Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Toloue Askarirad

[redacted]

This report is submitted in partial fulfillment of the degree of Master of Psychology (Health)

School of Psychology

University of Adelaide

November 2022

Word count: 7489

Author notes: *This article is intended for submission to The Australian Psychologist, which adheres to the APA7 reference style. At present, the article has been written according to the Master of Psychology (Health) thesis requirement of 6,000-8,000 words but will be edited prior to submission to meet the 6000-word limit specified by The Australian Psychologist.*

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Page of Contents

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Declaration

This dissertation contains no material which has been accepted for the award of any other degree or diploma in any University, and, to the best of my knowledge, contains no materials previously published except where due reference is made. I give permission for the digital version of my dissertation to be made available on the web, via the University's institutional digital repository, the Library Search and also through web search engines, unless permission has been granted by the school to restrict access for a period of time.

[redacted]

[redacted]

November 2022

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Statement of contribution

The primary supervisor and I conceived the presented idea for the thesis. An honours student undertook the primary data collection. I reanalysed the gathered data [using a biopsychosocial lens] and the primary supervisor, supervised the findings of this work. The primary supervisor and I collaborated in choosing the journal of The Australian Psychologist. The primary and secondary supervisors and I discussed the results, and I wrote the manuscript in consultation with the second supervisor.

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Acknowledgments

I would like to express my appreciation for my supervisors for their invaluable feedback and immense patience. Words cannot express my gratitude for my wonderful family and friends who have supported me throughout this journey.

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Abstract

To date, the world is experiencing its largest forced population displacement globally. The mental health of everyone forcibly displaced is likely to be affected, however, children remain amongst the most at risk of the group. Non-clinical service providers are often the first people working with refugee children. Therefore, they play a crucial role in the recognition of mental illnesses and link refugee children to appropriate support services. Yet there are limited studies that focus on school aged children and their understanding of mental health and illness. Furthermore, there is limited research taking a holistic approach regarding non-clinical service providers' understanding of refugee children mental health. This paper aims to add to the limited literature existing in this area by exploring how service providers understand refugee children's behaviours, and links to mental health and well-being, through a biopsychosocial lens. An exploratory qualitative analysis was utilised to explore non-clinical service providers' perspectives. The data suggested service providers have a low baseline of mental illness recognition beyond the child's expression, through externalised behaviours and displays of aggression. Service providers overlooked other aspects contributing to refugee children's mental health such as sleep, diet, and exercise. The lack of recognition, early intervention, and preventative measures to support mental health may adversely affect neurological development, serious and continuous mental illnesses, and poor quality of social life and connections, leading to poor quality of life and declined overall well-being.

Keywords: Biopsychosocial model, Children's well-being, Early intervention, Mental health, Non-clinical service providers, Refugee children

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Objective

Background

As of 2021, 89.3 million people worldwide have been forcibly displaced from their homelands due to human rights violations, persecution, war, and similar distressing events. Approximately 36.5 million, or just over 40% of all displaced persons were classified as children under the age of eighteen (United Nations High Commissioner for Refugees – UNHCR, 2022). These numbers are reflected as 153,642 people who immigrated to Australia by the end of 2021 (United Nations High Commissioner for Refugees – UNHCR, 2022). Peterson (2018) reported refugees often experience traumatic events, resulting from persecution or war either in their home countries or while they are travelling to their final destination. Such experiences are likely to affect children in numerous ways based on the severity of their experiences, their resiliency levels, and coping skills. Peterson (2018) reported in some children, the experience of such events could lead to profound and long-lasting effects that could impair daily functioning, such as school performance.

Hamrah et al., (2020) reported approximately half of the adult refugee population have symptoms consistent with post-traumatic stress disorder (PTSD). Psychological distress and anxiety disorders have been reported as prevalent among 40-50% of adult refugees and 16% have diagnoses such as bipolar disorder (Taylor et al., 2014; Guajardo et al., 2018). Such patterns have also been reported for children under the age of 18, with Fazel and Stein (2002) noting the evidence of mental health disorders such as anxiety, depression, and post-traumatic stress disorder. Similarly, Hodes (2000) approximated that 40% of refugee children suffered from disorders including anxiety, depression, and other trauma-related disorders. It has been argued that the risk of the development of psychiatric disorders is exacerbated in unaccompanied minors (Fazel & Stein, 2002).

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Impacts of Trauma

Refugee children are at an increased risk of experiencing several types of traumas. Griffin (2018) divided the trauma accumulation of refugee children into three phases; traumas incurred in the country of origin, during displacement, and post-resettlement. Impacting these phases Griffin (2018) added four more stressors that could exacerbate the experienced traumas in post-resettlement – traumatic stress, resettlement stress, acculturation, and isolation stress. Refugee children may also be exposed to early childhood trauma, family/domestic violence, physical abuse, sexual abuse, natural disasters, bullying, medical trauma, traumatic grief, terrorism, and violence, along with already existing refugee-related traumas (Peterson, 2018). The negative psychological impacts of traumatic experiences have been established in depth (Li et al., 2016; Silove et al., 2007; Neuner et al., 2004; Steel et al., 2002). Exposure to trauma increases a person's likelihood of developing mental illness, and as children are in their developmental stages, they are particularly vulnerable to these factors (Peterson, 2018).

A Biopsychosocial Lens

Conceptualising mental illness in refugee children from a diagnostic perspective is limiting in its ability to understand the child's experience. Diagnostic criteria and their underpinnings are normed in western cultures and presentations (The WHO World Mental Health Survey Consortium, 2004). While the utility of mental illness diagnosis is still very much relevant, it is important to support it through a unifying approach that considers both past and current experiences which may be influencing refugee children's mental health. The biopsychosocial model allows for a holistic approach to minimising the gaps within standardised diagnostic criteria (Porter & Haslam, 2001).

The biopsychosocial model aids in understanding the interactions between biological factors, social influences, and psychological mechanisms that impact a person's mental health and other aspects of life (Brown et al., 2011). Psychological stress such as exposure to conflicts and violence can consequently result in dysregulation of affect and disruption in attachment styles and relationships (McMahon et.al., 2002). Exposure to war during childhood can cause significant psychological disruptions and illnesses, such as depression and posttraumatic stress disorder (PTSD); however, it is

important to not the psychological response is also influenced by the child's gender, family, and social factors (Shaw, 2003). They may be exposed to familial conflicts, lack of friendship support, and possible helplessness (Short, 2002). Such experiences may alter the child's social interactions and connections with others. For example, children may display antisocial behaviour towards their peers.

The psychological response to chronic stress and trauma during childhood can have long-lasting neurobiological effects which can increase the risk of developing mood disorders, aggression dysregulation, hypo immune dysfunction, structural changes in the central nervous system, and medical illnesses (Shaw, 2002, Mulraney et al., 2021). Exposure to acutely stressful situations cascades a change in the nervous, endocrine, cardiovascular, and immune system; these changes are normally adaptive and last for a brief period (Schneiderman et al., 2005). However, as the stress response is constantly activated it becomes maladaptive, which can cause adverse effects on the body. This stress response has been linked to health issues and behaviours later in life, including eating disorders, substance use, risk-taking behaviours, and sleep issues (Schneiderman et al., 2005; Peterson, 2018).

Trauma can cause profound impacts on children's development. During the developmental stages from infancy through to adolescence, normal biological functions are influenced by the environment. If a child is exposed to prolonged extreme stress levels, the immune system and the natural body response may not develop at a normal rate (Peterson, 2018). As a result, when these children experience stressful situations their adaptivity in the face of the 'perceived threat' will be different and they may be present as detached, overacting, or unresponsive (Peterson, 2018). This is caused by body dysregulation which results in under-response to environmental cues (Lipowski, 1987).

Weiss et al (2009), reported different cultural groups respond to mental illness in different ways, such that are in line with their cultural norms, for example may be based on gender-based norms. People of Asian heritage tend to respond to stress with somatic symptoms, whereas Western populations tend to express symptoms through affect (Weiss et al, 2009). Somatisation can be defined as the presence of somatic symptoms in the absence of biological causes (Lipowski, 1987) associated

with psychological distress such as dizziness and headaches (Keyes & Ryff, 2003). Chronic and recurrent forms of somatisation increase healthcare utilisation and increase disability (De Gucht & Fischler, 2002). Persistent mental health disorders often begin during childhood and can manifest as internalised and externalised behaviours in dealing with a problem – for example, in school settings (Achenbach et al., 2016; Cabaj et al., 2014). Externalisation presents as a conflict against social norms such as aggression and defiance; internalisation, in turn, reflects the person's issues with self, such as withdrawal and anxiety (Achenbach et al., 2016).

Peterson (2018) outlined different behaviours based on the children's age and developmental stage. Primary school children (6-11 years) exhibited trouble in school, changes in behaviour such as aggression, irritability, withdrawal, anger, and experiencing trouble with peers. This is in contrast to secondary school youth (12-18 years) who may display conduct problems, issues with interpersonal relationships, and a sense of guilt and responsibility for negative past events. Wilson et al. (2021) identified violence, poverty, and marginalisation as risk factors. It is important to highlight that although childhood behaviours may not meet the criteria for a clinical diagnosis, these issues could have long-term impacts on the social and emotional well-being of the affected children (Beers & De Bellis, 2002).

