The FRIENDS Program for Young Former-Yugoslavian Refugees in Australia: A Pilot Study

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Young immigrants frequently experience anxiety as a consequence of the stress associated with migration. Despite being at high risk for the development of psychopathology, culturally sensitive assessment and intervention procedures for use with ethnic minority groups residing in Australia have yet to be developed and validated. The aims of the current study were to (a) investigate the level of anxiety in a sample of former-Yugoslavian teenage refugees; (b) appraise the efficacy of the FRIENDS program, a validated Anglo-Australian anxiety-prevention program, for use with this high-risk group; and (c) obtain information from both the program participants and facilitators regarding how the intervention could be modified to better meet the needs of this growing refugee population in Australia. Twenty female former-Yugoslavian youths completed standardised measures of internalising symptoms. Participants were allocated to either an intervention (n = 9) or a waiting list (n = 11) condition. In spite of the small sample size, post-assessment indicated that participants in the intervention condition reported significantly less internalising symptoms than participants in the waiting list condition. Social validity data indicated that, overall, participants were highly satisfied with the intervention. Suggestions for assessment and treatment program modifications are discussed.

The experience of becoming a refugee or migrating to a foreign culture is increasingly recognised to place young people at great risk for the development of psychopathology (Lavik, Hauff, Skrondal, & Solberg, 1996; Ying, 1999). Factors contributing to the psychological maladjustment of young refugees include the emotional experience of war stress (Zivcic, 1993), exposure to traumatic events (Weine, Kulenovic, Pavkovic, & Gibbons, 1998), and factors associated with the process of involuntary migration and resettlement, including family separation and acculturation problems (Baker, 1999; Magwaza, 1992).

Involuntary migration and resettlement places massive demands on the ability of young refugees to cope. Young refugees have been observed to react to such stress through the development of separation fears, social anxiety and withdrawal, eating disorders, sleeping problems, cultural identity confusion, and interfamilial conflict (Ajdukovic & Ajdukovic, 1993; Ying, 1999). The risk of symtomatology amongst refugees increases when parents become physically absent or emotionally unavailable to their children as a direct consequence of their own psychological distress, often associated with trauma and adjustment issues (Grunbaum, 1997). At the upper spec-

The authors gratefully acknowledge the staff and students of the Milpera School, Queensland, Australia, for their involvement in this study.

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trum of severity, stress-related reactions have the potential to develop into internalising problems such as anxiety. Such psychopathology may take the form of generalised anxiety disorder, adjustment disorder, and/or posttraumatic stress disorder. It is concerning to note that, despite the growing awareness of psychological distress in migrant and refugee populations, little clinical or research attention has focused on the adjustment of Australian migrants and refugees.

As a consequence of the civil war in the former Yugoslavia and other countries (i.e., most recently, East Timor), Australia has received a large number of refugee families. However, it is unknown to what extent immigrants and refugees to Australia experience psychological distress, or how the experience of forced migration may contribute to such stress.

Despite Australia's multicultural diversity, assessment and treatment protocols for non-Anglo Australian population groups are yet to be developed. Given the likelihood of significant psychological distress among refugee migrants, there is great demand on mental health agencies and government departments to increase the attention devoted to this issue.

Clinical Issues for Culturally Sensitive Interventions

Gong-Guy, Cravens, and Patterson (1991) reported that refugees in the United States who require mental health services are confronted with numerous challenges, including frequent misdiagnosis, inappropriate use of interpreters and paraprofessionals, and inappropriate treatment methods. Moreover, migrants whose cultural identity and values differ significantly from Anglo-Western society have pronounced difficulty accessing mental health services (Ying, 1999). According to Greene, Jensen, and Jones (1996), to overcome such cultural barriers, awareness of cultural self-identity becomes especially important for clinicians working with populations who are ethnically distinct. These authors advocate a constructivist approach to therapy, where existing therapeutic models are tailored to encourage "collaborative empowerment" in suitably applied crosscultural clinical settings. It is reasoned that culturally diverse clients become empowered through the construction of a therapeutic setting that encourages mutual explorative dialogue in the context of self-discovery and social learning.

