Young people, culture, migration and mental health: A review of the literature

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This chapter is a review of the literature dealing with young people and mental health. It is divided into an introduction and three sections. Each section opens with a 'scene setting' introduction and is then divided into broad topic areas, based on key areas raised in the literature.

The first section deals with young people and mental health in general and is designed to give a broad overview of mental health issues affecting all young people in Australia. This section is divided into the following topic areas: life-stage transitions from childhood to young adulthood; psychiatric morbidity; youth suicide; environment, lifestyle and other vulnerabilities; risk taking and risk behaviours; and protective factors and resilience.

The second section provides an in-depth analysis of the literature relating to mental health issues affecting young people of non-English speaking background (NESB). This section is divided into the following topic areas: culture and life transitions; the process of migration and settlement; psychiatric morbidity; attitudes to mental health and mental illness; family dynamics and family conflict; acculturation and acculturation stress; identity development; and experience in the broader community.

The third section reviews the literature on young people's experience of being a refugee and the impact of refugee experiences on young people's mental health. This section is divided into the following topic areas: the refugee experience and mental health problems and disorders; the refugee experience and the family; the refugee experience and impact on development and functioning; and vulnerable groups of young refugees.

Young People and Mental Health

The literature relevant to the mental health of young people of NESB can be found in a wide range of subject areas, such as adolescence, mental health, migration, refugee experience, adult mental health and children's mental health. However, the
literature specifically addressing this issue is limited both internationally and in the Australian context. The most comprehensive literature comes from the USA. However, the NESB populations of Australia and the ‘minority’ populations in the USA are quite different and parallels are therefore difficult to draw. The extensive literature on the experiences of Latino, Native American and African–American young people cannot be simply applied to the Australian experience, although some of the issues that are raised for ‘minority’ communities in the USA strike a chord with the experience of people of non-English speaking backgrounds in Australia.

In the Australian context adolescent mental health has a profile in research, although the specific experiences of young people of NESB have not been addressed in any great detail. It has been necessary to search for literature relevant to a number of topic areas to cover the mental health needs and issues of young people of NESB.

The areas addressed in this literature review include:

- the mental health of all young people, to establish their specific needs and experiences in relation to mental health;
- adolescent development and life-stage transition, in order to understand the life stages relevant to young people and the issues that arise for them; and
- the impact of migration and refugee experiences on young people and the relationship of that impact to their mental health.

Other areas of the literature that have served as useful reference points include the area of culture and mental health, environmental stressors and young people and mental health service utilisation.

This literature review has aimed to do the following:

- identify mental health issues pertinent to young people;
- identify potential risk and protective factors for young people in relation to mental health;
- establish the different or additional pressures experienced by young people of NESB in relation to mental health; and
- explore mental health issues that may arise for young people who have been refugees.

The broad range of literature included in this chapter considers the period of ‘youth’ to fall between the ages of twelve and twenty-five. This age range includes a number of developmental stages (such as adolescence and young adulthood) and as a result relevant literature can be found across a range of topic areas. These areas include research related to children, adolescence and adults.
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Mental health can be understood to encompass two main domains: the absence of dysfunction in the psychological, emotional, behavioural and social spheres; and optimal functioning or wellbeing in psychological and social domains (Kazdin, 1993). Australian policy documents at both a national and State level reflect the acceptance of this broad definition of mental health. For example, the National Mental Health Plan defined mental health as 'the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of cognitive, affective and relational abilities, and achievement of individual and collective goals consistent with justice' (Australian Health Ministers, 1992, p. 20). This definition relates both to the mental health and wellbeing of individuals and the communities in which they live.

Mental wellbeing can be seen in relation to promoting and developing strengths in personal and interpersonal development. Kazdin (1993) suggests that positive mental health draws attention to the development of competencies, proactive interventions and preventive interventions. However, a focus on impairment or dysfunction emphasises the identification and diagnosis of disorder (Kazdin, 1993).

Young people encounter a multiplicity of changing roles and tasks as they undertake life transitions as individuals and participate in their world as members of families and peer groups, as members of communities and the broader social world. This multiplicity of roles and tasks demands that a complex and broad view of mental health be used in order to encompass the issues and experiences of young people in relation to mental health.

Young people are a specific group in relation to health and specifically mental health due to a range of epidemiological, psychosocial and environmental factors. They become a discrete social entity on account of their life stage and the life transitions that take place through childhood to adolescence and adolescence to young adulthood. Several authors also distinguish between early adolescence, mid adolescence and late adolescence (Halibur, 1993; Rice, Herman & Petersen, 1993).

The impact of adolescent development in physiological and psychological terms is one of the major factors that separates young people out as a group with specific needs in relation to general health and specifically to mental health. Psychiatric morbidity in young people and the tragic phenomenon of youth suicide also demand that young people be considered as a population group in their own right. Risk factors for the development of mental disorders that are specific to young people, environmental factors, social issues and structural issues (such as access to appropriate health care) are major areas of interest in relation to mental health that have been flagged in the literature. A lack of real knowledge of the actual health status of young people has also been noted as an important issue.
Kazdin (1993) argues that the study of adolescent mental health has been neglected relative to work with adults because adolescence has often been viewed as a transitional period between childhood and adulthood rather than as a period of interest in its own right. As a transitional period, changes and problems in adaptation and emotional and behavioral problems are considered to be age and stage specific and likely to pass with time.

Young people have been identified as an important group in relation to prevention of mental health problems, intervention to lessen the impact of mental health disorders, and treatment to lessen the disability that might result in long-term poorer function and impact of disability (see, for example, National Health & Medical Research Council (NHMRC), 1993, for a review of the scope for prevention in mental health). Rey (1992) suggests that psychiatric services need to focus more on children, adolescents and young adults ‘with the aim of reducing morbidity (later onset is associated with greater recovery) or of identifying the disorder and starting treatment early (with the hope that early treatment will be more effective and reduce disability)’ (Rey, 1992, p. 203). Rutter (1987) has highlighted adolescence as an important period in life where possible turning points may occur:

Adolescence, with its challenges in love relationships and in personal autonomy, followed by work careers, marriage, and parenting, all provide further possible turning points whereby success in the form of personal relationships or task accomplishment may change the life course onto a more adaptive trajectory (Rutter, 1987, p. 328).

Millstein (1989) raises the concern that (in the American context) data may overestimate the health of the adolescent population.

The health status of adolescents is primarily based on mortality patterns and indicators of morbidity such as use of physician services, hospital discharge rates, and conditions cited in visits to office-based physicians. These data are limited by their emphasis on short-term, bio-medical outcomes (Millstein, 1989, p. 837).

Millstein raises a further concern that health statistics generally report on adolescents as a group and that this obscures the diversity of the adolescent population with respect to age, race, ethnicity and gender. This diversity, she suggests, would actually reflect a disparate statistical picture of young people’s health.

*Life-stage transitions from childhood to young adulthood*

Much of the early work on the adolescent life stage characterised adolescence as a time where it is ‘abnormal to be normal’ and where turmoil is seen as the
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determinant of development. This characterisation of adolescence as a time of ‘storm and stress’ dominated psychoanalytic approaches to the problems of adolescents for many years (Haliburn, 1993). For example, the works of early theorists in adolescence, such as Erikson, Blos and A. Freud, characterise adolescence as a time when turmoil is seen as essential for growth and development (Haliburn, 1993).

More recent approaches have considered the diverse experiences of young people during the period of adolescence and the range of life transitions that occur during that time. The process of how transitions from childhood to adolescence are negotiated, the outcome of developmental transitions and the social context in which they take place is important in understanding the overall impact of adolescence as a life transition (Rutter, 1989).

Youth is a period where extensive change takes place and where challenges and life events often occur with varying levels of influence upon one another. Thus, during the transitions and life stages in youth and adolescence, it is clear that issues in relation to health and particularly mental health are specific and different to the experience of both children and adults.

