial* approaches to mental health in people affected by armed conflict (Miller & Rasmussen, 2010). Kanner et al. (1981) proposed that simply measuring stressful or dramatic life events was insufficient in predicting psychological symptoms, and that the domination of this approach was “curious” in light of the evidence that cumulated life events was only weakly correlated with health outcomes (Kanner, Coyne, Schaefer, & Lazarus, 1981: 2). The researchers went on to note that the relatively minor stressors (and pleasures) of everyday life might have significance for adaptation, and their analysis showed “hassles” to be considerably better predictor of psychological symptoms than life events in the general population in the US (Kanner et al., 1981). Similarly, when describing the situation of unaccompanied refugee children the central themes have been loss, separation and trauma, with less attention to their resources and stressors in daily life (Seglem, 2012). This approach to mental health can be counter-productive, as it merely detects, describes and treats past trauma (trauma-approach), while more progress could possibly be made by focusing on the risks and protective factors in these children’s daily lives (psychosocial approach) (Miller & Rasmussen, 2010).

Psychosocial approach and the Mediation model

Psychosocial advocates focus on the stressful social and material conditions caused or exacerbated by armed conflict, so-called daily stressors or hassles. These daily hassles can be poverty, malnutrition, destruction of communities and social networks and discrimination (Miller & Rasmussen, 2010). “Hassles are the irritating, frustrating, distressing demands that to some degree characterize everyday transactions with the environment” (Kanner et al.1981: 3). In post-migratory settings these day to day hassles can be inadequate housing, poverty, restriction of rights, language and cultural challenges, discrimination, etc. (Hodes, 2000), but also worry about future and family in the home country (Sourander, 1998). The psychosocial approach suggests that altering stressful conditions (daily hassles) will improve mental health of war-afflicted people, while simultaneously nurturing the inherent human capacity to recover from long-term effects of war-related trauma experiences and loss, provided sufficient social support and the passing of time. The Direct Effect Model (figure 1) does not include any intervening variables, such as poverty or discrimination that might to a greater or lesser extent explain the impact of pre-migratory traumatic events on mental health. It is widely acknowledged that exposure to traumatic events has profound effects on people who experience them (Sourander, 1998; Thomas, Nafees & Bhugra, 2003; Derluyn, & Broekaert, 2007). Nevertheless, most pre-migratory traumatic events also heighten the occurrence of an array of very stressful circumstances, the daily hassles experienced by forced migrants (Miller & Rasmussen, 2010). This has led many researchers to add daily hassles to the direct effects model (Miller & Rasmussen, 2010), as seen in the Mediation model in figure 2.

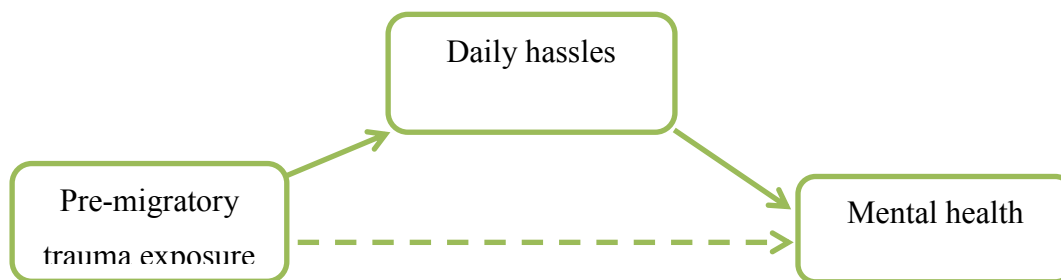


Figure 2. Mediation model, mediation by daily hassles of the relationship between trauma exposure and mental health (Adapted from Miller & Rasmussen, 2010).

Post-migratory hassles

As mentioned, daily hassles are the irritating, frustrating, distressing circumstances that somewhat characterize everyday lives (Kanner et al., 1981). Fazel and Stein (2002) described an array of such detrimental circumstances for forced migrants on arrival in the receiving country, such as asylum-application issues, integration, school difficulties, development of peer-relationships, etc., (Fazel & Stein, 2002). A qualitative study in Ireland found that the unaccompanied asylum-seekers aged 14-19 years talked about having to deal with the many challenges of the asylum process, including the ongoing fear of deportation. The researchers noted that it was evident that the participants had to deal with “past traumas, present difficulties and future uncertainties” (Ní Raghallaigh, & Gilligan, 2009, p. 228). A review article on asylum-seeking and refugee children in OECD countries noted that post-migratory stressors were found to have direct associations to higher scores of PTSD and depression, while specific factors such as uncertainty regarding asylum status or failed claims were significantly related to internalizing scores and depression (Heptinstall, 2003, ref. in Bronstein & Montgomery, 2011). A qualitative study in Finland noted that the principal concern of the unaccompanied children in the study were the well-being of their relatives, and worries about obtaining residency (Sourander, 1998). Oppedal et al. (2005) found that 70 % of the unaccompanied minors in their study experienced worries about the situation in their country of origin and the well-being of family and friends. The unaccompanied minors who worried for parents and siblings were in higher risk of psychological problems (Oppedal et al., 2005).

A Norwegian study on unaccompanied asylum-seekers between 10-16 years noted that little is known about the mental health of newly arrived unaccompanied asylum-seeking children before settlement, although they may be especially prone to mental health disturbances due to the uncertainties surrounding their situation and future (Jensen et al., 2013). The present study aims to look at the relationship between daily hassles (such as conflicts, loneliness, worries about family and future, and a sense of being hopeless, beyond help) in addition to past traumatic events, and their relation to mental health outcomes.

The need for a more holistic approach to immigrant mental health

Miller & Rasmussen (2010) points to three sets of research findings in explaining the recent interest for combining war exposure and daily hassles in predicting psychological distress. Firstly, the consistently large amount of unexplained variance in mental health outcomes when war exposure is used as the sole predictor of distress. Secondly, research with refugees in developed nations show that post-migratory daily hassles such as social isolation, unemployment and discrimination consistently predict degrees of psychiatric symptomology, in addition to or to a larger degree than pre-migratory experiences of organized violence (Steel, Silove, Bird, McGorry & Mohan, 1999). Thirdly, there are studies of non-war-affected populations where “hassles” are often more highly associated with mental health symptoms severity than traumatic life events (Miller & Rasmussen, 2010). A follow-up study of Middle-Eastern refugees in Denmark support this notion, as the researchers found that aspects of social life in Denmark and stresses experienced in exile were more predictive of mental health problems 8-9 years after arrival, than adverse experiences before arriving in the new country, thus highlighting the importance of post-migratory circumstances in fostering recovery from stressful experiences (Montgomery, 2008).

Cumulative stress

Refugee children may be subjected to what Bronstein and Montgomery (2011) coined the *cumulative stress* of forced migration or the “compounding stressors of childhood with the extraordinary and traumatic experiences of displacement” (Bronstein & Montgomery, 2011, p. 44). Cumulative adversities, in other words, the exposure to multiple stressors greatly reduce children’s abilities to cope successfully (Garmezy, 1987; Oppedal, Seglem & Jensen, 2009). Fazel and colleagues (2012) note that the most harmful pathways are those involving direct, witnessed or feared exposure to violence, added with the loss of family support by death or violence, for both behavioral and emotional mental health outcomes (Fazel et al., 2012). Hence, a more holistic approach to the experiences, past and present, seems warranted when investigating mental health in unaccompanied minor asylum-seekers.

Mental Health Problems in Unaccompanied minor asylum-seekers

Terr (1991) described four characteristics related to childhood trauma that appear to be long-lasting, regardless of the diagnosis; 1) repeatedly intrusive memories of the traumatic event, 2) repetitive behaviors, 3) trauma-specific fears, and 4) altered attitudes toward people, life, and the future (Terr, 1991). Experiencing traumatic events is assumed to be the predominant factor behind mental illness (Derluyn, & Broekaert, 2007). In adolescence, traumatic events are among the factors that have been proven to be related to development of depressive symptoms (Waaktar, Borge, Fundingsrud, Christie & Torgersen, 2004), and symptoms of PTSD (Dyregrov, & Yule, 2006).