This study explores the efficacy of an Australian standardised anxiety-prevention program that combines cognitive and behavioural techniques. Specifically, the program addresses anxiety and stress by focusing on physiological reactions, thought processes, and coping skills (for a detailed program review, see Barrett, 1999). While the necessity and considerations for a culturally adaptive intervention to be developed and evaluated in Australia have been outlined (Barrett, Turner, & Sonderegger, 2000; Sonderegger, Barrett, & Sonderegger, in press), culturally sensitive interventions have not been operationalised in the broader context of clinical practice prior to this study.

The Present Study

There exists an obvious need to develop a better understanding of the experience of young refugees entering Australia. Given the extent to which this group is at risk for the development of psychological problems, there is also a need to determine the effectiveness of "mainstream" interventions for use with refugees from non-English-speaking backgrounds (NESB). This information may then be used to modify interventions to ensure that they are culturally sensitive, appropriate, and as effective as possible.

The aims of the current study were twofold: (a) to assess the effectiveness of a group-based, anxiety intervention previously validated only with Anglo-Celtic participants and (b) to obtain information from the participants and facilitators regarding how the intervention could be improved to best cater for the needs of this specific group.

In keeping with past findings, with regard to the efficacy of the intervention, it was hypothesised that participants receiving the treatment program would report significantly fewer anxiety symptoms at post-treatment compared to pre-treatment. It was also expected that anxiety symptoms in the wait list group would remain stable over time. Finally, it was predicted that

the post-treatment internalising scores of the treatment group would be significantly lower than the corresponding scores for the waiting-list control group.

Method

Participants

Twenty female teenagers, ranging in age from 14 to 19 years (M = 16.3 years) participated in the study. All participants were from the former Yugoslavia; 11 identified their nationality as Bosnian, 6 as Croatian, 1 as Serbian, and 2 as Yugoslavian. Participants had arrived in Australia on average 2 months prior to their involvement in the study, and all had been granted refugee status. All participants attended a transitional school for NESB children. The government-funded school provides short-term assistance for students to aid them in their transition to "mainstream" high school. Acculturation into the Australian community is also fostered by simultaneously providing general education and training in the English language. On average, students attend the school for a period of 26 weeks. Students who appeared worried, sad, or stressed in class were referred by teachers to participate in the program. Students were recruited for internalising difficulties, not externalising or behaviour problems. Despite the participants receiving English language tuition, all preferred to converse throughout the program in their native tongue. Before commencing the program, prior English tuition of participants varied greatly from 0 to 1,092 hours (M = 395). All demographic information was obtained through the school's administration.

Measures

The Youth Self-report Form. (YSR; Achenbach, 1991). This aims to provide a measure of internalising and externalising behavioural symptoms in children aged 11 to 18 years. The checklist contains 112 items, which collapse to produce eight subscale scores. Three of these subscales combine to produce an adjustment score on the internalising dimension (withdrawn, somatic complaints, anxious/depressed), and two of the subscales combine to produce an adjustment score on the externalising dimension (delinquent, aggressive). The remaining three subscales (social problems, thought problems, attention problems) provide an indication of current social and occupational/academic performance. To determine the extent of participants' affective/anxious concerns, only those items contained within the internalising dimension were utilised in the present study. So as to be sensitive to potential trauma that participating refugees may have experienced during the war in their country of origin, one item regarding suicidal ideation ("I deliberately try to hurt or kill myself") was omitted, leaving a total of 30 items.

The Spence Children's Anxiety Scale. (SCAS; Spence, 1998). This is a measure of anxiety used with children aged 8 to 12 years. The SCAS consists of 44 items, 38 of which aim to assess six specific groups of anxiety symptoms (e.g., social phobia, separation anxiety, panic attack, and agoraphobia). The remaining six items are "filler items", included as a means of reducing negative response bias. The SCAS was employed to determine the specificity of anxiety problems that may be experienced by refugees.

Spence (1998), using a standardisation sample of 2,052 children aged between 8 and 12 years, investigated the psychometric properties of the SCAS. The SCAS achieved high levels of reliability, with a Guttman split-half reliability of 0.90 and an alpha coefficient of 0.92. A test-retest correlation of 0.51 (period between administrations was 6 months) was also obtained using 120 children from the standardisation sample. Spence (1997) found the SCAS to be acceptably correlated at .71 and .52 with the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978) and the Children's Depression Inventory (CDI; Kovacs, 1983) respectively.

Although the age range of the present sample falls outside the range of the standardisation sample used by Spence (1998), the scale was employed for its simplistic use of language, offering NESB students greater understanding of the terms and concepts in questions being

asked. Considering that the norms obtained by the SCAS, using non-ethnic children, are considered to be non-comparable with NESB students, the scale was adopted to reveal general trends of anxiety.