**Psychiatric morbidity**

In a review of the special needs of mid to late adolescents and young adults in relation to psychiatric disorders, Haliburn shows that longitudinal research into adolescent symptomatology suggests that adolescents ‘do not grow out of their symptoms’ (Haliburn, 1993, p. 47). However, manifestations of psychosis in children and adolescence are influenced by the developmental process (Tolbert, 1996). The impact of developmental processes on mental health problems and disorders makes diagnosis and assessment particularly complex. Anecdotal evidence from clinicians in Australia suggests that this complexity means that mental disorders in children and young people are often overlooked (Human Rights and Equal Opportunity Commission (HREOC), 1993).

The connection between social adversity and psychiatric morbidity has also been canvassed (Hoberman, 1992). Risk factors for psychiatric disorders among children and adolescents suggested by the Institute of Medicine in the USA include living in foster care, living on welfare, prolonged parent–child separation, physical or sexual abuse, catastrophic events, bereavement, marital discord and family instability, low birth weight and fetal alcohol syndrome or effect (cited in Hoberman, 1992).

Reviews of psychiatric disorders in young people have highlighted the breadth and impact of a range of disorders on young people (for example, Haliburn, 1993; Hoberman, 1992; NHMRC, 1997; and Tolbert, 1993), although some authors argue that little information is currently available on the precise extent of psychiatric disorders among adolescents (for example, Hoberman, 1992).
A range of psychiatric disorders have their onset, cause or gestation during childhood, adolescence and young adulthood. Schizophrenia, bipolar affective disorder, eating disorders (such as anorexia nervosa and bulimia nervosa), obsessive compulsive disorder and depressive disorders are all disorders that are of concern in relation to young people, at levels that demand attention (American Psychiatric Association, 1994; Haliburn, 1993; Hoberman, 1992; NHMRC, 1997). Other disorders, such as conduct disorders, attention deficit–hyperactivity disorder and developmental disorders (for example, disorders relating to learning and communication), that commonly have their onset during childhood and adolescence (American Psychiatric Association, 1994) also affect young people.

Data from a major epidemiological study in the USA indicate that 90 per cent of all psychiatric disorders have their onset in adolescence or early adulthood (cited in HREOC, 1993). Evidence presented to the Human Rights and Equal Opportunity Commission inquiry into human rights and mental illness by practitioners suggested a similar picture in the Australian context (HREOC, 1993). Rey emphasises the seriousness of psychiatric morbidity in children and young people, ‘In most cases, the onset of psychiatric disorder occurs during childhood and adolescence, follows a chronic course and produces most of its handicap during the productive years of life’ (Rey, 1992, p. 203).

The role of early intervention in psychosis has been raised in the literature (for example, Yung, McGorry, McFarlane, Jackson, Patton & Rakkar, 1996; Yung & McGorry, 1996). Early intervention encompasses earlier recognition and more accurate knowledge about first episodes of psychosis and the possibilities for more effective treatments and lessening of overall severity. Young people have been identified as particular targets for early intervention because first onset of schizophrenia and other affective disorders often occur in adolescence, or signs of psychosis may be manifest in young people before full psychotic episodes take place.

In a discussion of three cases from a specialised outpatient service for young people thought to be at high risk of psychosis in Victoria, Yung et al. (1996) concluded that, where psychosis may have been delayed, the delay may have enabled the young people concerned to achieve a range of developmental and education tasks, which may have positive flow-on benefits later in their lives. Where psychosis did manifest in those patients, the fact that psychosis was delayed could also reduce the symptoms and the negative life effects (such as leaving school early or not developing peer relationships).

While the study of early intervention in first episode psychosis and other mental illness is still in the early stages in Australia, the possible positive flow-on benefits for young people of a delay or cessation of symptoms is an important area for further study.
In a review of psychopathology and development, Rutter (1984a) found that many mental disorders had their antecedents in childhood, but that the types and rates of disorders rise sharply during the period of adolescence. For example, the rate of affective disorders rises sharply about the time of puberty, depression becomes more frequent and suicide attempts and completed suicide show a massive rise in prevalence during adolescence (Rutter, 1984a).

In a review of psychiatric morbidity among adolescents, Hoberman found that 'overall there is remarkable, albeit disturbing convergence in the results of all the existing epidemiological studies suggesting that at least one out of five adolescents has experienced a recent psychiatric disorder and that many of these individuals experience chronic and multiple difficulties' (Hoberman, 1992, p. 248). Hoberman (1992) identified anxiety disorders, conduct disorders and depression as the most common disorders among adolescents. Evidence presented to the Human Rights and Mental Illness Inquiry suggested that in New South Wales alone, it is estimated that there will be 1000 new cases of schizophrenia per year, most of whom will be adolescents (HREOC, 1993).

The Western Australian Child Health Survey identified more than one in six children as having a mental health problem in the six months prior to the Survey, using the Child Behaviour Checklist (Zubrick, Silburn, Barton, Burton, Dalby, Carlton, Shepherd & Lawrence, 1995). Mental health morbidity was more likely among those aged 12 to 16 years (21 per cent) than among younger children (16 per cent) and boys had a higher estimated prevalence than girls. Mental health problems measured in the Survey included delinquent problems, thought problems, attention problems, social problems, somatic complaints, aggressive behaviour, anxiety/depression and being withdrawn. Children and adolescents with mental health problems were also more likely to have fair or poor physical health than children without mental health problems (ten per cent compared with three per cent).

Depression has been shown to be of major concern in young people in Australia. In a review of depression in young people, the National Health and Medical Research Council found that 'at any one time between one and three per cent of adolescents suffer from a major depressive disorder and up to 24 per cent of young people will have suffered at least one episode of major depression by the time they are 18 years old. Moreover, between 15 and 40 per cent of young people report symptoms of depressed mood and depressive symptomatology' (NHMRC, 1997, p. 1).

The prevalence of co-morbid psychiatric conditions in young people with mental disorders has also been flagged as a major issue in relation to young people's mental health (Tolbert, 1996; Hoberman, 1992). One review suggests that rates of co-morbid psychiatric conditions range from 25 per cent to 75 per cent of all young people with mental disorders (Hoberman, 1995).
Co-morbid conditions that have been identified for young people with mental disorders include substance abuse (Tolbert, 1996) and depression (NHMRC, 1997).

In a study of 132 adolescents aged between 14 and 18 years with alcohol dependence in the USA, adolescents with alcohol dependence showed elevated prevalence rates for several other mental disorders, such that the authors concluded that it was ‘rare for an adolescent with alcohol dependence not to have another mental disorder’ (Clark, Pollock, Bukstein, Mezzich, Bromberger & Donovan, 1997, p. 1200). Adolescents with alcohol dependence had significantly higher rates of conduct disorder, oppositional defiant disorder, attention deficit–hyperactivity disorder, major depression and post-traumatic stress disorder (PTSD) than the community control group. Depression and PTSD were more strongly associated with alcohol dependence in females than males (Clark et al., 1997). Most of the adolescents with alcohol dependence were also involved with other drugs.

Even a brief analysis such as this of the incidence and prevalence of psychiatric morbidity in young people reveals the importance of recognising and responding to psychiatric symptoms in young people. The literature shows that psychiatric symptoms displayed in adolescence need to be taken seriously and treated appropriately.

**Youth suicide**

Youth suicide has attracted increasing attention in Australia in recent years, with youth suicide rates in Australia among the highest in the industrialised world and suicide identified as one of the leading causes of death in young people (Commonwealth Department of Human Services & Health (DHS&H), 1997). The high and rising rates of youth suicide in Australia and other industrialised countries in itself presents a compelling argument for understanding the specific mental health needs of young people.

Data on the number of suicide attempts in Australia are generally drawn from statistics relating to hospitalisation due to self-injury (DHS&H, 1997). These data show sharp rises in suicide rates in the late teenage years for males and females (DHS&H, 1997). However, the number of suicide attempts is generally believed to be under-reported. For example, Garland and Zigler (1993) reported that studies from the USA estimated that suicide attempts may be as high as 50 to 200 times that of completed suicides. They also reported that the ‘vast majority’ of suicide attempters do not seek or receive medical or mental health care (Garland & Zigler, 1993, p. 170). In Australia it has been estimated that the number of suicide attempts could be as high as 67 per cent more than reported rates. Davis and Schreuder (1990) suggest that in Australia there may be 30 to 40 suicide attempts for every completed suicide.
The risk factors identified in youth suicide encompass both the immediate interpersonal context and also underlying vulnerabilities that may predispose certain individuals to resort to suicidal behaviour. A recent study from New Zealand suggests that risk factors for suicide could be divided into three categories: childhood adversity; social disadvantage; and psychiatric morbidity (Beautrais, Joyce & Mulder, 1996).