PTSD. Posttraumatic stress disorder (PTSD) is considered the most characteristic psychiatric disorder following traumatic experiences, (Ginzburg, Ein-Dor & Solomon, 2009). However, it is also reported to be associated with resettlement stressors among refugees (Blair, 2000). Post-traumatic stress disorder can be argued to affect many displaced people, and continue to affect some individuals in significant ways for quite some time. In contrast to the lifetime prevalence of PTSD in peacetime adolescent populations ranging between 1.3 % (Wittchen, Nelson & Lachner, 1998) and 5.6% (Frans, Rimmö, Åberg & Fredrikson, 2005), one study reported that among 94 war-affected Iraqi children and adolescents, 88 % scored above the clinical cutoff value for PTSD on the Impact of Event Scale (IES) one year after the Gulf War (Dyregrov, Gjestad, & Raundalen, 2002).

Anxiety. The definition of an anxiety disorder is subject to interpretations that are rooted in in cross-culturally varied value judgments (Satcher, 2000, ref. in Shiraev, & Levy, 2010). Nevertheless, anxiety disorders manifest themselves in a set of central symptoms that can be observed in practically every culture, such as persistent worry, fear, or a constant state of apprehensive anticipation. These conditions are maladaptive and cause severe distress in the individual (Shiraev, & Levy, 2010). Generalized anxiety disorder have been reported with lifetime prevalence rates of 0.8 % in peacetime adolescent population (Wittchen, Nelson & Lachner, 1998), while unaccompanied refugee minors have been recorded with prevalence rates of 25.7 % (Vervliet, Lammertyn, Broekaert & Derluyn, 2013).

Depression. Although psychiatric disorders have been widely assumed to result from a combination of genetic vulnerability and environmental exposure, Risch and colleagues (2009) point out that few disorders have proven as resistant to robust gene findings as psychiatric illnesses, yet environmental factors such as traumatic events have been widely established as risk factors for a range of mental disorders, especially major depression (Risch et al., 2009). Depression is considered a serious mental health problem that entails significant personal and societal costs. Although early theorists characterized depression as a disorder of adulthood, contemporary perspectives view adolescence as a high-risk period for onset of depression (Rudolph, 2010). Depression is considered one of the most common mental health problems in the world, with a prevalence rate ranging from 2 – 15 %, and is considered to be associated with substantial disability (Berry et al., 2012). Depression was previously thought to be absent in non-western societies, but is currently recognized in all societies, and is believed to affect members of all cultural and ethnic groups, though the huge differences in prevalence rates across societies suggest some form of cultural influence (Berry, Poortinga, Breugelmans, Chasiotis & Sam, 2012). An example of these cultural or ethnic differences is found in a study by Seglem et al. (2011), who recorded Somali refugee minors to have significantly lower mean depression scores than all other groups, except from the Sri Lankan group (Seglem, Oppedal & Raeder, 2011). This can possibly be partly explained by the large number of Somali unaccompanied forced migrants in Norway, since same ethnic group contact has been found to reduce posttraumatic stress and depressive symptoms (Geltman et al., 2005, ref. in Hodes, Jagdev, Chandra & Cunniff, 2008).

Externalizing. Externalizing behavior is characterized as trauma-related “acting out”, such as anger, substance abuse, aggressive behavior, destruction of property, stealing, etc. (Bean, Eurelings-Bontekoe, Derluyn & Spinhoven, 2004b). Other conceptualizations of this type of problem behavior are “conduct problems” (Oppedal & Idsoe, 2012). Deater-Deckard & Dodge (1997) noted an emerging consensus that both genetic and environmental factors play a role in the development of externalizing behavior problems, all though there remains considerable disagreement about the nature and magnitude of these environmental factors (Deater-Deckard & Dodge, 1997). In Norwegian context, externalizing or conduct problems are reported to be low in unaccompanied refugee populations (Oppedal & Idsoe, 2012), and unaccompanied minor asylum-seekers (Jensen et al., 2013).

Comorbidities. PTSD is a known risk factor in developing other psychological problems and disorders, such as depression (Oppedal, 2009). Comorbidity between PTSD and depression after trauma is supported by findings in a sample of 403 Palestinian child refugees (Thabet, Abed, and Vostanis, 2004), as well as in 363 physical trauma patients (O'Donnell, Creamer, & Pattison, 2004). In Norwegian context, Jacobsen and colleagues found the largest comorbidity in the study between PTSD and depression ($r^2 = 0.25$, $p < 0.05$).

There are also indications of comorbidity of PTSD and anxiety in the literature (Ginzburg, Ein-Dor, & Solomon, 2010). Generalized anxiety disorder (GAD) and posttraumatic stress syndrome (PTSD) also co-occur at high rates following trauma (Ghafoori et al., 2009). Severe trauma often manifests itself in an experience of extreme vulnerability and constant threat, in which PTSD and anxiety are highly comorbid (Neria, Besser, Kiper & Westpal, 2010). A longitudinal study of war veterans noted that between 21 % and 94 % of PTSD sufferers report co-morbid depression, 39 % to 97 % report co-morbid anxiety. The researchers went on to find that almost half their sample reported triple co-morbidity between PTSD, anxiety and depression (Ginzburg et al. 2009).

Indirect effects. It has even been suggested that the effects of major life events on well-being are mediated through daily hassles (Kanner et al., 1981). Previous studies examining indirect effects have indicated that hassles fully mediated the path between critical life events and depressive symptoms in native and immigrant adolescents in Austria (Stefanek, Strohmeier, Fandrem, & Spiel, 2012). A Norwegian study indicated that daily hassles partly explained differences in depressive symptoms among groups of unaccompanied refugee youths, ethnic minority youths and majority youths (Seglem, Oppedal & Røysamb, 2014). A mediator variable is a term describing “the generative mechanism through which the focal independent variable is able to influence the dependent variable of interest” (Baron & Kenny, 1986., p. 1173). For the purpose of this thesis, one could picture the independent variable (traumatic events) influencing the mediator (Hassles), which then influences the dependent outcome variable (mental health problems). This is illustrated in the Mediation model in figure 2, adapted from Miller & Rasmussen (2010).

Aims of the Present Study

The present study aims to investigate:

- 1) Type and prevalence of pre-migratory trauma experiences,
- 2) Type and prevalence of post-migratory hassles,
- 3) Type and prevalence of mental health problems,
- 4) and the associations between traumatic events, hassles and mental health problems in a population of unaccompanied minor asylum-seekers.

Method

The present study is based on data from one wave of data collection at two refugee centers for unaccompanied minor asylum seekers in two different municipalities in Norway. The data was collected from late October until late November 2013.

Participants

The sample frame included all unaccompanied minor asylum-seekers in two refugee centers, in South-Western Norway, N = 49. The residents in the two centers were invited to participate during an information meeting organized at each center, and information letters including a consent form, written in Norwegian and English, given to them after the meeting. In Center A, all 27 residents agreed to participate in the study, however, 25 showed up at the day of data collection (93% response rate). Out of 22 residents in Center B, 13 out of 22 residents consented to participate, and 12 of them answered the questionnaires at the day of data collection (55 % response rate). Consequently, of the 49 residents in the two centers the total number of participants in the study was 37, implying an overall response rate of 76 %. For a graphical illustration of the response rate, see Figure 2.