Children with refugee backgrounds may present with symptoms such as nightmares, sleep disturbances, withdrawal, grief, inattention, disruptive behaviours, and somatisation (Pacione, et al., 2013). These symptoms should be considered in a larger social context that includes family and community when deciding on an appropriate target intervention (Kronick, 2018).

While some literature has considered the social and emotional well-being of refugee children, there is little known about somatisation in refugee children (Rohlof, Knipscheer, and Kleber, 2014). Somatisation can be defined as the physical manifestation (symptoms) as a result of psychological distress. Wilson et al. (2021) found refugee children were at a greater risk for psychosomatic presentation and mental health issues compared to children in non-conflict-affected regions. Additionally, they found a significant reduction in resilience-enhancing resources which negatively correlated with symptoms and mental health outcomes.

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Trauma-exposed children often have difficulties with identifying, expressing, and managing their emotions. Their use of language around their emotions may also be limited and not convey how they are truly feeling. Stress responses are often externalised which could lead to explosive responses concerning stimuli and or internalised responses which could lead to significant mental health problems such as depression and anxiety. In such cases, the child may appear to be removed, while in reality, they could be responding differently than non-traumatised children to their environment such as interacting with the teacher or other peers (Peterson, 2018).

Definitions

For the purpose of this study, the various legal statuses of migrants (e.g., refugees, asylum seekers, immigrants) will not be delineated, and the population is referred to as a collective under the term "refugee". The term refugee was defined by UNHCR (2017) as

> Any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country.

Service provider in this context refers to anyone/ organisation providing services and assistance directly to refugee children and/or their families. This includes schools, migrant resource centres, and the department of education.

Culturally and Linguistically Diverse (CALD) is an umbrella term to describe communities with diverse ethnic backgrounds, traditions, nationalities, religions, languages, and societal structures (Vaughan, et al., 2015). This abbreviation will be interchangeably used for refugee communities or refugee people.

Non-clinical service providers

Often, non-clinical service providers work with refugee children in clinical capacities, e.g., organisations and agencies. Non-clinical service providers can be described as anyone who delivers services that offer resource information, screening, education, and provide support until appropriate referrals have been made to clinical services and service providers. For example, in school settings,

non-clinical services include those that provide prevention and early interventions for higher-risk students, gauge students in activities that promote good mental health and prevention for students, provide coaching, available support at the student's request, peer support, short term crisis intervention and de-escalation strategies with the ability to link students to appropriate services (Valuing Mental Health: Next Steps - Open Government, 2015). This could also include raising awareness about mental health and reducing stigma around accessing mental health support/resources, counselling services available for sub-clinical problems, and electronic self-help modules (Valuing Mental Health: Next Steps - Open Government, 2015).

To date, research has primarily focused on emotional issues in addressing mental health in refugee children, with limited literature exploring the behavioural presentations of psychological distress in the interest group of this study. Different forms of support are needed for behavioural presentations rather than emotional presentations. There is a gap in service providers' knowledge in understanding the behavioural manifestation of mental health presentations. The limited studies which exist addressing refugee children's mental health and behaviours, have included small sample sizes and have reported that behavioural manifestations vary with age and based on whether the data are self-report or parental report (Montgomery, 2008; Ceri & Narisgolu, 2018). Furthermore, there is a lack of literature that focuses on the service providers' understanding of mental health and illness in refugee children. Thus, understanding service providers' perspectives on mental health and illness is necessary, as in many cases, they are the first contacts these children have outside of their homes. A holistic approach – such as the biopsychosocial model – is also important to consider. For example, understanding the connections between biological and psychological has implications for providing preliminary help and linking children and their families and broader communities with professionals for necessary treatment and support.

Aim

This research aims to add to the limited body of research in this area and to explore how service providers understanding refugee children's behaviours, and links to mental health and well-being, incorporating a biopsychosocial lens.

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Method

Participants

The current study includes pre-existing interview data collected from individuals with previous or current experience in working with children of refugee backgrounds (at the time of the data collection). The data set consisted of nine participants including two social workers, one behavioural support specialist, three individuals who worked in the education department, one program facilitator for refugee children, one support worker/case worker, and a team leader for refugee youth services (refer to Table 1).

Table 1

Participant Demographics

Names (pseudonyms)	**Gender**	**Position**	**Experience**	**Participant's Cultural Background**
Ana	F	Teacher	9 years	Caucasian
Chelsea	F	Former Social Worker	19 years	Hispanic
Joey	M	Team Leader for refugee youth services	9 years	African
Josh	M	Support worker/Case worker	5 years	Asian
Karla	F	Social Worker	4 years	Hispanic
Matthew	M	Refugee Liaison officer	8 years	Middle Eastern
Shaban	M	Program Facilitator for refugee children	3 years	Bhutanese
Stephen	M	Behaviour Support Specialist	5 years	European
Zeke	M	Education Department	3 years	Middle Eastern

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

The age of participants ranged from 27- 58 years (M = 37.7, SD =10.41). Participants had been working with refugee backgrounds children for an average of 7.2 years (SD =5.01).

Procedure

This study received ethics approval from the University of Adelaide School of Psychology's Human Research Ethics Sub-committee (21/16). These data were originally collected by an Honours Psychology student to fulfill the research component of their degree in 2021. Participants were recruited through a convenience and snowball method of sampling. Four of the interviews were conducted via phone and five were conducted in person over a period of four months (April – August 2021). All participants were resided in the state of South Australia, Australia. The inclusion criteria required service providers to communicate proficiently in English be at least 18 years of age and have worked with children of refugee backgrounds within the past five years.

The duration of the interviews ranged between 22 to 95 minutes (M= 50.61, SD= 27.06). A semi-structured methodology of interviewing was utilised, following an iterative approach to allow for a better flow and in-depth narrative to be captured by the researcher. The primary research data included questions relating to the mental health of refugee children, behavioural issues, mental health illnesses, childhood diagnosis, and support available for refugee children. All interviews were recorded and transcribed verbatim by the interviewer.

Reflexivity

I was a refugee child, from a Middle Eastern background, who immigrated to Australia as an adult. I am a linguistic interpreter that has been working with CALD communities in various settings (e.g., early settlement, immigration matters, Centrelink, hospital, education, and housing) for the past eleven years, including working with Afghan and Iranian community groups. This background provided me with an insider perspective as both a refugee and a service provider.

Data analysis

Inductive thematic analysis was employed to analyse the transcribed data (Clarke & Braun, 2013; Tracy, 2010). The aims of the study were to explore service providers' understanding of refugee children's behaviours, and their understanding of behavioural links to mental health and well-being,

incorporating a biopsychosocial lens. Codes relating to behaviour, mental health and well-being, and the intersection of physical and psychological and social factors were organised into themes. The most appropriate and relevant extracts relating to the overall research aims were chosen for each theme. Line numbers of transcripts are provided for rigour and trustworthiness (Tracy, 2010).

Results

Overview

This study aimed to explore refugee children's behaviours through service providers' perceptive and how they linked it to mental health and well-being, encompassing a biopsychosocial lens. Codes relating to behaviour, mental health and well-being, and the intersection of physical and psychological and social were organised into themes.

Five themes were identified, namely, observable behaviours with hidden meaning, effects of trauma on behaviour, foundation of well-being: the mind-body connection, influences of cultural elements on behaviour, relationships and social connections.

Theme 1: Observable behaviours with hidden meaning.

A key feature of participants' interviews in terms of understanding behaviours was that participants were orientated towards externalisation rather than internalisation when discussing behaviour. Where participants did speak to internalized behaviours, they often spoke of children being "withdrawn" (Josh – Case/support worker) and focused on changes in behaviour. Josh (case/support worker) explained it this way:

> We could see the behavioural changes so one day they might be very friendly with us, and then the next day they may not be friendly at all or in fact, totally withdrawn. So, yeah, the behavioural problems could range. (lines 40-42)

In terms of the focus on externalisation, participants most commonly discussed aggression and violence. For example, Shaban (Program facilitator for refugees) described aggression as common in the refugee children she worked with and highlighted that aggressive behaviours would typically require extra support in the program that she works for, saying: "[aggressive behaviour is]

quite common like if someone is aggressive, they would refer to them as like, special kid." (Shaban, lines 463-464)

Other participants also identified aggressive behaviours as predominant, often linking such behaviours with psychological trauma as highlighted further in a later theme of Orientation to trauma as an explanation for refugee children's behaviour. As an example, Josh (support/case worker) also focused on aggression – as well as self-harm and attempted suicide – as stemming primarily from trauma, saying: "some of them [refugee children] would become aggressive I do remember some instances of self-harm and attempted suicide and things like that so, behavioural, all the behavioural problems were related to trauma." (Josh, lines 36-38). Karla (Social Worker) also spoke of externalised behavioural issues as a consequence of mental health issues, again trauma, specifying Post Traumatic Stress Disorder (PTSD): "[What] I've noticed the most has been like having violent kind of outbursts, or I guess having PTSD those kind of behaviours…you know, big, big emotions like crying, screaming, that kind of stuff." (Karla, lines 76-78). Here, Karla speaks of emotional regulation difficulties observed in refugee children, particularly what she terms "big emotions." When orienting to discussions of aggression and externalised behaviours, participants sometimes described these behaviours as stemming from challenges in terms of communication. For example, Stephan (Behavioural support specialist) also focused on aggression when talking about his work with unaccompanied minors within the foster-care system but highlighted that this often played out when the young people he worked with were in interactions with their carers. He noted: "there's a lot of sensitive stuff I wouldn't want to go into, but just generally, like aggressive, you know, non-compliance, like always arguing with [their] own foster carer… they are always like having a power struggle." (Stephen, lines 78-80). Similarly, Joey (Team leader for refugee youth) attributed the behavioural issues he observed to communication struggles around emotions:

> [The behaviour] is a form of expressing something that is not working well but because one doesn't have an ability to communicate in a way that is regulated well, then it comes up as problematic for those who are interacting with children. (lines 68-70)

As such, participants often discussed the importance of paying attention to children's behaviours as potential expressions of emotion they were having trouble regulating. For example, Chelsea (Former Social Worker) highlighted that internalised behaviours require looking at observable behaviour beyond how the child may present: "I think that the child, the child needs to be heard, the child's got something to say if you're saying it not verbally saying it behaviourally. We need to have a look at that." (Chelsea, lines 813-815)

Overall, when asked about their understandings of refugee children's behaviours, participants oriented to externalised rather than internalised behaviours, while also discussing the importance of paying attention to behavioural expression (e.g., in relation to emotions).