Studies have found that most young people who attempt or complete suicide have experienced psychiatric illness or symptoms, although those who have received mental health treatment will not necessarily have been receiving mental health treatment at the time of the attempt (Garland & Zigler, 1993). Kosky and Goldney (1994) report that at least 90 per cent of young people who commit suicide have evidence of psychiatric illnesses before their death. Affective disorders are the disorders most strongly associated with suicide and recent research has shown that clinical depression has been associated with a particularly high number of suicides (DHS&H, 1997). Eating disorders have been associated with ‘medically serious’ suicide attempts in young women (DHS&H, 1997, p. 26). It has been noted that mental illness may have strong links to suicidality because of the stigma and loss of opportunity associated with being identified as psychiatrically ill (DHS&H, 1997). Co-morbidity has been reported as increasing the likelihood of a young person with a mental disorder committing suicide (DHS&H, 1997).

Analysis of the data from the Western Australian Child Health Survey shows that adolescents who reported suicidal behaviours had a much higher proportion of self-rated mental health problems compared with the mental health problem ratings from parents and teachers (Zubrick et al., 1995). The authors suggest from this that ‘there is a disturbing proportion of adolescents whose parents and teachers are unaware of their risk for further suicidal behaviour and other adverse behaviours associated with mental health problems’ (Zubrick et al., 1995, p. 46).

In the Australian context a number of interpersonal areas have been highlighted as potential risk factors for suicide in young people. Unemployment and social disadvantage have been highlighted as risk factors (DHS&H, 1997). The particularly serious problem of suicide among young people of Aboriginal and Torres Strait Islander descent has also been reported (DHS&H, 1997). A specific relationship between social disadvantage, identity issues and historical context highlights young people of Aboriginal and Torres Strait Islander descent as experiencing serious disadvantage that may put them at risk of self-harming (DHS&H, 1997).

Other risk factors include adverse childhood experiences, such as personal histories of physical and/or sexual abuse, family discord and breakdown, homelessness and/or incarceration (DHS&H, 1997). Drug and alcohol use, abuse
and dependency is also noted as a serious issue related to youth suicide (DHS&H, 1997).

More specific risk factors are suggested by American authors Garland and Zigler (1993) who note that primary risk factors for suicide include drug and alcohol abuse, prior suicide attempt, affective illness, antisocial or aggressive behaviour, family history of suicidal behaviour, and the availability of a firearm. They note, however, that many young people will experience some or many of these risk factors and never go on to commit suicide.

Lawlor and Kosky (1992) highlight the problem of suicide and serious suicide attempts among the population of young people held in detention. Many adolescents in custody in Australia have backgrounds which include some of the risk factors for suicide. Young people in detention have been characterised as generally 'from social backgrounds characterised by unstable, sometimes violent, and unsupportive families. Most have poor school records and are unemployed' (Lawlor & Kosky, 1992, p. 477). Lawlor and Kosky also found that adolescents in custody who were suicidal were more likely to come from foster care or welfare institutions than those who were not suicidal. A recent study of the impact of social and economic stress and child neglect on juvenile crime found a causal link between child neglect and juvenile crime (Weatherburn & Lind, 1998).

In a study of a clinical sample of clients using the outpatient clinics of a childhood and adolescent psychiatry service in Adelaide, Kosky, Silburn and Zubrick (1990) found no difference in the presentation of psychiatric symptoms between children and adolescents with suicidal thoughts and those who attempted suicide. However, they also found a number of factors that increased the likelihood of a suicide attempt, including chronic family discord, drug misuse and (particularly for boys) disruption of major attachments (Kosky, Silburn & Zubrick, 1990).

Differences in the rates of suicide between males and females and urban and rural young people further complicate the overall picture of youth suicide in Australia. Data on suicide attempts and completed suicides suggests that young females have higher rates of suicide attempts and that young males have higher rates of completed suicide (DHS&H, 1997). The differences in the number of suicide attempts and completed suicides between males and females may reflect the lethality of the method used rather than a significant gender difference in propensity to commit suicide (DHS&H, 1997). For example, males are more likely to use firearms and females are more likely to use poisoning (DHS&H, 1997). Males in rural areas in Australia commit suicide at a higher rate than their urban counterparts (DHS&H, 1997).

Environment, lifestyle and other vulnerabilities

There is general agreement in the literature that environmental factors and lifestyle choices that come about as a result of moving into a new life stage and older age
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group have an impact on the mental health of young people. At this time young people are exposed to different life stressors, take on more decision-making roles in their own lives and enter a period of life that increases their vulnerability to adverse experiences, such as mental illness and suicide. Conversely, exposure to a range of stressors or life events may assist young people to develop skills to deal with life experience and even develop a resilience to adversity (Rutter, 1987).

The role of social context in the health of young people has been addressed in recent years, with researchers looking beyond familial relationships to consider broader social environments, such as schools, neighbourhoods and communities (Kazdin, 1993). Adverse environments may be imposed (for example, where the family lives, socio-economic status of the family) or chosen (such as, health-compromising behaviour). Silburn and Zubrick (1996) suggest that while adolescence is a challenging period in terms of social and biological change, it is not an unusually problematic time unless societal conditions are such that it becomes so:

Most societies, including Australia, have been slow to recognise the increased challenge which our complex societies pose to healthy adolescent development and this has further increased the likelihood that adolescence will be a difficult period. The higher rates of psycho-social problems among adolescents deserve urgent attention as these behaviours appear to be compromising the future life-chances of an increasing proportion of our youth (Silburn & Zubrick, 1996, p. 1).

Young people are exposed to a range of environments that may affect their health. Young people form a distinct population group due to the many ways in which their youth interacts with some adverse environments. Young people are often dependent on the conditions of these environmental contexts through their parents and families, which may make them vulnerable to the impact of some conditions beyond their control (Kazdin, 1993).

Some of the adverse environments that have been identified in the literature as having an impact on young people include physical abuse and neglect, sexual abuse, poverty, living with a parent with a mental illness, family breakup and social isolation. Environmental stressors are interactive and being involved in an adverse environment may put the young person at risk of other adverse environmental factors. For example, living in poverty may bring with it some health risks (such as poor diet) that may then affect school performance and life prospects.

Physical abuse and neglect and sexual abuse have been identified as having an adverse effect on the mental health of young people (Kazdin, 1993).

A more detailed discussion on the impact of abuse and neglect can be found elsewhere (for example, Lewis, 1992), but the impact of these experiences — both repeated experiences of abuse and neglect, and the isolated experience of one or all
— relates to poor mental health. In the Australian context, practitioners making a submission to the Human Rights and Mental Illness Inquiry cited abuse and neglect of children and adolescents as a major mental health issue and noted the cross-generation impact of abuse on families (HREOC, 1993). Other authors have also noted that childhood experiences of violence in the family are frequently transmitted across generations (Silburn, Zubrick, Garton, Gurrin, Burton, Dalby, Carlton, Shepherd & Lawrence, 1996).

Recent research into early brain development has highlighted the impact of early experiences such as child abuse on the development and structure of children’s brains. For example, prolonged traumatic experience may permanently sensitize the individual to environmental cues that are similar to the original trauma, resulting in exaggerated reactions to everyday life experiences (Perry, Pollard, Blakely, Baker & Vigilante, 1995). One of the key researchers in the field has concluded that ‘[o]f course children “get over it” — they have no choice … In the process of “getting over it” elements of their true, emotional, behavioural, cognitive and social potential are diminished — some percentage of capacity is lost, a piece of the child is lost forever’ (Perry et al., 1995, p. 13).

It has been established in the literature that children exposed to violence and abuse within the family have an increased risk of adverse mental health outcomes (Silburn et al., 1996). Young people have identified the connection between abuse and neglect in the home or within families and young people becoming homeless (Daniel & Cornwall, 1993).