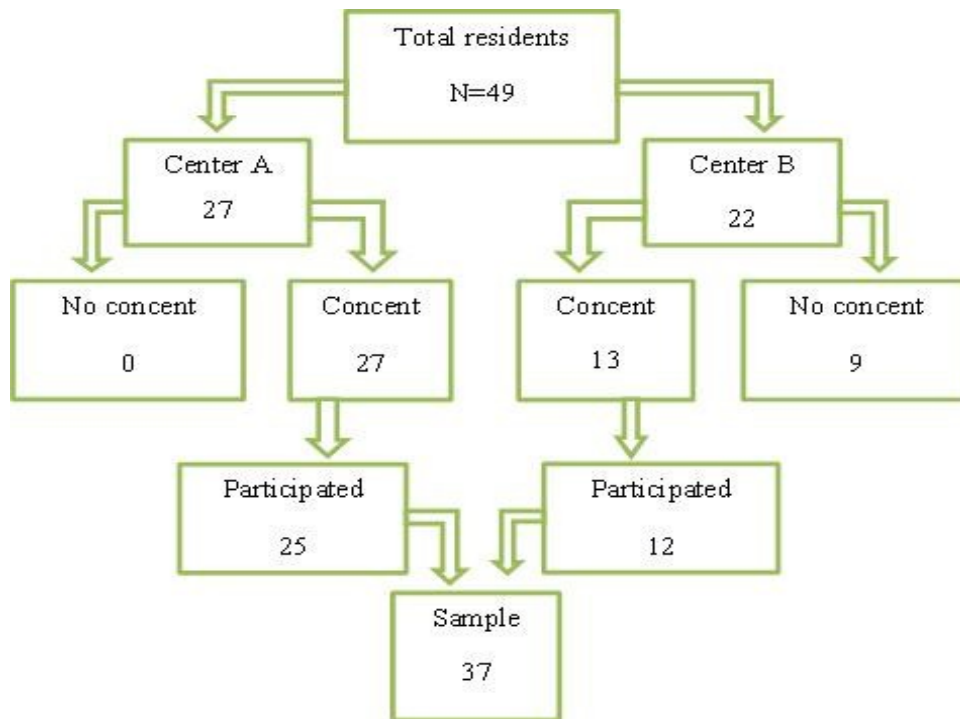


Fig2. Flowchart of the participation rate in the two asylum centers.

Sample descriptives

The average length of stay of the participants in Norway was 4-6 months. Two thirds of the sample reported journey time to Norway to be four months or more (N=33, 4 missing). Participants consisted of adolescents from Somalia (39.5%), Afghanistan (18.4%), Eritrea (10.5%), Syria (7.9%), Iran (5.3%), Albania, Ivory Coast, Tchetchenia and Palestine. 16 % of the participants were girls and 84 % were boys in the present study. The sample in the present study (Table 1) shows similar patterns of nationality within the population as the official numbers of unaccompanied minor asylum-seekers to Norway according to the UDI (Table 1, right column). The largest group is Somali youth though the percentage in the population (29.6 %) is somewhat smaller than in the study sample (39.5 %). The Afghani group is the second largest group, while Eritrea, Syria and Iran follow in the same order in both samples.

Table 1. Nationality in the sample (N=37) and in the total population (N=1070)

Country of origin	Male (%)	Female (%)	Total (%)	Total number of UMAs to Norway 2013 (%)
Somalia	11 (37.9)	4 (66.7)	15 (39.5)	317 (29.6)
Afghanistan	7 (24.1)	0	7 (18.4)	252 (23.6)
Eritrea	3 (10.3)	1 (16.7)	4 (10.5)	212 (19.9)
Syria	3 (10.3)	0	3 (7.9)	21 (2)
Iran	1 (3.4)	1 (16.7)	2 (5.3)	6 (0.6)
Other	6 (19.4)	0	3 (7.9)	

Furthermore, the percentage of boys in the sample were 83.7 %, which can be said to be quite a skewed distribution, but similar studies have found the gender distribution to be 65 % - 80 % boys, though the proportion varies dependent on the national origins in the sample (Oppedal, & Idsoe, 2012). In a similar study of UMAs, 84 % of the participating children were boys (Jensen et al. 2013). Consequently there is little reason to expect significant gender differences in the sample. The residents in the two asylums were all between 15 and 18 ($M= 16.57$ years, $SD=.778$). Further demographics are shown in table 2.

Table 2. Age and gender information in the sample (N= 37)

Age ($M=16.57$, $SD=.78$)	Males (%)	Females (%)	Total sample (%)
15	4 (13.8)	1 (16.7 %)	5 (13.2 %)
16	4 (13.8)	2 (33.3 %)	6 (15.8 %)
17	20 (69)	3 (50 %)	23 (60.5 %)
18	1 (3.4)	0	1 (2.6 %)
Not answered	2 (6.5)	0	2 (5.4 %)
Total	31(83.7)	6 (16.2)	

Measures

To make the response alternatives of the different measures more visually descriptive it was decided to adopt a layout with 4 circles increasing in size and changing color from green, yellow, orange to red above the verbal alternatives (see example at bottom of paragraph).

All questionnaires had been translated into several different languages by a Dutch research team, for the purpose of their investigation of the mental health of unaccompanied minor asylum-seekers in the Netherlands (Bean et al. 2004). The translated questionnaires are available to other researchers who can document competence in the field (<http://www.centrum45.nl/nl>). Whenever possible, the participants were given the questionnaire in their mother tongue. If the translation was not obtained in the mother tongue of the respondent, or they preferred other translations, it was made sure that the respondent was given a questionnaire in a familiar and readable language. For example, some Dari-speaking respondents were not sufficiently able to read Dari, though they spoke the language, and preferred Arabic translations. The sample in the present study called for the translations in Arabic, Albanian, Dari, English, Farsi, French, Russian, Somali, and Tigrinya.





Problems common to unaccompanied asylum-seekers				
Fill in one square, please!	Never	Sometimes	Many times	Often
Worries about family or friends abroad				
Worries about getting residence in Norway				

Figure X. Example of questions about “worries/uncertainties” in the survey

Traumatic events. The Stressful Life Events (SLE) questionnaire (Bean et al., 2004a; Bean, Derluyn, Eurelings-Bontekoe, Broekaert & Spinhoven, 2006) was used to investigate stressful and/or traumatic experiences, and registers the type, and number of stressful life events experienced by the adolescent. The instrument consists of one open question and 12 dichotomous

(yes/no) questions. Participants are directed to indicate whether they have experienced 12 different types of possibly traumatizing events, such as war, disasters, separation from family, physical or sexual abuse. The SLE does not measure the intensity or duration of experiencing the different stressful events. Whether a stressful life event had occurred was assessed by questions like “Has someone died in your life that you really cared about”. A total sum score is calculated based on the number of events the participants report to have been exposed to. The total score is then divided into 4 different “dose” clusters; 0 stressful life events, 1-3 stressful life events, 4-7 stressful life events, and 8-13 stressful life events (Bean et al. 2004a). Five independent studies have shown that refugee children report 6.5 stressful life events on average with the SLE (Bean et al., 2006).

Hassles. The present study wanted to investigate the daily hassles of unaccompanied minor asylum-seekers in Norwegian asylum centers, in what Hodes (2000) characterizes as the *on arrival* stage. The construct *Hassles* was comprised of six items reflecting some of the challenges of unaccompanied minor asylum-seekers. The questions were: 1) *Conflict with other youth in the Centre*, 2) *Conflicts with adults in the center*, 3) *Feeling lonely*, 4) *Worries about family or friends abroad*, 5) *Worries about getting residence in Norway*, and 6) *Feeling that nobody can help you with your problems*. The questions were answered with *Never/Sometimes/Many times/Often*. A reliability analysis rendered satisfactory Cronbach’s alpha values of .69 in the present sample.

Post-traumatic stress disorder. The Reaction of Adolescents to Traumatic Stress (RATS) questionnaire (Bean et al., 2004c) is a diagnostic instrument that may be used for screening adolescents at risk of developing Posttraumatic stress disorder. The items are derived from the 17 core symptoms of the B (intrusion), C (avoidance), and D (negative alterations in cognitions and mood). In this study we found Cronbach’s alpha value for PTSD Total to be satisfactory: 0.86).