Theme 2: Effects of trauma on behaviour.

Many service providers spoke primarily about trauma in their interviews, focusing on both exposures to traumatic events and any resulting psychological trauma. For example, Josh (support/case worker) spoke frequently of trauma, including specifically in relation to being a refugee beyond other traumatic events, saying: "…I think trauma is the biggest, the trauma of being a refugee being labelled a refugee." (Josh, line 312). Other participants focused on broader experiences, noting that traumatic events in any form are likely to adversely impact the behaviour of refugee children. As an example, Joey (Team leader for refugee youth) identified trauma as the key area to focus on when considering behavioural issues. However, he highlighted that this could be any sort of trauma, with refugee-related experiences just one of many examples of that trauma:

> Trauma is the key. So, trauma, whether it's due to family violence or neglect, exposure to traumatic events, or any it could be any other biological issues, maybe a child was born with things like alcohol syndrome. So, kids who have been exposed to situations that are not conducive for a child. (lines 87-89)

As can be seen, in describing refugee children's behaviours, service providers often oriented to talking about trauma as a key explanatory device in terms of maladaptive behaviour, or behavioural issues. This was also the case in the specific case of children's development. Ana (Teacher) compared

the effects of trauma on the children's developmental state to children with generalised neurodevelopmental disorders, saying:

> …it doesn't help you if you've had trauma, because the effect of trauma on the brain is very similar to children with intellectual disabilities. So, my kids with intellectual disabilities and teaching them that's why the styles and the teaching how I would do things is very similar to how they do it in there, and how they do their programming, planning their unit, because it's, it's a different brain set. Some of these kids do come with [lots] of trauma. (lines 101-105)

Here, Ana points to the fact that "some of" the refugee children she works with have experienced significant trauma, and due to its impacts on brain development, she draws in skills from working with other groups of children requiring support such as those with intellectual disabilities. Other service providers are similarly oriented to trauma at a developmental and biological level as explanatory in terms of refugee children's behaviour. For example, Stephen (Behaviour Support Specialist) touched on the effects of trauma on not only behavioural issues but also on the developmental and learning capabilities of refugee children:

> …trauma obviously has, like a huge implication on a child's development, it literally changes their brain and changes their entire ways of thinking, ways of functioning. So, it's extremely important, you know, you can take a child with um who would be otherwise predisposed to, you know, great things whose if they, if they experience significant trauma early in their life, and they don't receive adequate support. Yeah, they will, their development will be significantly compromised. (lines 243-247)

In summary, service providers understood the types of traumas and the impacts it could have on children's presentation as a key explanation for maladaptive behaviour and specifically in terms of influencing children's development.

Theme 3: Foundations of well-being: the mind – body connection.

This theme explored service providers' understanding of the aspects that could influence both the children's mental health and well-being; this includes health behaviours such as sleep, diet,

physical activity, and social connections. Analysis also explored if participants were able to identify how each of these aspects affects their mental health and overall well-being.

When asked about social connections in children and their mental and overall well-being, Shaban (program facilitator for refugee children) reported the following by alluding to the association between social connections and physical activity.

> …I feel like they are quite isolated from other groups […] they tend to spend like, spend more time in like, you know, using tablet or like, like, access to internet […instead of] going outdoor, like [going] to parks…and doing outdoor activities. (lines 44, 42, 408, 408)

He further reported on the dangers of social exclusion and its effect on mental health. "…she was treated as a special kid. And then the problem was, other students would go for excursion, or like any like gaming's she was excluded from the team. Yeah, and then that would cause like, mental issues." (Shaban lines, 415-417)

Chelsea (former social worker) also recognised the impact of social exclusion and identified improving social inclusion and physical activity by providing a one size fits all program.

> …you develop a program in which all the children do this same activity, and they all feel inclusive. You don't do a separate program for the person who has got polio, you don't do a separate program for the person who's got autism. You do activities and programs where everyone is enclosed included in there. (lines 278-240)

Service providers displayed a level of understanding on how social exclusion can inadvertently influence a child's physical health. Another influence on children's health was explored through diet and eating habits.

> The parents there did not have a lot of time to focus on these kind of issues, because it's very difficult to put a meal on a dinner plate. So there focuses more on basically providing two or 3 meals for the kids. So they've got a bigger problems to deal with than looking at. Not that this is not a big problem. It is a big problem. But for them, feeding them is a more challenge than doing anything else. (lines 260-264)

Zeke underlined eating habits could be impacted by a lack of resources which may facilitate regular meals. Ana (teacher) added the following about diet and its impact on children.

> …if these families aren't eating at home, you can tell when a child's not bringing food in their lunch box have got nothing in their lunchbox, then you know that there's a bit of a problem… they're not eating in the morning, and they can't keep their eyes open, or they're not being able to concentrate. And all it is that you give them some toast or a toasted sandwich and a drink and things, you're better off doing that, then giving them a good start. (lines 413-415, 418-420)

Ana suggests there is an ongoing impact from the lack of food on children's ability to engage in schoolwork. Similarly sleep-related issues were also discussed as a factor influencing a child's schooling, however, there was no recognition of impact on the broader well-being "…if they're not sleeping at night, and they're coming in really, really tired, and they're not coping" (Ana, lines 212-213) she added, "…they might be having night terrors, they might be having nightmares all through the night." (Ana, lines 214-215).

Inadequate or interrupted sleep, as a result of trauma or other reasons, can negatively impact mental health and interrupt daily activities and result in somatisation of mental health.

> …he was having difficulties sleeping. And how I mean, what was his problem had to do with nightmares, and he would always run, I mean, whenever there was bombs coming in, he would always run to his parents. And his reasons for running to his parents room was to check if they're safe. And how, how that affected him and his daily functioning to me, was not as bad in as much as he was having all these headaches and stuff like that. (lines 372-377)

Further to that, another participant spoke about the mind-body connection "…you try to teach them about the body triggers, like your temperature, your, the way you're feeling and so on." (Ana, lines 409-410).

To summarise, aspects such as sleep, physical activity, a balanced diet, and social inclusion/connections are crucial to maintaining a healthy balance. Service providers showed an awareness of the various factors which could impact a child's health such as their physical exercise,

diet, and sleep. However, service providers exhibited a low understanding of how these factors may influence a child's overall wellbeing, rather they focused on specific instances of domains influencing a child's health. As the biopsychosocial model suggests these aspects all interact and influence one another and were overlooked by most service providers.

Theme 4: Influences of cultural elements on behaviour.

This theme explores service providers' views on the influence of various cultural elements (the culture children are brought up in their homes) on refugee children's behaviours. Further exploration was undertaken to understand if they believed, cultural elements had negative impacts on behaviour. As part of this exploration, discussion arose on the impacts of cultural differences on views of mental health in various CALD communities

When asked whether refugee children's cultural background influenced any issues, Joey reported the following.

> I wouldn't say culture itself, but how culture is perceived by the dominant culture can lead to some kind of resistance for kids, for young people who feel like, oh you don't seem to acknowledge the fact that I have my own culture or something like that. That can lead to situations whereby the young person will misunderstand other person who's of a different culture to them. (lines 157-160)

Joey further spoke about the cultural differences between the CALD communities and what Australians find to be the norm.

> We had a number of young people that when we talk about mental health, they'll say, 'I'm not crazy'. So, in their community, or in their cultural background, if someone goes to see someone for something that is troubling them, that's that is seen as a weakness, or crazy being crazy. So, the backgrounds that are that are informed by that kind of thinking. (Joey, 424-428)

This underlines the influence of culture on potentially seeking mental health support and defining or understanding mental health.

Other structural cultural influences were discussed by Shaban who identified gender differences and how culture may influence perceptions of mental health between girls and boys.