Research has highlighted the relationship between child sexual abuse and increased vulnerability to adult psychiatric disorders generally and particularly borderline and multiple personality disorders (Paris & Zweig-Frank, 1992, in NHMRC, 1993). PTSD has also been shown to be found in children who have been abused, and there is some evidence to support a diagnostic finding of PTSD in children after sexual abuse (McCleer et al., 1988, in Kiser, Heston, Millsap & Pruitt, 1991).

A range of emotional and behavioural problems may stem from sexual abuse in childhood. Some of the difficulties may include poor self-esteem, difficulty in trusting others, hostility, aggression and inappropriate sexual behaviour, substance abuse and behavioural problems (NHMRC, 1993). The experience of sexual or physical assault has been suggested as a significant risk factor for suicide in girls (Garland & Zigler, 1993). Kiser, Heston, Millsap and Pruitt (1991) suggest that a range of symptoms resulting from sexual abuse may become more serious over time and become manifest in personality styles. Kiser et al. (1991) describe those ‘symptoms’ as ‘substance abuse, suicide attempts and other acts of self-destructiveness, chronic anger, unstable relationships, dissociation and mistrust with fear of abandonment’ (Kiser, Heston, Millsap & Pruitt, 1991, p. 776).
Poverty has been identified as an adverse environment that has an impact on young people (Jessor, 1993). Poverty’s impact on young people can be seen across a number of spheres in the young person’s life and it can interact with other environmental factors to place young people at risk of mental disorders (Saxe, Cross & Silverman, 1988). Poverty can also affect young people’s ability to access adequate food and shelter, their attendance at school, access to education, employment and training, and the development of positive self-esteem. Children from low-income families (household income below A$20,000 per annum) in Western Australia were found to have an increased prevalence of mental health morbidity compared to their peers in higher-income families (Silburn et al., 1996). However, the authors of the Western Australian study note that while this association allows health service providers to identify a group at risk for mental health problems, the causes of mental health problems are more complex than family income (Silburn et al., 1996). In a further analysis of the Western Australian data, the authors found that household income was less important than other relationships affecting the ability of parents to provide children with the security and stability they need (Silburn et al., 1996).

In a report of focus groups with disadvantaged young people around Australia, Daniel and Cornwall (1993) reported that young people made a clear link between poverty and crime: ‘Virtually all stealing and dealing, they believed, started because of grinding poverty and the instinct to survive’ (Daniel & Cornwall, 1993, p. 16). Young people also identified links between poverty and homelessness, violence, and poor health (Daniel & Cornwall, 1993).

In an extensive review of the literature on children of parents with a mental illness, Devlin (1996) found that research supported a relationship between psychiatric disorder in parents and their children and a high risk of psychosocial disorder in the children of parents with a mental illness. The literature supported both a level of genetic influence in the development of mental health problems in children of parents with a mental illness, as well as an influence of social and other adversity that may result from having a parent with a mental illness (Devlin, 1996). Some of the major environmental issues that contributed to psychosocial risk for children of parents with a mental illness identified in the literature included: family and marital discord, family breakup, impaired parenting, impaired relationship with mother, direct involvement in parental symptomatology, socioeconomic and other adversity such as social isolation (Devlin, 1996).

Homelessness has been shown to expose young people to many dangerous environmental factors — for example, committing crime or being the victim of crime or harassment (Daniel & Cornwall, 1993). Homelessness has also been shown to have a negative impact on the mental health of young people (Kazdin, 1993). Kazdin describes the possible adverse mental health outcomes for young people
who are homeless as including ‘higher rates of emotional and behavioural problems (e.g. depression, anxiety, substance abuse) and greater academic and developmental dysfunction (e.g. poor school attendance, dropping out of school) than their non-homeless peers’ (Kazdin, 1993, p. 129). The factors behind youth homelessness are also important when considering the impact of homelessness on young people. Young people may become homeless as a result of other environmental factors, such as family breakdown, sexual abuse or poverty.

Family breakdown and marital discord have been highlighted in the literature as having the potential for creating adverse environmental conditions for young people in relation to mental health (Kazdin, 1993; Silburn & Zubrick, 1996). Changing family constellations may present new stressors for young people and their parents, which in turn may have an impact on physical, emotional and mental health (Kazdin, 1993). The Western Australian Child Health Survey identified four family variables that were clearly associated with increased risk of child mental health morbidity: family income; family type; family discord; and parental disciplinary style (Silburn et al., 1996). Using a logistic regression, Silburn et al. (1996) found that the children who stood the greatest risk of having a mental health disorder would be those ‘living in a one parent family where significant family discord and a coercive parenting style are present’ (Silburn et al., 1996, p. 56).

Kosky et al. (1990) report the results of a study over three years of consecutive new referrals of children (average age 12.9 ± 2.9 years) to two outpatient clinics of a child and adolescent psychiatry unit in Western Australia. Of those who were identified as taking part in suicidal ideation, threats and attempts, Kosky and his colleagues (1990) found that chronic family discord was a major factor related to childhood suicidal behaviour in both girls and boys. They also reported that, although the study did not address the relationship between low self-esteem and suicide, ‘we were struck by the qualitative nature of the explanations for suicide attempts given by some of the children in our sample, which suggested a link between chronic family discord and low self-esteem’ (Kosky et al., 1990). Other research has also shown that family breakdown and disharmonious relationships within families may increase children’s vulnerability to mental health problems and disorders (Rutter, 1984b; Rutter, 1985; Rutter, 1987; Rutter, 1989; Silburn et al., 1996).

Lack of access to appropriate social and health services is another environmental factor that can have an adverse impact on the mental health of young people. When asked, young people have identified issues related to accessibility and appropriateness of services. The barriers that prevent young people from using services include inappropriate models of service provision, difficulty in accessing social services (particularly for those who have difficulty in procuring appropriate documentation to verify claims), discrimination from front-line staff, complex referral networks
that may prevent young people from accessing services, and a lack of appropriate services in regional areas (Daniel & Cornwall, 1993; Sawyer, Meldrum, Tonge & Clark, 1992). Young people’s lack of knowledge about available health services has also been indicated as a problem. Collaboration between systems (for example between health and education services) has also been identified as an issue in achieving better service provision for young people (Sawyer et al., 1992).

Lack of knowledge about mental health among people who work with youth and the resulting inability to make accurate diagnoses of mental health problems has also been suggested as an issue in the provision of services to young people (Sawyer et al., 1992).

It has been suggested that a lack of accessible and appropriate mental health facilities for young people, ignorance of mental illness, or unwillingness of practitioners to diagnose young people with mental illness, may mean that some young people who experience mental illness eventually receive attention through the ‘default’ system of the juvenile justice system (HREOC, 1993). One child psychiatrist, giving evidence to the Human Rights and Mental Illness Inquiry, went so far as to suggest that

young people in those facilities [juvenile detention centres] are about as badly off as the children who come to our mental health clinics — they are almost transposable. The major difference is that one group have committed some sort of offence for which they have been apprehended and the other group haven’t (HREOC, 1993, p. 634).

Research conducted in Australia and overseas supports this observation, suggesting a high prevalence of mental health problems among adolescents in juvenile detention (for example Kosky, Sawyer & Gowland, 1990; Lawlor & Kosky, 1992). Kosky et al. (1990) reported that adolescents remanded in South Australia experience a level of mental health problems comparable to that reported among adolescents attending mental health clinics. Nearly 40 per cent of the adolescents in the study scored above the recommended cut-off scores for the Youth Self-Report Checklist (YSR), four times more than in the adolescent community subjects. The authors concluded that:

[At] an early age, most are out of school, out of work and out of home, with nowhere to go. Few had completed more than their primary education, few had any family or social supports and most of them seemed to be on a circular path of offending and reinstitutionalization (Kosky et al., 1990: p. 26).

In Australia it has also been found that young people have continuing mental health problems and experience considerable social dysfunction after their release from custody (Kosky, Sawyer & Fotheringham, 1996). One year after their release,
of the subjects they could locate, Kosky et al., (1996) found that the young people generally had poor relations with their family, were mostly unemployed, had continuing high levels of alcohol and drug use, and reported behaviour problems typically associated with conduct disorders. Many of the young people also described symptoms of anxiety, depression and poor self-esteem. The problems of adolescents who have been in custody ‘do not go away’ after they return to the community (Kosky et al., 1996, p. 331).