Psychosocial problems. The Hopkins Symptom Checklist-37A for Adolescents (HSCL-37A) questionnaire (Bean et al., 2007) is a diagnostic instrument that can be used to measure psychosocial problems with refugee adolescents (Huemer, 2009). The HSCL-37A is an adaptation of the HSCL-25 which is a self-report screening measure for elevated symptoms of Anxiety (10 items) and Depression (15 items). The 37 item adaptation has added a subscale of 12

items investigating externalizing symptoms (substance abuse and aggressive behavior) (Derleuyn et al., 2009). In the present study we investigated the internalizing part of the measure, consisting of the sub-clusters anxiety and depression symptoms, as well as externalizing.

Internalizing symptoms. The Internalizing cluster consists of symptoms of anxiety and depression. In the present study we found very good Cronbach alfa values for total Internalizing ($\alpha = .93$). A longitudinal study on unaccompanied refugee minors found Cronbach alfa values on T1 to be $\alpha = .93$ for Internalizing with the HSCL-37A (Vervliet et al. 2013).

Anxiety symptoms. Symptoms of anxiety cluster comprises of 10 symptoms of generalized anxiety, such as nervousness, tension, restlessness, panic attacks, and a pounding or racing heart (Bean et al., 2004b). The items of the anxiety cluster are asked by questions such as *Suddenly scared for no reason* or *Feeling fearful*, answered by *never, sometimes, often, always*. A longitudinal study on unaccompanied refugee minors found Cronbach alfa values for anxiety to be satisfactory ($\alpha = .85$) (Vervliet et al., 2013). In the present study we found similarly satisfactory Cronbach alfa values for Anxiety ($\alpha = .86$).

Depression symptoms. Symptoms of depression involve 15 symptoms widely associated with the clinical syndrome of depression (Bean et al., 2004b). The symptoms in the depression sub-cluster are recorded through items like *Crying easily* or *Feeling blue*. The response alternatives range from *never, sometimes, often, always*. The answers are summed and divided by the number of items in the cluster. The HSCL-37A has good validity for use in young refugee population (Bean et al., 2007). A longitudinal study on unaccompanied refugee minors found Cronbach alfa values for depression to be satisfactory ($\alpha = .87$) (Vervliet et al., 2013). In the present study we found similarly satisfactory Cronbach alfa values for depression ($\alpha = .88$).

The internalizing cluster (consisting of anxiety and depression) has cut-off values which can be attained by dividing the score of the cluster by the number of items (25). In the research by Derogatis et al. (1974) a cut of point of 43.75 ($43.75/25=1.75$) was proposed, 2 standard deviations higher than the mean score of the researched adult American population, used as a guide for psychopathology in adults (Bean, Eurelings-Bontekoe, Derluyn, & Spinhoven, 2004b). In a report on mental health of adult asylum-seekers in asylum centers In Norway from NKVTS, Jakobsen and colleagues support this cut-off value equal or higher than 1.75, considered an

indication that the respondent probably qualifies for a symptom diagnose of anxiety, depression and internalizing (Jakobsen, 2007). This cutoff value has been applied in several studies with multi-cultural groups, both in Norway and abroad (Thapa, and Hauff, 2005), but is not specific for children or adolescents.

Externalizing. Adolescents may temporarily show increased risk behavior (externalizing behavior) following witnessed or experienced traumatic events (Bean et al., 2004b). The 12 questions in this cluster correspond with the eight criteria of conduct disorder and two criteria of oppositional-defiant disorder as defined in the DSM-IV (APA, 1994). Externalizing behavior is measured by items like *Becoming angry easily* or *Bullying or threatening others*, and answered with *never, sometimes, often, always*. Externalizing symptoms was found to have satisfactory inter-item reliability with a Cronbach alpha value of $\alpha = .69$. A similar study on mental health problems among unaccompanied minor asylum-seekers found Cronbach alpha values of $\alpha = .83$ (Jensen et al., 2013).

Procedure

The present study was part of a larger longitudinal study at the Norwegian Institute of Public Health and the University of Oslo (UiO). The study was approved by *the Regional Committee for Medical and Health Research Ethics* (REC), and was carried out in accordance with their directions. The research process was carried out in adherence to the *Helsinki Declaration* (World M.A.G.A, 2004). The research team signed a written agreement of “Instructions for privacy, ICT and security”, as provided by Directorate of Immigration (UDI, 2008).

Information and consent. To ensure that the asylum-seeking adolescents would understand the meaning and possible significance of the study it was essential to establish a good rapport with the target group, and the people around them. An information meeting was organized for the potential residents in the two asylum centers, their legal guardians, and the center staff, with presentations by representatives of the project team. The Principle Investigators presented the intentions of the study and the procedures. The project was presented with hand-

outs of PowerPoint slides with pictures and simple, clear language, since many of the residents in the center were said to be of somewhat limited competence in English and Norwegian. Some of the bilingual staff members contributed translation of the information into Dari at Center A and into Dari and Arabic at Center B.

It was underscored that the research project aimed to investigate the challenges associated with being an unaccompanied minor waiting for decision in the asylum-process, that participation was voluntary, that there were no advantages (e.g. related to the processing of their asylum application) associated with participation, and that participants could leave the project at any time without repercussions. A letter of information was given to the adolescents at the meeting, inviting them to participate in the study. The letter also contained a consent form for the adolescents to read, and sign if they agreed to join the project.

Legal guardians/representatives. Very few of the unaccompanied minor asylum seekers' legal guardians, (as of 01.07.2013 renamed "representatives" in relation to unaccompanied asylum seeking adolescents; UDI, 2014), were able to attend the information meetings. The project team therefore mailed information letters and consent forms to the remaining representatives. Some representatives were not reachable by e-mail or phone, nor were they listed in any phone number register. In the few cases where the representatives were not reachable, we made sure the participants were 16 years of age, in which a written consent form from the participant is sufficient.

Data collection. The asylum center leaders and employees were asked to help schedule the data collection at the most convenient time of the days in question, to secure as many respondents as possible for the study. Data collection was administered by a master student who was a research assistant of the research team, and who travelled to the municipalities where the refugee centers were situated. Data collection was conducted in the common areas of the refugee centers. A short introduction about the purpose of the project, and a reminder of the anonymity and confidentiality of all answers was verbally provided, in addition to the rule of voluntary participation and possibilities to withdraw from the study before the questionnaires were handed out. Sitting in small groups the participants filled in the questionnaires while the research assistant answered questions about the meaning of certain words or expressions where this was needed. The questionnaires took between 20 to 40 minutes to complete. The participants were

served soda, snacks, fruit and candy during and after the completion of the questionnaires. No monetary compensation was given.

It is important to note that the population in question in the present study is difficult to reach. Unaccompanied minor asylum-seekers are a group of people under severe psychological distress (Felsman, Leong, Johnson, & Felsman, 1990), so participation in mental health studies like the present one might seem emotionally difficult and even futile to many. The questionnaires in the present study were answered in the afternoon after long days of school or other activities, so some adolescents simply did not want to spend time filling in questionnaires. In addition the population in the two asylum centers were predominantly young (15-18 years of age), male (83.7 %), and from non-Western countries of origin. A review article on participation in health studies in Norway point out that young, male, non-Western populations have the largest attrition rates in the studies reviewed (Søgaard, 2004, ref in Antonsen, 2005). As such, the participation rate in the final sample is satisfactory.

Results

All analyses were performed using SPSS version 20. In the first section of the results the descriptive results will be presented, followed by prevalence of symptoms of internalizing, externalizing and post-traumatic stress disorder. The second result part features relationships between the measures.

Differences related to gender, age and nationality. After conducting an Independent samples T-test, there was found no significant gender differences in the current sample, as predicted. Age does not significantly correlate with any of the symptoms measured, neither does nationality.