> It's very typical in a culture that…the girl can, like, you know, like, they come to the parents, and they can open up anything but like, boys know, we're asked to be like, act like a man, you know, you shouldn't cry, you know, you can deal with this one. And those things can have like because I grew up in those same environments for like, you know, like, long years, and then yeah, it's hard to like shift. (lines 331-335)

Josh took a similar approach when addressing structural cultural influences on behaviour of the oldest children and having greater familial responsibilities.

> …many of these kids have been the oldest kids so once they come over. There is this pressure too, you know, continue supporting the family back home, find a job. Study well. And then there is the issue of teenage, you know the normal behavioural issues which come up with teenage hormones, settling into the school, into the community such as all these multiple factors and pressures which, which plays into the behaviour problems. (lines 79-83)

While Josh explored family responsibilities impacting mental health due to cultural influence, Chelsea described the loss of connection to extended family and sometimes even close family when moving away from one home country.

> …we don't have that that system that supports the family. So, we end up talking to people that are strangers to us so our, we don't trust them...some cultures will say yes, yes. No worries, I'm fine. Because what are they going to say, they don't even know what they're talking about. So, this is the thing. It's cultural as well and I would say the African communities are very similar [to Latin culture] as well, Middle Eastern communities are the same. They come from communities, where they don't go to a psychologist with a problem, necessarily. They try to solve that within the family. (lines 506-511)

Another participant reported "…culturally, some won't let them speak to other people or won't let them have therapy because their idea of therapies are so different and it's just so you're interfering." (Ana, line 696-697).

To summarise, a variety of cultural elements were examined concerning their influence on behaviour. A few of the participants touched on mental health views in different CALD communities and some of the perspectives held by those communities. For example, in many CALD communities, being the older child can come with greater responsibilities and expectations. Similarly, gender-based norms play a major role in the determination of 'acceptable' behaviours, and many communities hold a lot of stigma and shame around mental health and do not discuss things openly.

Theme 4: Relationships and social connections.

When asked how they have supported these children and their families, the common feature mentioned by service providers conveyed their understanding regarding building and maintaining relationships. Throughout the interviews, service providers highlighted the importance of connection. Their underrotating revolved around connection with services, connection with service providers, connection with the child, and with their families.

Chelsea rose awareness regarding the mental health services available through the Child and Family Health Service (CaFHS).

> …now that the CaFHS, for example, a child health and adolescent services. There are doctors, you know that you can actually go and refer the person to, the schools, they have got, the schools have got access to certain programs that help you supporting children who have got behavioural issue. (lines 807-810)

Joey discussed connecting and utilising a holistic approach to helping the children, particularly in acknowledging their cultural background.

> I'm not sure if you've heard of Ben Denticles' quote, 'connect before, correct'. I think that is the key. However, in terms of helping the child, it is also important to take a holistic approach where, for example, you thought of not only the child, you connect also with a family, and if the schools can make sure, that makes sure that their programs acknowledge the culture of the people that they work with from refugee backgrounds. (lines 287-292)

Furthermore, he added the following.

> …you consult with a young person and then also consult with the parents, get to know the family. Because I strongly believe that it is important to realize that when it comes to any child, whether they are of refugee background, I mean of multicultural background or mainstream it is important to understand the context, the family context, and also to accept that, for them to thrive, they need, they need an environment that is conducive and supportive of their well-being. So, understanding those backgrounds, and also connecting well with their support systems is very much important. (lines 496-503)

Josh further endorsed the importance of connection-building with these children.

> …to build that therapeutic relationship or trust by and being very patient because with some of most of these clients it takes months to even get to know them and get them to trust you as well, because kids go through that trauma, the journey, and they don't know what is coming. (lines 214-127)

Stephen highlighted the importance of reconnecting people to their communities.

> …So yeah, so it's definitely I think, for refugees. It's not just about like, clinical practice, like using this therapy, using the strategy, but actually helping them connect with the community. (lines 118-120)

Lastly, Zeke (Education Department) spoke about destigmatising mental illness which remains a taboo subject amongst many CALD communities.

> …now let's go and talk to your parents at the same time and educating them that this is a reality in life. The strongest men can have this problem. And we need to basically, take that stigma away from it. (lines 160-162)

In summary, service providers highlighted methods which they found to be helpful in their experiences while working with CALD children and their families. Rapport building and the maintenance of important relationships was indicated as an integral factor to maintain prior to any therapy or support provided.

Conclusions

This explorative analysis sought to examine service providers' understanding of refugee children's behaviours and their understanding of behavioural links to mental health and well-being, through a biopsychosocial lens. This study provides important insight into service providers' understanding of not only the mental health of refugee children but also the links to of their mental health to general well-being. It has also highlighted a number of the methods used by service providers to support refugee children and their families.

Orientation towards externalisation of behaviour

Service providers showed an understanding of mental illness in refugee children through the externalisation of behaviour indicating poor mental health. This understanding may be due to service providers limited understanding of behavioural range and only being able to recognise extreme forms of behaviour such as aggression or what they deemed as "troubling behaviour". This is consistent with those reported in the literature (Hodes & Vostanis, 2018). Service providers attributed the behavioural 'issues' to be driven by experienced traumas by these children, which is consistent with previous findings (Peterson, 2018; Scharpf et al., 2021; Ayşe Soylu et al., 2020; Nadeau & Measham, 2005).

Internalised behaviours were identified however to a much lesser extent to the externalised behaviours suggesting it is a factor which remains overlooked. Identifying internalised behaviours is critical to recognise as they are detrimental to mental health and overall well-being outcomes for refugee children (Teicher, 2018). Internalised behaviours may be less obvious to view, however, they play a pivotal role in what might be influencing a child's observable behaviour. Internalised behaviour such as withdrawal and attention deficit may be indicative of mental health issues such as anxiety and depressive disorders (Fegert et al., 2018) which can exacerbate negative outcomes concurrent to pre-existing developmental delays due to various traumas and increase the potential risk for their well-being (Anagnostopoulos et al., 2016).

Somatisation of mental health was identified by one participant. It is highlighted in this paper as it is crucial somatic manifestations are not overlooked or attributed to other factors. Based on the analysis, service providers have a limited understanding of somatic symptoms, which often appear to

go unnoticed compared to displays of aggression. Betancourt et al., (2012) found that war affected refugee children suffered from behavioural issues (21.4%), traumatic grief (21.4%), generalised anxiety (26.8%), somatisation (26.8%), and posttraumatic stress disorder (30.4%); they have highlighted functional issues and comorbid conditions should be taken into consideration when working with refugee children and adolescents. Therefore, preventative and community-based interventions should include family, peer support, and school settings for improving their condition and improving their quality of life.

It must be trauma

Service providers orientated towards trauma as a way to explain the externalisation of behaviour in refugee children. This may be due to providers heightened awareness of traumatic experiences children may face. Interestingly, service providers discussed neurodevelopmental disorders such as intellectual disability instead of mental illness issues such as depression and anxiety. This may be due to the specific working backgrounds of service providers who are not within a clinical but community setting. Service providers noted externalised behaviours due to trauma impacts refugee children's development in the same way they viewed neurodevelopmental disorders. Research by Jeong et al., (2021) suggested that trauma is an important risk factor that could alter the cortical thickness in the frontal (language, executive functioning) and cingulate regions (information processing and behaviour regulation) of the brain in children.

Cultural implications and service provision

Trauma-affected children and adults are likely to respond differently to traumatic events based on their cultural norms (Ford et al., 2015; Schnyder et al., 2016). Service providers within this study also acknowledged the role and influence of cultural factors which is reflective in the literature as noted above. However, other cultural challenges within include stigma and shame associated with seeking mental health support; this could be viewed as challenging while working with a service provider from diverse cultural/ethnic backgrounds (Gharibian & McCarty-Caplan, 2022).

Service providers referred to one common element prior to engaging in any form of therapy. The common denominator was building connections and maintaining them before being able to even

offer any provisions or linking CALD persons with the appropriate services. This was mirrored in the literature (Majumder, et al., 2019). Developing rapport and building a therapeutic alliance is the most pivotal aspect prior to providing any psychological services (Brown et al., 2016). Therefore, the service providers mirrored the literature (Hodes et al., 2018) and highlighted their understanding of working with CALD communities, based on their individual experiences and professional capacity. This related to the social aspect of the biopsychosocial frameworks and highlights the importance of the quality of social component of the model.

Next step for service providers – recommendations

Principles that should be considered for guidelines: There are leading psychological therapies designed for refugee children, however, they are currently not accessing the right supports when needed. It is important to understand how non-clinical service providers could help these children, particularly through the process of identifying the needs of the child. Early intervention is key and the ability to recognize and link CALD children and their families to the appropriate services could be paramount for their mental health as well as their overall well-being with respect to the biopsychosocial model and holistic approach to health. All service providers, including schoolteachers may be a pivotal resource to identify issues in children through undertaking outreach training such as mental health first aid training to broaden their understanding of mental health and behaviours in refugee children. It is best practice for all service providers to be employing trauma informed and culturally aware frameworks to provide the best possible service provision within their respective areas of work. In the above section, participants described an understanding that cultural differences create variabilities in perspectives towards mental health and illnesses which impact the connect and communication with refugee children and their families regarding this topic. It would be recommended that service providers engage in continuous cultural development and learning, as attending ad-hoc one-day conferences do little to support service providers competency or develop cultural authenticity.