Young people in the juvenile justice system, therefore, are another population at risk of mental health problems and disorders, suicide and social problems. The lack of appropriate psychiatric services during their detention has been noted in Australia and overseas. Mental health problems have been shown to continue after they are released from detention.

Adverse environments can compound other risk factors and exacerbate mental health problems (Kazdin, 1993; Saxe et al., 1988). The relationship between mental health problems and adverse environmental factors is complex and dynamic insofar as it is often unclear whether mental health problems are created by adverse environments, or whether mental health problems expose people to adverse environments.

**Risk taking and risk behaviours**

The impact of choices or behaviours that put young people at risk of mental health problems has also been canvassed in the literature. Risk behaviours have been defined as activities in which young people engage that increase the likelihood of adverse psychological, social and health consequences. They are related to, but different from, the other external environmental conditions to which young people are exposed (Kazdin, 1993).

Risk-taking behaviours that may compromise health include some sexual activity, drug and alcohol use and abuse, and other illegal activity such as speeding in motor vehicles. Zubrick et al. (1995) note that adolescents may be exposed to more health risk behaviours now than in the past:

The demands, expectations and temptations they encounter are more numerous and carry larger risks than those experienced by adolescents only a generation ago. By the age of 16 years, a significant percentage of Western Australian teenagers have tried marijuana, alcohol and cigarettes and may have become sexually active at an early age (Zubrick et al., 1995, p. 23).

In relation to mental health, risky behaviours may have many unintended consequences, both in the short and long term for young people. For instance, a longitudinal study of adolescent drug use and social support among young adults in California found that teenage drug use (with the exception of alcohol use) produced
Young People, Culture, Migration and Mental Health: A Review of the Literature

at least some impairment in physical, social and emotional functioning among the young adults in the study (Newcomb & Bentler, 1988). The negative effects of drug use were the result of a pattern of relatively heavy drug use during early and late adolescence, that is young people have developed a lifestyle of drug use (Newcomb & Bentler, 1988).

A longitudinal study of cannabis use among 1311 Norwegian adolescents aged from 13 to 19 years found marked differences between the group of young people who used cannabis in an experimental way and those who were heavy users of cannabis (Pedersen, 1990). Experimental use was associated more with ‘oppositional’ engagement, but not necessarily poor family relations or poor mental health; heavy users of cannabis were found to be more likely to have family problems and suffer from poor mental health (Pedersen, 1990).

The impact of risk taking by young people may be underestimated. Millstein (1989) suggests that behavioural factors are an important consideration in adolescent morbidity. The impact of risk-taking behaviour on adolescent morbidity may be unmeasured and unrecognised (Millstein, 1989).

**Protective factors and resilience**

Protective factors and the development of resilience are key areas in the study of young people and mental health. Rutter defines protective factors as ‘the influences that modify, ameliorate, or alter a person’s response to some environmental hazards that predisposes to a maladaptive outcome’ (Rutter, 1995, p. 600). The question of why some children and young people respond positively and others negatively to adverse social environments is important in determining how services for young people are targeted and how young people can be best supported through difficult situations.

The notion of interaction — such as how personal qualities interact with the kinds of stressors taking place at a point in development — is important in considering resilience and protective factors (Rutter, 1985). Protective factors interact with the stressors and other concerns, but are not absolute, and may change as other factors are introduced.

The notion of protective factors has been seen as increasingly important because, in the case of young people, ‘the major threats to their health and wellbeing are increasingly rooted in the organisation, economics, opportunities and expectations of everyday life’ (Resnick, Harris & Blum, 1993, p. 54) and protective factors that can promote young people’s wellbeing need to be based on the world around them. In an important, population-based research project in the USA, Resnick, Harris and Blum used the Minnesota Adolescent Health database to investigate and identify protective factors for quietly disturbed and acting out behaviours in both boys and girls. The authors defined ‘quietly disturbed and acting out behaviours’ as ‘representing two clusters of health compromising
behaviours that encompass the major social morbidities of adolescence’ (Resnick et al., 1993, p. S6). Through inquiring into whether ‘the experience of caring, and the feeling of connectedness to others demonstrably result in greater wellbeing, and correspond-ingly less health compromising behaviours among teenagers’ (Resnick et al., 1993, p. S4), the authors found that the most powerful protective factors were those of family and school connectedness. These factors were the most powerful for both boys and girls, regardless of their socioeconomic status. The study makes the important point that information about protective factors can help shape effective services for adolescents, particularly around the concept of the need for belonging. The authors conclude that:

[with the urge toward connectedness representing one of our deepest human desires, caring as a conscious, explicit quality must pervade the people and programmes that seek to optimise the life course of adolescents, particularly those at highest risk (Resnick et al., 1993, p. S8).

Yung et al. (1996) highlight the importance of risk and protective factors in the process of transition from at-risk mental states to psychosis. Research is being undertaken to understand the factors that ‘favour’ transition from an at-risk mental state (risk/vulnerability factors) and those that ‘inhibit’ it (resilience factors) (Yung et al., 1996, p. 299).

Devlín (1996) uses a model called ‘the Wheel of Fortune’ to demonstrate the way that individual characteristics of the young person interact with social environment, family environment and parental disorder, to demonstrate how risk and protective factors interact to influence how the child of a parent with a mental illness will cope with the related risk factors to which they are exposed. This approach exemplifies the complexity of the interaction between adverse environments, individual qualities and other environmental factors in determining how a young person will respond to, or be affected by, a range of circumstances.

National Crime Prevention (Commonwealth Attorney-General’s Department, 1999) has suggested a range of protective factors across individual, child, family, school, community and life events gained from an extensive review of crime prevention and resilience research. Its findings support long-held beliefs by practitioners that family and social support and environmental factors have an enormous impact on how young people and their families respond to adversity. While these factors are not identified as specifically related to the prevention of mental disorders, they outline the basic arguments around the importance of individual, family, community, cultural and environmental factors.

Table 1 (opposite page) shows the breakdown of protective factors (Commonwealth Attorney-General’s Department, 1999, p. 138).
Table 1  Protective factors associated with antisocial and criminal behaviour.

<table>
<thead>
<tr>
<th>Child Factors</th>
<th>Family Factors</th>
<th>School Context</th>
<th>Life Events</th>
<th>Community and Cultural Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>- social competence</td>
<td>- supportive caring parents</td>
<td>- positive school climate</td>
<td>- meeting significant person</td>
<td>- access to support services</td>
</tr>
<tr>
<td>- above-average intelligence</td>
<td>- family harmony</td>
<td>- pro-social peer group</td>
<td>- moving to a new area</td>
<td>- community networking</td>
</tr>
<tr>
<td>- attachment to family</td>
<td>- more than two years</td>
<td>- responsibility and</td>
<td>- opportunities at critical life</td>
<td>- attachment to the community</td>
</tr>
<tr>
<td>- empathy</td>
<td>- between siblings</td>
<td>- required helpfulness</td>
<td>turning points or major life transitions</td>
<td>- participation in church or other community group</td>
</tr>
<tr>
<td>- problem solving</td>
<td>- responsibility for chores</td>
<td>- sense of belonging / bonding</td>
<td></td>
<td>- community and cultural norms against violence</td>
</tr>
<tr>
<td>- optimism-school achievement</td>
<td>- or required helpfulness</td>
<td></td>
<td></td>
<td>- a strong cultural identity and ethnic pride</td>
</tr>
<tr>
<td>- easy temperament</td>
<td>- secure and stable family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- internal locus of control</td>
<td>- supportive relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- moral beliefs and values</td>
<td>- with other adult</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- self-related cognitions</td>
<td>- small family size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- good coping style</td>
<td>- strong family norms</td>
<td>- school norms re violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- and morality</td>
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</tr>
</tbody>
</table>
Deeper Dimensions — Culture, Youth and Mental Health

Rutter (1987) shows the importance of the activation of protective processes in order to prevent young people becoming exposed to a whole range of adverse experiences. He describes the positive benefit of protective factors and resilience as coming into play at crucial points in young people’s lives:

[Protection does not reside in the psychological chemistry of the moment but in the ways in which people deal with life changes and in what they do about their stressful or disadvantageous circumstances. Particular attention needs to be paid to the mechanisms operating at key turning points in people’s lives when a risk trajectory may be redirected onto a more adaptive path (Rutter, 1987, p. 329).