1) Type and prevalence of pre-migratory trauma experiences

The participants in the sample reported 6.86 stressful life events (SD = 2.3, range 0-10) on the SLE. There were no participants who reported less than two traumatic events, and the maximum reported traumatic events are 12 out of 13, reported by one respondent in the group.

Furthermore, 8 % of the respondents fall in the) 1-3 stressful life events group, 54 % in the 4-7 group, and 38 % in the 8-13 stressful life events group. In other words, most people in this sample reported between 4-7 traumatic events, and almost two fifths of the sample fell in the high frequency group of 8-13 events. The most frequently reported stressful events was “*Did you experience any other very stressful life events where you thought that you were in great danger?*” with 83.8 % in the sample. The second most frequent traumatic event was “*Has someone ever hit, kicked, shot at or some other way tried to physically hurt you?*” with an occurrence of 75.7 % in the sample. The least reported event was *sexual abuse*, though the event was reported by more than 1 in 10 (10.8 %). On overview of types and frequency of stressful life events is reported in table 3.

Table 3. Stressful Life Events in the sample

Items	N (%) that said YES
Did you experience any other very stressful life events where you thought that you were in great danger?	31 (83.8)
Has someone ever hit, kicked, shot at or some other way tried to physically hurt you?	28 (75.7)
Has someone died in your life that you really cared about?	27 (73)
Did you experience any other very stressful life event where you thought that someone else was in great danger?	25 (67.7)
Did you ever see it happen to someone else in real life? (Referring to “hit, kicked, shot at or some other way tried to physically hurt...”)	25 (67.7)
Have you ever been involved in a disaster?	23 (62.2)
Have you ever been separated from your family against your will?	22 (59.5)
Have you ever experienced a war or an armed military conflict going on around you in your country of birth?	20 (54.1)
Has there been drastic change in your family during the last year?	19 (51.4)
Have you been involved in a serious accident? (for ex. involving a car)	15 (40.5)
Not listed above but you found the event very frightening	9 (24.3)
Have you had a life threatening medical problem?	6 (16.2)
Has someone ever tried to touch your private sexual parts against your will or forced you to have sex?	4 (10.8)

2) Type and prevalence of post-migratory hassles

Worries about family and friends abroad was the most frequent of the items in the “Hassles” construct, with a reported occurrence of almost 86 %. *Worries about getting residency in Norway* was reported by almost 52 % of the sample. Further prevalence and type of hassles are found in table 4. *Worries about getting residency in Norway* was reported by almost 52 % in the sample.

Table 4. Frequency table for *Hassles*.

Items	N (%) that reported much/very much
Worries about family or friends abroad (9 missing)	24 (85.7)
Feeling lonely (7 missing)	18 (60)
Worries about getting residency in Norway (10 missing)	14 (51.8)
Feeling that nobody can help you with your problems (8 missing)	15 (51.7)
Conflict with other youth in the center (6 missing)	3 (9.7)
Conflicts with adults in the center (8 missing)	2 (6.8)

3) Type and prevalence of mental health problems.

Post-traumatic stress disorder. The mean score for PTSD in the sample was 47.2 (SD = 13.84). No cutoff values indicating needs for psychosocial intervention have been set for the RATS, though cutoff values have been proposed by Derleuyn, Broekaert & Schuyten (2008) at 33.5 for total PTSD in a study on migrant adolescents in Belgium (Derluyn et al., 2008). This cut-off has also been used in a comparative survey study on mental health in unaccompanied minor refugees in Norway (N = 204) and Belgium (N = 103) (Vervliet et al., 2014). The percentage of participants in need for psychosocial intervention in the present sample (N=37), were thus estimated to be 89.2 % for total PTSD measured by the RATS. See table 6 for range, mean, standard deviations and prevalence for PTSD total.

Table 5. Most frequent symptoms of PTSD.

Items	N (%) that reported much/very much
I try to stay away from people, places, or things that remind me of the event(s).	24 (68.6)
I think of the event(s) even if I do not want to. (for example; pictures of the event(s) pop into your head)	22 (64.7)
I try to push away my feelings about the event(s).	19 (63.7)

Internalizing. The HSCL has no set cutoff values, but Jakobsen and colleagues (2007) proposed a set cutoff of 1.75 for depression, anxiety and total internalizing, thus rendering prevalence rates of 51.3 % for depression, 48.6 % for anxiety and 51.3 % for internalizing in the present study sample. Range, means and standard deviations for internalizing, depression and anxiety are found in Table 6.

Externalizing. For externalizing symptoms Bean et al (2004b) suggested that a cut off value of 19 ($19/12=1.58$) based on the score at the 90th percentile may indicate need for psychosocial intervention among unaccompanied minor asylum-seekers. According to this cutoff (1.58) there are 2 respondents (5.4 %) in the sample (N = 37) indicating need for psychosocial intervention on behalf of externalizing problems. Range, means and standard deviations for externalizing are found in Table 6.

Table 6. Symptom score range, means, standard deviations (SD), and prevalence.

Symptoms	Range	Mean	SD	Prevalence % (cut-off)
Depression	1-3.36	1.97	.64	51.3 (1.75)
Anxiety	1-3.44	1.81	.68	48.6 (1.75)
Internalizing	1-4	1.91	.62	51.3 (1.75)
Externalizing	1-2.18	1.16	.22	5.4 (1.58)
PTSD	14-77	47.2	13.8	89.2 (33.5)

4) Bivariate associations between traumatic events, hassles and mental health problems

The correlations between all the included measures and level of significance are referred in Table 7. The number of traumatic events, was significantly correlated with hassles ($r = .43$, $p = .019$). The number of reported traumatic events correlated significantly with depression ($r = .329$, $p = .047$). SLE was uncorrelated with anxiety and the internalizing cluster of the HSCL. The number of traumatic events (SLE) was highly significantly correlated with total PTSD ($r = .46$, $p = .004$), as measured by the RATS. Further correlations, p-values and confidence intervals are found in table 7. There is no relationship between traumatic events (SLE) and externalizing (HSCL). Externalizing was not associated with traumatic events as measured by the SLE, and is consequently omitted from further analysis.

Table 7. Inter-correlations among main study variables for total sample

	1	2	3	4	5	6
1. Traumatic events (SLE)	-					
2. Hassles	.43**	-				
3. Total PTSD (RATS)	.46**	.52**	-			
4. Depression (HSCL)	.33*	.62**	.67**	-		
5. Anxiety (HSCL)	.12	.48**	.46**	.81**	-	
6. Externalizing	.06	.41*	.11	.19	.19	-

N=37. * $p < .05$. ** $p < .01$.

Multivariate associations. Pallant (2013) argues that different authors tend to give different guidelines concerning the number of participants needed for multiple regression, but notes that Stevens (1996) recommends 15 cases per predictor to obtain a reliable equation in social science research (Pallant, 2013). The present study has 37 participants, and only two predictors are included in the regression analysis per outcome variable. We performed multiple regression analysis to identify potential mediation effects of hassles (mediator) on the association between traumatic events (independent variable) and mental health problems (dependent variable) in the present study sample. Since anxiety is not correlated with traumatic events, no mediation analysis

is possible, since all variables must be significantly correlated according to Baron & Kenny (1986). Age, gender and nationality were similarly omitted. Baron and Kenny (1986) refer to Judd and Kenny (1981), who recommends a series of regression models to test for mediation. To test for mediation, one should estimate the three following regression equations: first, regressing the mediator on the independent variable; second, regressing the dependent variable on the independent variable; and third, regressing the dependent variable on both the independent variable and on the mediator. Separate coefficients for each equation should be estimated and tested. Baron and Kenny (1986) then recommend using a Sobel's test of significance for the indirect effect of the independent variable on the dependent variable via the mediator (Baron & Kenny, 1986). These steps were followed in testing the mediator effect of Hassles on the association between traumatic events and depression and PTSD, respectively.