Strengths and implications of the study

A qualitative method of data collection is a strength of the study as it aligns with the aim, allowing participants to freely describe and provide rich descriptive information regarding their understanding as service providers. Recruited participants represented a range of culturally and linguistically diverse communities including individuals who were once refugees themselves, allowing them to draw on their individual experiences as well. Participants represented a broad range of experiences in working with refugee children across various settings, including social workers, schoolteachers, and community officers. The implications of this study strongly suggest while service providers have some knowledge regarding the influences on refugee children's mental health, there are still substantial gaps in their knowledge and ability to recognise children's mental health difficulties. Furthermore, this study indicates service providers are able to consider various biopsychosocial factors which could be contributing to a child's mental health. However, it was highlighted service providers had little understanding of this could influence a child's overall wellbeing as well.

Challenges and limitations

The participants were recruited by snowball and convenience methods, which may not be generalised to other areas of practice – such as service providers who work in clinical settings. Similarly, service providers may have shared perspectives dominant from there area work, for example teachers understanding may be different to a community leader understanding. Similarly, the difference in service providers years of experience may have contributed to the level of understanding which may come from experience with working with refugee children. Another limitation of this study is the biopsychosocial model was not applied during the development of the questions for the semi-structured interviews. As a result, participants were not directly asked about their understanding regarding somatisation and the biopsychosocial model. This may have influenced the responses given by participants as that could have elicited different understanding of mental health and illness if the questions were designed from a biopsychosocial framework.

Future Directions

As established by this study, there is a large gap in knowledge and literature of non-clinical service providers' understanding of working with refugee children. Future research should aim to include a larger population across Australia, and endeavour to represent a more diverse range of professionals for a more in-depth understanding of their perspectives. This study hopes to provide a foundation on the current understandings contributing to the literature and enabling the creation a standardised guideline that is trauma-informed and culturally authentic as a tool to provide more support to people who are supporting refugee children and their families.

Culturally and linguistically diverse communities are not homogenous groups, therefore, it could be of benefit for future research to focus on ethnocultural groups and gain a more in-depth understanding of the challenges they may have faced. This would allow refugees experiences to guide future guidelines or programs to support service providers understanding of refugee children's mental health.

Conclusion

Refugee children are at a higher risk of being affected by mental illnesses due to pre-and post-immigration traumas. Often the first line of service providers who have the opportunity to work with these children and recognise the symptoms of mental health illness are those who do not work in clinical settings and have limited knowledge and understanding of refugee children's behaviours. Thus, mental illness can easily be overlooked as adjustment issues, neurodevelopmental conditions, or attributed to other external factors. Applying a biopsychosocial lens, this research has found that there are gaps in knowledge and a low baseline of recognition of mental illness misestimations in refugee children amongst non-clinical service providers. Early recognition and intervention reduce the risk of the development of serious mental illnesses in the future that could negatively impact the overall well-being of refugee children.

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

References

Achenbach, T. M., Ivanova, M. Y., Rescorla, L. A., Turner, L. V., & Althoff, R. R. (2016). Internalizing/Externalizing problems: Review and recommendations for clinical and research applications. *Journal of the American Academy of Child & Adolescent Psychiatry*, *55*(8), 647-656. https://doi.org/10.1016/j.jaac.2016.05.012

Anagnostopoulos, D. C., Heberbrand, J., Eliez, S., Doyle, M. B., Klasen, H., Crommen, S., Cuhadaroğlu, F. C., Pejovic-Milovancevic, M., Herreros, O., Minderaa, R., Karwautz, A., Svedin, C. G., & Raynaud, J. P. (2016). European Society of Child and Adolescent Psychiatry: position statement on mental health of child and adolescent refugees. *European Child & Adolescent Psychiatry*, *25*(7), 673–676. https://doi.org/10.1007/s00787-016-0882-x

Ayşe Soylu, Ahmet Kaysili, & Sever, M. (2020, January 22). *Refugee Children and Adaptation to School: An Analysis through Cultural Responsivities of the Teachers*. ResearchGate; Türk Eğitim Derneği. https://www.researchgate.net/publication/338760686_Refugee_Children_and_Adaptation_to_School_An_Analysis_through_Cultural_Responsivities_of_the_Teachers

Beers, S. R., & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *American Journal of Psychiatry*, *159*(3), 483–486. https://doi.org/10.1176/appi.ajp.159.3.483

Betancourt, T. S., Newnham, E. A., Layne, C. M., Kim, S., Steinberg, A. M., Ellis, H., & Birman, D. (2012). Trauma history and psychopathology in war-affected refugee children referred for trauma-related mental health services in the United States. *Journal of Traumatic Stress*, *25*(6), 682–690. https://doi.org/10.1002/jts.21749

Brown, C. J., S, C., Romano, J., & Engel, G. (2011). *Biopsychosocial model approach definition* (pp. 1–2). https://www.urmc.rochester.edu/medialibraries/urmcmedia/education/md/documents/biopsychosocial-model-approach.pdf

Brown, F. L., de Graaff, A. M., Annan, J., & Betancourt, T. S. (2016). Annual Research Review: Breaking cycles of violence - a systematic review and common practice elements analysis of psychosocial interventions for children and youth affected by armed conflict. *Journal of Child Psychology and Psychiatry*, *58*(4), 507–524. https://doi.org/10.1111/jcpp.12671

Clarke, V., & Braun, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*. ResearchGate; Sage. https://www.researchgate.net/publication/256089360_Successful_Qualitative_Research_A_Practical_Guide_for_Beginners

De Gucht, V., & Fischler, B. (2002). Somatization: A Critical Review of Conceptual and Methodological Issues. *Psychosomatics*, *43*(1), 1–9. https://doi.org/10.1176/appi.psy.43.1.1

Fazel, M, Stein, A., (2002). The mental health of refugee children. *Archives of Disease in Childhood*; *87*:366-370.

Fegert, J. M., Diehl, C., Leyendecker, B., Hahlweg, K., & Prayon-Blum, V. (2018). Psychosocial problems in traumatized refugee families: overview of risks and some recommendations for support services. *Child and Adolescent Psychiatry and Mental Health*, *12*(1), Article 5 (2018). https://doi.org/10.1186/s13034-017-0210-3

Ford, J. D., Grasso, D. J., Elhai, J. D., & Courtois, C. A. (2015). Social, cultural, and other diversity issues in the traumatic stress field. *Posttraumatic Stress Disorder*, *11*(2), Article 5(2018), 503–546. https://doi.org/10.1016/b978-0-12-801288-8.00011-x

Gharibian, T., & McCarty-Caplan, D. (2022). Bonds and barriers: Mental Health, service provision, and Middle Eastern/North African cultural identity in the U.S. *Qualitative Social Work*, *0*(0). 147332502211088. https://doi.org/10.1177/14733250221108829

Griffin, D. A. (2018). *About refugees*. The National Child Traumatic Stress Network. https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma/about-refugees

Guajardo, M. G. U., Slewa-Younan, S., Kitchener, B. A., Mannan, H., Mohammad, Y., & Jorm, A. F. (2018). Improving the capacity of community-based workers in Australia to provide initial assistance to Iraqi refugees with mental health problems: An uncontrolled evaluation of a

mental health literacy course. *International Journal of Mental Health Systems*, *12*(1), 1–13. doi:10.1186/s13033-018-0180-8

Hamrah, M. S., Hoang, H., Mond, J., Pahlavanzade, B., Charkazi, A., & Auckland, S. (2020). The prevalence and correlates of symptoms of post-traumatic stress disorder (PTSD) among resettled Afghan refugees in a regional area of Australia. *Journal of Mental Health*, *30*(6), 674–680. https://doi.org/10.1080/09638237.2020.1739247

Hodes, M. (2000). Psychologically distressed refugee children in the United Kingdom. *Child Psychology and Psychiatry Review*, *5*(2), 57-68. https://doi.org/10.1017/s136064170000215x

Hodes, M., & Vostanis, P. (2018). Practitioner Review: Mental health problems of refugee children and adolescents and their management. *Journal of Child Psychology and Psychiatry*, *60*(7), 716–731. https://doi.org/10.1111/jcpp.13002

Hodes, M., Anagnostopoulos, D., & Skokauskas, N. (2018). Challenges and opportunities in refugee mental health: clinical, service, and research considerations. *European Child & Adolescent Psychiatry*, *27*(4), 385–388. https://doi.org/10.1007/s00787-018-1115-2

Jeong, H. J., Durham, E. L., Moore, T. M., Dupont, R. M., McDowell, M., Cardenas-Iniguez, C., Micciche, E. T., Berman, M. G., Lahey, B. B., & Kaczkurkin, A. N. (2021). The association between latent trauma and brain structure in children. *Translational Psychiatry*, *11*(1), Article 240 (2021). https://doi.org/10.1038/s41398-021-01357-z

Keyes, C. L. M., & Ryff, C. D. (2003). Somatization and mental health: A comparative study of the idiom of distress hypothesis. *Social Science & Medicine*, *57*(10), 1833–1845. https://doi.org/10.1016/s0277-9536(03)00017-0

Kronick R. (2018). Mental Health of Refugees and Asylum Seekers: Assessment and Intervention. *Canadian Journal of Psychiatry*, *63*(5), 290–296. https://doi.org/10.1177/0706743717746665