The Ambiguous Situations Protocol. (Barrett, Rapee, Dadds, & Ryan, 1996) This aims to assess the cognitive styles of school-aged children. The protocol consists of seven ambiguous social situations that are read to participants. Participants then record whether they interpret the situation as being neutral or threatening. The development of the protocol was based on the premise that cognitive biases found in children with various mental health problems would result in their interpreting ambiguous stimuli in a corresponding fashion. Scenario responses are coded according to whether the child interprets the situation in a threatening or nonthreatening way (nonthreatening scores ranging from 0 to 7), and whether they would respond to the situation in an avoidant or positive manner (positive scores ranging from 0 to 7). This device was used to assess the degree to which ethnic children would interpret ambiguous situations as threatening, and therefore be at risk for anxiety problems.

To determine the validity of the protocol, Barrett, Rappee, et al. (1996) compared the interpretations and responses of anxious, oppositional, and nonclinical children. Results indicated that, compared to the non-clinical children sample (n = 27), the anxious (n = 152) and oppositional (n = 26) children were more likely to interpret situations in a threatening manner. However, clinical groups differed in their responses to the situations. Anxious children demonstrated a tendency for avoidant behaviour, whereas oppositional children tended to respond aggressively, offering tentative support for the protocol's validity.

In addition to self-report measures, which are often criticised for their questionable validity among NESB populations, the Ambiguous Situations Protocol is considered particularly valuable as it also offers experimental evidence. The protocol's sensitivity to change makes it an excellent pre/post evaluation task, and allows for the discrimination between rates of threat-interpretation bias and rates of avoidance response (Barrett, Dadds, & Rapee, 1996).

Treatment protocol. The FRIENDS Program for Youth (Barrett, Lowry-Webster, & Holmes, 1999) is a 10-week, cognitive-behavioural, group-based anxiety intervention for youth aged between 12 and 17. The program can be used as a treatment for anxiety, or as a preventative intervention for the development of internalising disorders. The program aims to build resilience and to develop skills in participants that have been shown to help in the management of anxiety (e.g., problem solving, relaxation).

The FRIENDS program has a long developmental history, evolving from the Coping Cat (Kendall, 1990) and Coping Koala (Barrett, 1995) workbooks. The intervention focuses on group discussions about strategies for combating anxiety through experiential learning and peer learning models. The practical elements of the program include identifying the relationship between thoughts and feelings, learning to cope with worries, encouraging positive behaviours, and promoting positive family skills.

This model of therapy has been validated several times in Australia (Barrett, 1998). The FRIENDS program has been used successfully in several cognitive-behavioural based intervention programs for children and youth (e.g., Barrett, Dadds, et al., 1996; Barrett & Turner, in press; Dadds, Spence, Holland, & Barrett, 1997; Lowry-Webster & Barrett, in preparation). However, the intervention has not previously been applied to NESB populations. The present facilitation of the FRIENDS program incorporated the use of one clinical psychologist, and one bilingual public health administrator.

Treatment integrity. Group facilitators received training and supervision throughout implementation of the program. Each group facilitator completed the Program Integrity Checklist (Barrett, Lowry-Webster, & Turner, 1999). This checklist lists session-by-session content areas, and asks trainers to rate the overall effectiveness of their implementation. For each session, trainers check the items they feel they successfully completed during the implementation of each session, and provide overall Likert ratings on a number of dimensions of group-process skills

(e.g., listening, including children, use of positive reinforcement, setting home tasks, implementation of group problem-solving tasks, and completion of activities as outlined in the manual).

Social validity (Barrett, 1999). Additional ratings were collected at the end of the intervention in order to further assess the social acceptability of the intervention for participants. Participants were assessed using 15 items, such as "How satisfied were you with the group?" and "How much do you feel you learnt from the group?". Ratings were made on a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*very much*).

Procedure

Owing to the small percentage of former-Yugoslavian students enrolled with the transitional school at any given time, the treatment and waiting list conditions were not undertaken simultaneously. At the outset of the study, 11 students (mean age = 16.6) were accessed from their "care" program, which is a weekly class where students of uniform ethnic background typically meet and hold discussions together with a teacher who speaks the same language. This group, who on average had arrived in Australia 3 months prior, was assigned to the waiting list condition.