Main effects. A standard multiple regression analysis was performed to test the unique predictive power the two independent variables in explaining the variance in depression and PTSD, respectively. Table 8 shows the results with both predictors included in the model. The results presented in Table 8 indicate that traumatic events are responsible for 18 % of the variance in depression symptoms reported in the sample (though not significant), and 38 % of the variance in PTSD. Hassles are responsible for 54 % of the variance in depression, and about 35 % of the variance in PTSD.

Table 8. Multiple regression analysis for total sample. Depression and PTSD as dependent variables.

Dependent variables	Depression			PTSD		
	β	t	p	β	t	p
Traumatic events	.18	1.11	.276	.38	2.28	.031
Hassles	.54	3.33	.003	.35	2.11	.044

Mediation analysis. Mediation analysis was performed to examine the interactive effects of traumatic events and hassles in predicting depression and posttraumatic stress symptoms, respectively. The first mediation model (Table 9) indicated that there was a statistically significant interaction effect of hassles in the relationship between traumatic events and depression symptoms. A Sobel's test indicated significant mediator effect in this model ($p = .046$).

In the second mediation model (Table 10), the results implied that hassles mediated the effects of traumatic events on PTSD. However, the Sobel's test indicated that this finding was not significant ($p = .107$).

Table 9. Hierarchical linear regression. Dependent variable: Depression

	Beta	R-square	R-square change	F-change	t
Block 1					
Traumatic events	.413	.171		5.771*	2.402
Block 2					
Traumatic events	.181				1.111
Hassles	.544	.412	.242	11.100**	3.332**

Table 10. Hierarchical linear regression. Dependent variable: PTSD

	Beta	R-square	R-square change	F-change	t
Block 1					
Traumatic events	.531	.282		10.987**	3.315**
Block 2					
Traumatic events	.380				2.275*
Hassles	.353	.384	.102	4.454*	2.110*

Discussion

The present study aimed to investigate the prevalence of traumatic events, everyday hassles and mental health problems, namely depression, anxiety and PTSD, in a sample of unaccompanied minor asylum-seekers between 15 and 18 years of age. As a part of this endeavor, a model in which “Hassles” were assumed to mediate the effects of traumatic events on mental health outcomes was examined. The study is one of quite few to assess this age group of unaccompanied minors waiting for decision on their asylum applications. More importantly, this study builds on the previous work on unaccompanied minor asylum-seekers and past traumatic events to broaden the scope by including daily hassles in the factors contributing to mental health problems.

It might seem logical from a developmental perspective to expect that younger children were more vulnerable to traumatic experiences than older children. Studies have shown that this notion is questionable, as younger children tend to report less symptoms of post-traumatic stress (Hodes et al., 2008), less depression, and fewer adversities than older children (Oppedal et al., 2009). Some studies indicate that depression increases in adolescence (Rudolph, 2010), while others indicate that this increase in adolescence is predominantly recorded in girls (Birmaher et al., 1996). In a cross-sectional survey of unaccompanied asylum-seeking children in the United Kingdom, age was associated with increase in post-traumatic stress symptoms, while accompanied children reported less posttraumatic stress symptoms with increasing age. The present study does not find significant associations between the symptom variables and age in the study sample. However, this group is quite homogenous in this aspect, as the age span is only 15-18, and only one respondent was 18. The sample is thus relatively small with such a small age range to be able to identify significant age differences.

Several studies have found small, but significant differences in relation to gender and mental health problems (Dittmann & Jensen, 2010, Bean et al., 2007, Oppedal, Seglem, & Jensen, 2009), notably in depression and internalizing behavior (combining anxiety and depression) (Berthold, 2000; Reijneveld et al., 2005; Derleuyn & Broekaert, 2007). No such findings were discovered in the present sample. This is in accordance with the predictions mentioned above, based on the relatively small sample size, and the low number of females.

Future studies with larger samples may find support for gender differences in mental health problems in this population, although the number of females among most national groups of unaccompanied minor asylum-seekers is consistently scarce with the exception of e.g. Somalia, Ethiopia and Eritrea (Oppedal et al, 2009).

Type and prevalence of exposure to traumatic events

The results in this study indicate substantial occurrences of potentially traumatic events in the lives of these immigrant children. None of the participants had experienced less than two traumatic events, and the majority (92 %) had experienced between four and twelve traumatic events. The study by Vrana & Lauterbach (1994) found that 9 % of their sample of 440 undergraduate students had experienced 7 traumatic events or more, though this study was done with different scales than in the present study. In our study sample 24 out of 37 respondents, almost 65 % reported 7 or more traumatic events. Another study, this time with unaccompanied minor asylum-seekers (N=78), found that the mean number of traumatic events was 6.83 (SD=3.87) in the sample (Hodes et al., 2008). Our sample reported a mean of 6.86 traumatic events (SD=2.25), consistent with these findings. Jensen and colleagues found a mean of 5.5 (SD= 2.4) traumatic events with the SLE in asylum-seeking children between 10-16 years of age in Norway, possibly indicating that younger children may report less traumatic events.

It is worth to note that these adolescents report severe prevalence of very dramatic traumatic experiences at such a high rate, such as being shot at, hit or kicked (almost 76 %), death of a loved one (73 %), but also abuse. Sexual abuse is reported by 10.8 % in this sample, relatively consistent with the findings of Bean and colleagues (2007), where 12 % of the boys reported sexual abuse, the girls reported 39 % (Bean et al., 2007). The low number of females in this study sample is probably the reason for the relatively low rate of sexual abuse in the whole study sample, since two out of six girls (one third) did report sexual abuse, relatively consistent with the findings of Bean and colleagues (2007), noted above.

Daily Hassles

Daily hassles were significantly correlated with all study variables, indicating a strong association between pre-migration traumatic events, post-migratory daily hassles and mental health problems. In accordance with studies on resettled unaccompanied minor asylum-seekers (Keles, Friborg, Idsoe, Sirin & Oppedal, 2013; Seglem, Oppedal & Roysamb, 2014) hassles were strongly correlated with depression ($r = .62, p = .00$). In contrast, traumatic events were less strongly correlated with depression ($r = .33, p = .05$).

The role of daily hassles as a mediator of the relationships between traumatic events and mental health problems was supported in the present findings, though only with depression. The research by Giannoupoulou et al. (2006) supports this notion, as post-event impact of earthquakes, meaning the stressful conditions after the disaster, is more related to depression, than PTSD and anxiety. Miller and Rasmussen's (2010) research supports the present study findings, as they note that post-migration hassles have been found to predict mental health status at least as strongly as past exposure to war (Miller & Rasmussen, 2010). This implies that health professionals need to assess the multiplicity of challenges to the wellbeing of unaccompanied minor asylum-seekers, also taking into account the risk factors associated with daily hassles, in addition to past traumatic events when developing or implementing help measures for this group.

“Worries about family and friends abroad” was frequently reported in this sample of unaccompanied minor asylum-seekers having finally reached a situation of security, but still waiting for the decision in their asylum case. This item was significantly correlated with symptoms of depression, anxiety, as well as PTSD total. This is a sad, but unsurprising finding, and worries about family are reported to be severely detrimental to mental health (Oppedal et al. 2009). Mental health problems

The prevalence of mental health problems was very high among the young children. The unaccompanied minor asylum-seekers in this study reported a high prevalence of symptoms of posttraumatic stress, depression and anxiety. In contrast, the prevalence of externalizing problems was low, consistent with a similar study on unaccompanied minor asylum-seekers aged 10-16 years (Jensen et al., 2014). Oppedal & Idsoe note that the unaccompanied minor asylum-seekers in their study hardly engaged in externalizing behavior at all. Furthermore, the level of

depression was found to be high in the years after resettlement (Oppedal & Idsoe, 2012). The present study found high prevalence of depression, and a significant mediator effect of hassles on the relationship between post-migratory traumatic events and depression. This indicates the potential for alleviating the daily hassles as a means to reduce long-term symptoms of depression, also after resettlement.