Li, S. S., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. *Current Psychiatry Reports*, *18*(9), Article 82 (2016). https://doi.org/10.1007/s11920-016-0723-0

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Lipowski, Z. J. (1987). Somatization: The Experience and Communicatiosn of Psychological Distress as Somatic Symptoms. *Psychotherapy and Psychosomatics*, *47*(3-4), 160–167. https://doi.org/10.1159/000288013

Majumder, P., Vostanis, P., Karim, K., & O'Reilly. M., (2019) Potential barriers in the therapeutic relationship in unaccompanied refugee minors in mental health, *Journal of Mental Health*, *28(4)*, 372-378, DOI: 10.1080/09638237.2018.1466045

McMahon, S. D., Grant, K. E., Compas, B. E., Thurm, A. E., & Ey, S. (2002). Stress and psychopathology in children and adolescents: is there evidence of specificity? *Journal of Child Psychology and Psychiatry*, *44*(1), 107–133. https://doi.org/10.1111/1469-7610.00105

Montgomery, E. (2008). Self- and parent assessment of mental health: Disagreement on externalizing and internalizing behaviour in young refugees from the Middle East. *Clinical Child Psychology and Psychiatry*, *13*(1), 49-63. https://doi.org/10.1177/1359104507086341

Mulraney, M., Coghill, D., Bishop, C., Mehmed, Y., Sciberras, E., Sawyer, M., Efron, D., & Hiscock, H. (2021). A systematic review of the persistence of childhood mental health problems into adulthood. *Neuroscience & Biobehavioral Reviews*, *129*, 182–205. https://doi.org/10.1016/j.neubiorev.2021.07.030

Nadeau, L., & Measham, T. (2005). Immigrants and mental health services: increasing collaboration with other service providers. *The Canadian Child and Adolescent Psychiatry Review*, *14*(3), 73–76. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2542908/

Neuner, F., Schauer, M., Karunakara, U., Klaschik, C., Robert, C., & Elbert, T. (2004). Psychological trauma and evidence for enhanced vulnerability for posttraumatic stress disorder through previous trauma among West Nile refugees. *BMC Psychiatry*, *4*(1), Article 34 (2004). https://doi.org/10.1186/1471-244x-4-34

Pacione, L., Measham, T., & Rousseau, C. (2013). Refugee children: mental health and effective interventions. *Current Psychiatry Reports*, *15*(2), Article 341(2013). https://doi.org/10.1007/s11920-012-0341-4

Peterson, S. (2018, February). *Effects*. The National Child Traumatic Stress Network. https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma/effects

Porter, M., & Haslam, N. (2001). Forced displacement in Yugoslavia: A meta-analysis of psychological consequences and their moderators. *Journal of Traumatic Stress*, *14*(4), 817–834. https://doi.org/10.1023/a:1013054524810

Rohlof, H.G., Knipscheer, J.W. & Kleber, R.J. Somatization in refugees: a review. Soc Psychiatry Psychiatr Epidemiol 49, 1793–1804 (2014). https://doi.org/10.1007/s00127-014-0877-1

Scharpf, F., Kaltenbach, E., Nickerson, A., & Hecker, T. (2021). A systematic review of socio-ecological factors contributing to risk and protection of the mental health of refugee children and adolescents. *Clinical Psychology Review*, *83*, 101930. https://doi.org/10.1016/j.cpr.2020.101930

Schneiderman, N., Ironson, G., & Siegel, S. D. (2005). Stress and Health: Psychological, Behavioral, and Biological Determinants. *Annual Review of Clinical Psychology*, *1*(1), 607–628. https://doi.org/10.1146/annurev.clinpsy.1.102803.144141

Schnyder, U., Bryant, R. A., Ehlers, A., Foa, E. B., Hasan, A., Mwiti, G., Kristensen, C. H., Neuner, F., Oe, M., & Yule, W. (2016). Culture-sensitive psychotraumatology. *European Journal of Psychotraumatology*, *7*(1), 31179. https://doi.org/10.3402/ejpt.v7.31179

Shaw, J. A. (2003). Children Exposed to War/Terrorism. *Clinical Child and Family Psychology Review*, *6*(4), 237–246. https://doi.org/10.1023/b:ccfp.0000006291.10180.bd

Silove, D., Austin, P., & Steel, Z. (2007). *No refuge from terror: The impact of detention on the mental health of trauma-affected refugees seeking asylum in Australia*. *Transcultural Psychiatry*, *44*(3), 359–393. https://doi.org/10.1177/1363461507081637

Steel, Z., Silove, D., Phan, T., & Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: a population-based study. *The Lancet*, *360*(9339), 1056–1062. https://doi.org/10.1016/s0140-6736(02)11142-1

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Taylor, E. M., Yanni, E. A., Guterbock, M., Pezzi, C., Rothney, E., Harton, E. et al. (2014). Physical and mental health status of Iraqi refugees resettled in the United States. *Journal of Immigrant and Minority Health, 16*(6), 1130–1137. doi:10.1007/s10903-013-9893-6

Teicher, M.H. (2018). Childhood trauma and the enduring consequences of forcibly separating children from parents at the United States border. BMC Medicine,16, 146.

The Effects of Parental Divorce During Childhood on College Students. (2022). Journal of Divorce & Remarriage. https://www.tandfonline.com/doi/abs/10.1300/J087v38n01_08

The WHO World Mental Health Survey Consortium. (2004). Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys. *JAMA*, *291*(21), 2581. https://doi.org/10.1001/jama.291.21.2581

Tracy, S. J. (2010). Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative Research. *Qualitative Inquiry*, *16(10)*, 837–851. https://doi.org/10.1177/1077800410383121

United Nations High Commissioner for Refugees. (n.d.). *UNHCR Resettlement Handbook and Country Chapters*. UNHCR. https://www.unhcr.org/protection/resettlement/4a2ccf4c6/unhcr-resettlement-handbook-country-chapters.html

Valuing mental health: next steps - Open Government. (2015). Alberta.ca. https://open.alberta.ca/publications/9781460134771

Vaughan, C., Davis, E., Murdolo, A., Chen, J., Murray, L., Block, K., & Quiazon, R., & Warr, D. (2015). *Promoting community-led responses to violence against immigrant and refugee women in Metropolitan and Regional Australia: The Aspire Project: (State of Knowledge Paper 7): Semantic scholar*. https://www.semanticscholar.org/paper/Promoting-community-led-responses-to-violence-and-Vaughan-Davis/9101ad11157130d743cb1880e8a5742ed80e6555

Weiss, B., Tram, J. M., Weisz, J. R., Rescorla, L., & Achenbach, T. M. (2009). Differential symptom expression and somatization in Thai versus U.S. children. *Journal of Consulting and Clinical Psychology, 77*(5), 987–992. https://doi.org/10.1037/a0016779

Service Providers' Understanding of Mental Illness in Refugee Children: Applying a Biopsychosocial Approach.

Wilson, N., Turner-Halliday, F., & Minnis, H. (2021). Escaping the inescapable: Risk of mental health disorder, somatic symptoms, and resilience in Palestinian refugee children. *Transcultural Psychiatry*, 58(2), 307–320. https://doi.org/10.1177/1363461520987070

Appendix A

Author Guidelines

Author Guidelines

1. SUBMISSION

PLEASE NOTE SUBMISSIONS TO AUSTRALIAN PSYCHOLOGIST ARE NO LONGER ACCEPTED THROUGH WILEY. Please refer to the Editorial Office contact below.

The submission system will prompt you to use an ORCiD (a unique author identifier) to help distinguish your work from that of other researchers. Click **here** to find out more.

2. MANUSCRIPT TYPES AND WORD LENGTH

Australian Psychologist accepts new and continuing empirical reports (quantitative/qualitative/case study). Reports must be completed to a high standard and relevant to psychological practice, health policy, and journal readership. *Australian Psychologist* publishes commentaries and response to commentaries of articles appearing in the journal.

Submission word limits include all materials i.e. title page, manuscript, references, tables, and figures. i.e.
Quantitative reviews (8000 words)
Narrative reviews (5000 words)
Commentaries (6000 words)
Case Studies (4000 words)

3. STYLE

Manuscripts must follow the American Psychological Association's publication style guidelines (6th ed.), except regarding spelling. *Australian Psychologist* uses Australian spelling - please follow the latest edition of The Macquarie Dictionary (3rd ed. Rev.). All articles published by the journal are in English.

4. MANUSCRIPT REQUIREMENTS

The following relates to quantitative and/or qualitative research, and Case Studies. Hypothesis in this context relates to research questions and hypotheses.

Empirical Reports

Empirical Reports submitted to *Australian Psychologist* must adhere to
(i) Journal Article Reporting Standards (JARS) guidelines for reporting psychological research reports and
(ii) Meta-Analysis Reporting Standards (MARS) guidelines for reporting meta-analyses (i.e., Appendix of APA Publication Manual, **http://www.apastyle.org/manual/related/JARS-MARS.pdf**).
Consistent with the American Psychological Association (6th ed.) publication guidelines, JARS and MARS guidelines provide a data reporting standard to ensure readers have appropriate information to evaluate findings' importance. Authors describing other review methodologies should also comply with JARS and MARS guidelines wherever possible.