Young People of NESB and Mental Health

This section deals with the impact of culture on the experience of adolescence, psychiatric morbidity in young people, and immigrant status and relevant psychosocial issues. Some of the key psychosocial issues that have been highlighted in the literature (both in quantitative studies and professional/clinical reflection) are: the process of migration and the migration experience; the experience of resettlement and tasks related to resettlement; acculturation and acculturation stress; family dynamics and family conflict; identity development; and experiences with the broader society, such as racism, discrimination and social supports. A separate section highlights the specific issues and experiences in relation to mental health of young people who have been refugees.

‘Young people of NESB’ is a broad category comprising young people with diverse life experiences. Young people of NESB are defined as people between the ages of 12 and 25 who were born overseas in a non-English speaking country or whose parents were born overseas in a non-English speaking country. Young people who are third- or fourth-generation Australian-born may also have cultural affiliation to the community from which their family originates.

It is important to examine mental health issues in relation to young people of NESB specifically in order to understand where young people of NESB may experience either additional pressures on their mental health or experience differently the pressures and experiences identified in relation to young people in general.

The focus here on problematic areas of adjustment does not suggest that it is inevitable that all young people of NESB will experience problems or have lives riven with conflict. Many young people experience the issues discussed in this section with minimal problems. However, the literature focuses on problematic areas and there is a dearth of research examining the strength and resiliency of young people of NESB. There is a need for further research examining why it is that while adverse environments and stressful life events may affect many young people,
particularly young people from NESB, only some young people experience a negative effect on their mental health.

**Culture and life transitions**

Developmental issues and life-stage transitions from childhood through adolescence and young adulthood are important for all young people. However, the impact of culture and life experiences (such as migration, refugee experiences and resettlement) need to be understood to gain a true picture of the diverse experiences of all young people. While there is often a focus on the ‘universal’ experiences of development in biological and psychosocial terms, there is a body of literature that emphasises the centrality of culture in determining what is ‘normal’ in adolescence. For example, culture may affect the timing of developmental transitions and expectations of how an individual will respond to developmental milestones. Kazdin (1993) suggests that the differences at the lower and upper end of the adolescent age range can be vast within a given culture, and that the timing of onset of puberty and movement to adulthood can vary widely among cultures. McDermott (1991) emphasises the plurality of ways that adolescence may be experienced cross-culturally, noting that ‘no single model can explain the complexity of child and family development across the cultures of the world’ (McDermott, 1991, p. 409).

Lau (1990) and McDermott (1991) both identify family structure, early childhood practices and child development as important in determining how, when and what the processes of adolescence will be. Writers dealing with specific communities have highlighted how communities from non-Western and non-English speaking backgrounds may see appropriate adolescent outcomes differently from Western-trained therapists. For example, Lau describes differences between what she describes as the ‘Western European’ nuclear family and the ‘non-Western European’ (Asian) extended family. She suggests that for Western European nuclear families ‘the competent adolescent is one with a confident, separate identity’, while for non-Western European extended families ‘the competent adolescent is one who will meet his/her obligations ... to his/her family and has been prepared to do so’ (Lau, 1990, p. 202). Timimi suggests that ‘[p]sychological theories describing adolescence as a stage involving autonomy and independence may bear only limited relevance to the common patterns of psychosocial maturation encountered in Arabic culture’ (Timimi, 1995, pp. 142-3). Timimi (1995) also draws attention to the differences that are manifest in family structure, for example in urban and rural families, in determining how adolescence as a life stage may be experienced and understood. The emphasis on individuality and autonomy from the family as the only appropriate outcomes from adolescence may be ethnocentric (McDermott, 1991). The impact of different approaches to adolescence in clinical work has also been addressed in the literature. For example, there is the potential for conflict between clients, young people or other family members, and practitioners from
different cultural backgrounds over what is perceived to be appropriate behaviour and life-stage outcomes for adolescents (Lau, 1990; Timimi, 1995).

It is clear from the literature that terms such as ‘non-Western European’ and ‘Arab’ may also mask the diversity of cultural groups that exist within language or national groupings. Substantial differences exist within groups that share language, religion and cultural orientation.

The process of migration and settlement

The process of migration has been identified as one which seems to be reasonably consistent across cultures (Sluzki, 1979). This is despite the broad array of cultural and personal experiences, reasons for migration, and diversity in the way the migration is undertaken. However, each group’s experience of the process will be characterised individually, becoming a ‘unique drama’ (Sluzki, 1979, p. 379).

The process of migration includes: the time of applying to migrate; the period of waiting that accompanies the application; the health and other checks that take place once the application has been successful; the time of organisation; leave-taking of family, friends and known environment; the actual passage/journey; and finally the arrival in the new country. For some migrants, this process may be truncated as imperatives force them to leave their country quickly — for example, those migrating from a country at war. A truncated migration experience may result in little, if any, preparation towards leaving and an inability to gather or organise all documentation and other valued possessions.

The period after arrival is the period of settlement. The process of (re)settlement may take many years, if not a lifetime (Jupp, McRobbie & York, 1991).

Sluzki describes the overwhelming nature of the changes posed by the migration experience on individuals and families:

One way or another, countless numbers of people manage to break away from their basic support networks, sever ties with places and people and transplant their home base, their nest, their life projects, their dreams, their ghosts (Sluzki, 1979, p. 379).

Young people come to Australia as migrants with their families and in other ways, including in a relationship, sponsored by a relative or friend already living in Australia, sponsored as fiancées and spouses, and independently. These young people may include people who chose to come to Australia, those who took part in family decision-making processes, those who made the choice themselves, and those who had no choice in the decision to migrate. Further, they may be sponsored from a country at war, or from a refugee camp by relatives who may or may not be close to them (Refugee Resettlement Working Group, 1994). Young migrants may have well-developed English language abilities, or have had little or no exposure to English language. They may be from a rural or urban background, and
have varying levels of exposure to Western-style technology and lifestyle. As migrants young people may be joining a substantial community from their country of origin in Australia, or be part of a small or emerging community. Sometimes young people have migrated to Australia, returned to their home country (with a view to resettling there), and subsequently returned to Australia (Fabrier, 1987).

Settlement is a complex concept, with a range of theoretical perspectives analysing what may constitute full settlement into the new country. These theoretical concepts cover what it means to start a new life and become part of the broad society, as well as the practical tasks involved in actually establishing a home, life and family in a new country. Settlement as a concept applies to individuals, families and whole ethnic groups (Jupp et al., 1991; Morrissey, Mitchell & Rutherford, 1991). The theoretical constructs of settlement range from a minimalist, individual notion of settlement to broad-based notions of how successfully settlement is achieved for whole ethnic communities (Jupp et al., 1991).

Jupp and his colleagues describe theoretically what would constitute ‘minimalist’ individual settlement. This is that a migrant is settled when: they secure accommodation and employment; do not become a charge on the public purse; their physical and psychological condition does not inhibit employment; they are not so alienated from society as to become a ‘social menace’; and they can socialise with workmates and neighbours (Jupp et al., 1991, p.11). They suggest that these settlement tasks could be achieved within two or three years.

A ‘maximalist’ concept of successful individual settlement would be that a migrant is settled when: they are employed at the same level of qualifications and experience as before departure; their lifestyle is better than in the previous homeland (by their own judgement); they have full command of the majority language; they have full access to public services; they have taken out citizenship and intend to remain and do not feel discriminated against (Jupp et al., 1991, p. 12). This maximalist version of settlement would take a lifetime.

Social policy in Australia has moved between these positions (Jupp et al., 1991) and this has affected the number and style of settlement services and social support available for newly arrived migrants and refugees. The different approaches to the concept of settlement have also affected the length of time special services are made available to migrants, that is, whether services are only available to newly arrived migrants or longer-term residents as well.