The present study recorded high and significant correlations between PTSD, depression and anxiety in the study sample. This can be interpreted as indications of high comorbidity between PTSD symptoms, depression and anxiety. The study by Jensen et al (2013) on unaccompanied minor asylum-seekers between 10-16 years of age in Norway found high significant correlations between PTSD, depression and anxiety, similarly. This is also supported by the findings of Ginzburg and colleagues (2009), mentioned above, who found indications of triple co-morbidity between PTSD, depression and anxiety in almost half their sample (Ginzburg, Ein-Dor & Solomon, 2009).

Limitations

Questionnaires filled out by asylum-seekers with little or no formal education may fail to capture mental health problems (Jakobsen, 2007). The language or education levels of the respondents was not tested in this study, consequently these concerns also apply here. Furthermore, studies with both self-report questionnaires and structured clinical interviews have indicated that self-report questionnaires seem to overestimate the occurrence of mental disorders (Turner, Bowie, Dunn, Shapo, & Yule, 2003) implying that the prevalence reported from our study may be slightly inflated. Still, relative to studies with other groups of adolescents with similar designs, the level reported by our participants, is high. A study that compared the level of depression between resettled unaccompanied minor asylum-seekers with other immigrant and non-immigrant youth found that the former group reported significantly higher symptom levels (Seglem, Oppedal & Roysamb, 2014). Another aspect of self-report measures is that they do not determine, but rather suggest diagnostic status, meaning that self-report measures must consequentially be complemented by clinical evaluation.

The gender ratio among participants in this study is unequal, though it is similar (around 80 % boys) to other research on unaccompanied minors as noted earlier. This does, however, leave us with very little possibility to investigate gender differences in levels of mental health problems and the associations between traumatic events, hassles and mental health problems.

The sample size of the study also is relatively small for quantitative research. Still, the study shows important and significant results, in spite of the small sample size. The small sample size did, however, prevent us from conducting subgroup analysis.

The representativity of the sample is also an issue, since there was such a large rate of non-participation in one of the centers. It is unclear why more adolescents refrained from participating in the one center. However, data-collection in that center took place during school classes, and many youngsters expressed that they prioritized their education over everything else. Because of the small sample size, it was difficult to conduct meaningful analyses to investigate similarities and differences between participants and non-participants. It is common in survey studies that more well-functioning individuals participate, so that the frequency of mental health problems might be even higher in the whole group (Oppedal, Seglem, & Jensen, 2009). As noted earlier, in terms of frequencies of nationalities, the present study sample is similar to the whole population - that is the official numbers of UMAs to Norway in 2013, in which many of the respondents were registered.

The current study is based on cross-sectional data, meaning that all data from each participant is recorded at one particular place in time. This implies the inadequacy of the cross-sectional data in making inferences about causal relationships. For example, when we find relationships between worry and depression, this does not necessarily mean that worrying leads to depression, it might be the other way around, as depressed people might tend to worry more than non-depressed people. When gathering information from respondent at different times, as in longitudinal research, we are better equipped to infer causation. This is however not easily implemented in practice, as many asylum-seekers are moved, resettled or repatriated within relatively short time.

It is important to point out that unaccompanied minor asylum-seekers are not a homogenous population, and have been reported to vary greatly, as they report to flee for several different reasons (Thomas et al., 2004), and differ in nationality, language, culture, etc. An

example of these differences is found in the previously mentioned report by Jakobsen and colleagues, who note that Somali asylum-seekers report significantly fewer symptoms of depression, anxiety and PTSD, as well as lower educational level. Future studies on unaccompanied minor asylum-seekers must consequentially be sensitive to these intergroup differences, and mental health interventions must be developed accordingly.

Huemer et al. (2009) have pointed out that the measuring instruments for mental health status may not be sufficiently adapted to the multicultural diversity in the group. Nevertheless, Derleuyn and Broekaert argue that they are convinced that emotional and behavioral problems measured with the same instruments as in the present study (HSCL, RATS and SLE) are not exclusive to Western cultural context. The researchers argue that the notion that being unaccompanied, combined with the difficulties of migration, is much more influential in developing emotional problems, than the differing cultural backgrounds in this group (Derleyn, & Broekaert, 2007). The present study relies on this assumption - that there is a relative homogeneity in the group of unaccompanied minor asylum-seekers regarding the challenges of being unaccompanied and forced to migrate.

When describing the situation of unaccompanied refugees the central themes are loss, separation and trauma, with little attention to their resources and stressors in daily life (Seglem, 2012). This approach to mental health in immigrant populations can be deemed counter-productive, as it merely detects, describes and treats past trauma, while more headway could possibly be made by ameliorating difficulties and fostering growth here and now. The present study supports this notion, as everyday hassles were found to be highly associated with mental health problems. Resources or protective factors should similarly be the subject of future research.

The present study aimed to describe and quantify the traumatic events, hassles and mental health problems experienced by unaccompanied minor asylum-seekers in Norwegian context, and look at the associations between these factors. As such, it is highly preoccupied with psychological pathology, in other words, disorders and mental health problems. It is however important to remember that there are considerable indications of resilience, growth and positive development in the literature on unaccompanied refugee minors and asylum-seekers. Oppedal and colleagues (2009) noted that all though the mental difficulties that may arise during forced

migration can be stable and long lasting, some youths manage to go through such experiences without psychological distress, or return to normal activity after some time (Oppedal et al., 2009). Moreover, parallel to suffering from high levels of mental health problems, normative developmental processes in terms of identity formation, acculturation and formation of supportive relationships take place (Oppedal et al., 2011).

Meeting respondents in the present study, the striking feature of these encounters were not the vulnerability of the individuals, but the good spirited humor, sociability, hopes for the future, careful optimism and interest in other people. Since the overall focus on the pathology in this survey study paint a somewhat bleak picture of the past and current circumstances of these adolescents, it seems remarkable that they show such positive emotions during these encounters. The resilience of this group is surprisingly potent, considering the noted adversities, and the elucidation of the protective factors, coping strategies and other sources of healthy adaptation may provide the framework for fostering positive development in this group.

Oppedal and colleagues note that developing and implementing research based interventions aiming to reduce the levels of psychological problems are important within the group of unaccompanied minor asylum-seekers who are resettled. This notion is supported by the present study, as relatively high rates of symptoms were reported, both in depression, anxiety and PTSD. These mental health issues may prevail, and possibly become chronic disorders, duly noted by Bean and colleagues (2007) who found the levels of PTSD, depression and anxiety to be severe and chronic in a 1-year follow-up of unaccompanied minors resettled in the Netherlands (Bean, Eurelings-Bontekoe & Spinhoven, 2007).

Chronic mental disorders are considered among the most important causes of disability in Norway today (Oppedal et al, 2009). Research also suggests that complex comorbidities of PTSD and other disorders are not uncommon in adults after forced displacement in childhood (Küwert, Brähler, Glaesmer, Freyberger & Decker, 2009). Furthermore, research suggests that even the children born of refugee parents after migration are at heightened risk of psychotic disorders compared with the majority group (Leao, Sundquist, Johansson, Johansson, Sundquist, 2005). The detrimental effects of displacement are far-reaching, it seems. Apparently, these challenges need to be dealt with in a variety of practical, supportive, educational, and therapeutic ways which may differ at different stages of the immigration or flight process, As of today, we lack

evidence based information about intervention that may be effective in reducing the burdens of mental health problems among unaccompanied minor asylum-seekers trapped between past disasters and uncertainties about how their future will unfold.

Practical implications and future studies

The present study has several implications. The high level of symptoms of PTSD, anxiety and depression in the sample is indicative of the need for systematic clinical evaluation of psychological traumatization and the overall mental health of unaccompanied minor asylum-seekers in Norwegian reception centers. As noted earlier in the thesis, most unaccompanied refugee or asylum-seeking youth are reluctant to contact mental health professionals, while their caretakers often misread and underreport the psychological hardships of children (Bean et al., 2006). Cost-effective and reliable screening tools and interventions should thus be the goal of future studies.