With the assistance of a bilingual member of the school staff, an experienced clinical psychologist administered the YSR, SCAS, and Ambiguous Situations Protocol to these participants. Prior to the administration of assessment and intervention, facilitators received training over 3 days in the administration of assessment devices, implementation of the FRIENDS program, and a follow-up evaluation. The assessment devices featured standard written English, so they were administered in a group format to ensure a complete understanding of each item. Questions were read aloud to the class and were subsequently interpreted by the trained bilingual staff member. Participants were instructed to tick the answer that best described them, and were given the opportunity to ask questions if they had interpretation difficulties. Ten weeks after the first administration of questionnaires, these participants once again completed the YSR, SCAS, and Ambiguous Situations Protocol. Ten participants in total completed both assessment administrations.

The second group of students was comprised of 9 individuals (mean age = 15.8) who were also accessed from the transitional school's care class. This group, who had spent an average of 1.94 months in Australia, was assigned to the treatment condition. As with the waiting list condition, participants were administered the YSR, SCAS, and Ambiguous Situations Protocol 1 week prior to the commencement of treatment. Participant responses were obtained in parallel fashion to the waiting-list control group.

The participants in the treatment condition were administered the FRIENDS program over 10 consecutive weeks, by the clinical psychologist and former-Yugoslavian public health professional. Each session was conducted in both English and the native language of the participants. At the conclusion of each session, participants were asked to complete the social validity scale (Barrett, Lowry-Webster, & Turner, 1999), which provided a record of the extent to which they enjoyed the session, and the extent to which they believed the material in the session would be useful in helping them to cope with stressful, anxiety-provoking situations. Based on in-session observations, the two facilitators of the group also recorded ways in which the program could be improved and tailored to better suit participants from this ethnic minority group. The facilitators also completed the Program Integrity Checklist (Barrett, Lowry-Webster, & Turner, 1999), a record of how well they considered they implemented the session.

One week following the program's conclusion, participants were again required to complete the YSR, the SCAS, and the Ambiguous Situations Protocol. Participants were also required to provide overall ratings of how much they enjoyed the program, and how useful they believed it to be. A total of 7 participants completed the post-treatment tasks, as 2 participants had graduated from the transitional school and went on to attend mainstream high school.

Results

In an attempt to reduce the likelihood of a Type I error occurring, only total scores and the general anxiety subscale scores of the YSR and SCAS were considered in analyses. Before undertaking analyses to test specific hypotheses, the data were checked to determine whether the waiting list and treatment groups were compatible, that is, both groups being representative of the same general sample, considering that they were assessed at different times. For the first assessment phase, *t* tests were conducted for both waiting list and treatment groups on all internalising measures, number of hours of former English tuition, and length of time in Australia. Results indicated that there were no significant differences between the waiting list and treatment groups.

A series of paired samples *t* tests was subsequently calculated for both the waiting list and treatment conditions to determine whether group means on the anxiety dimensions of the YSR, SCAS, and Ambiguous Situations Protocol had changed significantly from pre-treatment to post-treatment assessment. Table 1 presents means for the waiting-list control and treatment groups over the two assessment phases. Results of the contrast analysis for anxiety symptoms, as measured by the internalising dimension of the YSR, revealed a significant increase over time for the waiting list group, $t(9) = -4.10$, $p < .05$, scoring higher at post-treatment ($M = 17.2$, $SD = 3.60$) than the pre-assessment phase ($M = 10.82$, $SD = 6.00$).

For the treatment group, total anxiety, as measured by the SCAS, decreased significantly over time, $t(6) = 2.68$, $p < .05$, with scores being lower at post- ($M = 30.43$, $SD = 11.37$) than pre-treatment ($M = 39.89$, $SD = 13.22$). Accordingly, the Generalised Anxiety scale revealed a similar decrease over time for the treatment group, $t(6) = 2.52$, $p < .05$, participants scoring lower at post- ($M = 4.86$, $SD = 2.34$) than the pre-treatment ($M = 7.22$, $SD = 1.79$). Additionally, the mean number of ambiguous items interpreted in a nonthreatening manner on the Ambiguous Situations Protocol was found to significantly increase over time, $t(6) = -2.82$, $p < .05$, with scores at post- ($M = 5.86$, $SD = .69$) being higher than at pre-treatment ($M = 5.29$, $SD = .951$). Although pre/post measures on these scales reveal significant differences, they should be interpreted with caution as the variance of some participants' scores within groups (i.e., select participants reporting a substantial reduction in anxiety symptoms and interpretation of threat) was on occasion greater than the difference between pre- and post-intervention means.