Manuscripts should be presented as:
separate title page
abstract and key words, text, key points, acknowledgments, references, appendices, endnotes, tables with title and footnotes, and figures.

Text footnotes are not allowed – please use endnotes.

Note for qualitative research, the method, results and discussion sections may differ from directions d), e), and f) below as specified in the section entitled Qualitative Research.

a) **Title page**: Submissions are subject to anonymous peer review. Author details must not appear in your manuscript, but should appear in a separate Title Page containing (i) manuscript title (ii) running head (40 characters), and (iii) manuscript date. The title should be short, informative, contain the major key words and variables under investigation. Please do not use abbreviations in the title.

b) **Abstract**: *Australian Psychologist* manuscripts must include a 200 – 250-word abstract, structured to these headings: **Objective**, **Method**, **Results**, and **Conclusions**. Six key words for indexing should be placed after the abstract, in alphabetical order.

c) **Introduction**: *Australian Psychologist* will only accept manuscripts with data/research supporting the conceptual and theoretical positions. Please:

- outline the problem's importance, and theoretical and practical implications;
- provide a comprehensive, up-to-date literature review and critique using the best forms of evidence;
- state how present research differs from previous research;
- specify research aims, hypotheses or research questions;
- describe how theory was used to derive hypotheses or research questions; and how the research design and hypotheses relate.

d) **Method**: The method section of quantitative and qualitative reports must contain a detailed account of measures/procedures to ensure reader understanding/replication. The method should describe:

- the participant characteristics and any inclusion/exclusion criteria; demographic variables and any topic-specific characteristics;
- sampling procedures used for selecting participants, including information regarding the sampling method, percentage of sample approached that participated;
- where the data were collected (e.g., within the workplace, clinic, private practice, off-site setting e.g. independent office, via post, etc.);
- any conditional requirements for participation such as payment of participants, agreement to provide study results, entry into a prize raffle; informed consent;

- ethical approval statement; intended and actual sample size and power analyses used to determine sample size;
- all study instruments used, including those that are not being reported within the present study; interview transcripts, where relevant;
- whether parts of the database have been previously published or are being published separately; psychometric or biometric information on measures, where relevant; assignment method; and statistical analyses procedures.

Australian Psychologist retains the right to reject any manuscript on the basis of unethical conduct in research.

e) **Results**: For quantitative studies, *Australian Psychologist* requires adequate reporting of statistical significance of results. Please report means, standard deviations, and confidence intervals for all continuous study variables and the effect sizes for the primary study findings. If effect sizes are not available, please include this in your submission cover letter. Please report confidence intervals for any effect sizes involving principal outcomes.

This section should include participant flow (i.e., total number of participants, flow of participants through each stage of the study); recruitment, dates of the recruitment period and any repeated measures of follow-up assessments; all information regarding statistical analyses, including problems with assumptions or distributions that could affect findings validity, any missing data (including percentages or frequencies, theories regarding the cause of missing data and whether it is missing at random, and methods used to address missing data); information regarding cases deleted from any primary or secondary analysis, subgroup or cell sample sizes, means, standard deviations, and other descriptive statistics, and effect sizes and confidence intervals; information regarding the error rate adopted for inferential statistics and the direction, magnitude, degrees of freedom, and exact p level; variance-covariance matrix or matrices associated with multivariate analytic systems; estimation problems; the statistical software program used, information surrounding other analyses (e.g., exploratory analyses); and a discussion of implication of ancillary analyses for statistical error rates.

f) **Discussion**: For quantitative reports, this section requires a support or non-support statement for all hypotheses and how these were assessed (i.e., primary or secondary analyses, or post hoc explanations); similarities or differences between results and those in previous research; an interpretation of results accounting for any sources of bias and threats to validity, the imprecision of measures, the overall number of tests and the overlap among tests, and limitations or weaknesses of the study; generalisability of findings accounting for the target population and any contextual issues; and a discussion surrounding the implications for future research, programs, or policies. Please discuss study sample diversity and the generalisability of findings.

g) **Key Points**: Please include 6 key points: 3 Key Points for "what is already known about this topic" and 3 Key Points for "what this topic adds" in your manuscript. Please place the Key Points after the key words in the manuscript, and write your Key Points with a practitioner audience in mind.

i) **Acknowledgements**: The source of financial grants and other funding must be acknowledged, including a declaration of authors' industrial links and affiliations. Colleague or institutions contributions should also be acknowledged. Personal thanks are not appropriate.

j) **References**: All referencing, footnotes, tables and figures must be prepared according to the Publication Manual of the American Psychological Association requirements (currently 6th ed.). This includes Digital Object Identifiers (DOI's) wherever available.

APA – American Psychological Association

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. For more information about APA referencing style, please refer to the **APA FAQ**. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page one.

Journal article

Example of reference with 2 to 7 authors

Beers, S. R. *, &* De Bellis, M. D. *(*2002*)*. Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry, 159,* 483–486.https://doi:10.1176/appi.ajp.159.3.483

Ramus, F., Rosen, S., Dakin, S. C., Day, B. L., Castellote, J. M., White, S., & Frith, U. (2003). Theories of developmental dyslexia: Insights from a multiple case study of dyslexic adults. *Brain*, *126*(4), 841–865. https://doi: 10.1093/brain/awg076

Example of reference with more than 7 authors

Rutter, M., Caspi, A., Fergusson, D., Horwood, L. J., Goodman, R., Maughan, B., … Carroll, J. (2004). Sex differences in developmental reading disability: New findings from 4 epidemiological studies. *Journal of the American Medical Association*, *291*(16), 2007–2012. https://doi: 10.1001/jama.291.16.2007

k) **Endnotes** must appear as a numbered list at the end of the manuscript, not the foot of each page. Endnotes should be referred to with consecutive, superscript Arabic numerals in the text. They should be brief, containing short comments tangential to the paper's main argument, and not include references.

l) Please place **Appendices** at the end of the manuscript, numbered in Roman numerals and referred to in the text.

m) **Tables** should be self-contained and complement not duplicate, text information. Number tables consecutively in the text using Arabic numerals. Include tables on a separate page with concise but comprehensive legend information above. The table, legend and footnotes should be understandable without reference to the text. Please do not use vertical lines to separate columns. Use brief column headings, with units of measurement in parentheses; define all abbreviations in table footnotes. Use Footnote symbols: †, ‡, §, ¶, (in that order). Reserve *, ** and *** for p values. Identify statistical measures e.g. M, SD, SEM in the headings using appropriate statistical notation outlined in the Publication Manual of the American Psychological Association (6th ed.).

n) **Figure Legends**. Legends should be concise but comprehensive – the figure and legend must be understandable without reference to the text. Define any symbols used as well as abbreviations and units of measurement.

Preparing Figures: Although we encourage authors to publish the highest-quality figures possible, for peer-review purposes we can accept a wide variety of formats, sizes, and resolutions.

Click here for basic figure requirements for initial peer review, and high-resolution publication figure requirements.

Colour Figures: Figures submitted in colour may be reproduced in colour online free of charge. Please note it is preferable to supply line figures (e.g. graphs and charts) in black and white so they remain legible if printed by a reader in black and white. If you wish to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

Qualitative Reports

Qualitative research encompasses various paradigms for reporting primarily textual data. Although visual and graphical data are increasingly included in qualitative research. *Australian Psychologist* requires high standards of research and reporting to ensure research quality and social relevance of findings and interpretations. Although there are differences in the conduct of research between qualitative and quantitative research, there are similarities in reporting. Respect for participants is paramount.

Important publication factors include:

a) Research quality achieved through open-ended, meaningful questions to achieve rich responses. In the case of deductive logic, seeking disconfirmation, rather than confirmation, of theory/hypotheses;
b) The depth and length of interview/focus group data, describing data collection method/s (i.e., open-ended, flexible format; structured interview with pre-determined set of questions);
c) The variety of evidence, sampled from multiple and different participants and use of other data forms where relevant (i.e., field notes, site documents, participant observation;
d) The use of data sources quotes/excerpts; and
e) Attention to rigour via credibility checks, attending to findings trustworthiness/dependability, authors perspective/reflexivity, and a description of context to allow transferability of findings assessments. Refer to Empirical Reports sections (a) title page, (b) abstract, and (g) to (n) for further specifications on manuscripts.

Case Studies

Australian Psychologist values Case Studies as an important aspect of psychological practice development, adding depth to practitioner's knowledge and skill. Case Studies develop theory and practice, and extend upon empirical work in psychological practice, including individual clients, groups, or organisations. Please provide an objective account of the case, related variables, diagnostic features, interventions observed and measured effects, and any possible alternative explanations for observed variables. Give careful attention to ethical and legal considerations of reporting Case Studies, and abide by the Australian Psychological Society's *Code of Ethics*. Case Studies must include a statement that written informed consent was obtained from the subject/s. All efforts must be taken to anonymise/exclude demographic/identifying information less relevant to case presentation (e.g., employment type, location, gender, age, ethnicity, cultural identification). Where subject/s are under 18, the statement must show consent from legal guardians for Case Study procedure and publication.