Furthermore, the current, everyday needs and wishes of the asylum-seeking adolescents in reception centers, trapped between disaster and the uncertainty of the future, should be explored. The indication that post-migratory hassles significantly mediate the relationship between traumatic events and depression is indicative of the potential of interventions designed to alleviate such hassles, and promote strategies to cope with such adversities. Governmental policies to shorten the bureaucratic process of asylum-application for such a vulnerable group as the unaccompanied minor asylum-seekers may consequently be of importance. Secondly, fostering greater understanding of the asylum-process among the individuals, whenever feasible according to language and educational level, may be of large effect, as the uncertainties and complicated aspects of this process is reported to be a matter of worry and confusion for asylum-seeking children (Sourander, 1998).

Conclusion

The results indicate that unaccompanied minor asylum-seekers have experienced many past traumatic events, and suffer from elevated levels of posttraumatic stress symptoms, depression and anxiety. Findings suggest that pre-migratory traumatic events have a significant effect on mental health problems among unaccompanied minor asylum-seekers. However, also post-migratory daily hassles significantly affect mental health problems in this sample. The regression analysis rendered significant mediation effect of hassles on the relationships between traumatic events and depression, supporting the mediation model in which daily hassles mediate between post-migratory trauma and mental health.

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Appendix 1



Invitation to participate in a research project

Why are we contacting you?

We are contacting you because we want to find out if a stress coping course, called LiveSMART, has a good effect on wellbeing and social functioning among youths in reception centers, and who have come to Norway without their parents. We know that this is a difficult time for you, with a lot of stress, anxiety and uncertainty, and we wish to see if the LiveSMART-course, which includes physical exercises, breathing techniques, diet and more, to see if this can be of benefit to you. Earlier research findings show that similar techniques have favorable effects on wellbeing in different groups, both youths and adults.

What does participation mean?

We have developed a questionnaire (a booklet of questions) which we would like you to fill in. The questions concern your physical health, thoughts, feelings and social functioning. Some youths will also be invited to an interview about their experience of LiveSMART. The survey and the interview will take about half an hour each.

Anonymous and safe

The answers you give will be treated anonymously. Nobody will know what you have answered. It is voluntary to participate, and you may withdraw from the study at any time. We want to underscore that your participation will not in any way influence your application for asylum in Norway.

YES, I WILL PARTICIPATE! – CONSENT FORM

I have received information about the project "A pilot-study on the effect of LiveSMART, a stress coping course to enhance the wellbeing of unaccompanied youths in asylum centres".

Yes, I would like to participate YES NO

I give my permission to the Norwegian Institute of Public Health, to contact me in case I move out of the asylum center during the time of the project. YES NO

I will answer the questionnaire and answer the questions in the interview. I give my consent to the fact that the Norwegian Institute of Public Health and the University of Oslo will use this information to study the effect of the LiveSMART-program and other research purposes.

YES NO

YOUR CONTACT INFORMATION:

Name:

Language:

Email / Facebook:

Cell Phone:

Signature _____

Appendix 2



LiveSMART Evaluation

ID number: _____

Date: _____





IN NORWAY/ I Norge







How long have you been in Norway (Hvor lenge har du vært i Norge)?

- Less than a month? (Mindre enn 1 måned) 1-2 months (måned)
- 2-4 months (måned)
- 4-6 months(måned)
- More than 6 months (Mer enn 6 måneder)





FAMILY (Familie)	YES Ja	NO Nei
1. Do you have family here in Norway? Familie i Norge?		

How easy is it for you... Hvor lett er det for deg å...				
Fill in one square, please! Fyll inn en rute!	Very difficult (Veldig vanskelig)	Somewhat Difficult (Litt vanskelig)	Somewhat easy (Litt lett)	Very Easy (Veldig lett)
2. To speak Norwegian? Å snakke norsk?				
3. To make friends among Norwegian youth? Å få norske venner?				
4. To make friends among the other residents in the centre (mottak)? Å få venner på mottaket?				
5. To talk to adults in the centre (mottak) when you are sad? Snakke med voksne på mottaket når du er trist?				
6. To trust the adults in the centre? Stole på voksne i mottaket?				





Legal Guardian (Verge)				
Fill in one square, please!	Never Aldri	Seldom Sjelden	Once in a while Innimellom	Often Ofte
7. How often do you have contact with your legal guardian (verge)? Hvor ofte har du kontakt med din verge?				

When you think about your cultural background, how much do you agree?

Når du tenker på din kulturelle bakgrunn, hvor enig er du?

				
Fill in one square, please!	Strongly disagree Sterkt uenig	Somewhat disagree Litt uenig	Somewhat agree Litt enig	Strongly agree Veldig enig
8. I feel that people from other cultures don't accept me. Jeg føler at folk fra andre kulturer ikke akspeterer meg				
9. I have been teased or insulted because of my cultural background. Jeg har blitt mobbet eller fornærmet på grunn av min kulturelle bakgrunn.				
10. I have been threatened or attacked because of my cultural background. Jeg har blitt truet eller angrepet på grunn av min kulturelle bakgrunn.				

PROBLEMS COMMON TO UNACCOMPANIED ASYLUM SEEKERS. Vanlige problemer for enslige asylsøkere.





Has this happened to you? Har dette skjedd med deg?				
Fill in one square, please!	Never Aldri	Sometimes Noen ganger	Many times Mange ganger	Often Ofte
11. Conflict with other youth in the Centre. Konflikt med andre i mottaket.				
12. Conflicts with adults in the Centre. Konflikt med voksne i mottaket?				
13. Feeling lonely. Føle seg ensom?				
14. Worries about family or friends abroad. Bekymret for familie og venner i utlandet?				





15. Worries about getting residence in Norway. Bekymring for oppholdstillatelse i Norge?				
16. Feeling that nobody can help you with your problems. Føler at ingen kan hjelpe deg med problemene dine?				



WHAT KIND OF A PERSON ARE YOU? Hva slags person er du?

Please check the answer that best describes you! Fyll inn ved svaret som best beskriver deg.

How often do you...Hvor ofte...				
Fill in one square, please!	Never Aldri	Sometimes Noen ganger	Many times Mange ganger	Often Ofte
17. Speak your mind when others do not agree? Sier du din mening når andre er uenige?				
18. Speak up when you are being treated unfairly? Sier fra når du behandles dårlig?				
19. Stand up to people who tell you to do something unreasonable/wrong? Sier fra til folk som ber deg gjøre noe galt?				

RELIGION				
Fill in one square, please!	Not at all Ikke i det hele tatt	A little Litt	Important Viktig	Very important Veldig viktig
20. How important is your religion to you? Hvor viktig er religionen din for deg?				

FRIENDS Venner	None Ingen	1 friend 1 venn	2 friends 2 venner	3 or more 3 eller fler
21. Do you have any close friends among the other youths in the centre where you live? Har du noen nære venner i mottaket?				
22. Have you made any close friends outside of the centre where you live? Har du noen nære venner utenfor mottaket?				
23. Do you have contact with friends abroad (in other countries) through social media? (internet, telephone etc.) Har du kontakt med venner utenlands gjennom sosiale media (internet, mobil)?				

When you think about your friends how much do you agree? Når du tenker på vennen dine, hvor enig er du?

Fill in one square, please!				
	Strongly disagree Veldig uenig	Somewhat disagree Litt uenig	Somewhat agree Litt enig	Strongly agree Veldig enig
24. I feel close to my friends. Jeg føler meg nær mine venner.				
25. My friends value my opinions. Vennene mine setter pris på meningene mine.				
26. I can be of support to my friends. Jeg kan støtte mine venner.				
27. I can count on my friends when I need help. Jeg kan stole på mine venner for hjelp.				



Thank you for your time.

Feel free to contact us at ungkul@fhi.no!