A final series of *t* tests was calculated to assess whether differences existed between the post-assessment scores of the waiting list and treatment groups. Results indicated that the mean score of the waiting list group was significantly higher than that of the treatment group at post-assessment on the Anxious/Depressed subscale of the YSR, $t(6) = 3.29$, $p < .05$.

In order to determine whether the participants' length of time in Australia and amount of previous English language study had an effect on the scores on the dependent variables, analyses of variance (ANOVA) for each of these independent variables were calculated. No significant effects were found for these independent variables.

With respect to the intervention's social validity, the quantitative and qualitative responses of the participants from the treatment group were examined. Based on the social validation scale ranging from 1 *(not at all)* to 5 *(very much)*, the average response across weeks regarding how much participants enjoyed the session was 4.5, with the average rating of the concluded program being 5. The average response across sessions for how useful the intervention was in helping participants build resilience ranged from 4.25 to 5, with the average overall rating of the program's usefulness being 5.

Qualitatively, the participants' translated responses gave suggestions for improvement of the program related to the content of group sessions as well as the process for its administration. In terms of the program content, 85% of participants indicated that the program helped them deal with stress- and anxiety-provoking situations both at home and at school. The most frequent suggestions for improvement involved more emphasis on family support and relation-

TABLE 1

Means (and Standard Deviations) of Participant Self-report Measures for the Waiting-list Control and Treatment Conditions

	Waiting list[a]		Intervention[b]	
Scale	Pre	Post	Pre	Post
Youth Self-report				
Total Internalising				
M	10.82	*17.20	15.44	13.57
SD	4.71	3.43	4.50	4.28
Anxious/Depressed				
M	6.27	9.80	7.44	5.29
SD	3.17	3.08	2.83	2.93
Spence Children's Anxiety Scale				
Total				
M	30.64	34.20	39.89	*30.43
SD	13.54	8.48	13.22	11.37
Generalised Anxiety				
M	5.55	6.40	7.22	*4.86
SD	2.50	2.22	1.79	2.34
Ambiguous Situations Protocol				
Non-threat Perception				
M	5.00	4.50	5.29	*5.86
SD	.81	1.18	.95	.69
Positive Response				
M	4.20	3.90	4.29	5.00
SD	1.23	1.10	.75	1.29

[a] Pre-treatment $n = 11$, post-treatment $n = 10$. [b] Pre-treatment $n = 9$, post-treatment $n = 7$.
* Post-treatment measures significantly differ from pre-treatment measures at $p < .05$.

ships, more discussions and activities on normalisation of cultural differences, and a greater focus on the adjustment difficulties associated with migration. In terms of the process of the group, the majority of participants desired a greater opportunity for large-group discussion as opposed to talking with one other person or individually recording ideas. Analysis of the treatment integrity checklists indicated that protocol adherence was high across all 12 sessions.

Discussion

The main findings from this study indicate that, despite the small sample size, the efficacy of the FRIENDS program as measured by pre/post assessment appears to be adequate in reducing levels of anxiety in young NESB refugees, and deemed culturally acceptable by participants. However, the efficacy of the intervention should be interpreted with caution, as the sensitive nature of the pilot study has ensured the recruitment of few participants. Consequently, the statistical power for analysis is weak, and apparent post-treatment reductions in anxiety and threat interpretation should only viewed as intervention trends. The broad deviation in select participants' self-report measures may suggest that the intervention requires further adaptation to the cultural needs of former-Yugoslavian refugees to ensure maximum benefits from the program.

The aim of the study was to evaluate the effectiveness of an Australian standardised anxiety-intervention program with refugees from

the former Yugoslavia. It was predicted that those participating in the FRIENDS program would exhibit a reduction of anxiety symptoms from pre- to post-treatment. Although statistical power was evidently poor, this hypothesis was generally supported by the data trends. As anticipated, anxiety measures in the waiting-list control group did not decrease over time, but the internalising dimension of the YSR actually increased over the 10-week period between assessment intervals. Given the very recent migration experience of these participants and their families, and that the acculturation process often develops from initial idealisation of the new culture into disillusionment (Merrel, 1999), this finding is not surprising. Although the impact of migration, in terms of stressful life events, was not assessed in this study, it is an obvious factor that would contribute to the maintenance or advancing of anxiety symptoms over the 10-week period between assessment administrations.