Case Studies presentation should contain:

a) Case Context and Method: including case selection rationale, methodological strategies used to enhance study rigour, Case Study setting information, and confidentiality.

b) Practitioner Description: including demographic information, theoretical orientation, educational attainment, and relevant experience.

c) Client/s Description: including demographic/diagnostic information; case conceptualisation, including client's problems, goals, strengths, and history. Note: 'client' refers to individual clients, groups, communities, or organisations.

d) Formulation: a link between guiding conceptions of the client and previous research publications and the psychologist's previous practical experience.

e) Course of psychological service, including information on the alliance and relationship built between client and psychologist, assessment, intervention, and description of any strains encountered in the professional relationship with the consulting psychologist. Other useful information includes interactions between client and psychologist, interventions and strategies the psychologist used and client reaction (the best method being transcripts of important interactions).

f) Monitoring of psychological service and use of feedback information: if feedback was used, the report should consist of; i) psychologist completed and self-report questionnaires, ii) peer feedback, iii) psychologist self-reflection, and iv) feedback from professionals who have previously or concurrently worked with the client (consistent with the Australian Psychological Society's Code of Ethics). Case studies without appropriate evaluation of psychological services (i.e., using psychometrically based assessments) cannot be published.

g) Concluding evaluation of the outcome of service and its process: including information on reaching client goals and alleviating presenting problems at conclusion of service/follow-up, strengths and weaknesses of the approach, and funding issues. Discussion of the case in relation to previously reported cases, research and theory, and possible hypotheses or recommendations for practice should also be included.

Case Studies must follow *Australian Psychologist*'s standard publication submission format (ie title page, abstract, reference list, tables, figures). Refer to *Empirical Reports* sections (a) title page, (b) abstract, and (g) to (n) for further specifications on manuscripts.

Reviews (Quantitative and Narrative)

Review Articles provide research summation on specific issues/questions relevant to *Australian Psychologist* readers: general clinical practice, specialty practice, or public health. Review Articles should provide subject matter scope, background, and practice relevance, while describing recent empirical research, and conceptual and theoretical papers. Systematic reviews are preferred to narrative reviews, which may be published circumstantially. Please include the best-quality evidence (e.g., randomised controlled trials and meta-analyses). Novel findings may be included when especially relevant and justified. Include an impartial discussion surrounding the evidence and any controversies within the research. If using unpublished data, a source must be provided (e.g., registered trial, unpublished doctoral dissertation, etc.).

Review Article length may vary substantially according to size of research domain and issue. Narrative reviews must not exceed 5000 words, including references, tables, and figures. Quantitative reviews must not exceed 8000 words, including references, tables, and figures. Review Abstracts must include information on the context and relevance of the research, how review evidence was obtained

(i.e., databases/years searched, search terms), exclusion criteria, findings/conclusions drawn, and implications for psychological practice.

Refer to *Empirical Reports* sections (a) title page, (b) abstract, and (g) to (n) for further specifications on manuscripts.

Commentaries (and Response to Commentaries)

Australian Psychologist publishes Commentaries on previously published journal articles. Commentaries have a 6000 word limit, including all materials. A Commentary's purpose is to provide meaningful insight, alternative interpretation, clarification, or critical analysis. Commentary publication provides comprehensive issue understanding that significantly adds to the literature. Commentaries that focus on issues such as small sample size or statistical power alone rather than provide substantial critique will not be considered for publication. Commentaries must maintain a constructive and respectful tone.

All Commentaries (and responses) require an unstructured abstract stating major points and principal conclusions (200-250 words).

The Commentary title includes a subtitle reflecting the title and publication year of the article that engendered the comment, e.g. "Comment on A Model for Increasing Youth Engagement in Education (Smith & Jones, 2014)."

The original article author/s may be invited to respond to Commentary accepted for publication. The Commentary and Response/s may be published together, subject to the timely delivery of comments and journal space. Invited Responses should be no longer than half the Commentary's length.

Supporting Information

Supporting Information is non-essential article information that provides depth and background. Supporting information only appears online, without editing or typesetting. It may include tables, figures, videos, datasets, etc. **Click here** for Wiley's FAQs on supporting information.

Note, if data, scripts or artefacts used to generate article analyses are publicly available, authors must include a location reference within the paper.

Wiley Author Resources

Wiley author resources for manuscript submission preparation are here. Wiley's best practice tips on **Writing for Search Engine Optimization**.

Article Preparation Support: **Wiley Editing Services** offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence. Also, check out our resources for **Preparing Your Article** for general guidance about writing and preparing your manuscript.

5. EDITORIAL CONSIDERATIONS AND POLICIES

Peer Review

Acceptance criteria for all papers are research quality and originality, and significance to our readership. Manuscripts are double-blind peer reviewed by two anonymous reviewers and the Editor. Final acceptance or rejection rests with the Editorial Board, who reserves the right to refuse any material for publication.

Manuscripts should have a clear, concise, direct writing style. Where contributions are judged as acceptable for publication on the basis of content, the Editor and the Publisher reserve the right to modify typescripts to eliminate ambiguity and repetition and improve communication between author and reader.

Human Studies and Subjects

For medical studies manuscripts involving human participants, we require a statement identifying the approving ethics committee, and that the study conforms to recognized standards, for example: **Declaration of Helsinki**; **US Federal Policy for the Protection of Human Subjects**; or **European Medicines Agency Guidelines for Good Clinical Practice**. Individual participant images and information will only be published where authors have the individual's free prior informed consent. Non-essential identifying details should be omitted.

Conflict of Interest Statement

The journal requires authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that can be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly or indirectly related to work authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to, patent or stock ownership, committee/advisory/company board of directors membership, company consultancy, or receipt of speaker's fees from a company. Please note the existence of a conflict of interest does not preclude publication. It is the corresponding author's responsibility to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Data policy

The APS encourages data sharing wherever possible, and subscribes to the **Australian Code for the Responsible Conduct of Research**. The code states "Research data should be made available for use by the other researchers unless this is prevented by ethical, privacy or confidentiality matters." Authors publishing in the journal are encouraged to make data/scripts/other artefacts used to generate their analyses available via a publicly available data repository, however this is not mandatory. If the study includes original data, at least one author must confirm they had full access to all study data, and takes responsibility for data integrity and analysis accuracy.

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://**authorservices.wiley.com/statements/data-protection-policy.html**

Authorship and Acknowledgements

The submitting author ensures all listed authors are eligible for authorship. Each author takes responsibility for: substantial contributions to the conception or design of the work; the data acquisition, analysis, or interpretation of the work, drafting the work or revising it critically for important intellectual content AND final approval of the version to be published AND agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Contributions from anyone who does not meet the criteria for authorship should be listed in the Acknowledgments section, with their permissions. The Acknowledgments section For example, to recognize contributions from people who provided technical help, collation of data, writing assistance, acquisition of funding, or a department chairperson who provided general support).

Publication Ethics

Australian Psychologist is a member of the **Committee on Publication Ethics (COPE)**. The journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read our Top 10 Publishing Ethics Tips for Authors **here**. Wiley's Publication Ethics Guidelines can be found at **https://authorservices.wiley.com/ethics-guidelines/index.html**

6. AUTHOR LICENCING

If your paper is accepted, the formal corresponding author will receive an email directing them to Wiley Author Licensing Service (WALS) to complete a copyright license agreement on behalf of all authors.

Authors may choose to publish under the terms of the journal's standard copyright agreement, or under the terms of a Creative Commons License (OnlineOpen).

General information regarding licensing and copyright is available **here**. To review the Creative Commons License options offered under OnlineOpen, please **click here**. (Note that certain funders mandate that a particular type of CC license has to be used; to check this please **click here**.)

Self-Archiving definitions and policies. Note that the journal's standard copyright agreement allows for self-archiving of different versions of the article under specific conditions. Please click **here** for information about self-archiving definitions and policies.

Open Access fees: If you publish using OnlineOpen you will be charged a fee. A list of Article Publication Charges for Wiley journals is available **here**.

Funder Open Access: Please **click here** for more information on Wiley's compliance with specific Funder Open Access Policies.

UK authors: Note that all papers published in the journal are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

7. PUBLICATION PROCESS AFTER ACCEPTANCE

Accepted article received in production

When your accepted article is received by Wiley's production team, the corresponding author receives an email alert to sign a publication license.

Proofs

Once your paper is typeset you receive a PDF typeset page proof and full instructions on how to correct and return the file. Please note that you are responsible for all statements made in your work, including changes made during the editorial process. Proofs have a 48 hours turnaround time.

Early View

The journal offers rapid speed publication via Wiley's Early View service. **Early View** (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Your Early View article is fully citable and carries an online publication date and DOI for citations.

8. POST PUBLICATION

Article Promotion Support

Wiley Editing Services offers professional video, design, and writing services to create shareable video abstracts, infographics, conference posters, lay summaries, and research news stories for your research – so you can help your research get the attention it deserves.

Access and sharing

When your article is published online:

- You receive an email alert (if requested)
- You can share your published article through social media
- As the author, you retain free access (after accepting the Terms & Conditions of use, you can view your article)
- The corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to your article.
- You can order print copies of your article
- You can promote your article (more information here.)

Measuring the impact of your work

Wiley also helps you measure the impact of your research through our specialist partnerships with **Kudos** and **Altmetric**.

9. EDITORIAL OFFICE CONTACT DETAILS

For queries about submission, please contact [redacted]@journals.tandf.co.uk