While the literature uses definitions such as ‘minimalist’ and ‘maximalist’, one can conclude that the actual experience of settlement for individuals and families probably lies somewhere in between these theoretical positions. Making a conclusion from the literature, a general experience of settlement would incorporate both a basic level of income support, health, wellbeing and social integration and a more extensive accomplishment of lifestyle, social and political agendas.
The settlement process is usually managed by a small family unit. In this case, settlement tasks are undertaken by a group who have already experienced a high level of stress as a result of migration (Morrissey et al., 1991). In the process of migration and settlement, the family may have been stripped of the resources needed to perform many of the tasks associated with family activities, such as socialisation of the children (Morrissey et al., 1991).

Sluzki (1979) suggests that the migration process for families includes a number of stages during settlement: a period of overcompensation; a period of decompensation or crisis; and transgenerational impact. The period of overcompensation forces a family to focus strongly on survival, task-oriented efficiency and may result in a split in instrumental and affective roles within the family. During this time sheer survival takes over and the dissonance created by living in an alien environment and other conflicts often remain dormant. The period of decompensation or crisis takes place when basic survival tasks have been achieved and the family begins to reshape itself in its new reality, beginning the process of retaining some family habits and rituals and changing others to suit the reality of the new society or because they require social supports that are no longer available (such as extended family networks). The period of transgenerational impact often becomes obvious as the young people and their parents experience different kinds of socialisation and a clash in adaptive behaviours.

For young people, the massive changes that accompany migration and settlement may be happening in tandem with developmental transitions, the development of their identity as an individual and understanding of their place in the world (Bashir, 1993). Young people may be at a fragile stage in their life, experiencing some major personal changes at the time of migration and before they have developed adequate coping mechanisms (Fabrier, 1987).

Fabrier (1987) describes three key areas of stress in relation to migration for young people: stressors arising from individual circumstances; those typical of developmental stage; and those associated with resettlement. In considering the experience of young people within these areas of stress, it is important to consider that young people may not have had a choice about the decision to migrate, that the decision may have been based on imperatives (for example, economic or political) beyond the family unit, and that the young person and the family may have ambivalent feelings about the choice to migrate. This may result in a process of grief and loss, which may be resolved over time, or may continue to create emotional problems for the young person. The losses of young people, according to Fabrier, are of culture, friends, family, lifestyle, in short a way of life, and the security and reinforcement of that known life.

They have lost what used to reinforce them, to make them feel good and to let them know who they were and they have not yet learned how to elicit reinforcement from
the new environment. They may eat some food and feel ill, move close to a peer and see him/her wince or move away, sit quietly in class and find that the teacher gets upset because they don't contribute. The dissonance is intensified when a person in their new life, the teacher, quite clearly has different values and attitudes to theirs and to their families (Fabrier, 1987, p. 4).

The losses described above often take place at the same time as young people are starting to learn a new way of life and negotiate the changes which may be taking place as they reach adolescence (Bashir, 1993).

Age on arrival is another factor that may have an impact on a young migrant’s psychological development. Hepperlin (1991) points out that ‘non-English speaking migrants who arrived in early childhood have, by adolescence, the advantage of English language acquisition that most adolescent arrivals do not have’ (Hepperlin, 1991, p. 124). Those faced with language difficulties may have problems with educational achievement and other adjustment issues during the initial period of their arrival (Hepperlin, 1991).

The Canadian Taskforce on Mental Health Issues Affecting Immigrants and Refugees (Beiser, Barwick, Berry, da Costa, Fantino, Ganesan, Lee, Milne, Naidoo, Prince, Tousignant & Vela, 1988) argues that regardless of the individual situations of migrant or refugee young people, they become involved in the stressors and strains of the settlement issues of their families. Some of these issues may be homesickness, language problems, economic uncertainties, and painful absorption of a new culture (Beiser et al., 1988).

Fabrier (1987), Lau (1990) and Hepperlin (1991) also highlight the transmission of stressors between family members, with young people concerned over their own day-to-day settlement issues, as well as those of their parents and other family members. While the impact of these stressors differs between groups and individuals, the general climate of stress and uncertainty during the period of resettlement highlights the need for acknowledgment and understanding of the experiences of young migrants and their families.

The literature on migration and resettlement for young people generally focuses on young people within some kind of family unit. Young people may migrate on their own to join an extended family in Australia; or they may migrate to join a family unit from which they have been separated; or they may migrate completely on their own. Issues relating to these differing experiences have been raised in the field, although there is little published research in this area (Fabrier, 1987; Refugee Resettlement Working Group, 1994).

The experience of young people who migrate on their own, but who are not refugees, has not been canvassed extensively in the literature. However, some of the situations that may prompt this situation might include young women who have come to Australia to be married, young people who have been sponsored from
refugee camps by community organisations, and young adults who have left their country of their own volition. The issues that arise for these young people may be similar to those that impact on other young migrants; however, there may be additional issues in relation to income support, access to education, social support networks, and housing that highlight them as a group in need of specific attention.

**Psychiatric morbidity**

A brief review of the research about the connections between young people’s psychiatric morbidity and immigrant status reveals a complex and often contradictory picture. Some studies have reported higher rates of morbidity (Steinhausen, 1985); some have reported similar levels for immigrant and non-immigrant young people (Touliades & Lindholm, 1980; Klimidis, Stuart, Minas & Ata, 1994); and some have reported lower levels for immigrant young people (Cattel, 1962, cited in Touliades & Lindholm, 1980). The type of study, instruments used, determination of population group, and presence of control groups have all been cited as reasons for conflicting results in these studies (Monroe-Blum, Boyle, Offord & Kates, 1989; Aronowitz, 1984).

A number of community-based studies investigating aspects of morbidity in immigrant young people have found no differences in the levels of psychiatric morbidity in immigrant young people from non-immigrant young people. An analysis of the data collected in the Ontario Child Health Survey found that Canadian immigrant children (defined in this study as children born outside Canada) were not at increased risk for psychiatric morbidity (Monroe-Blum et al., 1989). Klimidis and his colleagues examined the ‘migration-morbidity hypothesis’ (that is, the proposition that immigrant status is associated with greater psychological morbidity) in a study of 631 adolescents in Victoria using questionnaires administered in the classroom (Klimidis et al., 1994). They found no evidence to support the ‘migration-morbidity’ hypothesis. Touliades and Lindholm’s findings from a study of 2991 children in Texas using a teacher checklist tended to support the notion that ‘foreign-born children do not differ, or [they] experience less psychopathology than native-born children’ (Touliades & Lindholm, 1980, p. 31).

Other community-based studies that have investigated specific ethnic groups in comparison with non-immigrant control groups have found differential levels of morbidity. In a large-scale study of all children in schools in an inner-London borough, Rutter, Yule, Morton and Bagley (1975) found higher rates of behavioural disturbance, on a teacher-rating scale, among the children of West Indian immigrants compared to the control group. However, no difference in behavioural disturbance was found at home using parent-rating scales. In a study in West Berlin, Steinhausen (1985) found differential levels of psychiatric disorders in groups of Turkish, Greek and German children. The Turkish immigrant group had the highest level of disorder, the Greek immigrant group the lowest, and the German group fell
between at an intermediate level. Similar findings were reflected in a measure of family dysfunction (Steinhaussen, 1985). However, it is not clear how ethnicity was determined and sampling methods may have differed between groups.

The differences in findings in these studies suggest that, in general, the so-called ‘migration–morbidity’ hypothesis (Klimidis et al., 1994) is inadequate to describe the complex relationship between immigration and psychiatric or psychological disorder in young people. Other authors have also suggested that data on immigrant status is only one aspect of the picture of morbidity (Steinhaussen, 1985), and that the impact of socioeconomic status, pre-migration, migration and post-migration resettlement factors (Klimidis et al., 1994) need to be considered. Klimidis and his colleagues suggest that a multifactorial approach to morbidity risk would find that:

there are risk factors common to all adolescents, regardless of immigrant status or ethnicity (for example, the effects of gender on symptom report) and that there are some specific factors applying to only some groups, such as exposure to traumatic incidents among refugee adolescents (Klimidis et al., 1994, p. 400).