Participants receiving treatment exhibited considerable pre- to post-treatment changes on the SCAS total score and the Generalised Anxiety subscale. Moreover, participants interpreted significantly more situations as being nonthreatening on the Ambiguous Situations Protocol at post-treatment than they did before the intervention. No significant change for the intervention group, however, occurred on the YSR. This finding is perhaps related to the discriminant validity of the scale. It is important to note that the participants' scores on the internalising measures of the YSR were within the "normal" range at pre-treatment, thereby explaining why there were only moderate changes from pre- to post-treatment. Previous studies have also shown a weakness in the YSR's ability to discriminate between clinical and nonclinical levels of anxiety (Johnson, Barrett, Dadds, Fox, & Shortt, 1999).

While the FRIENDS program appeared to be effective in reducing level of anxiety from pre- to post-intervention, comparisons of change in level of anxiety between the waiting-list control and treatment groups were less convincing. Findings indicated that only the mean Anxious/Depressed score of the YSR for the treatment group was significantly lower than that of the waiting list group at post-intervention. Considering that the intervention was not tailored to account for the specific cultural needs of this ethnic group, and that it did not account for the migration issues or intergenerational family conflict that often accompanies acculturation difficulties, it is likely that the previously Australian-validated intervention was not as effective as it could have been. In order for culture-specific therapeutic interventions to be effective, ethnically appropriate and sensitive procedures need to take into account multilayer contexts that account not only for anxiety, but also for family, acculturation, and self-identity issues (Baker, 1999; Westermeyer, 1989).

An additional aim of the study was to obtain information regarding how the intervention may be improved to best cater to the needs of this specific group. One example for modifying the FRIENDS program to be more culturally sensitive for this population relates to the process of the group. Participants indicated a desire for more opportunities to discuss issues as a large group (rather than with only one person next to them) and to verbalise responses in preference to writing them down. The observations of facilitators and reports from school staff confirmed that this particular population have a tendency for a greater degree of expression and general disclosure than Anglo-Celtic groups, despite the presence of internalising problems. In the design of the FRIENDS program for general use in Australian schools, it was considered undesirable to require group members to disclose and participate almost exclusively in a large-group format, as this may be anxiety producing for some participants.

One of the most frequently received recommendations regarding the content of the intervention related to the need to incorporate cultural and migration issues (e.g., adjustment difficulties) into examples and activities in the program. This feedback confirms the importance of this issue for refugees, and indicates that there was a corresponding desire to discuss not only traumatic or stressful events, but also participants' migration and post-migration experiences.

One important aspect of this study that may be improved in future research relates to the

way in which assessment of participants was undertaken. Considering that a formal translation and back translation was not performed on the assessment devices used in this study, the validity and crosscultural comparability of the data obtained may be questioned. Although all participants were provided with an interpretation of each question, there was no way of measuring the authenticity and consistency of the interpretation provided. Nevertheless, the procedure employed appeared to be satisfactory in helping participants grasp the meaning of, and provide a coherent response to, each question. Where circumstances permit, clinical interviews may be helpful to obtain a greater richness of information from participants than self-report measures alone. Despite the limitations of clinical interviews with refugee populations (e.g., difficulties in expressing feelings due to the individual's psychological distress; Gong-Guy et al., 1991), interviews conducted in a way that builds rapport with the interviewee would likely provide a better opportunity for the disclosure of information pertinent to an understanding of the individual's psychological state (e.g., the previous experience of a negative event relevant to the diagnosis of posttraumatic stress and other disorders).

The study described above represents an initial attempt to obtain information on the needs of this specific group and to accordingly tailor existing psychological interventions to promote their mental health. Future research examining the impact of migration in relation to anxiety would be greatly beneficial. In particular, studies investigating the impact of stressful life events may broaden our understanding of the difficulties that Yugoslavian youth experience, and the methods of psychological assistance most effective for this group. Although the quantitative and qualitative results suggest that existing interventions may alleviate psychological distress and be satisfactory for participants, it may be necessary to modify both the process and the content of programs to comply with the needs of ethnic groups, in order to maximise their effectiveness.

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