**Attitudes to mental health and mental illness**

For cross-cultural approaches to health the literature has shown that differences in beliefs and understandings about health, illness and illness behaviour are common, both between and within cultures (Fitzgerald, 1992). History, language, religion and belief systems intersect to create a range of understandings of mental health, mental illness and appropriate treatment styles (Fitzgerald, 1992).

Cultural understandings and beliefs about mental health and mental illness affect how mental health problems or disorders are experienced by young people and the presentation (or otherwise) of symptoms to mental health or other services (Klimidis & Minas, 1995).

Culture adds another layer to the intersection of developmental issues and mental health problems and disorders. The impact of mental health problems and disorders experienced by young people during developmental periods is culturally mediated (Lau, 1990). Perceptions about what constitutes a mental health problem will be determined by the beliefs and expectations of ‘normal’ behaviour by the range of significant adults in a young person’s life: parents, teachers, mental health workers, and others (Klimidis & Minas, 1995). Klimidis and Minas conclude that ‘[d]ifferent beliefs and expectations may result in substantial differences in perceptions of severity of abnormal behaviour and of the need for therapeutic intervention’ (Klimidis & Minas, 1995, p. 86).

There is a need for further research to understand the intersection between culture, development and mental health problems and disorders, particularly since these issues are often discussed in the literature (for example, Bashir, 1993).
Reflection by clinicians suggests that these intersections are encountered regularly in work with young people and their families (for example, Lau, 1990; Timimi, 1995). Rigorous clinical research is required to validate or challenge these clinical observations.

The impact of mental illness on families, whether the illness has been experienced by children, parents or extended families has not been extensively researched in a cross-cultural context. Exploratory cross-cultural research on the impact of depression on family functioning suggests that the negative effect of depression on family functioning is experienced across cultures, but that the impact is ‘significantly modified by the cultural milieu’ (Keitner, Fodor, Ryan, Millar, Bishop & Epstein, 1991, p. 257).

**Family dynamics and family conflict**

The family is one of the key contexts in the migration process and a range of family problems may be generated as a result of migration. These include changes in family structures and dynamics, intergenerational issues and conflict, transmission of stressors between family members, and parental expectations of young people.

A change in family structure and dynamics is an inevitable consequence of migration, as families adapt to their new reality (Sluzki, 1979). As has already been discussed, family structures change to accommodate new realities and changed circumstances, including the loss of support networks, extended family networks and the social environment. Family dynamics also change as roles transform and family members begin to reconstruct their roles in the new situation.

One of the family dynamics that is extensively referred to in the literature is the role of intergenerational relationships and conflict (for example, Sluzki, 1979; Klimidis & Minas, 1995). While intergenerational and cultural conflict should not be immediately assumed (Rosenthal, 1984), the conflict that can arise as a result of migration, settlement and acculturation processes is of importance in the mental health of migrant young people. Morrissey et al. (1991) note that the level of cultural dissonance between young people and their families and the new environment varies depending on cultural background, country of origin and life experiences (such as previous overseas travel and exposure to similar cultural beliefs).

The change in family roles that comes about as a result of migration is one of the key issues that arises. Roles within the family may be reversed as young people become more familiar than their parents with the dominant society, learn the language, and adapt to social mores. This is a result of young people being more exposed to the dominant culture than their parents through school and social experiences, language and behavioural styles. This may place the children in a more powerful family role, undermining established family roles (Fabrier, 1987; Beiser et al., 1988). Adaptational problems of parents may move young people into a role.
reversal where they become a parent-figure to their parents and younger siblings (Bashir, 1993). As they learn English more rapidly than their parents, young people may begin to undertake tasks that affect the family’s existence, for example assuming the role of interpreter at a doctor’s appointment, telephoning amenities, translating notes from school and so on (Lau, 1990).

A number of studies have demonstrated that migrant and refugee adolescents adhere significantly less to traditional cultural values than their parents following migration (Nguyen & Williams, 1989; Klimidis, Minas & Ata, 1993). In a study of Vietnamese refugee young people in Victoria, Klimidis et al. (1993) found differential levels of acculturation between young people and their parents, with young people in the sample and their siblings scoring higher on the question of affiliation with ‘Australian’ ways and conversely much lower on maintaining Vietnamese traditions. Sluzki (1979) suggests that where the second generation (young people) have been socialised in the milieu that reflects the norms and values of the new culture and while the first generation (parents) have remained wedded to the old, there will be a clash of values. In some ways the conflicts that may result between young people and their parents could be considered intercultural rather than intergenerational (Sluzki, 1979).

Recent studies with Vietnamese young people (Klimidis et al., 1993; Nguyen & Williams, 1989) found differing levels of perceived conflict between girls and boys, with girls experiencing more differences with their parents in relation to work in the home, social interaction, and involvement with the opposite sex. In an earlier study comparing intergenerational conflict between Anglo–, Greek– and Italian– Australians, Rosenthal (1984) found that the Anglo–Australian sample group reported less conflict than the other groups. Adolescent boys reported more conflict with their parents, but the parents perceived greater conflict with their daughters. In terms of conflict with daughters related to social activities, Italian–Australian girls experienced more conflict with their parents, relative to their male peers, than the other two ethnic groups (Rosenthal, 1984). Findings relating to gender differences in conflicts of values between parents and children seem to be consistent, suggesting that perceived sex role behaviours may be an important aspect in intergenerational conflict. Young women may be a group particularly at risk of experiencing conflict and stress in their relationships with their parents.

Rosenthal (1984) found that intergenerational conflict amongst immigrant families was heightened for adolescents who had rejected the ‘old’ culture (that is, their parents’ culture) for the ‘new’. She identified the conflict issues for the young people in her study as less about integrating two worlds than the fact that young people and their parents lived in different worlds. In a study examining ethnic identity and adjustment, Rosenthal and Cichello (1986) found with their group of Italian–Australian young people that the perceived embeddedness of parents in the Italian community made a positive contribution to the development of ethnic
identity and adjustment. A perception of parents' maintenance of Italian cultural ties was strongly associated with good family relations. The authors suggest that links with the Italian community may have facilitated integration between Italian and Australian cultural systems so that some enculturation was possible.

A number of studies undertaken in Australia suggest that family dynamics are complex and the impact on young people's identity and adjustment is related to a range of factors. These factors may mediate family conflict and assist in the development of an integrated identity for young people (Rosenthal, Moore & Taylor, 1983; Rosenthal, 1984; Rosenthal & Cichello, 1986).

**Acculturation and acculturation stress**

Acculturation is the process of change that groups undergo when they come into contact with another culture (Hoovey & King, 1996) and decide what is to be saved or sacrificed from the old (Bashir, 1993). The three possible outcomes of acculturation are: retain the old culture; take up the new; or blend both cultures (Bashir, 1993). Acculturation stress is the pressure experienced by members of the minority culture to undergo cultural change (Klimidis & Minas, 1995); the stress that directly results from and has its source in the acculturative process (Hoovey & King, 1996). Acculturative stress may be expressed as emotions and behaviours including depression and anxiety, feelings of marginality and alienation, heightened psychosomatic symptoms, and identity confusion (Williams & Berry, 1991).

Studies of first generation and later generations of Hispanic immigrants to the USA (Mena, Padilla & Maldonado, 1987; and Padilla, Alvarez & Lindholm, 1986, both cited in Hoovey & King, 1996) report that age and generational status have an impact on levels of acculturative stress, with first-generation immigrants experiencing a greater level of acculturative stress than succeeding generations. Those who immigrated before the age of twelve were found to experience less acculturative stress than those who immigrated after this age. Age at the time of migration has also been suggested as a determinant of the rate and extent of acculturation, with children and adolescents acculturating more quickly and to a larger extent than their parents (Klimidis & Minas, 1995). Differential rates of acculturation may create a generation gap between adolescents and their parents that is wider than that between non-immigrant parents and their children (Klimidis & Minas, 1995). Differential acculturation within families has been described as contributing to the stress of young people, their family members, and also as impacting on family dynamics in a negative way (Fabrier, 1987).

**Identity development**

The development of identity is a major task for young people to accomplish in order to function within a society. For immigrant young people this task is of particular importance as they adjust to their migration and refugee experiences and negotiate